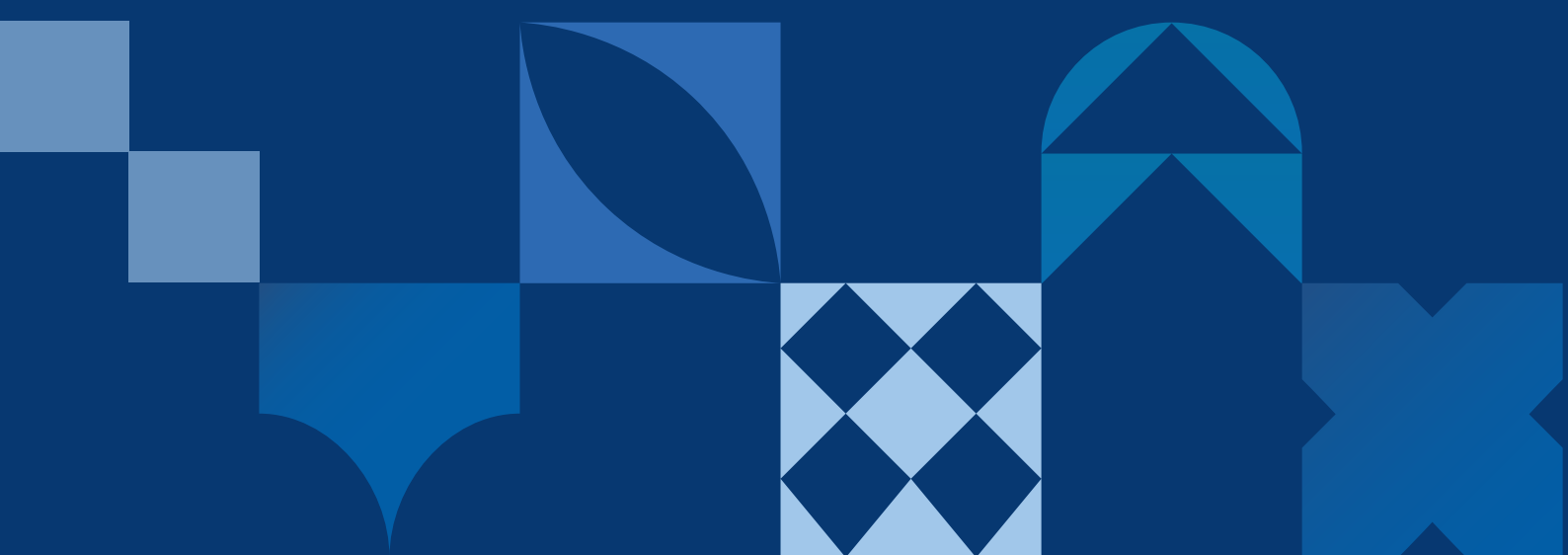


COLLEGE REPORT CR245

Job planning for psychiatrists

October 2026



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Foreword from the Registrar

I am delighted to introduce this report for which the credit very much goes to others. It was initiated by the previous Registrar, Dr Trudi Seneviratne, and many people across the College have contributed to its development. The report is titled 'Job Planning for Psychiatrists' and it is a response to the concerns raised by many psychiatrists about inappropriate or even undoable job plans.

To address this concern, each Faculty has been asked to write a chapter about the structure and activities specific to their area and to provide guidance regarding what would constitute an acceptable job plan. Psychiatrists work in a very wide range of settings and job plans will necessarily look different. I am aware that some people had hoped that the report would specify the number of patients a psychiatrist in a particular area should work with. Due to the wide range of different job settings, this has not been possible, however the report tackles issues such as clinical leadership, training, remote working and research and quality improvements activities. Guidance is also given on the time needed for assessments of different clinical complexity and the balance between clinical and non-clinical work.

Our hope is that this document will helpfully inform job planning meetings and support psychiatrists in identifying when organisational requests fall beyond this guidance.

The report is written for psychiatrists working in all four nations, and we have attempted to use common terminology where possible. To avoid this report becoming out of date, it will be available on the RCPsych website as a 'living' document which can be regularly updated as needed.

There is an important debate, wider than is possible in this report, about the role of the psychiatrist in our rapidly evolving health systems. Changes in workforce composition, emerging digital technologies and new models of service delivery are just a few examples of current challenges and opportunities. Over the coming months, as part of my

work as Registrar, I will be asking you to join me in further discussions about the best way to articulate and embed the role of the psychiatrist within multidisciplinary services. I look forward to hearing your views.

Finally, as with all College work, we welcome your feedback on this report and how useful you have found it. Please do not hesitate to contact me with thoughts on the report and any suggestions you may have.

A handwritten signature in black ink, appearing to read 'Owen Bowden-Jones', with a stylized, cursive script.

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Introduction

Initially released in 2017, 'CR207: Safe Patients and High-Quality Services - a guide for consultant psychiatrists' aimed to create a guide for job planners, setting out parameters for the provision and delivery of services in each of the psychiatric specialties.

Job plans can vary considerably between sub-specialties - by inviting each faculty to contribute, this document should give a clear guide as to what is expected in their psychiatric specialty. The updated document also moves away from the focus on consultant psychiatrists and should be considered for all psychiatrists.

Jobs will differ depending on many factors - location, service model and the population served being just a few - this document can serve as a starting point to ensure the correct components of the job description are accounted for.

There is 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.

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 Biopsychosocial Approach to Psychiatry

According to the [Royal College of Psychiatrists Strategic Plan \(2024–2026\)](#), psychiatrists will address the treatment gap (the disparity between those who need mental healthcare and those who received high-quality, safe, timely, therapeutic care) by taking a leadership role in re-establishing therapeutic relationships in mental healthcare. This includes developing relational skills, engaging in psychological approaches to personal development, normalising reflective practice, and embedding psychotherapeutic approaches within psychiatric training to support comprehensive biopsychosocial case formulation.

The Royal College of Psychiatrists advocates for a holistic approach to psychiatry in which all aspects of a person's lived experience, as well as their resources and vulnerabilities, are considered in building a comprehensive understanding of their mental health difficulties.

The Therapeutic Importance of Relationships within Mental Health Services

As leaders of clinical teams, psychiatrists need to be equipped with high-level communication, relational, and containment skills in order to offer compassionate, therapeutic, and safe care. There is emerging evidence of the importance of a trusting relationship with a psychiatrist in predicting response to medication (Konstantinidou et al., 2022).

Biopsychosocial Formulation

The capacity to formulate is at the heart of psychiatric care and is a core competency in training. The RCPsych supports a biopsychosocial approach to formulation in order to provide safe and effective care.

This biopsychosocial (BPS) approach recognises the complex interplay between a person's biological makeup (genetics, physical health, response to medication, etc.), psychological factors (personality development, attachment and relationship patterns, experience of trauma, etc.), and social factors (socioeconomic status, culture and diversity, employment, experience of discrimination, etc.) in conferring vulnerability to mental disorders.

Formulation brings together all available information to develop a coherent understanding of how a person's mental health difficulties have arisen, how they are maintained, and how they may be resolved. It is a dynamic, collaborative process involving clinical teams, patients, and carers. It underpins patient-centred care by ensuring that the individual is seen beyond their symptoms.

The purpose of a formulation is multifaceted. In addition to describing the patient's presentation, it seeks to explore a deeper understanding. It emphasises the central role of relationships in care and supports the development of management plans that are meaningful to the patient. The importance of safety planning, based on holistic risk formulation and psychosocial assessment, is strongly supported in NICE guidance and by NHS England (Self Harm, NICE Guidance, NG225, 2022., Staying Safe from Suicide, NHS England, 2025).

Alongside being experts in pharmacological, psychological, and social treatments and interventions, psychiatrists need to be equipped with high-level communication, relational, and containment skills in order to understand the central importance of clinical relationships and how these may be challenged and experienced by their patients, so that they can offer compassionate, therapeutic, and safe care. The ability to model this approach, and to support clinical teams to do so, is key to providing a trauma-informed approach to psychiatric management.

Job Planning Guidance and the Biopsychosocial (BPS) Approach

All psychiatrists must be equipped to deliver a holistic, bio-psycho-social (BPS) approach that prioritises a therapeutic relationship with their patients. Given the high prevalence of early trauma and social adversity among patients, psychiatrists must demonstrate leadership in navigating emotional distress and tolerating uncertainty. This involves containing complex emotional responses and understanding team dynamics. Furthermore, Consultant Psychiatrists must be equipped to hold in mind their patient's physical health concerns, family dynamics, and social disadvantage to ensure the delivery of truly comprehensive, person-centred care.

Psychiatrists must maintain competence in the full range of BPS treatments, encompassing medical, social, and psychological therapies, to deliver holistic, person-centred care based on containing complex clinical relationships and formulation. To support this, consultant job planning and CPD frameworks should explicitly recognise the diverse skill set needed within the practice of psychiatry.

The RCPsych Strategic Plan highlights the importance of reflective practice, including Balint groups, as well as coaching and mentoring. It also emphasises personal development as a core component of psychiatric practice. Psychiatrists may undertake additional training in psychological therapies to strengthen their relational and psychotherapeutic skills or engage in personal therapy to support their resilience and capacity to work with complex mental states. These activities should be recognised and incorporated within individual job plans.

References and links:

1.Konstantinidou H., Chartonas D., Rogalski D., Lee T. BJPsych Advances 2023;29(4): 265-273.

2.NICE Guidance NG225 – Self-harm: assessment, management and preventing recurrence (<https://www.nice.org.uk/guidance/ng225>)

3.NHS England, Staying safe from suicide – Staying Safe from Suicide National Guidance, 2025 (<https://www.england.nhs.uk/long-read/staying-safe-from-suicide/>)

Portfolio Careers

There has never been so much interest in the diversification of one's career. Many psychiatrists, similarly to many doctors (and maybe as a reflection of the nation's workforce as a whole) - are looking beyond 'the norm' and pursuing a different route. A portfolio career is simply one where a psychiatrist does not work for just one employer. In practice, this can mean a combination of many different options.

The common options include research, independent private work, medico-legal expert witness work, Mental Health Act (MHA) work – such as S12 assessments, second opinions (SOAD), tribunal work, occupational health assessments, teaching, training, writing and medical journalism, parole board work, GMC associate roles and advisory roles (e.g. NICE). All those roles would be paid. The most common roles that psychiatrists might take on are explored in more detail below. There are other interests and roles that would be unpaid, for example work for voluntary or charitable organisations, the Royal College or overseas voluntary work.

Those psychiatrists who pursue management roles in their own organisations, or who take on leadership roles with regards research or training, can create their own varied and rewarding mix of activities without necessarily having to explore working outside their organisation.

Mental Health Act work

Section 12 (2) work (Eng, Wal, NI), Approved Medical Practitioner (Scot)

Approval under S12 (2) of the MHA or becoming an AMP under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003, is usually a rite of passage for a resident having gained their MRCPsych. There is a simple process of application, with mandated attendance at a validated S12 induction course. Psychiatrists need to be registered medical practitioners with a licence to practice. Approval is not automatic or immediate but is usually complete in a couple of months. There is a different more in-depth process for those who do not have MRCPsych. For those who are psychiatrists, a minimum of four years full-time equivalent experience in psychiatry, preferably in a range of subspecialties, ideally following the structure of training that usually leads to MRCPsych, is required.

Associate Medical Practitioners (Scotland) are approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and perform statutory functions under that Act, including granting Short-Term Detention Certificates and providing reports in relation to Compulsory Treatment Orders. AMP approval brings specific statutory responsibilities, training requirements and medico-legal work that need to be recognised in the workload of psychiatrists. AMP status is subject to 5 yearly update training with specialist components for [forensic psychiatry](#) and [CAMHS](#).

Second opinion appointed doctors (SOAD in Eng, Wal, NI), Designated Medical Practitioner (DMP, Scotland)

The role of a SOAD, like that of a S12 approved doctor, is absolutely essential for the care of patients detained under the MHA. Given the statutory requirements for when an approved clinician (AC) must request a SOAD, there is no shortage of work! The role of the SOAD is to consider whether the treatment recommended is clinically defensible and medically necessary, and importantly, whether the views of the patients have been considered. A key issue is patient safety. SOADs are central to safeguarding the rights of patients detained under the MHA.

SOADs in England are recruited by the Care Quality Commission (CQC) who run an open recruitment system, with links to recruitment information on their website (2). Consultant psychiatrists with at least five years experience can apply. They need to be registered medical practitioners with a licence to practice and be members of RCPsych. They must be S12 approved or have been approved within the preceding 12 months if recently retired though this status does not need to be maintained while working as a SOAD.

There are equivalent application processes for Wales through the Health Inspectorate Wales.

There is an interview and the application process should be complete within 2-3 months.

Designated Medical Practitioners provide an independent statutory second-opinion safeguard in Scotland. The role is broadly equivalent to the SOAD role in England and Wales and Northern Ireland.

DMPs are appointed by the Mental Welfare Commission for Scotland to assess and, where appropriate, authorise certain treatments for people subject to compulsory treatment who do not or cannot consent. DMP work requires senior clinical judgement, independence, and detailed knowledge of consent to treatment provisions under Scottish mental health and incapacity legislation.

Mental Health Tribunal Doctor

These are the third in what could be considered a triumvirate of independent doctor roles linked with the MHA, all involved at different stages, but each with a crucial role to play. Unlike S12 approved and SOAD roles, being a medical member of the First-Tier Tribunal (Mental Health) involves explicit team working. Tribunal doctors sit with two other panel members (one legal and one lay specialist) and together they review the cases of detained patients and direct their discharge where the statutory criteria for discharge have been met. It is important to recognise that psychiatrists have powers above and beyond other doctors to compel patients to be in hospital and to comply with treatment against their will. Tribunals are one of the main safeguards that allow patients and the wider public to continue to allow psychiatrists this power and have trust in the system. Tribunals take very seriously the deprivation of liberty resulting from detention and consider very carefully the legality of ongoing detention.

The role of the medical member is to review the relevant reports and clinical information and, in approximately 60% of cases, the patient, in advance of the hearing and then use this information to help the panel opine regarding the statutory criteria. Medical members can also assist the panel when considering the capacity of the patient, communication and engagement issues, and how to address the patient with sensitivity based on their current mental state and any particular vulnerabilities. Given broader medical knowledge, the medical member will also be aware of wider health implications and risks of any treatment decisions made.

The Mental Health Tribunal for Scotland determines applications and reviews relating to compulsory measures under the 2003 Act. Tribunal panels include legal, medical and general members.

Medical members contribute clinical expertise to the Tribunal's decision-making, including consideration of the presence and nature of mental disorder, risk, treatment, care planning and statutory criteria. Medical members may meet or examine the patient before the hearing, depending on the circumstances and Tribunal procedure.

Medico-legal expert witness work

As expert witnesses, psychiatrists can be asked to draw on their knowledge and expertise to provide their opinion to help courts resolve specific matters. They are instructed by lawyers, usually for one party, but their overriding duty is to assist the court and their opinion needs to be impartial. This duty supersedes any duty the psychiatrist has to the instructing party, or indeed the party that is paying their fee. In some civil and family cases, there is provision to be jointly instructed by the different parties.

There is no 'minimum standard' legal requirement to becoming an expert witness. But it is necessary to be able to demonstrate and explain why a psychiatrist believes they have the necessary knowledge and experience to be able to offer an opinion in any given case.

Independent private work

There are several options if embarking on private clinical work. A psychiatrist can work on their own, running their own business, or can join something that is already established. Joining an established organisation means governance, administration, secretarial support, marketing and so on is managed by someone else. In the most straightforward of situations, such as working for online providers of psychiatric assessments (but also many organisations providing face to face consultations), agreement can be reached to do a certain number of consultations when the psychiatrist is most available. Where only assessments are undertaken, this is discrete and contained, with no requirement for ongoing clinical responsibility. While this can be advantageous for many, the disadvantages are that there is no opportunity to develop a service, or a relationship with a patient over time.

Practical considerations for all portfolio careers

Regardless of what sort of work is pursued as part of a portfolio career, if fees are being paid, they need to be declared. It can make financial sense to register as self-employed with HMRC. Registration for self-assessment and Class 2 National Insurance is also required. Getting the advice of a reputable accountant is often invaluable and they can advise best on the implications of being self-employed or setting up a limited company for example. HMRC has several flow charts which can help understand the processes but asking for specialist advice is often very reassuring.

Psychiatrists who are unpaid Carers

There are some psychiatrists with complex caring responsibilities and they should be supported to remain at work and thrive.

Job planning should take into consideration the individual needs of psychiatrists with complex caring responsibilities. Flexibility is essential to support colleagues with these requirements to ensure that the job is doable and sustainable. Consideration should be given to facilitating different ways of working that suit individual clinicians, including compressed hours, hybrid working that involves a mix of in-person work and virtual working as well as other innovative solutions that organisations may be able to support.

Not all psychiatrists with complex caring responsibilities may want or be able to avail themselves of less-than-full-time working, so it is important to consider how those willing and able to work full-time may be accommodated to continue to provide high-quality care to patients.

There should be explicit contingency plans in place to accommodate any unplanned leave so that the needs of the service are adequately managed, and the psychiatrist does not experience stress or worry when they need to take time off work to prioritise the caring needs of a loved one.

Remote Working

Remote consultations have been taking place within the NHS for a number of years, even before the pandemic. The pandemic itself caused a significant increase in remote working generally and the improvements in the technology related to remote consultations mean that employers see the employment of overseas doctors as an increasingly viable option.

The college supports innovations within the workforce in order to deal with the shortfall in capacity, where these innovations fall within a clear legal and clinical framework.

Job planning for remote psychiatrists should be the same as for in-person colleagues.

If the right job has been identified this should not present any issues. Job plans can be completed electronically and discussions and reviews done virtually.

Job Descriptions can be checked and approved for their feasibility by the College.

It is advised that employers devise a policy for remote working and that this should be reviewed regularly to accommodate any major changes in regulation and technology.

Consideration should always be given to following the principles of the UK GDPR and clinicians given training to ensure correct record management.

The [legal framework for remote working](#) has been published by NHSE; the college would encourage any psychiatrist or employer looking to recruit to these roles to follow this framework.

Job Description Approval Process

The Royal College of Psychiatrists provides an important service to those organisations employing psychiatrists by reviewing new job descriptions and offering advice to ensure that they are of a standard that enables the psychiatrist 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.

By engaging in the college approval process, employers can ensure that planned jobs are feasible and have the recommended balance between DCC and SPA that is required to ensure psychiatrists can fulfil each part of their increasingly demanding roles.

There is a wealth of information and guidance regarding the writing of job descriptions that does not need to be repeated here and are readily available at any time on our [JD Approvals](#) website.

Resources include:

- Exemplar job descriptions and checklists
- Guidance on Office Accommodation and Secretarial Support

While Health Boards in Scotland do not take part in the college process for the approval of Job Descriptions, there is an approval system run through the [Scottish Academy of Medical Royal Colleges](#) that performs a similar function.

Direct Clinical Care and Supporting Professional Activities

The table below represents the college recommendations on the allocation of DCC and SPA for full-time and less than full-time roles. Job descriptions will generally not be approved by the college unless they conform to these recommendations, which we think are necessary in terms of allowing the appropriate amount of time for psychiatrists to fulfil all aspects of their roles, including CPD and training. While less than full-time roles can be more negotiable, we would expect to see at least 1.5 SPA in any job plan to ensure psychiatrists have time built in to complete the necessary amount of CPD.

The College believes that seeking to reduce the number of supporting professional activities within any psychiatrists role risks losing the expertise of 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.

Psychiatrists directly contribute to teaching, training, quality improvement, service development and key governance tasks such as helping organisations learn from significant events. These activities not only improve patient safety and the quality of care but also help services adapt to the changing needs of our patients and keep up with advances in evidence-based care, ultimately improving the efficiency of services and saving resources.

SPA may also be used to take part in College roles which can be vital in developing strategies and actions that will affect policy and workforce across the UK. We would therefore urge employers to ensure that any college role taken by a psychiatrist is incorporated into the job planning process. There is a mutual benefit in allowing psychiatrists the leadership and improvement development that college roles can offer.

Consultant DCC and SPA Recommendations

Total PAs	DCC	SPA
10	7.5 7 (Wales)	2.5 3 (Wales)
9	6.5	2.5
8	5.5	2.5
7	5	2
6	4.5	1.5

SAS Psychiatrist DCC and SPA Recommendations

Total PAs	DCC	SPA Specialty Doctor	SPA Specialists
10	8	2	2
9	7	2	2
8	6	2	2
7	5.5	1.5	2
6	4.5	1.5	1.5

Clinical Leadership

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 remain up to date with the evidence-based treatments that should be provided. They should play a key role in leading service and quality improvement locally, regionally and nationally, ensuring the efficient and targeted use of limited resources. 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 typically 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.

Psychiatrists are often uniquely positioned to help identify and resolve complex problems and support staff through change.

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. Psychiatrists 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/carers groups and employers to improve public mental health and reduce stigma.

Training

Consultants supervising core resident doctors should have 30 min per new patient to review the patient and discuss the formulation and management with the resident 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.

Psychiatrists should have 0.5 PAs in their job plan for each resident or foundation 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, for which the college has produced its own guidance.

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.

Further details around supervision can be found in the [Silver Guide](#).

Research and Quality Improvement Activities

Psychiatrists 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 psychiatrists should be expected to support research and the careful evaluation of new treatments and methods of service delivery.

Importance of Research

- Research helps develop and strengthen the evidence base for mental health care, supporting more effective assessment, treatment and service delivery.
- Research drives innovation and enables new scientific discoveries to be translated into clinical practice.
- Academic and research activity supports workforce development, clinical leadership and policy influence.
- Research identifies unmet needs, evaluates services and informs improvements in mental health care systems.

Importance of Quality Improvement (QI)

- QI bridges the gap between best practice and routine care, helping to ensure consistent, high-quality services.
- QI provides a systematic approach to solving complex healthcare problems through continuous learning and adaptation.
- QI engages staff, patients and stakeholders in collaborative service improvement.
- PDSA cycles and the Model for Improvement allow safe testing of changes before wider implementation.
- QI improves patient safety, clinical effectiveness and patient experience through data-driven change.
- The College Centre for Quality Improvement supports assessment against standards and improvement of care quality.
- Participation in QI enhances team engagement, organisational learning and staff wellbeing.

Academic Psychiatry

The Academic Faculty of the Royal College of Psychiatrists considers academic psychiatry to be the business of all psychiatrists. However, it is well recognised that substantive clinical academic appointments are essential to the present and future of the NHS. Typically, a substantive clinical academic has undertaken the necessary training to become a clinical consultant or senior SAS doctor with sufficient postgraduate research training to work at a senior level (usually senior lecturer/associate professor or above) in a research role at a Higher Education Institution (HEI). Additionally, Psychiatrists working in formal educational or leadership roles within HEIs are usually considered to be substantive clinical academic psychiatrists.

Academic training varies, with no clearly defined 'ideal' path for an aspiring academic psychiatrist to take. One potential pathway is to follow the Integrated Clinical Academic Training pathway (ICAT). In England, ICAT routes include undertaking a National Institute for Health and Care Research (NIHR) Academic Clinical Fellowship. This may be followed by an externally funded fellowship to obtain a higher research degree (PhD/DPhil level). This is typically followed by a period of research at the equivalent of a postdoctoral researcher level (often as an Academic Clinical Lecturer) where additional research training and experience is acquired. In Scotland, Wales and Northern Ireland, there are distinct ICAT routes, which also offer the opportunity to pursue research, often with the opportunity to complete an externally funded PhD. Alternative pathways may be followed, with no requirement to follow the ICAT pathway, the range of potential paths to a career as a clinical academic psychiatrist are many and varied. It is also important for employers to recognise the unique skills and experience that may have been gained by the clinical academic psychiatrist in roles held outside of the UK, and at non-standard career grades.

When an academic psychiatrist is at the senior clinical lecturer / associate professor career stage (generally post-CCT), they will have typically obtained a higher research degree, have a record of peer reviewed research publications, student supervision, funding success, and engagement with relevant academic and scientific societies consistent with their career status as an emerging principal investigator and independent scientist. Related criteria apply for academic psychiatrists in medical humanities and educational roles.

A substantive clinical academic psychiatrist will often engage in research that includes (but is not limited in scope to) improving 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 the understanding and treatment of psychiatric conditions, as well as facilitating the application of evidence to clinical practice.

Clinical academics are generally expected to be very active in public engagement and thus make important contributions to the public understanding and recognition of psychiatry and allied disciplines. It is expected that substantive clinical academic psychiatrists will have the academic knowledge and skills that are commensurate with their career stage. Important clinical research can be also carried out by psychiatrists 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 an appraisal in line with the Follett principles. It is strongly recommended that joint appraisals are conducted, as this offers a number of potential advantages to the academic clinician and their employers.

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 with greater opportunities for patient engagement in research. This is likely to 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 (or in some cases, senior SAS doctor) and as a senior university academic.

They will often take on leadership opportunities across the full scope of their NHS (or other healthcare provider) and University roles. Appointments to these roles should reflect the challenges of balancing often competing clinical and academic demands. It is imperative that the Clinical Academic is able to work flexibly to meet these competing demands and this should be reflected in their job plan.

As research typically involves collaboration between different organisations and disciplines; well beyond the traditional clinical multidisciplinary team, clinical academics are well placed to maximise ideas and approaches from other medical specialties and intellectual disciplines (psychology, sociology, economics, systems theory, law, politics, physics, mathematics, biology, engineering, AI, etc.). Clinical academics also often have regional, national, and/or international leadership roles. Examples may include steering roles in organisations linked to their areas of specialism, leading on editorial activities (e.g. as an editorial board member of international peer-reviewed journals), and leading on multi-site grant submissions and research studies.

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 clinical practice. 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 with key stakeholders including policy makers and the public. 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.

Academic roles

The workforce of clinical academic psychiatrists has a key role in furthering 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 research. Clinical Academic Psychiatrists may lead on the delivery and quality assurance of teaching and training in psychiatry. For example, leading on the education of undergraduate medical students, other under or postgraduates (e.g. dentistry, psychology, neuroscience, nursing, social work, pharmacy, occupational therapy, law) and those in postgraduate clinical training. Clinical Academics thus have a key role in recruiting and training the psychiatrists of the future.

Information to support job descriptions and job plans

All Clinical 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 is generally expected that the funding will nominally fall into one of the categories below:

- clinical academic posts jointly funded by an HEI and the NHS (or other healthcare provider);
- clinical academic posts completely funded by the NHS (or other healthcare provider);
- clinical academic posts completely funded by an HEI

Clinical academic job descriptions should include all of the information required for a clinical job description of the relevant career stage. However, they should also set out the HEI roles that the clinical academic psychiatrist will be expected to undertake.

Within the clinical component of the job plan, The College strongly advocates for a minimum of 2 sessions of direct clinical care (DCC) and a minimum of 1.5 sessions of SPA for clinical academics. This SPA allowance should not be pro-rated and reflects a minimum allowance required primarily for CPD purposes. A clinical academic should have SPA time that is at least equivalent in duration to their clinical peers working the same WTE (as set out elsewhere in this document). It should be clear what this SPA time comprises, and additional SPA time should be considered when additional responsibilities are taken on by the clinical academic psychiatrist. In case of SAS psychiatrists taking on a clinical academic post, their job plans should follow the same principle as those for consultants.

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Addiction Psychiatry

This chapter should be read in conjunction with [College Document CR173](https://www.rcpsych.ac.uk) ([rcpsych.ac.uk](https://www.rcpsych.ac.uk)) outlining broad roles of Consultant Psychiatrists and other prescribers within Addiction Treatment settings.

A consultant in addictions psychiatry is a doctor on the GMC Specialist Register with a Certificate of Completion of Training (CCT) in general psychiatry with endorsement in Substance Misuse Psychiatry/Addiction, working to provide a full range of services to people with substance misuse, alcohol and Behavioural Addiction Disorders. Credentialling outside of formal training routes will be considered based on status of credentialing as agreed by the College and the GMC.

The evolution of addiction services through local commissioning arrangements leads to variance in services provided and or commissioned and who delivers them organisationally, this can range from NHS Trusts/ health boards/ UHB/ HSCTs, Independent/ Third Sector or Partnership/Sub-contracting arrangements between multiple providers. As a result, the specific role of any addiction consultant will vary based on the commissioned arrangement which requires a degree of flexibility in the job role.

Though commissioning landscapes are attaining a greater degree of stability, it cannot be overstated that the historic arrangements have led to a wide variation in the types of roles undertaken by an Addiction consultant, ranging from full oversight and governance to a service to specific and niche roles requiring the specific expertise of a consultant, community, In-patient/residential and Liaison roles supporting other services. This guidance therefore sets out broad principles rather than a defined exemplar to support the approval process of any given post.

Contracts and job descriptions approved by the Royal College would enhance the recruitment and retention of high-quality doctors and would be a requirement to support attachment of resident doctors and attract any additional funding associated with this role of the consultant or allow for training to be provided through this post should it be mandated as a future commissioning requirement.

In addition to the general roles set out in the job descriptions and job plans section of this document, a consultant in addiction 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, across a range of settings incorporating this into a robust person-centred biopsychosocial formulation and considering the best evidence-based approaches to address the acute intermediate and longer-term goals of any individual client whilst taking into account their capacitous choices and considerations of obligations under the care act and the Mental Health Act.
- 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 but not limited to antenatal and postpartum, and other complex groups which fall within the expertise of the addiction psychiatrist in the context of their specialist registration and any other areas of expertise.
- Particular expertise in diagnosing and managing comorbid mental Health and addiction disorders (COSUM as per terminology at time of writing this document).
- Expertise in complex prescribing delivery of novel or emerging treatment approaches for the treatment of addiction including risk balance decisions on legacy prescribing practices for longer term clients receiving medically assisted maintenance and recovery to a harm minimisation approach.
- Clinical supervision to a range of medical and non-medical practitioners involved in Prescribing, Psychosocial and mental health interventions.
- Providing addiction advice and liaison to general practice, other specialties within Psychiatry and medical/surgical specialties in hospital and community settings including interface with chronic pain management. either directly or in conjunction with local liaison psychiatry arrangements.

Leadership and governance role

Leading local clinical governance, client safety, quality improvement, and innovation in substance misuse services.

- Being the designated medical practitioner for NMP trainees.
- Liaison with commissioners to define and improve outcomes.
- Assuring 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.

Teaching and Training roles

This will cover a range of grades and professions dependent on service configuration including but not exclusively:

- Medical Students
- Foundation Doctors
- Core and Higher Psychiatric/GpVts residents in addictions.
- SAS doctors
- GPwsi doctors working within the treatment system
- Non-Medical Prescribers
- Team members
- External agencies requesting additional training or teaching

Consultants should be actively encouraged and supported in supporting training and development of addiction psychiatrists within their role to assure future workforce development.

Where medical residents are clinically supervised by consultants, It should be recognised that their inclusion in clinical activity must be commensurate to their grade and clinical activity is in the context of learning and development need and not to be considered as service provision in the context of expected targeted activity.

Commissioning and Contracting roles

Consultant addiction psychiatrists will be actively involved in commissioning, contract performance management, contract variation and tendering processes as they occur. Supporting and leading clinical aspects of service delivery as part of the local delivery team. It would be expected that a proportion of SPA time would be allocated in job plans for this function.

Information for Supporting Job Plans

Community consultants

It is recognised by the College that working patterns and indicative timetables will vary from role to role and individual negotiated circumstances of the employed consultant as jobs become more flexible to allow for reasonable adjustments, work life balance and to adapt to increasing consideration of 'portfolio' career options. Therefore an 'indicative timetable based on a '9-5 Monday Friday working pattern' has not been included with emphasis placed more on types of activity in the context of DCC vs SPA and retaining fidelity to the number of sessional PAs as agreed in the contract though this would be open to negotiation as part of annual job plan review.

The College faculty has placed no formal limits on case numbers, service numbers are ordinarily defined by the commissioners, and this will vary dependent on service and support infrastructure. But this should be kept under regular review and allow the consultant to adhere to GMC Good Medical Practice in terms of oversight and assurance for patients under their care. In this context, services will have clients accessing clinical interventions where direct oversight of consultants or medical prescribers may not be required for more straightforward cases, it would not be unreasonable to consider an agreed number of face to face indicative contacts.

Allocated DCC activity should reflect the expertise of the consultant role with emphasise on managing complexity and provision of assessment and reviews for the most complex clients seen within the service. It should not be expected for the consultant role to be focused on assessments for routine targeted activity and capacity demands outside of exceptional circumstances. Flexibility should be provided for time taken per assessment and review to reflect complexity, but a baseline expectation would be 1hr for a new assessment and 30 minutes for follow-up appointments to reflect complexity and allow adequate time to assess the complex biopsychosocial needs and risks of any individual.

A consultant addiction psychiatrist will work alongside other prescribers, Clear governance and accountabilities should be identified as to who holds specific accountability for prescribing within the system and that sufficient DCC sessions is apportioned to ensure appropriate time for robust clinical supervision of other prescribers in the system. It should be recognised that best use of a consultant's time and expertise is in provision of robust responsive

and accessible supervisory and governance support to prescribers and teams to empower guided decision making, as well as the management of potential risk aspects in any delivery of treatment interventions, as well as early involvement in complex cases for guidance and consideration of escalation as required.

Where consultants are working in an addiction service which is not specifically commissioned as a Dual Diagnosis/COSUM Service commissioned to provide mental health care coordination, it must be explicit that the addiction psychiatrist would NOT provide an RO (responsible officer) function for clients under the care of the service who have or are later identified to have secondary care level mental health needs. As per NICE and COSUM guidelines such clients will be supported with their substance misuse needs, but ongoing care coordination and mental health needs would be the responsibility of the appropriate community mental health services and not 'default' to the addiction psychiatrist working in a complementary role. There would however be an expectation of close working and liaison with relevant secondary care community/crisis and liaison services to support transitions of care boundaries and to advocate for clients not in receipt of appropriate interventions.

The College and Faculty welcome the opportunities and flexibility provided by remote and online working both in terms of job role and accessibility to clients of senior assessment and review when covering dispersed catchment area. This is to be delivered in line with existing Royal College and GMC Guidance on remote and online working best practice. It must however be recognised that any client under a service will need at times an in-person/face to face assessment and reviews with the team consultant. Complex clients cannot universally be reviewed and managed exclusively through virtual contacts and so any post which does not include an agreed commitment to in-person reviews would not be approved.

There would be an expectation for the job to maintain fidelity to 7.5:2.5 DCC SPA apportionment and equivalencies for less than WTE working as a minimum SPA requirement. This could increase depending on the specific SPA requirements of the post.

DCC Examples

- F2F/ Virtual Clinical Activities
- MDM
- Clinical Supervision of Doctors and NMP/AHPS
- Clinically related Admin/Letters/Communications
- Review and prep/signing of prescriptions.
- Other Clinical Meetings/ care planning reviews,
- Clinical case discussions
- Travel Time associated with Clinical activity off main site. Within contracted hours.

SPA Examples

- CPD
- Clinical Supervisor/ Educational supervision/CBD provision 1hr per trainee per week. CBD 1hr per case discussion
- Appraisal Activity
- Service-related Operational and governance meetings Inc DRD/Mortality meetings.
- Case Conferences/ learning events, group teaching,
- Qi Projects not otherwise covered through additionally contracted work.

Administrative support/medical secretary access

Administrative Support would be in keeping with the guidance in this document,

It is recognised that teams may be configured and commissioned in a way where administrative support may sit across organisations. That said dedicated named administrative support/medical administrative support who can work to a level and function of a medical secretary (AFC band 4 administrator) should be available to support the administrative and organisation/diary planning needs of the consultant to maximise efficiency.

Cover for Annual Leave/Study Leave off site activity and unplanned absences

The community role particularly in dispersed regions do not easily lend themselves to job planning and activity based on a single site of delivery. This being the case contingencies should be in place to cover the requirement of urgent and or prompt provision of prescribing continuity and or re-titration of OST and or other medically assisted interventions which should not be solely reliant on the presence of a Consultant Psychiatrist to physically be present at a given location to sign and make logistical arrangements for provision paper prescriptions. When working remotely, there should be access to prescribers who can conduct this function and or act under consultant guidance where deemed clinically urgent.

Where equivalence cross cover arrangement isn't feasible between Addiction Consultants, clear provision must be available for appropriate experienced and trained cover to be available to support standalone consultant roles either through competent Consultant cover within the organisation or through provision of direct cover for planned or unplanned absences.

Inpatient Addiction Services

In-patient provision may be delivered either through the NHS through Specialist treatment units, through Third/independent sector provision or a hybrid model of delivery.

Clear governance structures must be in place depending on the commissioned arrangement and relationship to the Unit and the Addiction Consultant Psychiatrist who would be responsible for clinical decisions relating to the patients admitted to and discharged from the unit.

Support resources in terms of staffing medical/non-medical and out-of-hours provision should be in place as agreed through commissioned structure in accordance with local and/or national guidance for in-patient provision.

This should include:

- Supporting medical staff, residents and SAS doctors working supporting the provision
- Nursing provision and support staff
- Specific plans and protocols for out of hours cover arrangements and local access to emergency medical or psychiatric Interventions outside of the skills and resources of the In-patient Unit including Escalation processes and relevant roles and responsibilities between medical staff and unit operational management staff/lead nurse AHP.

Staffing should consider the number of beds, expected throughput/flow and levels of interventions commissioned to be provided in the environment. And in Keeping with current approved guidance for Inpatient Provision.

Activity in the context of DCC/SPA would retain fidelity with the categorisation of activity and 7.5/2.5 split based on a WTE post and modified as appropriate for less than WTE commitments.

Liaison Psychiatry Addictions role

Guidance in the context of approval for Liaison Psychiatry approval will be covered in the relevant section of this document for Liaison Psychiatry. Where Consultants are working in conjunction with or part of a liaison psychiatry team clear roles responsibilities and cross cover aspects should be incorporated and where Consultants are working outside of their roles on the specialist register that there are assurances around support structures and training/supervision when assessing and managing clients outside of their specialist area of practice.

Out of Hours Commitments

In keeping with work life balance and to encourage a diverse and representative workforce, strong consideration should be given for out of hours work to be considered as an optional commitment rather than a contracted expectation of the role. It is recognised that this is not routinely an expectation for consultants working in the third and independent sector and as such this should be reflected within NHS Consultant roles. It should Also be Recognised that many Addiction Psychiatry Posts are stand-alone Consultant posts, without routine availability to cross-cover availability. Where this is the case If out of hours on-call commitments are part of any planned role, this should include provision of adequate cover options through the existing clinical workforce such that if adequate rest is not attainable, that no planned care activity is expected the subsequent day that would impact on targeted activity or complex cases where cancellation or lack of equivalent expertise is available to carry this activity out. i.e. college approval will not be contingent on an on-call commitment but will need to maintain their A/C R/C and Sectional 12 (2) approval status and will need to engage with the relevant requirements to retain these.

Portfolio Positions

Where posts are offered at less than WTE or consideration is given to portfolio job descriptions, sufficient time allocation should be afforded in the context of DCC: SPA for agreed sessions attached to the post for role specific activity. Clear Lines of accountability will be required to include RO responsibilities and relevant Appraisal/Revalidation Aspects to Cover the full scope of the consultants work in Line with GMC Appraisal and Revalidation requirements.

SAS Psychiatrists

For SAS jobs to gain college approval they should adhere to the broader guidance related to job plans and broader agreed ratio for DCC:SPA with activities categorised as per examples above for community posts.

SPA time should be ring-fenced to allow for productive use of this and due consideration and encouragement should be given to allow for further career development to include adequate time and resource for meaningful supervision outside of clinical case supervision (a DCC activity) and to encourage career progression if desired to consultant grade either through supporting in obtaining membership of the royal college and higher specialist Training or to consider alternative routes (e.g. Cesar or emerging credentialing opportunities).

It is recognised that the SAS role incorporates a range of experience and expertise and requirements and supervision available to those in SAS roles should be commensurate with their level of training, experience and expertise and this to include being allocated supervisory roles to other professionals where they have the relevant training and infrastructure to support this work.

Child and Adolescent Psychiatry

The primary role of a consultant child and adolescent psychiatrist is to use their skills as an experienced medical professional to work collaboratively with children, young people and their families/ carers to achieve the best possible outcomes. With knowledge of child development, physical health, psychopharmacology, emotional health, therapeutic modalities, families, safeguarding, complex systems and interpersonal relationships, as well as psychiatric conditions and substance misuse, child psychiatrists are best placed to apply an integrated biopsychosocial model in understanding, diagnosing and managing mental illness, emotional disturbance and behavioural difficulties. There has been an increase in prevalence of mental health conditions in children and young people in recent years, with increasing risk and complexity, which has contributed to an increased workload for child and adolescent psychiatrists. In addition, many young people who in the past would have been treated in hospital are now cared for in the community (e.g. using intensive home treatment) which results in increased need for psychiatric input.

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 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 mental health concerns in parents. While it would not be expected for them to directly assess and treat parents, they are well placed to liaise with primary care or relevant adult mental health services, with the consent of that person. In addition, their adult mental health training and experience

enables them to support transition of young people to adult mental health services, usually at age 18 (although there may be local service variation).

- 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 and evidence-based practice
 - 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 complex information, including knowledge of mental illness, child development, interpersonal/family dynamics, Children's Act legislation, 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, which includes flexibility needed to respond to urgent situations at short notice.
- Taking part in and attending care programme approach (CPA) reviews, other care and treatment reviews (e.g. CeTRs in England) and looked after children (LAC) meetings, including children and young people admitted to inpatient units or 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 tasks in job plans.
- Supporting the emotional development and early identification of neurodevelopmental and mental health conditions in infants and those under 5 years old.
- Assessment and advice to social care and youth justice with regard to the developmental, mental health and welfare, and criminogenic needs of children and young people.
- Prescribing will be a part of the Consultant's role, but not solely; they have a tremendous variety of clinical skills and training, and application of a biopsychosocial model to inform comprehensive assessment and treatment for children and young people.

Leadership Role

Consultant child and adolescent psychiatrists will have an inherent leadership role within their clinical teams and services, even if they do not have a formal leadership job.

- 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. Some roles, such as Deputy/Chief Medical Officer (CMO) or Medical Director would have a separate job description and job plan, whereas other tasks e.g. RCPsych would fall under the usual consultant contract and additional responsibilities or SPA time, and would be agreed as part of the job plan negotiation locally.
- Governance tasks should also be factored in to the job plan, including the investigation of incidents and complaints, which are often tasked to consultants and can be time-consuming.

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 may 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. Some of these tasks can be carried out and supported by other members of a MDT and would not be expected to be done solely by the consultant.

Child and adolescent psychiatry covers the full range of psychiatric disorders, including conditions 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 arrangements, 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, which may vary depending on local geography.

A standard community follow-up appointment would be 1 hour and for new patients 90 minutes minimum, with additional time needed for required paperwork. 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 reviews may be shorter.

Geographical and Demographic Factors

Factors within the catchment area to consider include:

- deprivation indices
- inner city v. rural and very remote areas
- 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 sub-specialties (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.

In principle, the Consultant should not usually be holding cases alone: they should be co-worked and shared with other clinicians in the multi-disciplinary team and/or have a separate Care Coordinator. The role of the Consultant is more around offering consultation to a team and network, and time should be allowed for this important part of the role in the job plan. This is a particular aspect of the child and adolescent psychiatrist role, due to the nature of MDT working and working with schools, social care etc. It is suggested that at least 1PA is needed per week for consultations to a team, and 1PA to the wider network of children and young people's services.

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, and time should be allowed for this within job plans. 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, specialty or resident 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 residents 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. 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. As outlined above, at least 0.5PAs should be allowed in the job plan for each trainee supervised by the consultant. This allows for the required 1h per week direct supervision, as well as time for more informal ad hoc supervision/advice and time to have joint clinical appointments. Additional time will also need to be allowed for educational supervision roles and should be negotiated locally depending on the number of educational supervisees.

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.

There is such variation in types of job role within the specialty and variation in services that it is difficult to give recommended numbers for caseloads. For example, a specialist service such as early intervention for psychosis may have low caseloads but higher intensity; vs. an ADHD clinic might have high caseloads; vs. liaison role would have a transient but complex patient group. This should be discussed locally according to job role and service needs, and agreed collaboratively in an individual consultant's job plan, to consider the type of clinical role, risk, complexity etc.

Caseloads should be determined through a robust job planning system which takes into account number of assessments, complexity of patients, review appointments, and consultation appointments to ensure that the consultant has an effective case load number which should be seen as a ceiling not a floor. The vital consultative role should be included as DCC in addition to work on an allocated caseload: to include reviews, consultations to MDT or networks and assessments that may not lead to ongoing direct support. It is likely that 2 sessions a week (pro-rata for less than full-time) will be required for consultation given the make-up of a multidisciplinary team and multi-agency networks. Flexibility will be needed in the division of PAs depending on the number, risk and complexity of a caseload at any given time.

Clinical admin needs to be allowed for within DCC time. There is a particular admin load for the Consultant Child and Adolescent Psychiatrist e.g. increased requirement for networking compared to other specialties. Also, they are likely to need to write more letters than other MDT members e.g. need to write a

letter each time medication is changed, vs other MDT members may update the GP only once per 6 months. In principle, clinical admin time is likely to equate to the direct clinical time again.

Consultant child psychiatrists would not usually do the initial assessment in a service: new referrals would usually be seen for an initial assessment by another MDT member who refers on to psychiatry internally if required. It is important to ensure the Consultant sees the appropriate patients in the service who really need their skills, experience and training e.g. due to risk, complexity, and/or medication requirements.

In principle, the Consultant should not usually be holding cases alone: they should be co-worked and shared with other clinicians in the multi-disciplinary team and/or have a separate Care Coordinator.

Given the huge variability in roles and services, it is not possible to specify precise splits of DCC and SPA sessions. However, the following serves as a guide for which particular tasks should be considered as part of these PAs for a child and adolescent psychiatrist (in addition to the general DCC/SPA guidance in the introductory section of this document):

DCC:

- Direct clinical work with children, young people and families
- Clinical work includes emails and telephone calls in relation to cases, as well as any clinical administrative tasks, including letters, reports, completing forms
- Consultation to the MDT and wider network is a core part of the role and requires more DCC time than other specialties
- Consultations around safeguarding and key legislation to MDT and networks
- Includes joint clinical appointments with residents on placement: as even higher residents may be new to child and adolescent psychiatry, they are likely to need more direct clinical shadowing and observation
- Family work is a core aspect of the work of a child psychiatrist, with more time needed for direct clinical work and liaison with families, parents and carers

SPA:

- Weekly supervision with resident doctors
- Ensure remain up to date with key relevant legislation e.g. safeguarding, Children Act
- Service development activity in local area

There would need to be a local conversation and negotiation around the particular local circumstances and skills of that consultant to agree this.

Community CAMHS

The individual consultant caseload will vary considerably depending on local need and it is therefore not possible to specify numbers in general. The expectations of an individual consultant should be negotiated locally taking into consideration the type of service, complexity of cases, nature of the clinical work, skill mix of the team and other factors as described earlier. A lower caseload would be appropriate for consultants engaged in a highly complex or high-risk clinical patient group, or where there are less than adequate consultant or multidisciplinary staffing numbers or skill mix. A higher caseload would be appropriate for a patient group of predominantly uncomplicated medication reviews.

An indicative reasonable workload for a 10PA consultant would be 1-2 'new to psychiatry' cases per week pro-rata, but not usually personally completing a whole new assessment (which usually involves more paperwork and liaison): as above, this would more appropriately be done by another member of the MDT.

They would also offer a number of follow-up slots, including individual interviews, family meetings, case reviews, but could also include network meetings, consultation, safeguarding meetings, etc. 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. Many community CAMHS consultants will also need to work with acute hospital services for children and young people admitted to hospital, including to provide responsible clinician (RC) cover under the MHA, especially as many acute paediatric services do not yet have CAMHS-Paeds liaison services.

Owing to the variation of service design, funding arrangements and multidisciplinary teams, it is difficult to recommend numbers of consultants in relation to population numbers.

As above, due to the variation of services, DCC and SPA figures are indicative only and should be negotiated locally in terms of the precise job plan, although the child and adolescent faculty strongly supports the split of 7.5 DCC and 2.5 SPAs for a full-time consultant.

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 and sufficient time for liaison with families and other agencies.

The caseload, 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 caseload for a 10PA psychiatrist is 10-12

beds (RCPsych QNIC standards recommend 1 WTE consultant for a typical 12 bedded unit). For a unit entirely focused on emergency admissions, the caseload will be lower. For a unit operating in a less acute setting or with many planned admissions, the caseload may be higher. 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.

Specialist Outpatient Services

Services that provide specialist assessment and treatment, often via a liaison and consultation model (e.g. national specialist services, community forensic psychiatry, FCAMHS), on a regional or national 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 are often provided 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.

Paediatric Liaison

Paediatric liaison refers to the psychological/psychiatric care of children and adolescents in paediatric settings who:

- Present with an acute physical health illness (e.g. asthma) and have a co-morbid mental health illness (e.g. anxiety) that makes treatment of the acute physical health illness difficult.
- Present with an acute / chronic physical health illness (e.g. diabetes / encephalitis) and develop symptoms or signs of mental health illness.
- Present with physical health symptoms but where no physical (organic) cause is found for the symptoms (e.g. non-epileptic seizures)
- Present with acute mental health illness.

Paediatric liaison work is therefore not just child and adolescent mental health services providing in-reach support to paediatric services (wards, outpatients or emergency departments) for children and adolescents presenting with acute mental health illness or in crisis. Paediatric liaison is integrated work between mental health and paediatric services to provide timely concurrent physical and mental health care to children and adolescents.

Infant Psychiatry

An Infant Psychiatrist is a specialised psychiatrist who focuses on the mental health and well-being of infants and very young children. They assess, diagnose, and treat mental health conditions, developmental concerns, and behavioural issues in the early stages of life. The role involves working closely with parents, caregivers, and a multidisciplinary team to provide comprehensive care. By providing early intervention and support, Infant Psychiatrists contribute to the overall health and resilience of infants and their families with positive lifelong effects.

Key Responsibilities:

1.Assessment and Diagnosis:

- Comprehensive assessments of infants to understand their emotional, social, and developmental well-being.
- Diagnose and treat mental health disorders and developmental challenges in infants.
- Consideration of the impact of parental genetic and environmental factors including use of substances or pharmacological treatments during pregnancy

2.Therapeutic Interventions:

- Treatment plans for infants, incorporating psychotherapeutic, systemic and medical interventions based on evidence-based practices.

3.Collaboration with Parents and Caregivers:

- Work closely with parents and caregivers to understand family dynamics and provide strategies and support in fostering a healthy and nurturing environment.

4.Team Collaboration:

- Multi agency and multidisciplinary collaboration to discuss complex cases and provide coordinated care.

5.Education and Training:

- Provide education and training to parents, caregivers, and other healthcare professionals on infant mental health topics.

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principle as above. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference,

which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Psychiatry of Eating Disorders

Consultant Psychiatrists specialising in Eating Disorders bring advanced expertise in the assessment and treatment of complex conditions including anorexia nervosa, bulimia nervosa, binge-eating disorder, and related presentations. In this role, consultants develop highly specialist skills not only in psychological and behavioural aspects of these disorders, but also in managing their acute and long-term physical health consequences.

Eating disorders frequently coexist with other psychiatric conditions such as obsessive-compulsive disorder, mood disorders, personality difficulties, and neurodivergent profiles. The Consultant Psychiatrist plays a vital role in navigating this complexity, delivering holistic, formulation-driven care that integrates both mental and physical health perspectives.

Consultants work across the full treatment pathway — community, intensive outpatient, and inpatient settings — as part of a skilled multidisciplinary team alongside dietitians, psychologists, specialist nurses and therapists. Beyond direct patient care, they act as a trusted source of specialist advice to wider health and social care partners, strengthening system-wide confidence in the assessment and management of eating disorders.

A key element of the role includes providing senior clinical leadership in the application of the Mental Health Act and related legal frameworks. This includes nuanced consideration of mental capacity, best interests, proportionality of intervention, and the risk of iatrogenic harm — areas in which specialist expertise is essential.

As eating disorder services continue to evolve, Consultant Psychiatrists play a central role in:

- Service development and innovation
- Designing integrated care pathways
- Supporting safe and effective resource use
- Strengthening partnerships with primary care, acute hospitals, and liaison psychiatry

The role offers meaningful opportunities to influence new models of care and improve outcomes for a highly vulnerable patient group.

Consultants lead the development of individualised treatment plans and support multidisciplinary teams in managing complex or high-risk presentations. Effective care is underpinned by an integrated approach combining psychological therapies, psychoeducation, dietetic support, and medical management.

In addition, Consultant Psychiatrists contribute to the sustainability of the future workforce through the supervision and development of higher and core trainees. Participation in reflective practice, peer supervision, and teaching is actively encouraged and supported within Supporting Professional Activity (SPA) time.

Clinical Role

1. Lead on the comprehensive assessment of patients with eating disorders, offering specialist advice through consideration of differential and comorbid diagnoses, requesting appropriate investigations, and supporting the multidisciplinary team.
2. As part of the multidisciplinary team, ensure patients receive evidence-based treatments such as enhanced cognitive behavioural therapy (CBT-E), family-based interventions, MANTRA (Maudsley Model of Anorexia Nervosa Treatment for Adults), or specialist supportive clinical management. The consultant psychiatrist provides clinical leadership and oversight of these interventions but will rarely deliver psychological therapy directly. They are responsible for formulating individualised care plans for complex patients, including consideration of alternative diagnoses where there is limited response to first-line treatment.
3. Provide psychopharmacological assessment, prescribing, and monitoring where indicated.
4. Assess medical and psychiatric risk and advise on safe management in collaboration with patients, carers, and relevant internal and external stakeholders.
5. Assess and manage the physical health sequelae of malnutrition, including escalation to general medical and primary care colleagues where appropriate.
6. Provide in-reach support to acute medical wards and general adult psychiatry wards to support the management of eating disorders in these settings.

7. Demonstrate knowledge and appropriate use of mental health legislation in England or the devolved nations in the management of patients with eating disorders, providing clinical leadership in relation to ethical considerations and safeguarding.
8. Prepare reports to support patients with eating disorders in relation to relevant legal frameworks, including Mental Health Review Tribunals, courts, and matters relating to social care, employment, education, training, and access to benefits.
9. Work with the wider multidisciplinary team to ensure seamless transition from CAMHS to adult services, in line with national guidance for young people moving through services.
10. Work collaboratively with the multidisciplinary team, including attending CPA meetings where appropriate, to support transition from inpatient to community care and reduce the risk of relapse following discharge.
11. Provide specialist advice and guidance for the management of complex cases, including patients requiring intensive, compulsory, or multi-agency treatment.
12. Contribute to the local implementation of national best-practice guidance, including NICE eating disorder guidelines.
13. Work closely with families, carers, and people with lived experience of eating disorder services to support continuous quality improvement and service development.

Leadership Role

1. Provide clinical leadership in the development, implementation, and embedding of local good-practice guidelines and care pathways for eating-disorder services. Active engagement with relevant regional and national Royal College of Psychiatrists (RCPsych) bodies is encouraged.
2. Lead liaison with managers and Experts by Experience to promote co-production and support service development, including pathways for the management of patients with eating disorders in acute hospitals and general adult psychiatry wards.
3. Engage in regional discussions with commissioners and provider organisations to support the development, sustainability, and funding of eating-disorder services.
4. Work in partnership with managers and commissioners to provide leadership on safe medical risk management, including community-based medical monitoring arrangements.

5. Take an active leadership role within local and regional clinical networks to enhance understanding of eating disorders and promote collaborative working across professional groups, with a focus on improving quality and standardising care across services.
6. Lead or supervise quality-improvement activity informed by patient- and carer-reported feedback, clinical outcomes, and service-level data.
7. Contribute to a research-active culture by supporting recruitment to studies, contributing to publications, and encouraging engagement with research within eating-disorder services.
8. Work with key stakeholders and commissioning organisations to identify and address health inequalities, including those related to ethnicity, gender, age, disability, and comorbidities such as autism spectrum conditions.

Educational Role

1. Take an active role in undergraduate and postgraduate medical education, delivering teaching across all levels from medical students to higher specialist residents. Provide educational and clinical supervision to foundation, core, and higher psychiatry residents, and teaching to medical students, in line with Royal College of Psychiatrists (RCPsych) standards.
2. Deliver teaching and training to staff working within specialist eating-disorder services and other mental health teams to enhance knowledge and skills in the evidence-based assessment and management of eating disorders
3. Contribute to the education and training of staff working in relevant partner agencies, including primary care, acute trusts/ health boards, and third-sector organisations, with the aim of reducing stigma and promoting awareness, early detection, diagnosis, and effective management of eating disorders.

Information to support Job Descriptions and Job Planning

1. There is wide variation in the staffing, configuration, and delivery of eating-disorder services across the UK. This variation is particularly evident between children and young people's, adult, and inpatient services, both in staff background and staffing levels. While the principles of evidence-based treatment remain consistent, consultant recruitment and retention remain challenging. It is therefore essential that job descriptions include safe and manageable caseloads, and that trusts provide support for individual career development, including opportunities for research and senior leadership.

2. Current guidance for consultant psychiatrist provision in children and young people's community eating-disorder teams is 1.2 consultant psychiatrists per 100 annual referrals, or 4.5 consultant psychiatrists per 1,000,000 population (Access and Waiting Time Standard for Children and Young People with an Eating Disorder, NHS England, 2015).
3. There is considerable variation in service design across adult eating-disorder services nationally. Given the inherent clinical complexity and associated physical and psychiatric risks, commissioners must ensure that services adhere to safe staffing levels. The faculty of eating disorders recommends the following 1.5 whole-time equivalent (WTE) community consultant psychiatrists per 1,000,000 population; however, this should be adjusted according to local referral rates. As a minimum, services should aim for 1.0 WTE consultant psychiatrist per 200 accepted referrals per year in a service that aims to treat a range of eating disorders.
4. For inpatient eating disorder services, consultant psychiatrists should be allocated 10 programmed activities (PAs) per 12 beds. This allocation does not account for the additional workload associated with recent Mental Health Act reforms, which are expected to significantly increase the administrative and statutory demands for detained patients. The implementation of these reforms will require an increase in medical or approved clinician provision.
5. The required consultant psychiatrist time will vary depending on the skill mix, accessibility, and experience of the multidisciplinary team. This includes access to physical health nurses, general practitioners, psychologists, residents, and administrative support, in addition to specialist eating-disorder practitioners and dietitians. In practice, however, such comprehensive support is often limited, particularly within community services.
6. A full-time (10 PA) consultant psychiatrist post should typically comprise 7.0 PAs of Direct Clinical Care (DCC) and 2.5 PAs of Supporting Professional Activities (SPA).

SAS Psychiatrists

Job planning for SAS psychiatrists should follow the same core principles as consultant job planning, in line with British Medical Association (BMA) guidance. These principles include transparency, equity, recognition of all work undertaken, and a clear alignment between programmed activities and agreed responsibilities. SAS psychiatrists should have job plans that are safe, sustainable, and reflective of their clinical contribution.

The Royal College of Psychiatrists supports an 8 Direct Clinical Care (DCC) to 2 Supporting Professional Activities (SPA) split for both specialty doctors and specialist doctors. Where exemplar consultant job plans include 2.5 SPA, the 0.5 SPA differential for SAS psychiatrists should be explicitly recognised and reallocated to patient-facing DCC activity, ensuring parity of workload expectations and avoiding unrecognised work.

In accordance with BMA job-planning guidance and the BMA SAS Charter principle that all work undertaken must be reflected in the job plan, where an SAS psychiatrist does not hold formal or informal educational responsibilities—such as supervision of resident doctors, teaching of medical students, or education of other medical or healthcare professionals—the time allocated for these activities within a consultant job plan should be converted into clinical time. This conversion should include recognition of the associated administrative and indirect clinical workload linked to patient care.

Job plans should be agreed collaboratively and reviewed regularly, particularly where service configuration, workforce capacity, or clinical complexity changes. Reviews should ensure that:

- Workload remains safe and achievable within contracted hours
- There is clarity regarding role expectations and boundaries
- SAS psychiatrists are supported to develop professionally in line with their experience, aspirations, and service needs

In keeping with the BMA SAS Charter, employers should ensure that SAS psychiatrists are treated with respect, have equitable access to job-planning processes, and are supported through clear governance, appropriate SPA allocation, and opportunities for development, leadership, and progression where desired.

This approach supports consistency with consultant job-planning frameworks, promotes fairness across medical roles, and contributes to recruitment, retention, and high-quality patient care within eating disorder services.

Forensic Psychiatry

Forensic Psychiatry is a highly specialised and intellectually rigorous medical specialty that demands advanced expertise in the assessment, treatment, and management of individuals with severe mental disorders who pose an associated risk of significant harm to others. These patients often have complex, treatment-resistant presentations, including enduring psychiatric illness, sequelae of trauma, personality disorder, substance use, and co-morbid illnesses of physical health. Patients typically have a history of criminal offending or display behaviours that pose a serious threat to public safety, as well as their own, and they often cannot be managed effectively within general psychiatric settings. Risks often span the domains of violence, sexual violence, and fire-setting.

Psychiatrists in Forensic Psychiatry are extensively trained doctors with exceptional clinical skills, developed through years of experience in managing individuals whose needs lie at the interface of mental health services and the criminal justice system. They are adept at leading multidisciplinary teams and collaborating with a wide array of agencies including the police, courts, prisons, probation services, social services, housing authorities, and third-sector organisations. This intricate inter-agency work requires a sophisticated understanding of both clinical and legal frameworks, as well as the ability to navigate complex ethical and risk management challenges. This approach is essential to developing effective treatment plans and ensuring a comprehensive and coordinated response to patient needs and victim safety.

Forensic Psychiatrists are particularly skilled in risk assessment, diagnosis, treatment, and the identification of individuals who require forensic rehabilitation. Their ability to work in clinical partnership with patients and other professionals to formulate tailored, evidence-based management strategies is critical in preventing harm and promoting patient recovery. In the context of their own knowledge, skill, and experience, many Consultants in this field also put themselves forward to provide expert testimony in legal settings, offering invaluable insights into the relationship between mental illness and crime.

The specialty is both demanding and intellectually stimulating, requiring psychiatrists to maintain a high level of professional competence through continuous learning and development. The role demands not only technical expertise but also an unwavering commitment to ethical practice, empathy,

and a capacity for nuanced decision-making. Forensic Psychiatrists play a crucial role in shaping the future of mental health care within the criminal justice system, making a profound impact on both individual patients and broader societal outcomes.

Clinical Role

Forensic Psychiatrists work across diverse settings within or alongside the criminal justice system, including secure hospitals (high, medium, and low secure), prisons, and the community. The nature of their work requires a carefully structured job plan that ensures sufficient time for safe, high-quality clinical practice with individuals who often present substantial clinical risks. While specific duties vary, key responsibilities can include:

- **Clinical Assessment and Diagnosis:** comprehensive evaluation of mental state and diagnosis.
- **Risk Management:** cyclical assessments and management of risk in patients with mental disorders, including in complex, high-risk cases.
- **Treatment of Enduring Illnesses:** management of mental disorders that are, as yet, treatment-resistant and enduring.
- **Formulation and Treatment Planning:** multi-source integration of biological, psychological, and social factors to develop holistic treatment plans with the patient and MDT.
- **Gatekeeping Assessments:** evaluating the necessity of secure inpatient care and determining appropriate levels of security.
- **Legal and Safeguarding Frameworks:** application of mental health law, including the Mental Health Act, the Mental Capacity Act, issues involving the Court of Protection, and safeguarding processes. Exercising the duties of a Responsible Clinician (when approved.)
- **Impact of Security Measures and Restrictive Practices:** understanding the balance between public safety, patient autonomy, and rehabilitation within secure settings.
- **Victim Safety:** addressing victim issues and liaising with relevant agencies for victim protection.
- **Advising and liaising with the Secretary of State:** providing annual statutory reports to the Secretary of State for Justice and making informed requests in relation to restricted patients.
- **Clinical Leadership:** leading multidisciplinary teams and coordinating care across agencies. Modelling a calm and focused environment within the organisation

- **Professional Testimony:** in legal proceedings, including preparing and presenting evidence at Tribunal hearings and Hospital Manager meetings.
- **Out-of-Area Placements:** clinical review of patients placed outside of their home area.
- **Advice and Second Opinions:** providing specialist advice to colleagues and psychiatrists in other specialties.
- **Collaboration:** collaborating with primary and secondary care teams on the management of co-morbid physical and mental health conditions.
- **Expert Testimony:** Psychiatrists may choose to put themselves forward as expert witnesses to give their expert evidence and opinion within judicial processes.

Leadership Role

Consultants provide clinical leadership within their teams to ensure the delivery of high-quality care and treatment for patients. In complex clinical cases, involving a substantial degree of risk, effective leadership requires psychiatrists to foster a calm and focused environment within the multidisciplinary team and department. By modelling clear communication, valuing diversity, exploring differing viewpoints, and promoting collaborative decision-making, Consultants strengthen team cohesion and enable the delivery of safe, recovery-focused treatment while upholding patients' rights and maximising the safety of all involved.

A flexible approach to job planning is crucial for organisations wishing to support psychiatrists in pursuing advanced leadership roles, such as local medical management or regional and national positions. The opportunity to integrate advanced leadership activities within a 10 Programmed Activity (PA) job plan can help to ensure that these responsibilities are appropriately managed, though some psychiatrists may prefer additional PAs to accommodate their leadership commitments.

Educational and Academic Role

Forensic Psychiatry is a complex tertiary specialty, with psychiatrists playing a critical role in training related to medico-legal issues, risk, and interfaces with the criminal justice system. To maintain and enhance their own expertise, it is imperative that psychiatrists are allocated dedicated Continuing Professional Development (CPD) time for both their own growth and to provide training to others.

Psychiatrists should be given the opportunity to engage in research to advance the specialty and contribute to the broader medical field. Additionally,

involvement in educational and academic roles is crucial for training the next generation of specialists and should be incorporated into job plans. This requires time to develop educational skills alongside time for teaching.

Supervising roles are a key responsibility for psychiatrists. Adequate time must be allocated within job descriptions for supervision, with clear distinctions between psychiatric, educational, and clinical (direct) supervision. For educational supervision, the Royal College of Psychiatrists recommends 1PA per week for supervising up to five residents. The job plan of Clinical Supervisors should allow for at least weekly one-hour sessions of psychiatric supervision i.e., 0.25 Supporting Professional Activities (SPA) per resident. Additional time should be allocated for direct supervision of clinical cases. In forensic settings, resident doctors in training posts should ordinarily review patients from the Consultant's clinic list, rather than an additional list, to allow the opportunity for direct Consultant supervision over time.

Supervision of other medical trainees, such as foundation and GP doctors may in general resemble the above arrangements, but with consideration of the relevant specialty training guides. Psychiatrists require time to develop and maintain their skills as trainers.

Psychiatrists may agree to the supervision of non-medical professionals as part of a job plan. It is worth remembering that supervision is not the same as ordinary multidisciplinary working. The exact extent and commitment of that supervision should be clear within job descriptions. It might range from supervision of non-medical prescribing to direct or close supervision of clinical cases. Arrangements are potentially highly variable and so clarity around time and responsibility is important. Job plans must have the appropriate level of allocated time: this will be Direct Clinical Care (DCC) time when it relates to direct or close clinical supervision of a case, and it may be SPA time if it is more reflective and general. Many such roles are likely to require both DCC and SPA time.

Unlike doctors, Physician Associates are dependent practitioners and will therefore require additional direct clinical supervision by a consultant. It is recommended that job plans afford at least one hour of weekly psychiatric supervision per physician associate, in SPA time, but there must be additional provision for supervision of clinical cases within DCC time. An example of this will be in considering how many patients can be reviewed in a clinic by the Consultant whilst also affording sufficient time for detailed and real-time discussions of physician associate cases. Consultants should have a minimum of 0.25 SPA and 0.25 DCC in their job plan for each Physician Associate

supervised, though additional DCC time is highly likely to be required for less experienced supervisees.

Development of Forensic Psychiatry requires collaboration on an international level, and we encourage organisations to allow study budgets to be used for international professional visits, conferences, and training.

Information to support Job Descriptions and Job Plans

Given the diverse nature and locations of roles in Forensic Psychiatry, job descriptions must account for the time and complexity specific to each post. For example, prison-based roles often require additional administrative time for writing hospital referrals, while inpatient roles demand time for the extensive responsibilities of the Responsible Clinician (RC).

If a psychiatrist's role involves more than sessional or visiting input to a prison, job planning should allocate sufficient time for all required tasks including responding to clinical queries outside of clinic sessions. Given the unique operational and clinical challenges of a prison setting, which is dependent on the rules and regime of the establishment, particular note should be given to the assumptions described in the table below, with the number of patients booked being adjusted in terms of actual clinic duration and patient availability. This is crucial for ensuring safe and high-quality care.

Many of a Consultant's core responsibilities cannot be delegated to others, either due to legal requirements or the level of knowledge and skill required. In this context, organisations should be mindful when making requests of consultants.

The example recommendations given in the table below take account of the complexity of forensic work, as well as the significant time needed for optimal liaison with external agencies that so often is necessary. Reviews of out of area placements should account for travel time and implications of security arrangements.

Job descriptions should clearly indicate the level of input from other members of the MDT, as well as resident doctors, so that the team composition can be considered within the anticipated workload of the Consultant. Models of care that require additional regular meetings beyond traditional multidisciplinary team approaches should be fully and transparently described and accounted for within job plans.

Consultants may agree to be Medical Approved Clinician (AC) to a non-medical Responsible Clinician (RC.) Such a commitment will need to be reflected in job planning. There are a range of responsibilities that a medical AC will have in such circumstances, and this will vary according to the competencies of the non-medical RC. For example, because non-medical RCs are not medically qualified, the medical AC is likely to be consulted for situations requiring specialist psychiatric advice such as, for example, physical disorders and how they may interact and impact upon mental disorder. Non-medical ACs, even if they are prescribers, may not be able to prescribe the full range of medication which may require consideration. Non-medical ACs are not Section 12 approved, and all of the tasks associated with this role will need to be undertaken by a Section 12 approved doctor. The Medical AC will need to have a good and up to date understanding of the patient histories and presentation and are likely to attend at least some of the MDT meetings. They also require time for patient assessment, reading of reports, preparation of statutory forms, and consultations related to treatment. Although less than the time required if they were the RC, the role is likely to require substantial regular time within that Consultant's job plan.

While video conferencing technologies are a convenient communication tool, they do not reduce the time needed for clinical contact, treatment planning, or documentation. These tools primarily facilitate collaboration rather than lighten the clinical workload. However, they may offer convenient options for reviewing some out-of-area placements, which is accounted for in our example recommendations in the below table. As technology continues to evolve, there may be increasing benefits in supporting patient reviews at key transition points between levels of security and services. Nevertheless, this convenience could inadvertently lead to higher workloads and greater expectations on consultants. Therefore, careful planning is essential to ensure the effective use of technology without compromising safe and balanced job plans.

We welcome choice for consultants who wish to have flexible ways of working. This may include a preference to work longer hours over fewer days (compressed hours), and consultants who wish to have job plans that are less than full time. We encourage organisations to be flexible and accommodate these preferences as far as is possible.

We encourage employers to value the expertise of Consultant Forensic Psychiatrists who wish to undertake expert witness work for Courts. The legal system depends on the availability of experts so that patients can have expeditious and well-advised progression of their legal cases. By allowing Consultants to undertake this work flexibly, the organisation also benefits from that maintained expertise including for the essential delivery of training to

higher trainees. We encourage organisations to allow Consultants to time-shift their work, to assess patients and attend Court.

The following table offers some 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 caseload mix may vary between services. It is based on a standard job description of 7.5 PA of DCC time and 2.5PA of SPA time.

Forensic Psychiatry	
Description	Professional Activities
Direct Clinical Care:	Max 7.5
Per 2–4 in-patients in secure environment: low, medium or high. Factors such as patient complexity (e.g., acuteness, the sequelae of trauma, frailty / physical health co-morbidity), length of stay, resources available, nature of care, and team composition will also determine which end of the range is reasonable. Gatekeeping assessments require additional time (see below.)	1
Per 3-8 inpatients supporting a non-medical AC in secure environment low, medium or high. Factors such as patient characteristics (including physical health co-morbidity), resources available, team composition e.g., whether supported by an SAS doctor, whether non-medical AC is a prescriber and the range of their prescribing ability, will 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 and size of catchment area will determine which end of the range is reasonable	1
Per 15 -25 community forensic patients supporting a non-medical AC. Factors such as patient characteristics (including physical health co-morbidity), resources available, team composition and whether the non-medical AC is a prescriber and the range of their prescribing ability, will determine which end of the range is reasonable.	1

Forensic Psychiatry	
Description	Professional Activities
Prison session: per 2–3 new patients or up to 6 follow-up patients (or a combination of these) assuming a 3 hour session and patients readily available to be seen. Regarding parole reports, if a brief professional report is required for patients under active care, this will be in the form of a clinical letter. If a more detailed professional report is required and is part of contracted activities, at least 1-2 PA per patient per week is likely to be required and may need to be repeated over multiple sessions.² Gatekeeping (access) assessments: assuming 1 referral every 14–28 working days of the year. Factors such as patient complexity, acuteness, current location, resources available, team composition, travel requirements, and type of service being provided will determine which end of the range is reasonable. Additional time may be required for complex cases and for distant travel.³ Assessments for advice: assuming 1 referral every 7–14 working days of the year. Service provision differs around the country, with some services only providing an assessment service for potential admission to secure care (see above) while others provide advice and supporting the management of high-risk patients. Factors such as patient complexity, acuteness, resources available, team composition, travel requirements, and type of service being provided (i.e., whether a review is required or only a discussion) will determine which end of the range is reasonable. Additional time may be required for especially complex situations and for distant travel. 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 1 1 1

Forensic Psychiatry	
Description	Professional Activities
Per 15–30 out-of-area treatments from catchment area: factors such as distance from base unit, possibility of some remote attendances, resources available, team composition and type of service being provided (e.g. level of attendance at Care Programme Approach (CPA) (promoting quality care in Northern Ireland (PQC)) meetings, frequency (e.g., 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, possibility of some remote attendances, resources available, team composition and type of service being provided (e.g. level of attendance at CPA (PQC) meetings, frequency (e.g., annual or 3 monthly), will determine which end of the range is reasonable.	1
Supporting Professional Activities (CPD, QI, supervision, appraisal and Job Planning)	Max 2.5
Psychiatric Supervision - 1 hour per week per resident	0.25
Educational Supervision - per week per 5 residents	1

The new Mental Health Act amendments will, in stages, add responsibilities for consultants. Although these duties are not yet reflected in the proposed PA allocation table of this guidance, organisations should plan for the extra time needed to comply. In practice, this will likely require reduced caseloads, phased in alongside the staggered commencement of the legislation. Future guidance will again review recommendations considering the changes to legislation.

SAS Psychiatrist Job Plans

SAS psychiatrists job plans should follow the same principle as those for consultants. The College supports 8 DCC: 2 SPA for both specialty and specialist psychiatrists. Amendments to the exemplar job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal and informal educational responsibilities in relation to resident doctors, medical students

and other medical and health professionals, the specific time allocated for this in the consultant job plan should be changed into clinical time, including the associated administration linked to it.

References

1. In each case the level of time and expertise available from resident doctors and/or SAS doctors will partly determine which end of the range is reasonable – up to 7.5 DCC sessions will be made up from an appropriate combination 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 example ways this can be organised: time-shifting – up to 1 PA per week could 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

2. Please note that where a forensic psychiatrist provides more than a couple of clinic sessions, and where main role is prison-based rather than visiting / sessional, all aspects of the prison work should be carefully afforded time within the job plan, along with any other roles such as leadership, academic and teaching.

3. The amount of time required for a gate keeping assessment, and preparation of an outcome letter, will vary according to factors such as the complexity of the case, the location (e.g. hospital / prison) and distance of the patient, the quantity and quality of reports and records to read, and whether multiple interviews are required. One standard assessment may take between 1 and 2 days of time (2-4 PAs), but frequently longer for more complex cases. Individual job descriptions should take account of added complexity of cases, and frequency of referrals, when calculating the time required.

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 inpatient 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 having different medical teams working in the community and inpatient services. Such a split does offer some benefits, most notably in the inpatient setting, with fewer consultants working on a busy inpatient ward. However, for the patient this introduces a significant interface in their care pathway potentially creating a significant discontinuity in their care. Appropriate planning to manage this interface needs to be explicitly specified in job descriptions where functionalised models of care have been adopted.

Clinical Role

Quality Factors

Job plans should make express reference to quality benchmarks, these could be local, regional or national standards such as National Institute for Health and Care Excellence (NICE) quality standards. Accomplishing these standards can impact on consultant time, for example review patients 2-4 weekly when medication is being changed, and methods will need to be developed to overcome the limitations.

Population factors

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. There has also been an increase in diagnosing adult ADHD that has an impact on assessments and follow up care as most patients chose to have treatments that require specialist prescribing.

Since the COVID epidemic much has been learnt about health inequalities, the impact on physical and mental health and how to address them.

Understanding and responding to the local population need is important in considering the mental health resource required, including psychiatrists. The local deprivation index indicating the social determinants of mental health include factors such as income, employment, socioeconomic status, education, food security, housing, social support, discrimination, childhood adversity, and the ability to access acceptable and affordable health care will adjust the need in the local area for mental health services.

Consideration should also be given to local “hot spots” of need and the impact on the service – such as bail hostels, supported accommodations and nursing homes.

Staffing factors

Safe and effective working with patients depends on the presence of an effective multidisciplinary team. So the size, clinical seniority and stability of a team will have an impact on the consultant roles and responsibilities and therefore the job plan.

Mental health services are facing a significant recruitment crisis, and it is not unusual for employers 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 will impact on the workload of substantive staff. Some locum consultants may not have AC approval and require a colleague to provide this role.

Agency staff in mental health teams can hamper continuity of care and can be especially anti-therapeutic for patients who have experienced trauma and find building trusting relationships difficult.

Working with colleagues who are less than full time can also put pressure on others within the team as there could be requirements for significant ongoing cross-cover.

The move to electronic patient records and prescribing in many organisations has come with a rationalisation of clinical administrative support. However, with the greater complexity of services and requirements to evidence quality practice, administrators play a vital role in supporting the consultant psychiatrist to ensure they are efficient and effective to carrying out their clinical duties.

All of these dynamic staffing factors should form part of the job planning discussion and indicate the need for interim support while the staffing issue is resolved.

Legislative factors

In England, Wales and Scotland local use of Community Treatment Orders can have a great impact on the workload of Consultant Psychiatrists, particularly those working in the community.

There is great variety in how CTOs are used across teams, services and Trusts that will depend on the nature of the team (CMHT vs AOT) and the complexity of the team's caseload. Discussion should be had in the job planning meeting about the use and number of CTO and how these impact on the role. Some roles may require smaller caseloads, less time dedicated to routine follow up as more time is required in Mental Health Act work.

Leadership role

Consultant general adult psychiatrists are key clinical leaders in the delivery and development of mental health services. All Consultants should have the opportunity to develop and use their leadership skills, with training and access to times when they can understand and influence service improvements. The job planning discussion can lead to these developments.

Their involvement in the local health system with partners such as primary care, social care and commissioners is important to play a key role in modelling high-quality patient care, in building continuously drive quality improvement and to ensure that patients have a caring, responsive and safe pathway of care. Service objectives should be set in job plans to deliver on this with SMART (specific, measurable, attainable, relevant and time-bound) objectives that encourage improvements for the local population health.

The effectiveness of this SPA can be increased by engaging in a team job planning process. Team job planning helps consultants to work together and share tasks, so they can prioritise an area of interest rather covering the many demands as individuals such as smoking cessation, physical health, suicide prevention etc.

Educational role

Education and training is a fundamental part of the Consultant role to develop their team and prepare the clinicians of the future service.

It is important to ensure that job descriptions take into account the different professions and grades of trainees. For example, foundation doctors may need additional support, especially in a 4-month placement, compared with higher specialist residents. College guidance suggests allocating 30 min per new

patient for discussion with core residents/GP trainees and foundation doctors; with time also required to supervision FY/ CT doctors for follow up appointments. This is in addition to the protected weekly clinical supervision time.

When a consultant is required to supervise multiple trainees, consideration needs to be made to the time this will take.

Where the consultant is expected to deliver training to medical students, this will also need to be given the appropriate time to deliver in the job plan. Many consultants now also provide multi-professional educational roles and supervision – for non-medical prescribers, Advanced clinical practitioners, Physical assistants. Sufficient time is required in the job plan for all these training activities.

Some consultants also have a role in teaching, that will require additional time to providing supervision.

Maintaining Psychotherapeutic Skills

All Consultants need to maintain their psychotherapeutic skills aligned to their clinical role to ensure that they consider the psychological aspects of presentation and management. This might be reflective practice, attending a Balint group or running group therapy. It is integral to the work of a Consultant psychiatrist and should be 0.5 DCC in all general adult job plans.

Information to support job descriptions and job plans

Full-time community posts

Job descriptions must set out allow the consultant to have sufficient time and support to deliver all aspects of their expected role so allocated sessions will depend on these expectations and the other staff available to undertake clinical and support functions.

A full-time consultant should expect to deliver 5 PAs per week of patient facing care in outpatient clinics or community assessments (clinic, home visits and emergency assessments). New patient assessments will require a longer amount of time than a follow up appointment, generally 1 hour for new patients and 30mins for follow up, but this may vary locally depending on the referral process and the complexity of the referral.

Sufficient time in the week should be available for urgent cases, liaison with other professionals when it is members of the MDT who require supervision and support in decision making. How much time and when it is in the week should be agreed with the team depending on when it is most needed. Consideration should be given if patients to be seen outside routine outpatient settings for those who are unlikely or unable to attend. Additional time must be allocated for home visits.

Time will be required to attend MDT meetings, business meetings and governance meetings – how much time will be dependent on the local team and service. It is important to factor in timetable clashes with clinical work that might not allow the consultant to attend regularly.

Consideration needs to be given to the work required to support patients who are on CTOs, as this will be more than for other patients; more frequent reviews for renewal, consent to treatment and tribunals/ managers hearings.

Depending on the organisation of the service and the operation of local forensic services, general adult psychiatrists may have forensic patients as inpatients or community patients and consideration should be given to the Ministry of Justice work that could be required as a result.

All jobs will need sufficient time to complete clinical administration tasks. Most clinicians are reporting a significant increase in clinical administrative duties, including dealing with the rising number of requests for housing, benefits, employment and DVLA reports. Consideration should be given to administrative tasks that could be better done by administrative staff and ensuring consultants are best employed doing clinical tasks.

All community consultant psychiatrist job descriptions must include caseload analysis indicating the number of new referrals, diagnostic or cluster profile of caseload and average numbers of patients on a community treatment order (CTO) over the past 1–3 years. However, there is great variation in practice and this should be kept under review as it is likely to change over time.

Understanding the differences in team or Consultant caseloads is difficult as even within a service how this is managed can be very different. It is important then to be thoughtful and understand the caseload mix, offering peer group led case load reviews to support with decision making and caseload management could be helpful, including primary care in supporting discharge from services.

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.

In Northern Ireland, the introduction of the Mental Capacity Act (2016) is likely to have a significant impact on consultant time and this must be reflected in job plans and job descriptions. This cannot be quantified fully at this stage.

Community Psychiatry	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Out-patient work/home visits	4
Emergency Clinical Work	1
Mental Health Act work/Complex patient reviews	0.5
Clinical Administration	1
Clinical team meeting/support for team members outside the meeting	1
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

Full-time inpatient posts

Inpatients are the most unwell people in mental health services and should be reviewed personally by their consultant at least once a week. Consultants should therefore expect to input into the ward every day in order to be available for day-to-day decisions requiring consultant input.

There are different models of providing consultant input into inpatient wards. Most wards have a daily team handover where all patients are discussed daily and then either meet with patients as a clinical team or individual clinicians.

All full-time inpatient 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 and team members working on the ward.

Clinical care and administrative duties, such as documentation, meeting with relatives, liaising with community colleagues, social care, commissioners and writing reports fill the other DCC sessions in the job plan. Special consideration should be given to time taken in discharge planning and risk assessment as it is of utmost importance that the Consultant leads on this and is assured that the discharge plan is safe and robust.

There is a considerable amount of mental health legislation work that is required of inpatient consultants and this is likely to increase with the Mental Health Act review. Consideration needs to be given to the time required in the administration of the Mental Health Act and Mental Capacity Act, preparation for hearings and attendance at hearings, both to present and to supervise residents presenting evidence. Often, it is not possible to delegate this work to team members and so the flexibility and availability of the consultant in their job plan needs to be factored in.

Inpatient services often attract training posts for Core and Higher residents and/or SAS grade doctors who are able to undertake medical tasks required with appropriate supervision. The college expects that all inpatient Consultants should be supported by a medical colleague on an inpatient ward. The benefit of working with a larger team needs to be balanced with time required for clinical supervision particularly for the most junior residents.

Inpatient services can differ depending on whether they are assessment units, with a shorter length of stay and higher turnover, treatment wards or specialist services. An outline of the ward performance indicators is helpful to ascertain what the consultant will be expected to do in their clinical time – new assessments, MHA work, complex case reviews. For an acute adult ward, a full-time consultant can manage 15-20 beds without an additional Approved Clinician.

Patients on a Psychiatric Intensive Care Unit will likely require consultant review more frequently than once a week, reflecting the acuity, risks and complexity of the patients. 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.

Inpatient Adult Psychiatry	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Ward-based clinical activity	5
Mental Health Legislation work	2
Clinical administration	0.5
Supporting Professional Activities (SPAs) including 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 needed for travel between sites. The advantages of mixed posts are the opportunities for continuity of care. The division of the services will depend on the local need and caseload and is likely to require some flexibility. A full time Consultant who covers a geographical area is not going to be able to manage the same number of beds or the community caseload as consultants working in one service or provide the same frequency of input into either service as their time will need to be split between the two. However, any consultant with inpatients 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 working in teams intended to provide intensive support to patients as an alternative to hospital admission need to have sufficient time to personally review all patients, or supervise senior colleagues who are managing such patients. Time should be considered for travel and home visits

as much of the work is likely to be seeing patients in the community rather than office based.

Mixed inpatient and home treatment team posts

Some consultants manage the whole acute care pathway; both inpatient and home treatment services. There are advantages to such posts because of continuity of care. Time within the job plan needs to be allocated for travel involved. Flexibility will be required in the consultant's job plan to be able to attend to community emergencies or inpatient emergencies at short notice if their presence is required. Because of this caseload analysis is important to understand the capacity of the consultant and their team.

Assertive outreach and early intervention services

Consultants working in assertive outreach and early intervention services will need to spend more time in care planning and less time in routine follow-up clinics than colleagues in generic community teams.

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principle as above. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Psychiatry of Intellectual Disability

People with Intellectual Disability (ID) are more likely to experience mental illnesses and a number of medical conditions than people in the general population. Consultant psychiatrists in intellectual disability (learning disability) are specifically trained to identify mental disorders in people with ID and work in varied clinical settings from in-patient to community services for a variety of organisations in the United Kingdom in the NHS, independent sector, and Local Authorities. Different terms and conditions exist for those working across the 4 jurisdictions of the United Kingdom and a multiplicity of arrangements for people working abroad. This guidance cannot possibly cover all eventualities and seeks to create a template by which to quantify the work that could be carried out in a consultant post.

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 and their associated treatment
- a deep understanding of the complex factors that contribute to mental disorders – physical, psychological, and social
- an understanding of physical health issues, particularly epilepsy (bronze, silver, gold accreditation) and how both health conditions and their treatment can affect behaviour

- the application of legislative frameworks as they relate to people with intellectual disability
- knowledge of the presentation of mental disorders in people with neurodevelopmental disorders
- understanding risk assessment processes to ensure that clinical risks are appropriately managed
- providing clinical expertise to commissioning bodies and care providers
- health advocacy with other agencies e.g. primary care, secondary care services

Leadership Role

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

- clinical leadership to teams
- leadership in service development and service planning with ICBs and commissioning bodies
- leadership in identifying areas of need, introducing new ways of working, learning from incidents or mortality reviews
- leading on ensuring that people prescribed psychotropic medication are reviewed
- leading on ensuring that reasonable adjustments are made for those people with intellectual disability accessing generic services in order to ensure the best outcomes
- 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 an essential role in educating colleagues about the intellectual disability and how people may present to the wider health service:

- direct clinical supervision and educational supervision is required when working with residents, SAS psychiatrists and locally employed doctors/clinical fellows.
- education to non-medical colleagues on the presentation of mental health difficulties in people with intellectual disability.
- Education of medical students attending meetings or clinics as part of their rotation

Active participation in Academic meetings to ensure that people with Intellectual Disability and their presentation is understood.

Information to Support Job Descriptions and Job Plans

People factors

People 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. People with ID often depend on carers and professional informants for support and to provide information, that may require multiple discussions. On occasions, behaviour may disrupt appointments or may require home visits. People with ID frequently have significant physical health problems, some associated with complex genetic syndromes. They are often prescribed numerous drugs for different conditions that may have interactions, may impact behaviour, epilepsy and mental health. Psychiatrists will often directly manage epilepsy as part of a patient's ongoing care or need to advise and support GPs on physical healthcare in relation to some genetic disorders.

A standard community follow-up appointment slot would be 30 minutes and for a new patient 90 minutes (occasionally split if patient does not tolerate lengthy appointments). More complicated new cases (e.g. children, forensic) or autism assessments/court reports can take much longer, in excess of 180 minutes (usually split). For home visits, travel time 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;
- Supported living and residential care arrangements and the quality and training of the care staff employed by the care organisations in community homes
- Placements into the area by out-of-area commissioners (or more people moving from rural settings to inner-city provision)
- 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;
- The commitment of local authorities and health commissioners to support intellectual disability services.
- Arrangements for admission to assessment and treatment beds for those who require more support than can be offered in the community
- Local Residential Colleges that support students between the ages of 18 – 25 who accept students that require term-time review

Local trust/health board/UHB/HSCT 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 secretarial and other allied professions: community nurses, speech and language therapists, occupational therapists, dietitians, psychologists and physiotherapists
- Support from junior medical staff (psychiatrists in training)
- Support from IST and Forensic ID teams
- the availability of resources of specialist expertise in their teams eg (epilepsy, challenging behaviour, autism)
- whether all clinicians are employed by the same organisation and their roles are determined by the same eligibility criteria
- pooled budgets and co-terminous criteria with Social Services; if not existent, health professionals may be working in isolation with some people
- 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.

General adult intellectual disability posts

Community only	
Activity	Required Time Allocation
New patient assessment	90mins
Complex cases	120mins
Where these are performed by a psychiatrist, a pervasive developmental disorder assessment with diagnosis	240min
Routine follow up	30mins
CPA/PQC review or vulnerable adults meeting	60mins (more if MAPPA or forensic issues)
weekly team meeting	120mins
mental health legislation work including assessments	120mins
managing community treatment order patients: managers and review tribunal meetings	120mins each at least yearly (more if regular recall)
report preparation	4 hours

A WTE community post might expect to carry an active caseload of 100 patients, with 30–40 new referrals each year.

In-patient acute assessment and treatment

One WTE consultant for up to 12 acute beds. The unit would need a well-resourced multidisciplinary team including social work involvement and additional medical support (e.g. 0.5 WTE specialty doctor or 1 WTE CT3).

Forensic intellectual disability posts

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

In-patient posts: high secure, medium secure and low secure settings
For forensic intellectual disability bed-based services, a full-time consultant could lead services with:

- 15– high secure unit beds with national assessment duties; or
- 12– medium secure unit beds and 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– 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.

Community Forensic posts

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.

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principle as above. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Liaison Psychiatry

Liaison psychiatrists specialise in the provision and development of integrated services and pathways which focus on improving the care of people of all ages with complex health problems. They work closely with health and social care colleagues in a variety of settings, including the general hospital (e.g. emergency department, intensive care, inpatient wards and outpatient clinics) and more recently the community (e.g. primary care). The recent expansion of liaison mental health services outside of the general hospital setting supports improvements in integrated care pathways across the wider health and social care system. Liaison mental health services (sometimes known as integrated psychological medicine services) are usually multidisciplinary comprising nurses and doctors, and variably clinical psychologists, allied health professionals and social workers.

Clinical expertise covers a wide range of areas including mental health problems in those with physical illness, psychological factors affecting physical health, persistent physical symptoms, substance misuse, organic brain disorders, dementia and delirium, eating disorders, self-harm, learning difficulties and autism, transplant surgery, the use of medication in physical ill health and psychological therapies in the context of physical illness.

An increasing number of liaison mental health services now serve people of any age. In some areas one team provides liaison expertise regardless of age, whilst in other areas there are separate teams for children, adults and older people. In these configurations there will be liaison consultants who are specialists in the mental health care of children, working age adults or older adults. In 2019 the college produced this [position statement](#) on the provision of liaison psychiatry services across the lifespan which gives helpful context (rcpsych.ac.uk)

Clinical Role

A liaison psychiatrist has the following specific expertise:

- Understanding the interface between physical illness and mental illness (e.g. comorbid mood disorders, persistent physical symptoms, organic mental states)
- Diagnosis and formulation of management plans in complex situations, and advising medical teams on appropriate integrated care informed by guidance

- Prescribing and giving advice on medication, including psychotropics
- 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
- Providing evidenced based care of people with physical symptoms which are not wholly explained by the extent of pathology
- Working at the interface between physical and mental health care in clinical populations with long-term conditions
- Bridging the gap between primary and secondary care in the management of persistent physical symptoms and long-term conditions in the community
- Supporting the care of people who present with acute psychiatric conditions or behavioural disturbances who are admitted to general medical beds, including whilst they wait for a specialist mental health bed or a social care placement. This may include people with delirium, dementia, eating disorders, autism and learning disabilities.

Leadership Role

A key part of the liaison psychiatrist's consultant role involves leadership and service development.

Leadership:

- Leadership within clinical teams, including clinical supervision of colleagues. (Line management of non-medical staff would usually be provided by the team manager).
- Identifying good practice from national guidance and research and aligning the work plan and goals of the liaison mental health team according to these.
- Familiarity with the Psychiatric Liaison Accreditation Network (PLAN) quality assurance framework and providing leadership to support the achievement of these standards.

Service Development:

Working with clinical leaders, managers and commissioners from across the wider health and social care system (e.g. primary and secondary care, social care, third sector, mental and physical health trusts/boards) with a focus on improving pathways and integrating and improving care.

Educational role

A liaison psychiatrist will play a key role in training non-mental health staff to support people who have complex co-morbid mental and physical health difficulties. Having a presence in physical health settings and delivering both informal and formal education and training, including case discussion, will both help challenge stigma and improve the quality of care and associated outcomes. This support includes helping colleagues recognise and manage common mental health conditions and know when and how to refer on to appropriate pathways.

Most liaison mental health teams will have a variety of training placements which the consultant is expected to supervise. These include foundation, core, specialty residents, and advanced practitioner trainees. There should be 0.5 PAs in the job plan for each trainee supervised to support the formal 1 hour of supervision per week and additional ad hoc supervision and administrative tasks needed for training, including clinical and educational supervisor's roles.

Information to support job Descriptions and Job Plans

There is great variation in liaison mental health services across the four nations, reflecting local demographics, needs and priorities, available resources and historic development of services.

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

- Emergency department liaison psychiatry
- Self-harm service
- Liaison mental health service for general hospital in-patients
- Substance misuse liaison teams
- Out-patient clinics
- Additional specialised services (e.g. chronic fatigue syndrome, persistent physical symptoms, psycho-oncology, transplant surgery, persistent pain, post covid syndrome, gender dysphoria)
- Primary care and community-based clinics
- Home visits
- Multidisciplinary meetings with health and social care staff
- Teaching, training and supervision
- Leadership of service developments and pathways of integrated care

There is a wide variation in the composition and size of the teams. The nature and volume of work may differ according to the local referral criteria (e.g. age range, referral sources, catchment area), hours of operation, other resources available (e.g. separate alcohol and substance misuse liaison services) and focus of the service (general hospital or community). Some liaison psychiatry teams provide services for people of all ages (often with specialist sub-teams in larger hospitals). If the consultant works in more than one site, then travel time should be taken into consideration in their job plan.

The expected workload and distribution of work-related activities of a consultant liaison psychiatrist therefore depends on the nature of the post, including whether it is an acute health or community-based post, the nature and size of the hospital, the proportion of consultation vs direct clinical care, and the amount of involvement in service development, education and training roles. For hospital-based services in England guidance from the National Institute for Clinical Excellence in 2016 proposed a model of care called 'Core 24' which operates over 24 hours, 7 days a week. This stipulates 2 whole time equivalent liaison consultants for a hypothetical 500 bedded hospital. There is no similar guidance for community-based posts currently.

The distribution of activities below is for guidance only and should be adapted according to local needs in terms of the leadership role, the model of service and staffing of the team. For example, a liaison service in a large hospital may need increased professional activity time in the job plan of the consultant to support leadership, service development and governance arrangements. Similar will apply to a liaison service working within integrated pathways of care across the community, primary and secondary care at the interface of physical and mental health. To fulfil all the below roles in one team more than 1 consultant is likely to be needed. For both efficiency and context feedback from the PLAN process, Friends and Family Test and 360-degree review can be used to support the appraisal process.

The hospital model would work if staffing numbers are appropriate. Where staffing numbers do not match PLAN suggestions, I would suggest more time for consultation work with other team members. In this instance I would suggest for hospital based liaison mental health services, face to face is limited to 3, sessions, emergency work 1 session, MH work 1.5, admin 1 session with 1.5 PAs for MDT meeting / support for team members.

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principle as above. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Model Job Plan for a FT Consultant in a hospital-based Liaison mental health service.
The job plan will vary with the nature and role of the team and may vary from service to service:

FT Liaison hospital-based	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Face-to-face contact with patients in clinic or wards	3-4
Multidisciplinary team meeting and support for team members outside the meeting	1
Emergency work and clinical administration	1-2
Mental health legislation work/complex patient reviews or liaison with other specialties	1.5
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5
FT Liaison community based	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Face-to-face contact with patients in clinic or wards	3
Multidisciplinary team meeting and support for team members outside the meeting	1.5
Consultation and liaison with and supervision and training for health/ social care staff outside the team	1.5
Mental health legislation work/complex patient reviews or liaison with other specialties	1.5
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

Medical Psychotherapy

Consultant psychiatrists in medical psychotherapy (abridged to consultant medical psychotherapists for the purposes of this chapter) integrate the delivery of talking therapies with other effective biopsychosocial interventions. They promote the therapeutic value of relationships, working together, and the application of knowledge from psychiatry, psychotherapy and the neurosciences. They have a range of skills that are particularly helpful for patients who present with complex difficulties such as personality disorders, complex trauma, treatment-resistant affective disorders, eating disorders, and medically unexplained symptoms. They specialise in diagnostic and therapeutic complexity and deepen the understanding of complex interactions between the patient, healthcare professional, and the wider team in order to provide the best and safest quality of clinical care.

Clinical Role

The consultant medical psychotherapist has specific expertise in:

- **Assessment:** Carrying out psychotherapeutic assessments of complex conditions by integrating an individualised biopsychosocial approach.
- **Intervention:** Providing a range of evidence-based interventions that alleviate symptoms and address underlying factors. The aim is to reduce suffering and support holistic recovery and development.
- **Consultation:** Offering psychotherapeutic clinical consultations to teams. This involves contributing psychological perspectives to patients presenting in a variety of complex ways which may have led to situations of clinical impasse, anxiety, or conflict with other teams or services.
- **Systemic Support:** Supporting the integration of families, the wider community, and broader systems alongside the patient.
- **Supervision:** Providing clinical supervision to a range of staff.
- **Governance:** Ensuring robust clinical governance frameworks for psychological therapy services.
- **Institutional Health:** Developing and maintaining psychological, social, and cultural health within institutions.
- **Leadership:** Providing strategic leadership in reflective practice, ensuring staff are supported in managing emotional demands while enhancing clinical expertise.
- **Advocacy:** Promoting public understanding of mental health.

Leadership Role

Based on their specialised and highly skilled training in organisational, team and individual relations, across a range of psychotherapeutic models, consultant medical psychotherapists are well placed to offer expert advice on service and organisational development.

The consultant medical psychotherapist's leadership expertise is applicable to a wide range of settings (e.g. community, inpatient, crisis team, secure unit, specialist service) for patients presenting with various complex needs. Specialist services for example, may include those supporting individuals presenting with medically unexplained symptoms, treatment-resistant affective and anxiety-related disorders, personality disorders, eating disorders, perinatal disorders, and complex trauma.

Consultant medical psychotherapists lead integrated models of care organised across a variety of agencies, as well as advising on the psychological basis of organisational principles generally. This may involve leading on the development of reflective practice to all teams throughout the organisation as well as the development of specialist panels for complex and high-risk cases.

Consultant medical psychotherapists may also be involved in:

- Working in a wide range of psychiatric settings including inpatient and outpatient services in which the combination of their psychiatric and psychotherapeutic skills contributes to the overall holistic clinical care.
- Developing existing psychological treatment services in keeping with the current evidence base.
- Developing and maintaining psychological therapy care pathways for patients presenting with different levels of complexity, across a range of primary, secondary and tertiary care services.
- Advising on (evidence-based and sustainable) innovations in psychological and psychotherapeutic practice.
- Establishing and monitoring a clinical governance framework for psychological and psychotherapeutic treatments.
- Developing protocols regarding the use of psychological and pharmacological interventions.
- Planning and developing new services in line with local, regional, and national priorities including within the field of academia and research.
- Supporting the mental health of the workforce, to ensure the delivery of psychologically minded practice and supporting teams to enable them to sustain compassionate care for their patients. Given the consultant medical psychotherapist's skillset, this may also include leading staff wellbeing services.

- Bringing their distinctive medical, psychiatric, psychological, and psychotherapeutic perspective to the leadership of the organisation.
- Working collaboratively with a range of other psychological professions across the workforce.

Training Role

Consultant medical psychotherapists have a mandated essential role to play in the training of psychiatrists in specific psychotherapy capabilities and towards the overall development of psychotherapeutic psychiatrists across all levels of training and experience.

Psychotherapy Tutor

Core psychiatry training schemes are mandated to ensure that a Consultant Psychiatrist in Medical Psychotherapy is employed as the designated “Psychotherapy Tutor” (GMC 2013).

The Psychotherapy Tutor has responsibility for the leadership, educational, and clinical governance of the delivery of mandatory psychotherapy training as per Royal College of Psychiatrists curricula for core and higher specialty psychiatry resident doctors.

The Psychotherapy tutor has oversight of the core psychiatry resident doctors ensuring they have the opportunity to meet Royal College of Psychiatrists curriculum requirements for their developmental level. These requirements may include Balint groups and the delivery of psychotherapy to patients in terms of their short and long cases in differing modalities of therapy.

The Psychotherapy Tutor ensures that competencies developed in core training are extended and built upon further in higher specialty training.

The Psychotherapy Tutor along with local psychotherapy colleagues support higher speciality resident doctor (across the range of psychiatric specialties) to access a variety of psychological and psychotherapeutic opportunities, such as, Balint, case-based discussion, formulation, or reflective practice groups.

The Psychotherapy tutor in conjunction with local consultant medical psychotherapists and non-medical psychotherapy colleagues can also advise and support the higher specialty resident doctor to gain further experience in other individual or group psychological treatments locally and regionally.

All the above contributes to the continuing development of psychotherapeutic psychiatrists. The tutor along with local consultant medical psychotherapy colleagues can also support the training of non-medical psychotherapists in the use of medical psychotherapy Work-Based Placed Assessments to allow ongoing assessments of core and higher residents in psychiatry, and to maintain the relevant standards held by the Royal College of Psychiatrists ePortfolio.

The Psychotherapy Tutor also supports and actively encourages the development of psychotherapeutic thinking and integration within the biopsychosocial model of formulation throughout the training years.

In order to carry out the extensive requirements for the medical psychotherapy tutor role, the consultant medical psychotherapist needs to work within a psychological therapy service to ensure availability of psychotherapy cases for resident doctors.

Information to support job descriptions and Job Plans

In addition to their own direct contact with patients, consultant medical psychotherapists play a key role in supporting other staff in the management of patients. This activity (e.g. reflective practice groups, Balint groups, supervision) is clinical work and should be considered as part of direct patient care activity.

Consultant medical psychotherapists should have at least 3 PAs for supporting professional activities, reflecting their major and significant contribution to education and training for the whole clinical workforce, as highlighted by the section above.

Given the full scope of the Psychotherapy Tutor role outlined above, the role may comprise a combination of PA (DCC) and APA work.

Consultant medical psychotherapists commonly work in psychological therapies services alongside psychology teams and adult psychotherapists. Medical line management must be in place for consultant medical psychotherapists as this fulfils and maintains requirements for clinical governance, appraisal and revalidation, along with ensuring that the medical psychotherapist has an attainable and realistic job plan.

The GMC requirements for good medical practice must be met by the consultant medical psychotherapist 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.

Robust, designated, and timely administrative support is vital for the role of the consultant medical psychotherapist. Effective delivery of psychological therapy services requires consistency and containment within the clinical setting and this needs to be reflected in the provision of suitable rooms and equipment for the consultant medical psychotherapist and clinical service.

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principles as above. The College supports 8 DCC plus 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Medical Psychotherapy	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Referrals Management for psychological therapy services including management of waiting list	0.5
Therapeutic assessments of complex cases in out-patients, on the wards, or in patients' homes as indicated	0.5
Treatment of complex cases on inpatient wards or in the community as indicated (e.g. individual psychotherapy, group psychotherapy, family therapy)	2.5
Supervision including direct clinical supervision of clinical staff and resident doctors, 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	1
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

Neuropsychiatry

A consultant in neuropsychiatry has particular expertise in the psychiatric care of patients with organic brain disorders including acquired brain injuries, movement disorders, neuroinflammatory conditions, sleep disorders, epilepsy and other neurological conditions. They also have specialist knowledge of and skills in assessment and management of neurocognitive disorders, psychiatric aspects of complex neurodisability and functional neurological disorders. In addition to the general consultant roles set out earlier in this document, 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 symptoms associated with known or suspected neurological conditions. These may include but are not limited to Epilepsy, Movement disorders, Neuro-inflammatory disorders, Neuro-oncology, Acquired brain injury, Neuro-degenerative disorders.
- Expertise in diagnostics where psychiatric presentations are suspected to have an organic cause.
- 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.
- Assessment, diagnosis and formulation of management plans with patients and carers for functional neurological conditions.
- Expertise in assessment, diagnosis and management of neurocognitive disorders in younger adults.
- Expertise in the diagnosis and management of delirium in Clinical Neuroscience settings.
- Expertise in pre and post-operative assessment and management of neuropsychiatric presentations associated with neurosurgical procedures such as resective surgery, ablations, shunting, vagal nerve stimulation and deep brain stimulation.
- Expertise working in varied settings, including neuroscience centres, neurorehabilitation settings, specialist inpatient settings, general hospitals, residential/nursing homes and patients' own homes, with multi-professional and multi-agency teams.
- Providing expert opinion and assessment of patients for primary care, secondary hospital care, 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 in neurosciences centres or mental health settings, neuropsychiatric in-patient units, neuropsychiatric liaison on general hospital wards and neuro-rehabilitation centres. In these services, consultants work with a broad range of multidisciplinary staff from neurosciences, neurorehabilitation, mental health 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 role'. 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 4.5-5 PAs per week for direct patient care in out-patient assessments. Each clinic would typically attract 1.5 PAs (1PA for clinic plus 0.5PA administration time). New patients in the out-patient clinic require approximately 60 min. Follow-up appointments require 30 min. These times are increased when a new patient is assessed during a home visit; up to 2 h should be allowed. Clinics should be structured so that there is time built into the clinic to teach and supervise trainees.

Time needs to be made available within a job plan for urgent 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 urgent and emergency work in the form of a 'hot clinic' / urgent ward reviews.

In combined outpatient – liaison posts, consultation liaison visits to in-patients will vary in complexity and level of need and times to provide assessment are variable, depending on the patient and the context in which they are being seen.

Multidisciplinary working necessitates attendance at multidisciplinary team meetings to discuss neuropsychiatric aspects of patient care.

Neuropsychiatrists working in teams (resident doctors, ACPs, nursing staff) require 1 PA, which includes time for a weekly meeting plus support and advice to members of the multidisciplinary team about patient care outside the team meeting. Neurosciences centres will require neuropsychiatric input to some of the core weekly, bi-weekly and monthly MDT meetings and sessional time should be made available for this if the consultant is required to attend.

Additional clinical administration time is needed for attendance at multidisciplinary complex patient reviews / requests for 1:1 complex case discussions with wider members of the neurosciences and/or mental health team – a minimum of 0.5 PA per week is recommended and could be used flexibly for urgent reviews where no meetings are scheduled. Some jobs will need specific sessional time for analysis and reporting such as EEG and PSG data for sleep clinics. This is uncommon but should be considered in relevant circumstances.

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 out-patient	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Outpatient work (clinic and associated admin)	5
MDT Team meetings and support for members outside the meeting	1
Urgent/Emergency clinical work	1
Complex case discussions/ urgent reviews	0.5
Supporting Professional Activities (SPAs) including 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.

Full-time neurosciences liaison neuropsychiatry posts

This job would require a balance between outpatient clinics and ward-based liaison work. There could be a combination of between 1 and 3 PAs for outpatient clinics and 1–3 PAs for ward assessment and advice. In total, these two roles should amount to 5 PAs.

A weekly ward round would be required to review the patients on neurosciences wards. 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	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Out-patient clinics	1-3
Ward based clinical activity including clinical decision meeting & interviewing patients and carers	5
Ward round	1
Multidisciplinary work	1
Clinical Administration	0.5
Supporting Professional Activities (SPAs) including 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.

Leadership Role

Consultant Neuropsychiatrists have an important role in Leadership. This includes:

- Leading Local clinical governance, patient safety initiatives, Quality Improvement, and innovation in clinical practice. Leading on Quality Network for Neuropsychiatry accreditation.
- Liaison with management and commissioning teams from across the wider health and social care system to engage in modelling of high-quality integrated patient care, care pathways and outcomes. Providing clinical input into commissioning and procurement exercises, for example making valid assessments of need, through to setting and monitoring appropriate standards via engagement with quality networks.
- Leadership in the profession through work with the Royal College of Psychiatrists, The British Neuropsychiatry Association, the Association of British Neurologists, the Neurological Alliance and other national / international organisations.

All Consultants should have the opportunity to develop and utilise leadership skills, with access to training and real-world opportunities to understand and influence service improvements.

SAS psychiatrists

SAS psychiatrist job plans should follow the same principles as above. The College supports 8 DCC plus 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Useful Links:

[Specialised Neurology Service Specifications \(Adult\) April 2026](#)

[Specialised Neurology Service Specifications minimum services for neurology sub-specialities](#)

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.

There are different age and need related criteria for old age services across the country, but the following criteria would be recommended.

- People of any age with a primary dementia
- People with mental disorder and physical illness or frailty that contributes to, or complicates, the management of their mental illness. This may include people under 65 years of age.
- People with psychological or social difficulties related to the ageing process, or end-of-life issues, or who feel their needs may be best met by a service for older people. This would normally include people over 70 years of age.

A consultant in old age psychiatry has a particular expertise in the psychiatric care 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.

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.
- Working with PCNs/Primary care to deliver services (please see '[Community Mental Health Framework](#)')

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 and psychiatric inpatient ward, with multi-professional and multi-agency teams.
- There is an increasing number of older adults presenting with Complex Emotional Needs, Eating disorders, Autism and ADHD, Substance Misuse and Personality Disorders and the Consultant in Old age Psychiatry has an important role in their management

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 Approved Clinician status, 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 reduces 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, but some will have roles in both settings. Liaison old age psychiatry can also be part of these roles however this is not viewed as ideal compared to a dedicated Consultant in Old Age Liaison.
- Old Age Psychiatrists like other psychiatrists can deliver care in non-traditional methods including remote working and hybrid working which can have its own unique challenges. Initial medical assessments should preferably be conducted face to face.
- Old Age psychiatry continues to evolve with Old Age Psychiatrists being appointed as consultants providing care in Crisis teams for older adults, Care home liaison and home treatment, working with PCNs.

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 30min for assessment, with 30 to 45 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 with additional time included 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. For example, a full-time Consultant (10 PAS) could expect 4 to 7 new patient referrals a week depending on whether patients are assessed at clinic or at home (allowing for travel time depending on or/and complexity).
- The time needed for direct assessment and review may be reduced if significant parts of the assessment and management are carried out by other members of the MDT, however, time will need to be allocated to discuss the assessment and further management.

- Liaison with primary, secondary care old age medicine services, community services as well as carers and family is an important part of the old age psychiatry consultant role. This indirect patient contact will also need to be allocated time in the job plan
- 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. Clinical Supervision of non-medical professionals and resident doctors should be time-tabled separately in the job plan under DCC.
- There is an increasing number of older adults presenting with Complex Emotional Needs, Eating disorders, Autism and ADHD, Substance Misuse, Personality Disorders. If there are no age appropriate services available locally including dedicated old age crisis and home treatment teams then the Consultant Old Age Psychiatrist will need additional time for new assessments, review and MDT work or a smaller caseload.
- Time for the completion of necessary clinical administrative tasks from clinical work will need to be allocated in the job plan separately.
- Most jobs will need 1 programmed activity (PA) for clinical administration. Most clinicians are reporting a significant increase in clinical administrative duties, resulting from direct patient contact including recording assessments on electronic records, clinical letters to other professionals, ordering and reviewing investigations, DVLA assessments etc.
- 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.
- It is difficult to be precise about the required number of old age consultants per population served. Many factors influence the appropriate caseload 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.

- 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).
- 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 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 National or NICE or similar quality standards to ensure that patients are receiving high-quality care.
- The above principles can also be used for consultants who work in other community-based posts such as memory clinic, crisis and home treatment teams etc (but may need modification depending on the post).

SAS Psychiatrists

SAS psychiatrist job plans should follow the same principles as below.. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Old Age Psychiatry	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Outpatient/community work (including direct patient contact, advice and guidance with other professionals, discussion with carers)	4
Multidisciplinary Team meetings	1
Mental health legislation/adult protection and mental capacity legislation work/ emergency work	1
Clinical administrative tasks	1
Supervision of non-medical practitioners and MDT, clinical supervision of trainees	0.5
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

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. The following applies to both single and mixed gender wards.

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. Ideally the consultant will be available daily to visit the ward and participate in multi-professional decision making and complex risk management, especially if the service is solely for inpatients. While this may not be possible in a mixed job, adequate time should be given for remote contact within the job plan. 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.

- 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 in the preparation of the report and attendance at the tribunal. However, the increase in approved clinician, or responsible medical officer, work and the tendency towards longer and more complex tribunals may mean that 1 PA for in-patient consultants may not be adequate, and the job plan modified accordingly.
- 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 residents (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 doctors. These trainees require closer supervision and this needs to be factored into the consultant's job plan.
- Some services may not have access or support from services such as Care of The Elderly, Neurology or Advanced Nurse Practitioners. If this is the case, then the job plan will need to reflect the extra time needed to manage these additional physical conditions.
- Principles of caseload analysis discussed for community psychiatrists also apply to in-patient consultants. 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.

FT Consultant - functional illness	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Ward-based clinical decision meeting, interviewing patients and meeting carers, MDT supervision of non-medical practitioners, clinical supervision of residents	6
Mental health legislation mental capacity legislation work	1
Clinical administrative tasks	0.5
Supporting Professional Activities (SPAs) including 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 older adults can manage between 14 and 17 beds with additional support from another middle grade and /or an ST4–6 preferably with section 12 approval (or equivalent).The consultant would expect to supervise a more junior doctor to assist in the management of the physical healthcare needs of these patients. The work relating to mental health act work and mental capacity act may vary from hospital to hospital and should be job planned accordingly.

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. 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 in the preparation of the report and attendance at the tribunal.

This work is likely to require a minimum of 1 PA per week for all in-patient consultants. However, the increase in approved clinician, or responsible medical officer work and the tendency toward longer and more complex

tribunals may mean that 1 PA for in-patient consultants may not be adequate, and the job plan modified accordingly.

Other clinical administrative tasks concerning in-patient care (e.g. unscheduled telephone calls to patient's relatives/ carers, correspondence, checking of blood tests, neuroimaging and metabolic parameters) 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 residents (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 doctors. These trainees require closer supervision and this needs to be factored into the consultant's job plan.

Some services may not have access or support from services such as Care of The Elderly, Neurology or Advanced Nurse Practitioners. If this is the case, then the job plan will need to reflect the extra time needed to manage these additional physical conditions.

Principles of case-load analysis discussed for community psychiatrists also apply to in-patient consultants. 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.

FT Consultant - dementia and assessment treatment	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Ward-based clinical decision meeting, interviewing patients and meeting carers, MDT supervision of non-medical practitioners, clinical supervision of residents	6
Mental health legislation mental capacity legislation work	1
Clinical administrative tasks	0.5
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

The consultant would expect to supervise a more junior doctor to assist in the management of the physical healthcare needs of these patients. The work relating to mental health act work and mental capacity act may vary from hospital to hospital and should be job planned accordingly.

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 with relevant skills who will require clinical supervision and leadership from the consultant involved in the service delivery and such will need dedicated time to deliver this.

Sector-based posts

In areas where consultants provide both in-patient and community services, the principles set out for community and inpatients apply with time allocated for travel between the two. Sector based posts are likely to require a balance of PAs for both wards based and community-based work. The population size of community patches and number of in-patients will need to be adjusted according to the number of sessions. It would not be feasible for a consultant to attend the ward each day but should be available to discuss issues that might arise with their patients. They should have flexibility within their timetable to allow this and to be attend the ward at short notice if necessary.

Crisis/Home based treatment and Intensive support Consultants

Consultants may be appointment to provide input for older adults as part of a Crisis or Home-Based treatment. This can include people with functional illnesses as well people with dementia and the wider team will need to have the relevant skills to manage the full range of presentations of older people. If the wider MDT do not possess the relevant skills then the consultant will need more time with assessment and management. Consultants contracted to posts in crisis team/home treatment for Old age psychiatry only should not be

expected to provide clinical input for working age adults (unless they have been appointed to provide ageless care or if the patient has dementia of early onset). The timetable will be similar to a consultant based in the community.

Principles of case-load analysis discussed for community psychiatrists also apply to allow calculation of a viable, timetabled job plan.

Perinatal Psychiatry

Consultant perinatal psychiatrists have expertise in the prevention, assessment, and management of mental disorders newly occurring or coexisting with pregnancy or the postpartum period, including assessment of the parent-infant relationship. Perinatal Mental Health Services see patients for pre-conception assessments, during pregnancy, and in the postnatal period until the end of the first postnatal year. In England, patients can be offered continued access to perinatal services into the second postnatal year.

Consultant perinatal psychiatrists see patients with severe mental illness and moderate mental illness with additional complex psychosocial needs or comorbid conditions. This extends to pre-conception care for patients with severe mental illness and caring for patients with a history of severe mental illness who are currently well but who are at high risk of relapse during the perinatal period. Consultant perinatal psychiatrists work in collaboration with fathers/co-parents and other family members to help them support the patient in their recovery. In England, this extends to offering partners an assessment and signposting for further mental health support. Posts may include inpatient mother and baby unit, perinatal community, and maternity liaison responsibilities.

Clinical Role

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 relationships, and the developing relationship with the infant from pregnancy onwards.
- Understanding of psychopharmacokinetic and psychopharmaco-dynamic alterations occurring in pregnancy, the early puerperium, and in breastfeeding.
- Understanding of physical problems that may arise during the patient's journey through pregnancy and the puerperium, including the physiology and complications of childbirth, and ensuring patients have access to assessment, monitoring, and interventions to improve their physical health.
- Understanding of legislation and guidance in relation to child and adult safeguarding including child protection and domestic abuse.

- Understanding of embryology, fetal, and early infant development.
- Understanding of the normal parent-infant relationship and its development through early childhood.
- Understanding the prevention, detection, and management of mental disorders in pregnant and postnatal patients, the interrelationship between mental disorders and pregnancy and the postpartum period, and the wider effects of mental disorders on child development and the parent-infant relationship.
- Diagnose and formulate management plans in complex cases, including decisions on prescribing in pregnancy and breastfeeding.
- Formulate individualised comprehensive perinatal care plans following pre-birth planning meetings.
- Assess and manage risk, including understanding the risk of relapse associated with specific mental illnesses in the perinatal period, the risk of suicide, and the risk to children.
- Deliver care which responds to maternity time scales and adjust thresholds to distinctive perinatal needs and complexity.
- Perinatal psychiatrists see the full range of psychiatric disorders and when needed are required to joint work with other mental health teams, such as adult mental health, learning disabilities, addictions, eating disorders, and child and adolescent teams.
- Provide prescribing advice on psychotropic medication in pregnancy and breastfeeding to patients and their families, general psychiatry, maternity and primary care services.
- Provide expert assessment of the parent-infant relationship in the context of acute parental mental disorder, recognising any disturbances in bonding and attachment, and identifying areas necessitating support and intervention.
- Understanding of policies and national guidelines relating to perinatal psychiatry, and parental and child health, including those from the Confidential Enquiry into Maternal Deaths, NICE, Scottish Intercollegiate Guidelines Network (SIGN), and relevant government strategic policy documents.

- Ensure that perinatal mental health services meet the standards set out by the accreditation and peer review processes of Perinatal Quality Network (PQN), a member of the Royal College of Psychiatrists Centre for Quality Improvement (CCQI)
- Work collaboratively with other psychiatric services, maternity services, primary care, health visiting, social care, and other safeguarding teams, to ensure optimum outcomes for the patient and child.
- Work by involvement of the patient, and their family where appropriate, as an active partner in treatment, including facilitation of the patient's ability to make informed decisions about their care and the welfare of their pregnancy/child.

Leadership Role

- Awareness of guidelines and national frameworks for service provision as these develop. Leading the process of revision and accreditation of their own and other perinatal services, in accordance with national guidelines.
- Skills in the participation in, and responsibility for, clinical governance activities and quality improvement activities, including audit of practice 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 patients and the promotion of infant health and development in the context of parental mental illness.
- Ensuring that underrepresented communities access perinatal mental health care and that there are strategies in place to ensure effective engagement of all communities, including minority ethnic, LGBTQ, and those with other protected characteristics.
- Developing partnerships between agencies involved in the care of pregnant and postnatal patients who experience mental disorders, including primary care, health visiting, maternity services, social care, general psychiatry, the voluntary sector, and services providing urgent and emergency care such as A&E, liaison services, and crisis teams.

- Ensure perinatal services routinely collect recommended process and outcome measures on patients' mental health and experience of care, and the parent-infant relationship and receive feedback from patients and their carers.

Educational Role

- Challenging stigma and discrimination against pregnant and postnatal patients with mental disorders, by teaching and raising awareness with the public, public representatives, professionals, and patients.
- Designing and delivering training packages including provision for the specialist perinatal mental health workforce and for non-specialists involved in the care of pregnant and postpartum patients, including general psychiatric teams, GPs, obstetricians, re doctors, midwives, health visitors, and psychological treatment services such as NHS Talking Therapies and other national equivalents.
- Enhancing public mental health through physical health promotion in pregnancy, and education for patients and professional groups on transgenerational effects of poor parental 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 the local birth rate, whether all elements of service provision are included, the size and composition of in-patient and community teams, the number of maternity units, geographical distribution, and the population served. In addition, those providing maternity liaison services in larger centers will have to take account of a 'drifting in' of more complex cases to centers of maternity expertise.

SAS psychiatrists

SAS psychiatrist job plans should follow the same principle as above. The College supports 8 DCC; 2 SPA for both specialty and specialist psychiatrists. The model job plan for SAS psychiatrists should reflect the 0.5 SPA difference, which should be added to patient facing DCC. If the SAS doctor does not have formal or informal educational responsibilities in relation to resident doctors, medical students and other health professionals, the specific time allocated for this in the consultant model job plan should be added to DCC activities for either patient reviews or for liaison with families/carers/other professionals in relation to patient care as appropriate to the service and their role in the team.

Perinatal - Mother and baby unit	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Multidisciplinary team meetings and support for team members outside the meeting	2
Meetings with patients and carers	1
Clinical administrative tasks	1
Out-patient and maternity liaison work	1.5
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
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

Perinatal - Community Services	
Description	Professional Activities
Direct Clinical Care	7.5
Including:	
Out-patients work/home visits	3
Multidisciplinary team meeting/support for team members outside the meeting	1
Emergency work/liaison visits	0.5
Complex patient reviews/child safeguarding meetings/mental health legislation work	1
Clinical administrative tasks	2
Supporting Professional Activities (SPAs) including CPD, QI Activity, supervision, appraisal and job planning	2.5

Rehabilitation Psychiatry

Rehabilitation psychiatrists work with people with long-term and complex mental health problems, the majority of whom have a diagnosis of schizophrenia or other types of psychosis. People who require mental health rehabilitation are those whose problems are of such complexity or severity that they are unable to be discharged home following an acute admission or whose needs cannot be met by general adult services in the community. These difficulties 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, a motivation, blunted affect), and/or 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 may lead to challenging behaviours that impede recovery and increase the risk of adverse outcomes. Significant long-term physical health problems are also commonly present.

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

- Inpatient rehabilitation wards (including: high-dependency rehabilitation units; community rehabilitation units; longer term high dependency rehabilitation units; highly specialist rehabilitation units)
- Community mental health rehabilitation teams

Clinical Role

In addition to the general roles of the consultant, the consultant in rehabilitation psychiatry has the following specific expertise:

- Detailed assessment and management of patients with complex psychosis. 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 mental health and mental capacity legislation, safeguarding processes, and the Court of Protection
- Detailed knowledge of local mental health supported accommodation provision
- Expertise in managing patients' transitions between different settings.
- Providing 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 people with complex mental health needs.

Leadership Role

- The consultant in rehabilitation psychiatry uses their leadership skills alongside their experience in conflict resolution and good communication in everyday clinical practice to manage the challenges of 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, education, vocational training and employment.
- Rehabilitation psychiatrists should be part of local funding processes 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 (if they are sent away).

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 subject to compulsory treatment, and the staffing of the rest of the team, including the amount of CT1–3, ST4–6 and S time. The geographical spread of services also needs to be considered given the importance of having both community and rehabilitation consultant provision in all catchment areas.

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	
Description of service	Professional Activities
High-dependency inpatient 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, care review meetings, family interventions, mental health legislation work, clinical administration	7.5
Long-term high-dependency rehabilitation unit (average 14 beds, most patients on compulsory treatment, average length of stay >2 years): direct patient care, assessment of referrals, care review meetings, family interventions, mental health legislation work, clinical administration	6
Community rehabilitation unit (average 14 beds, may have patients on compulsory treatment, average length of stay 18 months): direct patient care, care review meetings, assessment of referrals, family interventions, mental health legislation work, clinical administration	4
Community rehabilitation team (average case-load 80, some patients under CTO): direct patient care, home visits, care review meetings, weekly MDT meeting, family interventions, mental health legislation work, clinical administration	7.5
Other specialist tasks: assessment of patients placed out of area and attendance at their care review meetings, membership of placement funding panel (usually monthly), assessment and advice to colleagues regarding patients with complex needs, assistance to supported housing providers.	1

SAS Psychiatrists

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