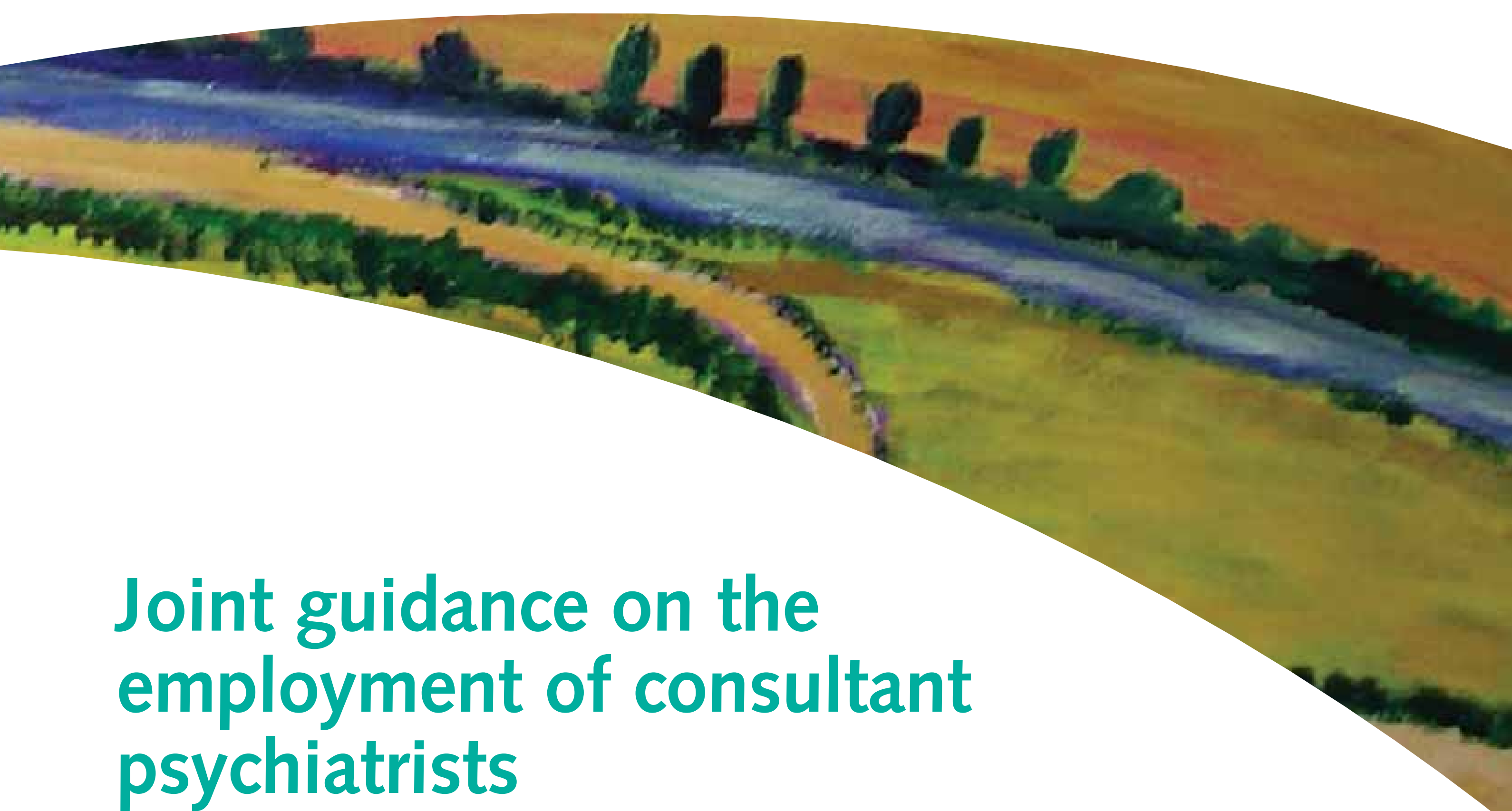
Department of Health



Joint guidance on the employment of consultant psychiatrists

Royal College of Psychiatrists
NHS Confederation
National Mental Health Partnership

Supported by the National Institute for Mental Health in England and the Department of Health in conjunction with the Sainsbury Centre for Mental Health

This guidance is intended for Trusts, regional advisers, and commissioners of mental health services to understand the factors involved in:

- creating roles for consultant psychiatrists
- maintaining current posts for consultant psychiatrists
- recruiting psychiatrists for those roles
- developing effective working relationships for consultant psychiatrists
- promoting new ways of working

Care Services Improvement Partnership CSIP

National Institute for
Mental Health in England

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DH INFORMATION READER BOX

Policy	Estates
HR/Workforce	Performance
Management	IM&T
Planning	Finance
Clinical	Partnership working

Document Purpose	Best Practice Guidance
ROCR Ref:	**Gateway Reference:** 5068
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Circulation List	
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Action Required	To consider how best to use the guidance in the light of local needs and circumstances
Timing	
Contact Details	Roslyn Hope Director, NIMHE National Workforce Programme, NIMHE North East, Yorkshire and Humber Development Centre Genesis 5, Innovation Way off University Road Heslington York YO10 5DR e-mail: roslyn.hope@nimhe.wmids.nhs.uk
For Recipient's Use	

Contents

1.	**Foreword**	**3**
2.	**Executive summary**	**5**
3.	**Introduction, purpose and coverage**	**8**
4.	**Developing the foundations for an effective working relationship**	**10**
5.	**Service development – Implications for change**	**16**
6.	**Creating posts for consultant psychiatrists**	**24**
7.	**Role of the Royal College of Psychiatrists advisers**	**27**
8.	**Process of recruitment**	**29**
9.	**Appendices**	
	Appendix One – Consultant contract for England	**34**
	Appendix Two – Consultant duties and responsibilities	**44**
	Appendix Three – New Roles & Staff Skills Map: The Creating Capable Teams Toolkit	**45**
	Appendix Four – Framework for developing consultant psychiatrist job descriptions and person specifications	**47**
	Appendix Five – Membership of joint guidance group	**51**
10.	**References and other resources**	**53**

1. Foreword

Health and social care in the UK has been transforming at an unprecedented rate in recent years, with myriad inevitable pressures and drivers including political changes (such as devolution and new legislation), social changes and new technologies. In each country, these are being translated into service development in different ways, but the direction of travel, the opportunities and challenges presented are broadly similar. For mental health services, for the people who provide them and for those who use them, there is a need to respond to such a changing world and to consider what it means for them and their future.

However, in addition to the need for such responsiveness, some professions have identified further internal problems with existing practice, leading to some fundamental rethinking of roles and how they may create a better, more effective and rewarding way of providing services. For consultant psychiatrists (and others), this work has been overseen by the National Steering Group on New Ways of Working, which produced an Interim Report in August 2004 that pointed the way to solving some of the historical problems and responding effectively to the new challenges. The final report will be produced concurrently.

The Royal College of Psychiatrists has previously produced guidance on consultant job descriptions (commonly known as 'the Red Book') with the aim of driving up standards of services and improving the training of doctors. Specifically, it was to help employers clarify their expectations of psychiatrists, to consider their working environment and to help consultants by ensuring they had reasonable workloads.

Therefore, as we move into an era of ever greater change, there is a need to adopt more flexible and adaptable professional roles, while at the same time safeguarding and improving standards of practice and training. So new guidance is needed to reflect these realities in order to enable Trusts, and the consultants who work in them, to strike the right balance and be as clear as possible about the expectations each has of the other. That is the purpose of this document.

In order to achieve such a balance and create the circumstances for productive agreement at local level, this document has been produced in partnership and collaboration with the Royal College, the NHS Confederation and the National Mental Health Partnership. In addition, it has been supported and sponsored by the National Institute for Mental Health in England, the Changing Workforce Programme and the Department of Health in England. The intention has been to reflect the consensus views of the psychiatric profession and NHS employers on good practice in employing consultants. As such, it is joint guidance, which replaces the College 'Red Book' and which we hope will be a powerful tool in promoting the best outcomes for psychiatrists, Trusts and for the people who use mental health services.

The process involved in producing this document began from an English perspective, and therefore the recommendations apply primarily to England. Nonetheless, discussions have also begun with colleagues and representatives from Northern Ireland, Scotland and Wales. We hope that similar agreements can be negotiated in each of those countries, based on the principles contained herein. We recognise that they may need to be adapted to ensure that they are appropriate to each jurisdiction.

Producing this guidance has depended on good will and collaboration on all sides. It has not always been easy, but there has always been a clear focus on being constructive and on resolving issues effectively for the good of all. It is to be hoped that the same level of co-operation and understanding will continue to be reflected in local services.

We also anticipate that NHS Foundation Trusts will use this guidance as indicated and find it helpful. Foundation Trusts are public benefit corporations independent of the Secretary of State. As a consequence, they are not performance-managed through NHS machinery, nor are they bound by guidance on such issues as appointments. However, Foundation Trusts will want to get the best possible advice on issues such as consultant appointments. On behalf of Foundation Trusts, the Foundation Trust Network is developing a concordat with the Royal Medical Colleges on such appointments. The Royal Colleges are clarifying what they can offer as a service to Foundation Trusts in making such appointments, and the Foundation Trust Network is issuing guidance to Foundation Trusts to ensure they are clear about the nature and level of involvement they want from Royal College nominees and the kind of support they might offer to such nominees when they choose to use the services offered. It is expected that the concordat and guidance will be issued in July 2005. When mental health Trusts become Foundation Trusts they will be able to avail themselves of the concordat and accompanying guidance.

Hugh Griffiths
Chair, Joint Guidance Group

2. Executive summary

Introduction

Mental health and social care across the UK are undergoing radical change and expansion, with significant investment, policy change and guidance to deliver better services. Each country has developed its services in line with its mental health development agenda, and this has led to new service configurations, teams and individual roles.

This guidance has arisen out of a broad, strategic approach to New Ways of Working (NWW) for psychiatrists, led by a National Steering Group, jointly chaired by the Royal College of Psychiatrists and the National Institute for Mental Health in England (NIMHE). It published an Interim Report on New Ways of Working for Psychiatrists in August 2004, and a final report will be published concurrently.

This guidance replaces previous guidance, issued by the Royal College of Psychiatrists, on 'Model Job Descriptions and Recommended Norms' for consultant psychiatrists, with job numbers based on population catchment sizes. As services and roles are changing, so there is a need to provide a more flexible approach to planning for and assessing consultant roles, within the context of the team and the service required by service users and carers.

Foundations for an effective working relationship

For a constructive working relationship, the consultant psychiatrist, the employer and the service user/carer need to be clear about their respective expectations. Central to this are the consultant job plan, the multidisciplinary team and the contractual framework for the post. Employers, consultants and teams need to work closely together to redefine services to meet the needs of service users and carers. It is important to make clear:

- what the consultant psychiatrist can expect from the employer;
- what the employer can expect from the consultant psychiatrist;
- what service users and carers can expect from the consultant psychiatrist;
- how the relationship will be supported and managed;
- expectations for role development over time.

Often these are unspoken expectations, which can result in conflicting perspectives and viewpoints. These can, in turn, lead to tensions in working relationships and in relationships with users and carers. Making expectations clear is not intended as a restrictive process, but as one that allows positive and productive working arrangements to be created.

Consultant psychiatrists are a scarce resource, so their role and responsibilities should seek to make the best possible use of their time. The precise nature of this will vary depending on the service, the service user/carer group, geographical patch, other members of the team and other services accessible for service users.

Service development implications for change

Mental health policy in the UK has been undergoing modernisation in recent years. The direction of travel has been towards community-based, person-centred services within a context of social

inclusion. The need for capability development to work in partnership with people who use services and their families, using recovery, values and evidence-based practice has also emerged.

It is vital that Trusts, with their consultant psychiatrists, other health and social care practitioners and partner agencies, create services and staff roles in a system that is understandable and effective for service users. The guidance provides brief descriptions of each specialty: general adult and community psychiatry, child and adolescent psychiatry, forensic psychiatry, liaison psychiatry, psychiatry of learning disability, psychiatry of old age, psychotherapy, rehabilitation and social psychiatry and substance misuse. The development of the role of psychiatrists needs to be considered in the context of both general service change and their own specialty.

Mental health reform has put a greater emphasis on services based in the community, and this aims to provide: (1) treatment and care that are close to home, including acute hospital care and long-term residential facilities; (2) response to disabilities as well as to symptoms; (3) treatment and care specific to the diagnosis and needs of each individual; (4) consistency with international conventions on human rights; (5) a focus on the priorities of service users themselves; (6) co-ordination between mental health professions and agencies; and (7) services which are mobile rather than static (Thornicroft & Tansella 2004).

Workload measurement/caseload indicators

Job planning It is expected that the job planning process and annual reviews will become the mechanism for defining what is expected of the consultant psychiatrist, supported by the job description and person specification for the post. This moves away from workload measurements and population norms, used previously, to devise a challenging but achievable consultant role. It is no longer appropriate to judge consultant workload in isolation; the consultant's role needs to be placed within the context of the service and the multidisciplinary team.

Consultant indicators Whilst the job planning and the annual review process become established, there needs to be some indication of consultant job size. Guidance is suggested, whilst services are in a transitional stage (based on previous guidance from the Royal College of Psychiatrists). They are offered as a guide only and should not be used as prescribed maxima or minima. It is expected that services would make rapid progress in moving from a reliance on indicators to using effectively the Creating Capable Teams Toolkit and job planning, and the inention is to review progress and this Joint Guidance document within three years.

Creating Capable Teams Toolkit In reflecting on the consultant role there should be a review of team function, capabilities (values, knowledge and skills/competencies) and skill mix. To aid this process, a Creating Capable Teams Toolkit has been devised and is being piloted. The toolkit will help teams achieve greater clarity about local needs and the number and mix of skills required within mental health teams to meet service user needs. This will enable the role of the consultant psychiatrist to be considered and agreed to maximise opportunities for NWW. This will result in an effective, efficient and cohesive whole-team approach that places service user need at the centre of modern mental health services.

The role of the Royal College of Psychiatrists advisers

In each area of the country, the Royal College of Psychiatrists has 'advisers' and 'deputy advisers'. These College advisers are called 'regional advisers'. They have a close relationship with the postgraduate deaneries and are sometimes also called 'deanery advisers'. In addition to regional advisers, each faculty appoints consultants to represent their specialty in local areas, and these people are known as 'regional representatives'.

The regional advisers are representatives of the College on all matters relating to postgraduate education in psychiatry. They will have considerable knowledge of local services and training issues, and can give advice on the development of posts and services. The adviser can be helpful to Trusts when they are having difficulty in filling particular posts.

The Royal College of Psychiatrists regional advisers have a formal role with Trusts in formulating consultant roles, preparing job descriptions, person specifications and job plans, and in resolving any difficulties related to consultant posts.

The process of recruitment

The process for appointing consultants is laid down in The National Health Service (Appointment of Consultants) Regulations 1996 as amended (see references) and good practice on recruiting consultants is provided in The National Health Service (Appointment of Consultants) Regulations Good Practice Guidance 2005.

The regional adviser of the Royal College must be involved in the development of the job description, person specification and selection criteria drawn up for the post. This is to ensure the post contains a proper balance of clinical, academic, research and managerial activities to be performed. It is expected that job descriptions and person specifications will be agreed with the regional adviser.

The process of recruitment, as laid down, covers:

- preparing job descriptions and person specifications;
- preparing selection criteria;
- advertising;
- the interview panel, the Advisory Appointments Committee (AAC);
- exemptions to the normal process of recruitment, e.g. honorary appointments.

The guidance provides a framework to assist Trusts in creating comprehensive job descriptions and person specifications

Developing consultant roles in a modernised mental health and social care service

It is essential to move away from prescription of services, current working practices and numbers of posts, and to move towards a more flexible approach that directly addresses the needs of the population, the service configuration, the capabilities required of staff and the roles to be undertaken by all professions. Consultants need to know what they can expect from their employers; Trusts need to be clear and reasonable in their expectations of their consultant psychiatrists; and both need to be working to meet service user and carer expectations.

This new guidance seeks to spell this out. Unlike its predecessor, this guidance is produced jointly by the Royal College of Psychiatrists, and the NHS Confederation and National Mental Health Partnership, as representing the views of mental health Trusts. It is sponsored by the Royal College of Psychiatrists, NIMHE, the Changing Workforce Programme and the Department of Health.

3. Introduction, purpose and coverage

This guidance has arisen out of a broad, strategic approach to NWW for psychiatrists, led by a National Steering Group, jointly chaired by the Royal College of Psychiatrists and the National Institute for Mental Health (NIMHE). It published an Interim Report on New Ways of Working for Psychiatrists in Multidisciplinary and Multi-Agency Contexts in August 2004.

The original purpose of the guidance issued by the Royal College of Psychiatrists on job descriptions for consultant psychiatrists, together with their associated norms, was to drive up standards of services and the training of doctors. Specifically, it was to help employers clarify their expectations of psychiatrists, to consider their working environment, and to help consultants by ensuring they had reasonable workloads.

The guidance has been updated over time, the most recent being published in 2002. It has covered all specialties reflected in the College faculties. Overall, recommendations have specified population size per consultant and these have been reducing over time.

Although the guidance was not intended to be heavily prescriptive, it has been interpreted in many different ways. This has caused problems, on occasion, between Trusts and Royal College regional advisers.

The norms associated with posts assume service models, which do not take full account of NWW and new services, except as an addition to existing workload and traditional geographic responsibility. There is, therefore, a mismatch between the guidance and new service developments.

There have also been significant consultant vacancies in many services, and this varies geographically and across specialties. This has led to a significant increase in the use of locums to address vacancies, often resulting in overspend and poor value for money.

Psychiatrists, as is evidenced by two national conferences in 2003 and subsequently reinforced by internal college consultation, are unhappy with their jobs. They feel over-worked, ineffective due to lack of time and span of responsibility, and burdened by perceived overall responsibility for all secondary care service users.

Although there has been a significant increase in the number of consultant psychiatrists, 24 per cent from 1999–2004 (Department of Health Census 2004) and further training numbers planned, it is possible that there will be insufficient consultant psychiatrists to meet service demands. The current Royal College guidance, if implemented fully, would require a further 3,000 posts in England alone.

Furthermore, people who use services, and their carers and supporters, have been critical of those services: long waiting times, short consultations, sometimes an over-reliance on a 'medical model' of their problems, and lack of continuity due to reliance on locums. They want to be central to the assessment and care planning process, feel valued for their contribution and have outcomes that are meaningful to them.

The Interim Report from the National Steering Group stated that 'The overall purpose of the Mental Health Workforce Strategy for England, led by NIMHE and supported by all partners, including the Royal College of Psychiatrists, is to ensure that services reflect the needs and preferences of the population they serve, are delivered by sufficient numbers of well trained staff who have the appropriate capabilities and are well led and effectively managed.' Similar work is ongoing in Wales, Scotland and Northern Ireland. Services of this kind will meet the needs and wishes of the people who use them and their families and supporters.

So, things need to change. We need to support consultant psychiatrists and their employing Trusts to develop services that satisfy users and bring job satisfaction to the psychiatrists and to other members of the multidisciplinary team. We need to promote NWW for all staff in order to make the best use of their expertise, and to develop new roles to meet the increasing demands for services from people with mental health needs. The use of care pathways for the service user can highlight where the consultant psychiatrist can use his or her skills to best effect.

The solutions to achieve this outcome will vary according to local needs and circumstances. It is essential, therefore, to move away from prescription of services, current working practices and numbers of posts, and to move towards a more flexible approach that directly addresses the needs of the population, the service configuration, the capabilities required of staff and the roles to be undertaken by all professions. We need to ensure that consultants know what they can expect from their employers and that trusts are clear and reasonable in their expectations of their consultant psychiatrists.

This new guidance seeks to spell this out. We would hope that services would make rapid progress in moving from a reliance on indicators to using effectively the Creating Capable Teams Toolkit and job planning, and the intention is to review progress and this guidance in three years.

This document has been primarily written for use in England, with the aim that it will also be helpful in Scotland, Wales and Northern Ireland. Although starting points may differ, we expect that the outcomes will become similar and lead to an improvement for all.

4. Developing the foundations for an effective working relationship

Introduction

For a constructive working relationship the consultant psychiatrist and the employer need to be clear about their respective expectations. This chapter considers the expectations a consultant will have of their employer in their role, their support and development. It also considers the expectations of the employer and how these are then framed through the contract and the job plan.

What the consultant psychiatrist can expect from the employer

The consultant should expect to be supported from the day of appointment and thereafter throughout his/her career. This can best be achieved by clear agreements as to the scope, expectations and responsibilities of the role, and by making use of the consultant contract to enable job planning, reviews, and agreed objectives. 'Consultant Job Planning – Standards of Best Practice' (2004) gives more detail of how employers should support consultants.

NHS employers need to work closely with consultants to help redefine services around the needs of service users. Ways of working for consultants and wider clinical teams also need to take into account:

- the planned expansion in consultant numbers;
- the implementation of the European Working Time Directive; and
- Modernising Medical Careers and changes to teaching and education practices.

Alongside these changes, organisations should be seeking to make ongoing improvements to the quality of consultants' working lives. This includes:

- helping manage consultant workload, through effective deployment of consultant expansion, optimum prioritisation of work, better administrative support, and greater delegation of some duties to other members of the health care team as appropriate;
- supporting consultants who wish to work in more flexible ways, for instance by better organising work to reflect family responsibilities, using annualised hours or similar approaches, where appropriate, to fit around childcare responsibilities, and introducing job shares;
- a more planned and phased approach to consultant careers, with – for instance – greater opportunities for more senior consultants to adapt their range of duties and greater use of sabbaticals;
- greater rewards for those who make the greatest contribution to the NHS.

In addition, the table below sets out how supporting services should be agreed on an annual basis to ensure that consultants can be supported and that best possible use is made of their time.

This should also be in place prior to the consultant taking up a post; they will need administration/secretarial support, office accommodation, telephones and IT equipment.

Supporting resources

- The consultant and his or her clinical manager will use Job Plan reviews to identify the resources that are likely to be needed to help the consultant carry out his or her Job Plan commitments over the following year and achieve his or her agreed objectives for that year.
- The consultant and his or her clinical manager will also use Job Plan reviews to identify any potential organisational or systems barriers that may affect the consultant's ability to carry out the Job Plan commitments or to achieve agreed objectives.
- The Job Plan will set out:
  - agreed supporting resources, which may include facilities, administrative, clerical or secretarial support, office accommodation, IT resources and other forms of support;
  - any action that the consultant and/or employing organisation agrees to take to reduce or remove potential organisational or systems barriers.

What the employer can expect from the consultant psychiatrist

The employer should expect the consultant, as a senior and professional employee, to become an integral part of the Trust staff, and that there are mutual obligations in order to achieve the best service for users and their carers.

To do this it will be essential to:

- co-operate with each other;
- maintain goodwill;
- carry out respective obligations in agreeing and operating a Job Plan/contract;
- carry out respective obligations with appraisal arrangements;
- have respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols;
- support service improvement and organisational development.

What service users can expect from their psychiatrist

In developing consultant psychiatrist posts, it is essential to reflect on the needs of the mental health service user and ensure these are reflected in the job description and person specification for the post.

'Service users can expect to be treated respectfully at all times. The human and therapeutic quality of the relationship between the psychiatrist and the service user is a key factor that facilitates recovery. The psychiatrist will be aware that the service user may feel nervous about the interview, and will always introduce any other persons present and explain their reasons for being present. The service user will be entitled, where practicable, to bring an advocate or other suitable person with her/him for moral support, and information on advocacy services that may be available will be provided. Information about the local mental health, social and community services will be provided, and advice offered on understanding what choices are available to the service user, or information on where such advice can be obtained. Service users, who speak languages other than English, or who have learning disabilities or communication difficulties will be entitled to information that is accessible to them.

Service users can expect that psychiatrists will be as open as possible in giving information. This could include: written and verbal information about the purpose of the psychiatric appointment or ward round, what the service user can expect from the psychiatrist, what diagnosis has been given, what this diagnosis means, and where to find other information and help in relation to this diagnosis, e.g. voluntary organizations. The psychiatrist may want to state any special expertise he/she has that relates to the service user's diagnosis, and explain the treatment plan, how often the service user will be seeing the psychiatrist, and the likely duration of contact. Service users who are liable to be treated under the Mental Health Act can expect that the psychiatrist will inform them about their rights and any choices available to them, and will explain the reasons why the Mental Health Act may be used. If the service user is unable to understand such explanations during a period of distress the psychiatrist will endeavour to give an explanation later as to why this was considered necessary

When treatment is prescribed, service users can expect to be given written and verbal explanations about the medication or other treatment, what to expect in terms of effects and side effects, how long it is likely to be before the treatment begins to take effect, and how long the course of treatment is likely to be necessary. The service user will be encouraged to discuss the involvement of family, friends or other carers in their treatment. The psychiatrist will be happy to answer any questions the service user has about alternative or complementary treatment approaches that might be available, any anxieties about employment and family responsibilities, and the prospects for the service user's recovery and rehabilitation.'

Jan Wallcraft, NIMHE Expert by Experience Fellow

An example of how the needs of service users can be reflected in the role and new ways of working for consultants and teams may be seen in this example from the Avon and Wiltshire Partnership Trust.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) has fostered the development of NWW for consultants by providing a central steer and then supporting local initiatives. One of these, in West Wiltshire, became one of the first pilot sites, and the changes there are now being rolled out more widely.

AWP's approach has been to encourage the development of NWW in the following way:

1. **Support from the Executive Team and the Board.**
2. **Defining the boundaries of the role of the consultant.** The Trust produced its own 'Trust Guidance on the Role of the Consultant Psychiatrist', which sought to interpret the currently available national guidance, clarify what is law and what is guidance, and define responsibilities of individuals (including consultants) and teams. The guidance supports a model of distributed responsibility, and has led to a number of practical changes which have emphasised the new approach (e.g. defining episodes of care by team rather than by consultant, PCTs no longer commissioning GP to consultant referrals). Legal advice and the endorsement of Clinical Negligence Scheme for Trusts (CNST) were obtained before the document was approved by the Trust Board.
3. **Defining the boundaries of the work of the team.** A Trust-wide workshop was held, with commissioners, service users and carers, to produce a 'framework' for the development of entry and exit criteria for services and teams. The framework was then modified according to local/speciality need.

In West Wiltshire a project was then launched to move from a traditional referral and outpatient model, to a new multidisciplinary assessment clinic. On receipt of the electronic referral (using the local acute hospital system) a senior practitioner in the team makes the decision to assess the patient and the letter inviting the patient to ring to book an appointment is sent. The patient is assessed by two clinicians from different professions; one does most of the assessment while the other types the information into a standard template which is considerably shorter than the usual 'core assessment', risk assessment and CPA. The management plan is decided upon and agreed with the patient, who receives a copy of the form. A copy is also emailed to the GP.

A service user survey has shown high levels of satisfaction with this approach, and although two clinicians see each patient there is an overall saving of staff time, as CMHT meetings can be shorter, there is less paperwork, and the DNA rate has fallen to less than 10 per cent. The consultant's skills are well utilised by their involvement in the assessment clinic. In addition, the consultant has stopped 'routine' outpatient appointments and sees patients as and when required, making use of telephone consultation when appropriate. A nurse prescriber is being trained in the team, and this will enable the SHO to concentrate on providing more intensive input to a smaller number of community patients, including supervised Cognitive Behaviour Therapy.

This way of working has now been rolled out to other teams, who have decided to develop it after seeing the results, and who have modified the model to suit local needs. The next stage of development is to improve the ability of teams to work with new cases as quickly as necessary, and their overall understanding of their caseloads; to this end a caseload management tool, which allows for risk and intensity of input as well as numbers of patients, has been developed with the local NIMHE and incorporated into the Trust's clinical information system.

Managing the relationship

It is very important that the consultant and other staff have a good experience with appointment process and that senior human resources staff are available to them in the early days of their contract and throughout their career. To ensure that they are fully integrated into the trust's culture, an induction period is needed, with the opportunity to meet senior staff, as well as the teams they will work in and with. They will need time to plan their work with their new team/teams.

For the commencement of a new role, appropriate mentoring should always be offered to the consultant.

The Consultant Contract in each UK country (Appendix One) sets out the details of the role, such as:

- post;
- work: location, job planning, programmed activities;
  - direct clinical care*;
  - supporting professional activities;
  - additional NHS responsibilities and external duties;
- other conditions and terms;
- pay and pensions;

- leave and holidays;
- other entitlements.

*Direct clinical care does not necessarily imply direct face-to-face contact with users.

Job planning

Job planning is central to assessing any consultant post, as it is the document that specifies how a consultant should use their time across the working week. Job planning should be an effective tool for planning the work of consultant psychiatrists.

Job planning mutual benefits

Effective job planning, covering the full range of consultants' NHS duties, should have strong mutual benefits both for consultants and for NHS employers.

For consultants it should help:

- clarify the commitments that are expected of them and the resources and other support they can expect from the employer to help meet those commitments;
- prioritise work and better manage excessive workload;
- promote flexible working;
- support, where appropriate, a phased approach to consultant careers;
- provide evidence of current practice that could form part of the evidence for GMC revalidation procedures.

For NHS employers effective job planning should help in:

- planning the most effective use of overall resources;
- ensuring compliance with the Working Time Regulations;
- agreeing and providing transparency as to how consultants' work can most effectively support the employing organisation's wider objectives;
- identifying possible changes in capacity, skill mix and/or ways of working;
- agreeing appropriate time and resources to support clinical governance, quality improvements, teaching, education and research.

Expectations of role development over time

Mental health services are changing rapidly. New services and approaches mean that the role of consultants will need to be flexible, so that the best possible use can be made of their knowledge, skills and experience to meet the competencies required of the role and the needs of service users and carers.

There will be an expectation that the consultant is engaged in the strategic development of services they deliver and of those provided by the Trust as their career develops over time.

The work on new and changing ways of working for consultants in mental health suggests that moving to a team-based referral system, and away from a named-consultant approach, can have benefits, in that it enables consultants to release time to deal with the more difficult and complex cases, and have time to support teams using a consultancy approach.

The teams involved gain much from having time available to discuss their work with the consultant.

Work is under way nationally, through pilot development sites, to explore NWW, including using outpatient sessions in a different way, reducing the number of sessions and making slots available for ad hoc appointments for users. These sites will be evaluated independently and reported on in 2007.

Hambleton and Richmondshire Primary Care Trust: A positive practice example

Hambleton and Richmondshire Primary Care Trust (PCT) provides mental health services to a very rural part of North Yorkshire. For many years it has provided a sectorised service, with consultants being responsible for inpatients, day patients and community patients, as well as responding to crises from GPs. As a result, responsibilities, caseloads and workloads have slowly increased.

In order to address this, it was agreed that doctors and managers would work together in order to help the consultants become more available to the teams, spend more time with severe illness and be better able to fulfil their role as clinical leaders. It was envisaged that this would all decrease the stress on the consultants.

An action plan was developed jointly by the consultants and the managers, led by the Associate Medical Director. There were three elements to this:

New consultant contract. As the consultants work so closely together, it was agreed locally that, after workload diaries were completed, the hours would be averaged for all, so that everyone was paid the same amount of programmed activities. In addition, it was agreed that all consultants would work fewer hours than the mean, which was reflected in their programmed activity payment. This resulted in the removal of any financial incentive for working longer hours.

Appraisal and job planning. This was done thoroughly with clear aims from the appraiser and appraisee to change the working practices of the consultant. All consultants already had a half-day in their Job Plan. It was agreed that all consultants would only have fixed commitments for half a day, so that they would always be available to deal with unexpected crises. It was agreed that the consultants would decrease their caseloads. In addition, extra training in management and leadership was offered to all consultants.

Team managers. The team managers worked with the Associate Medical Director to develop action plans from the document on NWW for Consultant Psychiatrists. They also helped the consultants present their role to their community teams. These actions resulted in all team members seeing the benefit to the team of the change in the role of consultants. Also the team managers developed a system of crisis intervention, where all emergency referrals were triaged by the non-medical members of teams.

The combination of these three approaches has improved the working lives of the consultants, while ensuring they are more available to other members of the teams and service users. This approach was underpinned by joint working between doctors and managers and facilitated by a robust job planning and appraisal system.

5. Service development – Implications for change

Introduction

Mental health policy in the UK has been undergoing modernisation in recent years. The direction of travel has been towards community-based, person-centred services, within a context of social inclusion. The need for capability development to work in partnership with people who use services and their families, using recovery, values and evidence-based practice has been areas that have also emerged.

In England, the development of functional teams of Assertive Outreach, Crisis Resolution/Home Treatment and Early Intervention has challenged traditional ways of providing services, in particular the role of Community Mental Health Teams and Acute Inpatient Centres. These new service configurations bring with them the potential for fragmentation and discontinuity of care. It is vital, therefore, that Trusts, with their consultant psychiatrists, primary care and other health and social care practitioners and partner agencies, work to re-engineer services and staff roles into a system that is understandable and effective for service users. The development of the role of the psychiatrist needs to be considered in this context.

Mental health services in England operate within a variety of sub-specialties in primary, secondary and tertiary care settings. What follows is a commentary and description of services currently from each specialist faculty within the Royal College of Psychiatrists: general adult and community psychiatry, child and adolescent psychiatry, forensic psychiatry, liaison psychiatry, psychiatry of learning disability, psychiatry of old age, psychotherapy, rehabilitation and social psychiatry and substance misuse.

Mental health reform has put a greater emphasis on services based in the community, and this aims to provide: (1) treatment and care that are close to home, including acute hospital-care and long-term residential facilities; (2) response to disabilities as well as to symptoms; (3) treatment and care specific to the diagnosis and needs of each individual; (4) consistency with international conventions on human rights; (5) a focus on the priorities of service users themselves; (6) co-ordination between mental health professions and agencies; and (7) services which are mobile rather than static (Thornicroft & Tansella 2004).

General adult and community psychiatry

General adult and community psychiatry operates in primary, secondary and tertiary care settings. The consultant psychiatrist role in primary care is complex and evolving, where a key challenge lies in establishing and managing effective partnerships with other local care agencies. In community mental health teams, psychiatrists offer therapeutic interventions, prioritising adults with severe mental illness, co-working with others, including community psychiatric nurses, social workers, psychologists, occupational therapists, and new roles.

The role of the consultant is likely to change, with more emphasis being placed on the following: (1) direct clinical management of people with the most complex problems; (2) greater use of advice and consultation with other members of the multidisciplinary team for those with less complex disorders; and (3) clinical leadership in the development of services. Some services are already operating in this way.

In recent years three main alternatives to acute inpatient care have been developed: acute day hospitals, crisis houses and Home Treatment/Crisis Resolution teams. Acute day hospitals offer programmes of day treatment for those with acute and severe psychiatric problems, as an alternative to admission to inpatient units. Crisis houses are houses in community settings that offer services for those who would otherwise be admitted to hospital. Crisis Resolution/Home Treatment teams offer intensive support and treatment at the service user's home or at an acute day hospital. The team can function as a gate-keeper to inpatient services, so that only those presenting higher levels of risk or difficulty in management are admitted to hospital. Assertive Outreach Teams focus on those with serious mental illness who have a repeated pattern of inpatient admissions and disengagement from traditional community services. Such teams have been shown to engage users more successfully in services, produce greater user satisfaction and fewer days spent in hospital. Early intervention services focus on those developing a psychotic illness, with the aim of early identification and treatment. The aim is to reduce the duration of untreated psychosis and produce better outcomes.

Such developments may require new roles for consultants within the multidisciplinary team. At the same time, more traditional services, such as inpatient care and the generic community mental health team, are being re-evaluated. The increased number of functionally specialised teams is raising questions about how far consultants themselves should become specialised within adult psychiatry.

Child and adolescent psychiatry

The term child and adolescent mental health services (CAMHS) is a broad concept embracing all services that contribute to the mental health care of children and young people, whether provided by health, education, social services, the youth justice system or other agencies. It includes those services whose primary or sole function may not be mental health care, e.g. general practice or schools, referred to as Tier 1. Specialist CAMHS (i.e. CAMHS at Tiers 2, 3 and 4) are provided not only within the NHS, but also by specialist social care, educational, voluntary and independent mental health services. The primary function of these services is to provide mental health care for children, young people and their families. They are mainly delivered by a multidisciplinary workforce, which has had specialist training and/or experience in child and adolescent mental health care.

Application and development of the four-tier CAMHS has created a common language for describing and commissioning services across the UK and Ireland. However, it is increasingly recognised that neither children and adolescents nor services meeting a local need fit neatly into a structural interpretation of the tiers. Children's journeys involve movement through services as their condition is recognised as more complex, or as and when conditions are ameliorated. Some children need to utilise a number of services that can involve and span each or all of the CAMHS tiers at the same time.

The tiered approach was not necessarily intended to refer to particular service structures or locations or groups of children, disorders, problems or staff, but to focus on: (1) strategy rather than organisational matters; (2) planned diversity of functions to meet the needs of the population; (3) The nature of the assessments, interventions and other work that children and young people require; and (4) promoting flexible and responsive working patterns.

Currently specialist CAMHS are functioning at levels where demand greatly exceeds their capacity, and this accounts for many of the difficulties with waiting times and lists for assessment and treatment, stress and burnout in staff, and difficulties with recruitment and retention. Service users greatly value continuity of care, clinician flexibility, reliability and continuing support. Effective multi-agency working requires time to liaise and plan. It is crucial that specialist CAMHS are

properly resourced for all these reasons. Clinicians and commissioners need to know what their service can provide within the given resources. Service users and carers need to know what to expect from their local service, and consultant psychiatrists need to be able to work within teams, where employers and employees can work together with mutual trust and respect to deliver child and family-centred, evidence-based, comprehensive services, while ensuring the continued well-being of the clinical team.

Forensic psychiatry

Over the past decade there has been a rapid expansion in this tertiary mental health service, driven by pressures acting in different directions. A substantial reduction in bed numbers in High Secure (formerly Special or Maximum Security) Hospitals has led to the expectation of more local provision of services in medium or low security. In parallel with this, extended mental health inreach to prisons identifies more prisoners who require transfer to hospital for treatment.

Acting in the other direction, there is an expectation that, where service users in the community demonstrate actual or perceived risk of serious harm to others, then an assessment by a specialist forensic mental health team is often expected. There is a developing role for forensic psychiatrists in providing expert opinions on risk management. Increasingly, service users with personality disorder are being referred, and this emphasises the need to work in a genuinely multidisciplinary manner. Clinicians from all disciplines must provide opinions on the basis of strong evidence. When this has been done, it will often remain the responsibility of the referring professional to continue to accept responsibility for managing both the mental disorder and the continuing risk. Particularly in the community, there will only be sufficient resources in the forensic services for a small minority of high-risk individuals to be directly managed by the tertiary service.

With changing service expectations, forensic psychiatrists have had to change their roles. High Secure services are now managed by large specialist mental health Trusts, and consultants employed there will have the opportunity to take up responsibilities in a variety of services, thus avoiding past risks of professional isolation. Consultants will have the chance to work in different specialist areas during their careers, such as rehabilitation, personality disorder and community work. Medical Directors, or their deputies with forensic responsibilities, will be expected to balance service needs with career development for staff. Others, either while training or subsequently, will look to develop skills in ‘super-specialties’ including adolescent forensic psychiatry, forensic psychotherapy and forensic learning disability.

The indications are that forensic psychiatry will continue to attract clinicians who value the opportunities to work with challenging service users, so long as services are adequately resourced, and both colleagues and employers accept the fact that risk management does not equate to risk abolition.

Prison health care was radically reformed following the publication of ‘The Future Organisation of Prison Health care’ in 1999. In England, responsibility for providing healthcare to prisons will rest with PCTs by April 2006, with the majority taking some responsibility from April 2005. Health care in prisons will be provided through primary care and secondary multidisciplinary mental health teams.

Consultant psychiatrist posts in prisons are relatively new and there are no accepted ‘norms’ for their input to multidisciplinary teams. The Royal College of Psychiatrists already recommends a competency-based approach to consultant appointments in adult prisons. Depending on local circumstances, input may be provided by adult or forensic psychiatrists. In large prisons, input from both adult and forensic practitioners can have merit. In dispersal prisons, where prisoners are

serving long sentences, forensic rehabilitation skills may be most useful. Psychiatrists in prisons need to work across primary, secondary and tertiary levels of care.

Those under the age of twenty-one are held in young offender institutions; because of the developmental needs of these young people, the skills of child and adolescent psychiatrists will be appropriate in that setting.

All appointments to prison posts should follow this Joint Guidance.

Liaison psychiatry

Liaison psychiatry is a sub-specialty, formally established in 1997, that provides psychiatric treatment to people attending general hospitals, whether they attend outpatient clinics or accident and emergency departments, or are admitted to inpatient wards. It deals with the interface between physical and psychological health. There is now abundant evidence that medical and surgical patients have a high prevalence of psychiatric disorder, which can be effectively treated with psychological or pharmacological methods.

A liaison psychiatry service is concerned with providing a clinical service to an acute general or specialist hospital. The remit of the general hospital does not always coincide with the geographical catchment area of the local mental health trust. It is important that this is recognised in the job description of a consultant appointed to run a liaison service and that contracts with primary care trusts recognise the need to provide psychiatric assessments and treatment for service users who may reside outside the immediate catchment area.

There are several matters that need consideration when drawing up a job description and understanding the mechanisms of a liaison psychiatrist post. How effectively the liaison psychiatry service is managed can be influenced by which trust manages it. Whether the service includes a provision to an accident and emergency department, in addition to medical and surgical departments, can also impact on service delivery. How the funding is arranged for the post is crucial, and this should reflect the demands made on the service. Also, there should be adequate accommodation within the main general hospital it serves to fulfil the needs of providing the service. If a service to an A&E department is included, there should be adequate room within the A&E department to allow clinical assessment to occur in confidential surroundings. Which other mental health workers will form the team in liaison psychiatry needs to be thought through accurately. These should include nurses, clinical psychologists and social workers. Junior medical posts should be provided. Many trainees find experience of a liaison post very valuable in their training. Also, adequate administrative and secretarial staff should be available to support the service. Finally, facilities for data collection should be available to allow audit and clinical research to be carried out.

Psychiatry of learning disability

Services for people with a learning disability have undergone radical changes over the last twenty years thanks to social and political drivers. The most recent formulation of this is in the White Paper ‘Valuing People’ (2001) and ‘Same as You’, (2003) in Scotland, which emphasise person-centred services, independence, rights and the use of mainstream services where appropriate, while recognising the role of specialist services. There is considerable variation in the provision of mental health services to people with a learning disability. Mental health services are present at primary, secondary and tertiary levels.

The role of the consultant in primary care is well developed in some areas and mainly entails liaising with other organisations and agencies. In community learning disability teams, psychiatrists offer

assessments and therapeutic interventions, especially focused on complex cases. Throughout, the work is carried out in a complex multi-professional network, with community nurses, psychologists, social workers, occupational therapists, speech and language therapists and physiotherapists.

Most consultant psychiatrists in learning disability work mainly with adults. However, there is considerable variation here, with some offering a lifespan service, while others concentrate on children with learning disability.

Those who need urgent psychiatric assessment or treatment requiring high-intensity specialist support may be admitted to inpatient units, usually staffed by specialised learning disability teams. In some cases, admission to generic mental health settings is possible, and the consultant psychiatrist in learning disability will then retain some clinical responsibility: either as the responsible clinician, or as specialist adviser, depending on local arrangements.

The service network for the psychiatry of learning disability also includes medium-term rehabilitation facilities, specialist forensic (medium secure, intensive care and high secure services), in addition to other services and specialist teams.

In recent years community specialist services have developed under the Mental Health NSF (for England) and the NHS Plan. It seems the development of such services for people with a learning disability has been slow. There are examples of assertive outreach services.

One of the most successful of the specialist initiatives, in which many psychiatrists in learning disability are involved, concerns the development of psychotherapeutic and other focused interventions for the emotional needs of people with learning disability.

Services to people with pervasive developmental disorders and other neuro-developmental disorders are at an early stage of development in many centres, but in some areas the consultant in the psychiatry of learning disability has taken the lead in providing for this group of high-profile individuals.

In summary, the psychiatry of learning disability is an exciting but rapidly changing field, requiring expert knowledge in many areas – essentially, a microcosm of all other psychiatric specialties, applied to one challenging and rewarding population of needy individuals.

Psychiatry of old age

Demographic trends in the UK are well documented and predict a significant increase in the older population, with an inevitable increase in the mental health problems associated with ageing. In addition, ageing brings added complexity for those with longstanding or chronic mental illness.

The care of older people with mental health needs is increasingly being provided within the community, rather than in institutional settings. However, older adults in institutional settings (e.g. residential, nursing homes, in acute hospital beds) need to receive a service and this is a potentially enormous area. This will involve specialist old age psychiatry input and support to staff in acute hospitals, nursing and residential care.

The increase in treatments for dementia has impacted on the job of consultants, with an increase in referrals and demand for investigation and diagnosis.

Older people often have complex and specific needs resulting from a combination of the accumulated effects of ageing and the consequences of physical as well as mental illness. Thus old age psychiatrists need to liaise closely with all those settings where older people with physical illness are found.

There is concern about the potential abuse of older adults in institutional settings, and there has been a series of reports highlighting this (the Rowan Report, the Avonside Review, 2004). The role of old age psychiatrists in such settings remains important.

It is likely that future generations of older adults will be more demanding of psychological treatments which have often been limited in availability in old age psychiatry services.

Stereotypical prejudices relating to age and mental illness effectively stigmatise older adults and perpetuate both discrimination and exclusion from communities and services. Old age psychiatrists have a role in advocating for older people with mental health challenges.

The Mental Capacity Act may have considerable impact on the work of old age psychiatrists, as many of their service users may fall within its remit.

The needs of older people with mental illness are often perceived as being low down the political/planning and providing agenda. Older people were excluded from the National Service Framework (NSF) for Mental Health, and, although properly included in the NSF for Older People, the older people's NSF concentrates predominantly on physical illness and has arguably provided too little stimulus to the development of mental health services in later life. It is likely that old age psychiatrists will need to work across this divide and attend to developments in mental health and older people's (medical) services.

Psychotherapy

All consultant psychiatrists should have completed their mandatory psychotherapy training as Senior House Officers and thus be able to use cognitive and psychodynamic understanding in their treatment of all service users. This includes an understanding of and ability to use transference and counter-transference. They should possess the ability to assess and refer to specialist services, including psychotherapy, personality disorder services and psychology. An understanding of group dynamics is important in order to function well in teams and in the wider Trust. Such an understanding can also make a contribution to trust management at every level. Management and planning skills are essential, too.

Many consultants now undertake higher psychotherapeutic training in a modality of their choice as part of their Personal Development Plan. Mental health Trusts may usefully support this, particularly as a way of increasing the therapeutic benefit of inpatient services.

Given the prevalence of personality disorders, consultants need a thorough understanding of personality development throughout life and of the psychopathology of personality disorders. They also need some knowledge of the range of treatment packages currently available or being piloted for this group of service users. Psychotherapeutic understanding will help in dealing with service users with multiple pathology with complex needs. Understanding systemic therapy theory helps the consultant to see the service user in the context of their family or helpers.

Rehabilitation and social psychiatry

Consultants in rehabilitation psychiatry are in an ideal position to prioritise recovery and to influence new types of socially inclusive service development. They are working in a clinical environment which has changed markedly over the past decade, with new groups of service users requiring longer-term rehabilitation. Asylum closure resulted in the development of intensive community-based rehabilitation services, including hostels and intensively supported housing schemes. These services are now emphasising both the recovery ethos and social inclusion. The retraction of the high secure hospitals has resulted in the move of 400 people requiring long-term inpatient rehabilitation to a lower and more appropriate level of security. This Accelerated Discharge Programme (ADP) to meet the targets of the NHS Plan has led to the development of long-term medium secure rehabilitation services for men, and to secure gender-sensitive services for women. These services all need to develop links with existing community-based rehabilitation and recovery services. Forensic rehabilitation is an emerging specialty requiring an interesting blend of rehabilitation and forensic skills, and expertise in gender-sensitive service development. This is an exciting new area of work for rehabilitation consultants.

The introduction of the three new types of functional teams (Assertive Outreach, Early Intervention and Crisis Resolution, and Home Treatment teams) requires skills which may have been developed in rehabilitation services. These developments in line with the NHS Plan have, in some places, resulted in the reduction of local rehabilitation resources available to longer-term service users, some of whom become misplaced in alternative and often unsuitable parts of the local service. Some with high-dependency needs have been placed in the independent or voluntary sector, often at great distances from their homes and families. Service quality is variable in Out of Area Treatment placements (OATs) and may not be socially inclusive, or be oriented toward maintenance rather than recovery.

The challenge for rehabilitation consultants is to overview this range of needs within their local high-dependency population, and to work in partnership with commissioning agencies to develop socially inclusive recovery services. These need to be developed with appropriate support services for families, and for work, education, social and leisure activities. Rehabilitation consultants need expertise in the treatment of co-morbid personality disorder, as some rehabilitation service users may have problems related to personality vulnerability, in association with childhood trauma and/or abuse.

Rehabilitation consultants also need to develop expertise in complex multi-agency liaison, including work with the Criminal Justice System, substance misuse services, local neighbourhood groups, and the voluntary or independent sector providers. Good communication and management skills are essential for a rehabilitation consultant.

Specialty training in rehabilitation has expanded over the past five years to provide consultants with the range of skills and experience needed in a changing and pluralistic health care economy. However, training needs to keep pace with policy-driven change, as does research. The quest for evidence on which to base the practice of rehabilitation continues, but the methodology is a challenge, as many of the interventions are complex and interdependent. However, regular and rigorous audit can provide much of the stimulus for improvements in quality of rehabilitation and recovery services. Consultants have a significant role to play in these fields.

Rehabilitation consultants work in services which should be focused on service users and which prioritise service user involvement. Rehabilitation consultants are, therefore, ideally placed to promote the recovery ethos throughout local general mental health services through skills-sharing, education and training.

Addiction psychiatry

The National Drug Strategy (1998) heralded a substantial increase in the number of drug users entering treatment, with a significant increase in the capacity and variety of treatment services both in the NHS and the voluntary sector. Further developments affecting consultant jobs include the changing role of prison treatment services and throughcare, developments in dual diagnosis services, the National Harm Reduction Strategy and new evidence-based interventions.

The expanding sector, together with consultant shortages, has led to an increase in the number of general practitioners providing services for substance users, with the development of a variety of services. A document on Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (RCPsych/RCGP/NTA 2005) has outlined the evolution of these changes and the respective roles.

In this increasingly complex and diverse treatment environment, consultants in addiction psychiatry work within systems. This will include partnership work with other statutory bodies, such as probation and police, the voluntary sector, and primary care services. Roles and challenges include managing these treatment partnerships, effective clinical leadership and supervision, establishing efficient referral pathways, and sharing information both efficiently and safely.

Models of Care for drug misuse (NTA 2002, revision 2005) provides the framework for tiered and integrated drug addiction services provided by multidisciplinary teams. Community-based specialist treatment teams (Tier 3) and inpatient services (Tier 4) are headed by consultants in addiction psychiatry, with an emphasis on partnerships with Tier 2 services.

The consultant's role involves working with other professionals to assess, manage and treat people with substance misuse problems. In community addiction teams, psychiatrists offer diagnostic assessments and therapeutic interventions, prioritising adults with severe addictions and more complex needs, and taking part in shared care arrangements with primary care, general hospital medical teams, and community mental health teams. In inpatient settings, psychiatrists have the key role in making assessments and providing treatment for people with severe addictions, including those with co-morbidity and those at high risk for self-harm, harm to others and self-neglect. The consultant should have a significant clinical leadership and supervisory role in these teams.

The consultant is expected to take a leading role in the strategic development and the delivery of effective services both at a trust and local partnership level. Further important roles include supervision and mentoring of many professionals.

New developments and challenges include models of care for alcohol misuse (NTA 2005) which will set out a much-needed framework for alcohol services, the new Mental Health Bill, a rapidly changing political climate, and a changing clinical population.

6. Creating posts for consultant psychiatrists

Introduction

This chapter deals with issues to consider in creating a consultant post. These relate to the size and distinctive nature of the role and ways in which consultant psychiatrist roles are changing in mental health services. Consultant posts need to be designed in the context of the service, the needs of the population served, the team providing the service, and other services provided by the trust and others in the local mental health economy.

The guidance is not meant to be definitive, nor are consultant number indicators intended to be prescriptive. It is intended to aid in the development of the role and in the writing of job descriptions, person specifications and job plans.

It is assumed that, over the coming years, the job planning process will take central place in describing jobs and creating challenging and achievable consultant posts, and that a range of new ways of working will be introduced. However it is also recognised that job planning and new ways of working are in the early stages and that there needs to be a managed transition from the current to the new arrangements.

Workload measurement/caseload indicators

Traditionally, the Royal College of Psychiatrists developed norms for the numbers of consultant psychiatrists needed to provide a service for any given population. These norms were created by the faculties of the College based on 'best practice', but with no firm evidence as to their validity. Those norms have been applied too rigidly in the past, and now, with new ways of working and the development of new teams and services, it is no longer appropriate to judge consultant workload in isolation.

Taking into account the need to provide a framework for agreeing a baseline for consultant workload, while allowing for the flexibility that both new ways of working and the job planning process should provide, the following indicators are suggested for the transitional stage. We would hope that services can make rapid progress in moving from a reliance on indicators to using job planning within a service context and the intention is to review progress and this guidance within three years.

It is no longer appropriate to describe idealised numbers of posts as 'norms'. They are indicators of desired levels of posts based on custom and practice. A simplified version of consultant indicators is offered in considering job descriptions. These are offered as a guide, not as prescribed maxima or minima.

Simplified version of consultant indicators

General adult	5.0 per 100,000 of the total population (to include rehabilitation, liaison and substance misuse)
CAMHS	1.5 per 100,000 of the total population
Forensic	0.8 per 100,000 of the total population
Learning disability	1.0 per 100,000 of the total population
Old age	1.8 per 100,000 of the total population
Psychotherapy	1.0 per 100,000 of the total population

In many services these consultant indicators are unachievable and are, along with other problems of recruitment and retention, resulting in the high use of locums. Different models of service provision may help either to make up for the shortfall, or indeed provide a more appropriate way of delivering specialist services.

Trusts need to ensure that they develop a clear description of the service model being developed, the team responsible for its delivery, and an estimate of the total caseload likely to be carried by the team, including the consultant. It is envisaged that we will move to a more sophisticated approach, where there is a review of team function, capabilities and skill mix, with all possible speed.

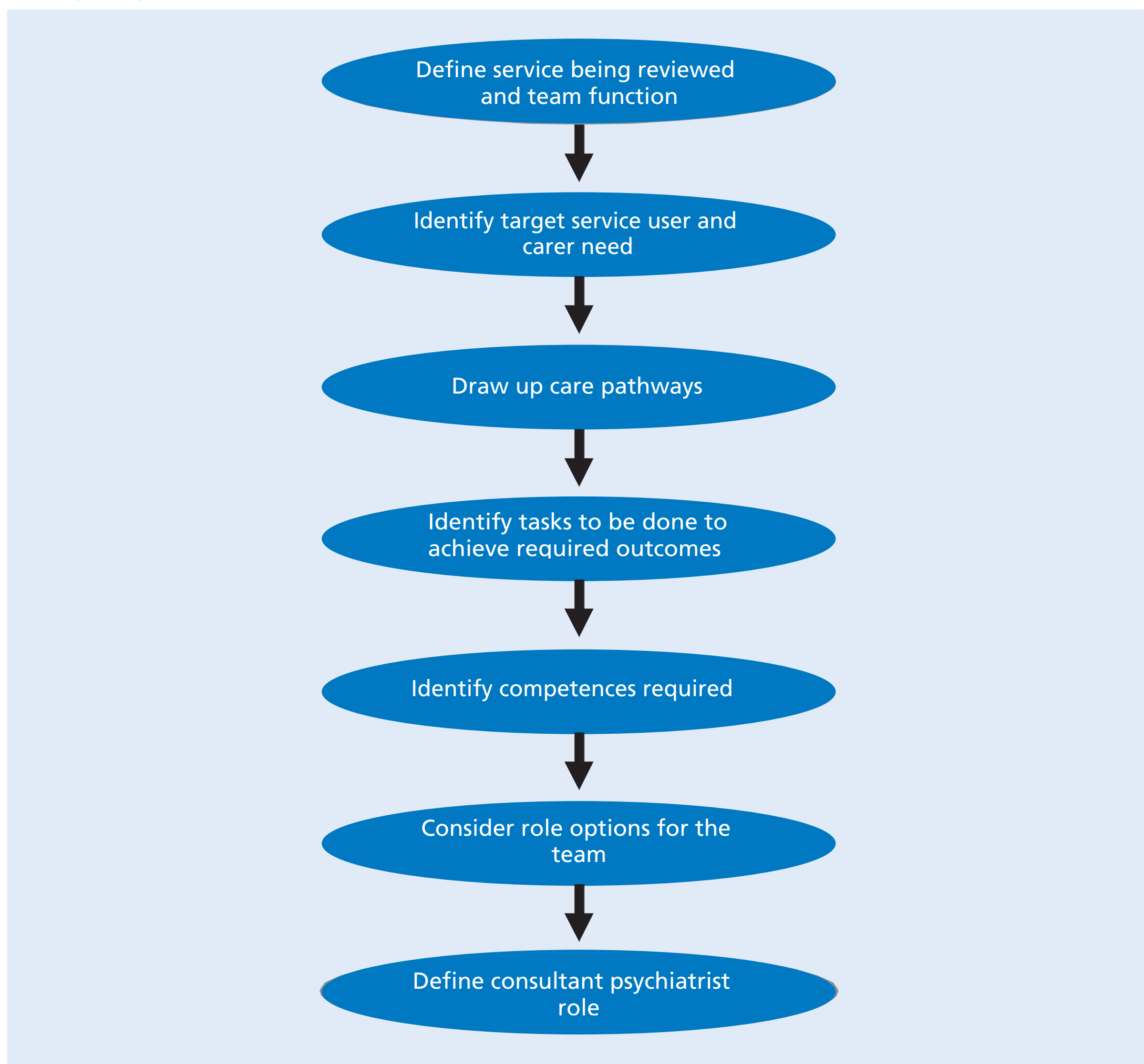
To aid this process, a toolkit called 'Creating Capable Teams' is being devised by the National Steering Group. This will enable mental health teams/providers, through a stepped process:

- to review the needs of service users in the locality served;
- to consider the possible options for staff configuration within the team, based on identified competencies necessary to meet need, rather than on the traditional professional roles;
- to make the most effective use of the capabilities identified within existing staff groups;
- to identify gaps within the skill mix;
- to outline possible solutions in terms of roles, including the consultant role, that may be applicable for the team in the context of its organisation; and/or
- to enable the team to seek new and creative solutions that meet its needs but fall within the wider context of the grading, pay and reward systems, and career development.

A brief synopsis is given overleaf of the Creating Capable Teams process, analysing service demand and staffing roles with a worked example. Further detail is outlined in Appendix Three.

It is envisaged that, as the job planning process and annual reviews become established and more robust, these processes should be the mechanism for defining what is expected of the consultant psychiatrist. However, the Creating Capable Teams Toolkit will be a further aid to achieving greater clarity about team function in the context of the local service user needs, and about the number and mix of skills required within mental health teams to meet this demand. This will enable the role of the consultant psychiatrist to be considered and agreed to maximise the use of NWW. This will result in an effective, efficient and cohesive whole-team approach that places service user need at the centre of modern mental health services.

Analysing service demand and the consultant role



Example

Local multidisciplinary teams served a population of 20,000 older adults. It was predicted they would have fifteen new referrals each week. Care pathways were analysed and operational policies developed, providing a single core assessment to be used by all professionally qualified staff, a single service entry point and a seven-day service with home-based assessment and intervention. The amount of time for assessment was agreed and used to benchmark qualified staff operating as case managers; time for observation and practical support was identified and translated into health care assistant roles; the balance of qualified and unqualified staff was set at 1:2.

7. Role of the Royal College of Psychiatrists advisers

Introduction

The Royal College of Psychiatrists regional advisers can prove very helpful to Trusts in formulating consultant roles, preparing job descriptions, person specifications and Job Plans, and in resolving any difficulties related to consultant posts. They provide both an informal and a formal service to trusts and consultants, as described below.

Role of the Royal College of Psychiatrists advisers

There has been an organisation of doctors working in mental health since 1841. The first Royal Charter was received in 1926. The Royal College of Psychiatrists in its current form was established in 1971 by a Supplemental Charter, which outlines the objects, purposes and powers of the College. This includes the power 'to act as a consultative body'.

Much of the work of the College is devolved to the 'divisions', representing local geographical areas; there are currently 12 divisions. The College also has a number of 'faculties', representing the different sub-specialties. At the moment these are: child and adolescent psychiatry, forensic psychiatry, general and community psychiatry, liaison psychiatry, psychiatry of old age, psychiatry of learning disability, psychotherapy, rehabilitation and social psychiatry, and substance misuse. each division and faculty has an Executive Committee.

In each area of the country the College also has 'advisers' and 'deputy advisers'. Advisers are consultants, appointed by the Court of Electors of the College, following nomination by the Chairman of the relevant division. In all areas, the College advisers are called 'regional advisers', reflecting their historical role of advising the old Regional Health Authorities. They have a close relationship with the postgraduate deaneries and are sometimes also called 'deanery advisers'. In addition to regional advisers, each faculty appoints consultants to represent their specialty in local areas, and these people are known as 'regional representatives'.

The regional advisers' role is to act as 'representatives of the College on all matters relating to postgraduate education in psychiatry' (Royal College of Psychiatrists 2002); as such, they are closely involved with the psychiatry training schemes in their area. They are also members of the division's Executive Committee. They will have considerable knowledge of local services and training issues, and can give advice on the development of posts and services, and make informal comments on job descriptions at an early stage in their development. The adviser can sometimes be helpful to trusts where they are having difficulty in filling particular posts.

At an early stage of developing the job description it can be helpful to consult the regional adviser for advice and guidance. Before a post is advertised, the adviser must be given the opportunity to comment formally on the job description, person specification and selection criteria drawn up for the post. This they should do quickly and positively, commenting only on issues relevant to the College's role.

In commenting on job descriptions, their central concern should be with the professional content of the post in relation to clinical, teaching and research work. In considering job descriptions, they should look at the proposals in relation to other posts in the same specialty in the Trust, recognising that Trusts will often be seeking consultants with particular interests (e.g. in service or teaching) or specialisms to balance teams. Posts should be considered on their merits, rather than against a standard template for a consultant post in the specialty. It is not the role of regional advisers to second-guess what individual employers want, but to consider whether the post represents a satisfactory consultant post in the local circumstances of the Trust. The NHS (Appointment of Consultants) Regulations Good Practice Guidance 2005.

When seeking guidance from the regional adviser, the same person within a Trust should send job descriptions to the adviser on each occasion; this will normally be the Medical Director. In commenting on any job description, the adviser is expected to liaise with the regional representative of the relevant faculty. Reference should also be made to any guidance on posts and services that the College may produce from time to time, while also supporting flexibility and NWW as indicated in the National Steering Group's guidance on "New Ways of Working for Psychiatrists" (2005).

If an adviser has concerns about a post, these should be discussed with the relevant Medical Director. Trusts should seek to respond positively to comments from regional advisers, but it is for them to decide whether or not to amend a job description in the light of the adviser's comments. Where a regional adviser is concerned that an employer has chosen not to accept their advice, they may wish to raise the issue with the College President. This will not, however, prevent an employer advertising the post, as ultimately the responsibility for job descriptions and advertising posts rests with the Trust.

It is expected that instances of disagreement will be rare and that all concerned can work effectively together to produce posts that are satisfying to work in and services that meet the needs of service users and carers.

There are discussions within the College, which may result in more responsibilities being devolved to the local divisions, and in cases of disagreement it may be useful to involve the division's Chair and Executive Committee at an earlier stage, before referring to the central part of the College.

In moving to new methodologies for creating posts, which rely on capable team-working, it will be important for regional representatives and advisers to receive training and development in these approaches. This will enable them to develop in their role and support trusts in change management.

8. Process of recruitment

Introduction

The process for appointing consultants is laid down in The National Health Service (Appointment of Consultants) Regulations 1996 as amended (see references) and good practice on recruiting consultants is provided in The National Health Service (Appointment of Consultants) Regulations Good Practice Guidance 2005. The regulation and direction provide the statutory basis for consultant appointments, and their provisions must be followed by employing bodies. The 1996 Regulations and subsequent amendments do not apply to NHS Foundation Trusts although they can follow this guidance when appointing to a consultant post if they so choose.

Consultant appointments, with certain specified exemptions, are made by employing bodies on the advice of an Advisory Appointments Committee (AAC), a legally constituted committee established by an employing body. Appointments are made by the employing body, which may delegate the power of appointment to one of its members or officers on the committee. However, that delegated power can only operate where the committee's recommendation is unanimous.

A major change in these regulations from previous practice was the legal requirement for all doctors to be included on the General Medical Council's Specialist Register before they can take up a consultant appointment. This requirement was laid down in The European Specialist Medical Qualifications Order 1995, Statutory Instrument 1995 No. 3208.

Preparation of job description and person specification

The initial work of preparing the job description will be undertaken by the future employer and will cover the service needs and other demands of the post. The job description should be clear and informative, and should provide all the relevant information about the post and the service. It should show the potential/existing work programme, programmed activities, and other commitments, e.g. associated postgraduate or medical teaching. The job description should form part of a general information package for candidates, which will also include a person specification, other organisational information/planned service developments, and details on terms and conditions of service, etc. The end of this section includes a checklist of aspects to be included in the job description.

The regional adviser of the Royal College can be contacted at an early stage for comments and advice on drawing up the job description, person specification and the selection criteria for the post. This is to ensure that the post contains a proper balance of clinical, academic, research and managerial activities to be performed. Once the Trust has formulated the job description, person specification and selection criteria, the regional adviser should be sent a final version of the job description, person specification and selection criteria by the Medical Director for formal comment, advice and agreement.

The role of the regional adviser is covered in Section 7.

Additionally, where the post has a significant teaching commitment, the draft should go to the Dean of the relevant medical school.

Person specification – The person specification should be submitted to the Royal College of Psychiatrists regional adviser with the job description. This is because the wording of person specifications and advertisements can sometimes discourage doctors from applying for consultant posts.

The person specification from the Trust or other employer should outline the essential and desirable qualities it requires in the successful candidate, and it is vital that it uses the correct terminology to

encourage as wide a pool of applicants as possible. It should outline the minimum qualifications, skills and experience required to perform the job. Clearly, all person specifications and advertisements should be written so as not to contravene any UK or EU equal opportunities legislation and Department of Health (DH) policy.

A framework for the job description and person specification is provided in Appendix Four.

Selection criteria – Employing organisations should prepare selection criteria for each post. The selection criteria should be drawn from the job description and minimum qualifications, skills and experience to fully perform the job. Selection criteria should be sent to regional advisers with the job description to enable them to comment.

THE THREE MYTHS

1. Consultant psychiatrists must have the MRCPsych

Trusts should not advertise posts for applicants with the MRCPsych. This is because overseas specialists are unlikely to hold this qualification. It would be more appropriate for trusts to ask for MRCPsych or equivalent. However, the vast majority of psychiatrists who are on the Specialist Register will already hold the MRCPsych or have demonstrated such equivalence.

Please note that all overseas specialists who are included on the Specialist Register and who take up a National Health Service (NHS) consultant post (not locum) are eligible to apply to the College for membership without examination, under Byelaw 322b/c.

2. Consultant psychiatrists must have a CCST

Trusts should not advertise specifically for applicants with a Certificate of Completion of Specialist Training (CCST). This is because this qualification did not come into effect until 12 January 1996. The only doctors who hold a CCST are those who have completed a full UK specialist medical training since that date. Organisations should be advertising for doctors who are:

- Included on the General Medical Council (GMC) Specialist Register, or Specialist Registrar within 3 months of completing their CCST.

However, it has recently been clarified with the Department of Health that trusts may advertise for doctors who are included on the GMC's Specialist Register or who are eligible for such inclusion. This is of help to overseas doctors who might wish to secure an offer of appointment prior to submitting a formal application for the Specialist Register.

Here is a list of doctors who are on (or are eligible for inclusion on) the Specialist Register. All are eligible to apply for consultant posts:

- doctors with a CCST;
- doctors who took up an NHS consultant post prior to the award of CCSTs;
- doctors with a European equivalent to a CCST;
- doctors from non-European countries with training and qualifications equivalent to a CCST;
- doctors with an equivalent level of expertise to a CCST holder;
- doctors with a specialist expertise gained from academic and research work.

All doctors on the Specialist Register must be considered equivalent to CCST holders.

3. Consultant psychiatrists must be on the Specialist Register in the exact specialty or sub-specialty of practice

Inclusion on the Specialist Register is the legal requirement for substantive, honorary or fixed-term consultant appointments in the NHS. It is not a legal requirement that appointees to consultant posts hold specialist registration in the specialty of the post.

This is in recognition of the fact that some doctors change the emphasis of their careers and others, especially overseas doctors, can only be listed generically, even though they might have a more specialised level of expertise. It is therefore the case that, provided doctors are not practising outside their area of competence (as per the GMC document on Good Medical Practice), they may be appointed on the basis of their overall expertise for a particular post (provided they are on the Specialist Register in relevant specialty).

Clearly, the College would prefer all appointees to have the appropriate specialty listing, but it is important not to discount applicants on the basis of their specialist registration if they appear well able to undertake the duties of the post and satisfy the overall requirements of the person specification. Doctors who are appointed outside their registered specialty will need to clarify their educational supervisor status with the College. It may be the case that they would have to be assessed for College recognition via the Specialty Assessment procedure.

Advertising the post

All posts should be advertised, unless prior consent has been obtained from the Secretary of State. Advertisements should normally appear in at least two professional and nationally distributed journals which are commonly used for similar advertisements. If possible, the date of interview should be included and the closing date should be clear, normally three to four weeks after the publication of the advert.

In addition to conventional advertisements in journals, the electronic recruitment service of the NHS (at www.nhs.uk/jobs), is an efficient and cost-effective means of advertising jobs.

There are a number of exemptions from advertising and holding an appointments committee:

- honorary contracts;
- locum appointments;
- appointments following redundancy or reorganisation;
- appointments to a hospice, university or public health laboratory service.

These have their own arrangements specified in The NHS (Appointment of Consultants) Regulations 1996.

The Advisory Appointments Committee (AAC)

This should be arranged within six weeks of the closing date. The composition of the AAC should be in accordance with the requirements of the statutory instrument which sets out the provisions of the AAC for different types of appointment. Based on the regulations, it is recommended that the panel has:

- a lay member (normally the employing organisation Chair or a non-executive director);

- an external assessor from the relevant College or faculty;
- the Chief Executive of the employing organisation or nominated deputy;
- the Medical Director of the employing organisation or nominated deputy;
- a consultant from the employing body (normally from the relevant specialty);
- a university representative for posts with substantial teaching or research commitments;
- a service user representative.

Other representatives may be added to the AAC where it is deemed relevant, but in all cases the AAC membership should be kept to a minimum.

Function of the AAC

'The AAC decides which, if any, of the applicants is suitable for appointment and recommends a name, or names to the Trust. It is normal (and acceptable) practice for the Trust to delegate the decision on appointment to its representatives on the AAC in order to enable decisions to be made speedily.'

The NHS (Appointment of Consultants) Regulations Good Practice Guidance 2005

The AAC determines its own procedures, subject to the provisions of the regulations and of current legislation on employment practice, and taking account of general selection procedures and equal opportunities policies of the Trust. The roles and responsibilities of members of AACs are described in the Good Practice Guidance (2005). All members of AACs should have received appropriate training.

Use of external consultants

External consultants can be used in seeking out potential candidates and doing preliminary vetting of candidates. However, this does not change the requirements for advertising and the process of appointment through the AAC.

The Filling Consultants Posts: Toolkit for employers (2004)

This offers help on:

- consultants working flexibly;
- flexible retirement and extending working lives;
- consultants returning to practice;
- assisting and supporting new consultants;
- international recruitment;
- utilising the international fellowship scheme;
- managed placements to allow consultants to sample life as an NHS consultant.

The Filling Consultants Posts: Toolkit (2004).

The International Fellowship Programme

This offers qualified medical specialists from outside the UK the opportunity to undertake a two-year Fellowship working as a consultant in the NHS (England only). These Fellowships are for fully trained independent specialists who wish to obtain valuable experience of living and working for a short while in a different country.

The managed placement scheme

This scheme aims to attract consultant-level doctors who wish to sample work in the NHS before applying for a long-term post. Managed-placement doctors fill a vacant permanent post, initially on a temporary basis. They are appointed for a period of six months and are seconded to Trusts with consultant vacancies in the relevant specialty. All doctors on the scheme are on the Specialist Register, have undertaken a linguistic assessment and undergone full employment checks. The trust is represented on the interview panel, and the doctor is assigned an independent mentor.

Wider international recruitment

Interest among potential candidates is generated through advertising in the international medical and national press, and seminars are arranged in countries where there is agreement to hold them. Expressions of interest are compiled in a database of those on the specialist register, or doctors entitled to be on the specialist register.

All of the international recruitment programmes are under review and the process is being streamlined through the NHS electronic recruitment service (www.jobs.nhs.uk). This will allow employers to take ownership of recruitment through the programmes. The work is being carried out with key stakeholders.

Difficult-to-fill posts

In some areas and for some specialties, the current shortage of consultants makes posts difficult to fill. Innovative approaches may be required to solve such recruitment problems. It is advisable to work closely with The Royal College of Psychiatrists regional advisers, who often have experience of tackling such issues elsewhere, and NIMHE regional development centres or equivalent organisations, which may also be able to offer advice and expertise.

All innovative approaches that change the composition of the job will require a new job description and person specification to be created by the employing organisation and sent to relevant bodies and regional advisers for comment and agreement as usual.

Appendix One

Consultant Contract for England

This is the new consultant contract applicable in England. Wales, NI and Scotland have their own contractual arrangements.

Table of Contents

THE POST	34
THE WORK	35
OTHER CONDITIONS OF EMPLOYMENT	39
PAY	40
PENSION	41
LEAVE AND HOLIDAYS	42
OTHER ENTITLEMENTS	42

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The Post

1 Consultant

Your job title is Consultant in [ ].*

Your employing organisation is [ ].*

2 Commencement Of Employment

Your continuous employment for the purposes of this contract began on [ ].*

Your continuous service for the purposes of the Employment Rights Act 1996 began on [ ]. *

Schedule 1 of the Terms and Conditions contains guidance on commencement of employment.

3 General Mutual Obligations

Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for service users and to ensure the efficient running of the service:

to co-operate with each other;

to maintain goodwill;

to carry out our respective obligations in agreeing and operating a Job Plan;

to carry out our respective obligations in accordance with appraisal arrangements;

to carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols.

* Employing organisation to complete

The Work

4 Location

Your principal place of work is [ ].* Other work locations including off site working may be agreed in your Job Plan where appropriate, e.g. for supporting professional activities and some direct clinical care such as audit notes. You will generally be expected to undertake your Programmed Activities at the principal place of work or other locations agreed in the Job Plan. Exceptions will include travelling between work sites and attending official meetings away from the workplace.

You may be required to work at any site within your employing organisation, including new sites.

5 Duties

5.1 Main Duties and Programmed Activities

Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities and undertaking the Programmed Activities set out in your Job Plan, as reviewed from time to time in line with the provisions in section 6 below.

5.2 Associated Duties

You are responsible for the associated duties set out in Schedule 2 of the Terms and Conditions.

5.3 Objectives

The purpose of including agreed personal objectives in your Job Plan is to set out in clear and transparent terms what you and your clinical manager have agreed should reasonably be achieved in the year in question. These objectives are not contractually binding in themselves, but you have a duty to make all reasonable efforts to achieve them.

5.4 On-Call Duties and Emergency Responses

You may also be required to participate in an on-call rota to provide emergency cover (see section 9). When not on an on-call rota, we may in exceptional circumstances ask you to return to site for emergencies if we are able to contact you. You are not, however, required to be available for such eventualities. Where emergency recalls of this kind become frequent, we will review the need to introduce an on-call rota.

6 Job Planning

Job Plan

You and your clinical manager have agreed a prospective Job Plan that sets out your main duties and responsibilities, a schedule for carrying out your Programmed Activities, your managerial responsibilities, your accountability arrangements, your objectives and supporting resources.

You and your clinical manager will review the Job Plan annually in line with the provisions in Schedule 3 of the Terms and Conditions. Either may propose amendment of the Job Plan. You will help ensure through participating in Job Plan reviews that your Job Plan meets the criteria set out in the Terms and Conditions and that it contributes to the efficient and effective use of NHS resources.

7 Programmed Activities

7.1 Scheduling Of Activities

You and your clinical manager will agree in the schedule of your job plan the programmed activities that are necessary to fulfill your duties and responsibilities, and the times and locations at which these activities are scheduled to take place. You and your clinical manager will seek to reach agreement in the scheduling of all activities. We will not schedule non-emergency work during premium time without your agreement.

Subject to the provisions for recognising work done in Premium Time (see section 8 below), a Programmed Activity has a timetable value of four hours. Each Programmed Activity may include a combination of duties.

Your job plan will contain [ ] * Programmed Activities per week on average, subject to the provisions below for recognising emergency work arising from on-call rotas. A standard full-time Job Plan will contain 10 Programmed Activities subject to the provisions in Paragraph 7.6 to agree up to two extra Programmed Activities. Remuneration for Programmed Activities is set out in section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service.

[Note: the number of Programmed Activities will need to be adjusted for part time consultants. Where a consultant has a part-time contract, the employing organisation will need to agree the number of weekly Programmed Activities that should be included in the Job Plan.

Where a consultant appointed after 1 January 2004 wishes to work part-time **in order** to undertake private practice, such contracts should normally be for no more than six Programmed Activities]

7.2 Flexibility

Attaching a time value to Programmed Activities is intended to provide greater transparency about the level of commitment expected of consultants by the NHS. However, you and your clinical manager can agree flexible arrangements for timing of work.

Programmed Activities may be scheduled either as a single block of four hours, or sub-divided into smaller units of time.

The precise length of Programmed Activities may vary from week to week around the average assessment set out in the Job Plan.

You and your clinical manager may agree, as part of your Job Plan, arrangements for the annualisation of Programmed Activities. In such a case, you and your clinical manager will agree an annual number of Programmed Activities and your Job Plan will set out variations in the level and distribution of Programmed Activities within the overall annual total.

You and your clinical manager may agree, as part of your Job Plan, other arrangements for flexible scheduling of commitments over an agreed period of time.

Any variations in your scheduled weekly commitments should be averaged out over 26 weeks, so that your average commitment is consistent with the provisions of the Working Time Regulations.

7.3 Balance Between Direct Clinical Care And Other Programmed Activities

Subject to the provisions for recognising emergency work arising from on-call rotas below, the schedule in your Job Plan will typically include an average of [7½] * Programmed Activities for Direct Clinical Care duties and [2½] * Programmed Activities for Supporting Professional Activities. Where your agreed level of duties in relation to supporting professional activities, additional responsibilities and other duties is significantly greater or lower than 2½ programmed activities there will be local agreement as to the appropriate balance between activities. Part-time consultants need to devote proportionately more of their time to Supporting Professional Activities. This should be agreed on an individual basis. Refer to the guidance on part time and flexible working for further information.

The precise balance will be agreed as part of Job Plan reviews and may vary to take account of circumstances where the agreed level of duties in relation to Supporting Professional Activities, Additional NHS Responsibilities and External Duties is significantly greater or lower than [2½] Programmed Activities.

Responsibilities as a Medical Director or Clinical Director may be reflected by substitution for other whole or part Programmed Activities or by additional remuneration agreed locally.

7.4 External Duties

Where you wish to seek agreement to have External Duties included in your Job Plan, you must notify your clinical manager in advance. Scheduling of such duties will be by agreement between you and your clinical manager. Where carrying out these External Duties might affect the performance of direct clinical duties, where possible you will give us sufficient notice to ensure that, where such external duties are agreed, you and your clinical manager can agree a revised schedule of activities at least a month in advance.

7.5 Recognition For Emergency Work Arising From On-Call Duties

Where emergency work takes place at regular and predictable times, your clinical manager will seek to schedule it as part of the Programmed Activities in your Job Plan schedule. You may, however, be required to participate in an on-call rota to respond to less predictable emergencies.

The provisions in Schedule 5 of the Terms and Conditions apply to recognise unpredictable emergency work arising from on-call rota duties that takes place other than during a Programmed Activity scheduled in your Job Plan.

7.6 Extra Programmed Activities

You and your clinical manager may agree that you will undertake extra Programmed Activities over and above the [ten] Programmed Activities that constitute your standard contractual duties, up to the maximum permitted under the Working Time Regulations. [Note: add contracted number for part-time consultants] The remuneration for these activities is covered by section 21 below and Schedules 13 and 14 of the Terms and Conditions.

Any such agreement will be made in writing and the additional Programmed Activities will be incorporated into your Job Plan schedule.

Subject to the provisions in section 7.7 below, and without prejudice to section 7.8 below, you do not have to agree to carry out more than ten Programmed Activities on average per week. [Note: to be adjusted for part-time consultants] However, where you do give your agreement, you must undertake such activities. The remuneration for these activities is

covered by Section 21 below and Schedules 13 and 14 of the Terms and Conditions. Any additional Programmed Activities that you carry out beyond the standard [ten] [Note: to be adjusted for part-time consultants] Programmed activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions.

7.7 Transitional Arrangements

Where the provisions for recognising on-call work in Schedule 5 of the Terms and Conditions would otherwise result in a reduction in the time available for the other duties undertaken by you and other colleagues on these new contractual arrangements, compared with the time normally available for such duties in the immediate period before the introduction of this contract, we will agree appropriate arrangements with you and your consultant colleagues to prevent such a reduction, if necessary by arranging for additional Programmed Activities to be provided. These arrangements may apply only during the period ending on 31 March 2006.

7.8 Extra Programmed Activities And Spare Professional Capacity

Where you intend to undertake private professional services other than such work carried out under the terms of this contract, whether for the NHS, for the independent sector or for another party, the provisions in Schedule 6 of the Terms and Conditions will apply.

8 Premium Time

From 1 April 2004, the provisions in Schedule 7 of the Terms and Conditions will apply to recognise the unsocial nature of work done in Premium Time and the flexibility needed by consultants who work at these times as part of a more varied overall working pattern.

On any occasion where a consultant is scheduled to work during the Premium Time period, the employing organisation will ensure that the consultant has adequate rest both before and after this period of duty.

9 On-Call And Emergency Duties

9.1 On-Call Rotas

Where you are on an on-call rota, the provisions in Schedule 8 of the Terms and Conditions will apply.

Your on-call duties will be set out in the published rota or in accordance with any alternative arrangements that you agree with your colleagues for providing on-call cover.

9.2 On-Call Availability Supplements

Where you are on an on-call rota, you will receive an on-call availability supplement according to the provisions in Schedule 16 of the Terms and Conditions. The level of supplement will depend on the frequency of your rota and the typical nature of the required response when you are called.

Other Conditions of Employment

10 Registration Requirements

It is a condition of your employment that you are, and remain, [a registered dental practitioner and] **[Note: delete as appropriate]** a fully registered medical practitioner and are included on the Specialist Register held by the [General Dental Council (GDC)] **[Note delete as appropriate]** General Medical Council (GMC), and continue to hold a license to practice.

11 Fee Paying Services And Private Professional Services

Minimising Potential For Conflicts Of Interest

In carrying out any Fee Paying Services or Private Professional Services, you will observe the provisions in Schedule 9 of the Terms and Conditions in order to help minimise the risk of any perceived conflicts of interest to arise with your work for the NHS.

Fee Paying Services And NHS Programmed Activities

Examples of Fee Paying Services are set out in Schedule 10 of the Terms and Conditions.

You will not carry out Fee Paying Services during your Programmed Activities except where you and your clinical manager have agreed otherwise. Where your clinical manager has agreed that you may carry out Fee Paying Services during your Programmed Activities, you will remit to us the fees for such services except where you and your clinical manager have agreed that providing these services involves minimal disruption to your NHS duties. Schedule 11 of the Terms and Conditions contains guidance on this subject.

Private Professional Services And NHS Programmed Activities

Subject to the provisions in Schedule 9 of the Terms and Conditions, you may not carry out Private Professional Services during your Programmed Activities.

Publications, lectures, etc

A practitioner shall be free, without prior consent of the employing authority, to publish books, articles, etc., and to deliver any lecture or speak, whether on matters arising out of his or her NHS service or not.

12 Deductions From Pay

We will not make deductions from or variations to your salary other than those required by law without your express written consent.

13 Appraisal And Clinical Governance

The National Appraisal Scheme for Consultant Medical Staff (Department of Health Circulars AL(MD)5/01 and AL(MD)6/00) applies to your post. You must co-operate fully in the operation of the appraisal scheme. You must also comply with our clinical governance procedures.

14 Gifts And Gratuities

You are required to comply with our rules and procedures governing the acceptance of gifts and hospitalities.

15 Policies And Procedures

You are required to comply with our Policies and Procedures as may from time to time be in force.

16 Grievance Procedures

The grievance procedures, which apply to your employment, are set out in [ ]. * **[Note: to add reference to local procedures]**

17 Disciplinary Matters

Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of [ ] * **[Note: employing organisations to insert reference to their code of conduct]**, or that your professional competence has been called into question, we will resolve the matter through our disciplinary or capability procedures, subject to the appeal arrangements set out in those procedures.

18 Intellectual Property

You will comply with our procedures for intellectual property, which are in line with 'The NHS as an Innovative Organisation, Framework and Guidance on the Management of Intellectual Property in the NHS'.

19 Other Conditions of Service

The provisions in Schedule 12 of the Terms and Conditions will apply.

Pay

20 Salary

Basic Salary And Pay Thresholds

Your basic salary on commencement is [£]. * **[Note: employing organisations to complete based on Schedules 13 and 14 of the Terms and Conditions]** This has been calculated in accordance with the provisions in Schedules 13 and 14 of the Terms and Conditions.

Your basic salary will increase when you receive pay thresholds in accordance with the provisions of section 0 and Schedule 15 of the Terms and Conditions.

The value of each pay threshold and the number of years' service required before you become eligible for pay thresholds are set out in Schedules 13 and 14 of the Terms and Conditions.

Where a pay threshold is awarded, the date on which your salary will increase to take account of the threshold will be the anniversary of transfer to this contract.

Your basic salary, together with any payments for extra Programmed Activities (see section 21 below), includes payment for all Contractual and Consequential Services.

Criteria for Pay Thresholds

You will not receive pay thresholds automatically, but it is expected that you will progress through the thresholds and will do so if the criteria set out in Schedule 15 are met. We will make all reasonable efforts to support you in meeting the criteria for pay thresholds.

21 Payment For Additional Programmed Activities

Any additional Programmed Activities that you carry out, beyond the standard [ten]/[ ] **[Note: to be adjusted for part-time consultants]** Programmed Activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions.

22 Distinction Awards And Discretionary Points

Where the Advisory Committee on Distinction Awards or its proposed successor body has recommended that you receive a Distinction Award or Clinical Excellence Award, or we have decided that you should receive one or more Discretionary Points or a Clinical Excellence Award, these will be paid at the rates set out in the latest Advance Letter from the Department of Health concerning pay and conditions of service for hospital medical and dental staff and doctors in public health medicine and the community health service.

23 On-Call Availability Supplement

If you are required to participate in an on-call rota, you will be paid a supplement in addition to your basic salary in respect of your availability to work during on-call periods. The supplement will be paid in accordance with, and at the appropriate rate shown in, Schedule 16 of the Terms and Conditions.

24 Recruitment and Retention Premia

We may under certain circumstances decide to award a recruitment or retention premium in addition to your basic salary in line with the provisions in Schedule 16 of the Terms and Conditions.

25 Directors of Public Health

Directors of Public Health will be entitled to supplements in addition to basic salary in line with the provisions in Schedule 16 of the terms and conditions.

26 London Weighting Allowance

The provisions in Schedule 16 of the terms and conditions shall apply.

Pension

27 Pension

The provisions in Schedule 17 of the Terms and Conditions shall apply.

You will be eligible for membership of the NHS Pension Scheme, the provisions of which are set out in the NHS Pension Scheme Regulations 1995 (as amended). The Scheme is a final salary scheme with benefits based on the best of the last three years pensionable pay. Pensionable pay will include basic salary (up to ten programmed activities, but not any additional programmed

activities above this), on-call availability supplements, clinical excellence awards and any existing discretionary points or distinction awards, and any other pay expressly agreed to be pensionable.

You are contracted out of the State Second Pension Scheme.

Leave and Holidays

28 Leave And Holidays

Schedule 18 of the Terms and Conditions sets out your entitlements in respect of:

1. annual leave and public holidays
2. professional and study leave
3. sabbaticals
4. sick leave
5. special leave
6. maternity leave and domestic personal and care relief.

Other Entitlements

29 Expenses

You are entitled to be paid expenses, which should be submitted in a timely manner (normally within one month), for:

excess travel

subsistence; and

other expenses in accordance with [ ]. Expenses will be as set out in schedule 21 or some local alternative, which must be at least as favourable).

30 Charges for Residence

Except where facilities are provided for a doctor to be on-call a charge may, where appropriate, be made for residing at your Place of Work in accordance with our local procedures.

Duration of Employment

31 This is a permanent post. [Amend this paragraph as appropriate for a Fixed Term Appointment].

Termination of Employment

32 Provisions governing termination of employment are set out in Schedule 19 of the Terms and Conditions.

Entire Terms

33 Entire Terms

This contract and the associated Terms and Conditions contain the entire terms and conditions of your employment with us, such that all previous agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference such incorporation is only to the extent so stated and not further or otherwise.

I [name] and [employer]

have understood and agree to honour the terms and conditions set out in this contract of employment

[ ] *Consultant's signature*

[ ] *Representative of employing authority's signature*

Date of this agreement [ ]

Appendix Two

Consultant duties and responsibilities

1. A consultant has continuing clinical and professional responsibility for service users admitted under his or her care or, (for consultants in public health medicine) for a local population. It is also the duty of a consultant to:

    - keep service users (and/or their carers if appropriate) informed about their condition;
    - involve service users (and/or their carers if appropriate) in decision-making about their treatment;
    - maintain professional standards and obligations as set out from time to time by the General Medical Council (GMC) and comply in particular with the GMC's guidance on 'Good Medical Practice' as amended or substituted from time to time;
    - maintain professional standards and obligations as set out from time to time by the General Dental Council (GDC) (dental consultants only).

2. A consultant is responsible for carrying out any work related to and reasonably incidental to the duties set out in their Job Plan such as:

    - the keeping of records and the provision of reports;
    - the proper delegation of tasks;
    - maintaining skills and knowledge.

3. Consultants shall be expected in the normal run of their duties to deputise for absent consultant or associate specialist colleagues so far as is practicable, even if on occasions this would involve interchange of staff within the same employing organisation. This does not include deputising where an associate specialist colleague is on a rota with doctors in training. When deputising is not practicable, the employing organisation (and not the consultant) shall be responsible for the engagement of a locum tenens, but the consultant shall have the responsibility of bringing the need to the employer's notice. The employing organisation shall assess the number of Programmed Activities required.

Terms and Conditions – Consultants (England) 2003

Appendix Three

New Roles & Staff Skills Map: The Creating Capable Teams Toolkit

The Interim Report on Guidance on New Ways of Working for Psychiatrists in a Multidisciplinary and Multi-Agency Context August 2004, referred to: 'the challenge ... to map capabilities that meet the needs & preferences of service users'.

This challenge has been taken forward through the work of the Cross Boundary Subgroup of the National Steering Group on New Ways of Working for Psychiatrists and has led to the development of the Creating Capable Teams Toolkit.

The Cross Boundary Subgroup comprises representatives of all the main mental health and social care disciplines. It has looked at the existing roles of all professions and non-professionally affiliated staff, exploring the flexibilities of competencies, roles and responsibilities, together with the potential for multidisciplinary team-working in new and changing models of mental health care.

The Creating Capable Teams Toolkit has been developed in the context of existing professional frameworks and registration bodies and acknowledges their impact upon new ways of working and new roles. However, it provides a process which, it is hoped, will help manage the transition from existing roles and responsibilities to the emerging new roles and NWW for the consultant psychiatrist and others within the modern multidisciplinary mental health services.

The Creating Capable Teams Toolkit has been designed:

- to focus on service user need
- to provide a user-friendly toolkit;
- for use by NHS trusts & other mental health service providers and stakeholders;
- to enable providers to be creative in developing new ways of working and new roles;
- to make most effective use of the expertise and experience of all team members;
- to work within the context of their particular model of service and within their own particular organisational context and setting.

The approach is service user-centred in that it focuses on the capabilities (values, knowledge and skills) required within a team, to deliver the designated service to the individual team's defined group of service users in order to meet their identified needs and achieve the required outcomes. It is fully informed by the Ten Essential Shared Capabilities and requires service user and carer participation as part of the process. It provides a systematic and stepped approach to ensure a methodical review of service within the context of national initiatives and guidance, as well as local circumstances.

The Creating Capable Teams Toolkit is being tested in a variety of settings (community mental health team, early intervention team, inpatient unit) across England. The toolkit will be available in its first format on the internet in autumn 2005. The completed toolkit, comprising a user guide/handbook that details guidance on the individual steps of the approach, together with the learning and worked examples from the trial sites, will be published in December 2005.

The work on the Creating Capable Teams Toolkit also supports and is supported by current work on mapping skills and competency sets across mental health services. This is being jointly undertaken by the Department of Health, Skills for Health and NIMHE. It maps the National Occupation Standards competencies against the NHS Knowledge and Skills Framework dimensions and the Ten Essential Shared Capabilities. It is available on the Skills for Health web-site at www.skillsforhealth.org.uk. This will enable the Creating Capable Teams Toolkit to be underpinned by a web-based mental health National Occupation Standards database that will incorporate a search facility against mental health functions and interventions.

Further information about the Creating Capable Teams Toolkit is available on the NIMHE Knowledge Community website under the Capable Team Working Group. This will be updated with learning and progress as the process is field tested.

Appendix Four

Framework for developing consultant psychiatrist job descriptions and person specifications

Name of Trust or organisation

Brief introduction to the Trust or organisation

To include general information about the Trust

Key aims of the Trust

The postholder's clinical role

Details of the service

To include:

Population served by the multidisciplinary team

Population served by the post

Other staff in the team

Details of all members of the team

Details of how the team operates

Administrative support

Access to information technology

Access to library facilities

Job title

Number of Programmed Activities

On call – rota, category and supplement

Location

Reports to

Trust management arrangements

Job planning and review process

Brief summary of the post

Main duties of the post

Clinical

Education

Administration

Management

Leadership

Other aspects of the post

On-call rota, category and supplement

Appraisal arrangements

Section 12 approval

Office facilities and base

CPD arrangements

Academic

Research

Teaching and development

Audit arrangements

Access to mentoring

NHS

Other

Provisional Job Plan and timetable

a) The postholder should normally have 7.5 planned clinical activities per week.

b) The postholder should normally have 2.5 Programmed Activities allocated to support professional activities, one for CPD and two for audit, teaching, educational supervision, research, special interest or management.

Timetable of agreed commitments

Day	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Any additional information about the Trust or organisation that potential candidates might find useful

PERSON SPECIFICATION	Essential	How measured	Desirable	How measured
Qualifications and training				
Knowledge				
Experience				
Skills				
Personality and attitude				

The specifications set will need to show how they are measured by the application form, interview or reference.

Appendix 5

Membership of Joint Guidance Group

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Child and adolescent psychiatry
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Dr. Susan Benbow, Psychiatry of Old Age
Dr. Jane Knowles, Psychotherapy
Rehabilitation and social psychiatry
Dr. Eilish Gilvarry, Addiction psychiatry

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The Filling Consultants Posts: Toolkit (2004)

Go the Department of Health website at www.dh.gov.uk
- Follow the link to ‘Policy and guidance’
- Select ‘Human resources and training’
- Click on ‘More staff’ and see the toolkit link on the page

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