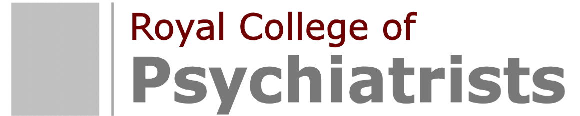
National Institute for
Mental Health in England



Joint Guidance on the Employment of Consultant Psychiatrists

Report from a joint working group of the Department of Health, NHS Confederation, Royal College of Psychiatrists and the National Institute for Mental Health England

March 2009

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The following section comprises submissions which have been invited from the various faculties in the Royal College of Psychiatrists which have oversight of standards as they apply in the particular sub-specialty area. They are intended to provide an overview of relevant issues that may particularly impact on Consultant jobs in that area. As such they should help employers in planning and designing jobs to the benefit of all parties. The views and advice presented here are those of the relevant faculty alone. It is intended that they will be updated periodically....................................32

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Introduction

To deliver mental health services of the highest possible quality, it is essential that professionals with the right training and skills can operate in a supportive work context that encourages rather than inhibits excellence. Consultant psychiatrists are key to the effective delivery and development of most mental health services and so it is vital that the processes for recruiting and employing them reflect the excellence expected of their practice.

But there have been significant, even unprecedented, changes in the provision of services in recent years with new investment, new teams, new roles and changing practice. Current changes to reform the whole system of healthcare mean that organisations and individual professionals will need to continue being adaptable and should expect their services and roles to evolve further in months and years to come. As they do, it is clear that employers (and the wider NHS) will expect that consultant psychiatrists are employed in a way that allows them to develop fully their leadership roles and skills. It is this which will enable them to make the full contribution to service excellence for which their training, background and expertise should ideally equip them.

The purpose of this document is to highlight the current best practice in employing consultant psychiatrists in a changing world, particularly in relation to:

- creating posts and writing job descriptions
- maintaining and enhancing current posts
- getting appropriate advice
- recruitment processes
- the process of appointment
- dealing with problems

Whilst this guidance is aimed primarily at mental health trusts in England, it is hoped that it will be helpful in other parts of the UK and will also be used by the private and voluntary sectors as well as by NHS Foundation Trusts in keeping with the concordat between the Foundation Trust Network and the Academy of Medical Royal Colleges.

As in 2005, producing this has depended on good will and collaboration across different organisations. There has been a clear focus on being constructive, resolving difficulties and doing what we genuinely believe is right for services, those who use them and those who work in them. Once again, it is hoped that the same level of co-operation and understanding can be reflected in local organisations.

This document supplements “The National Health Service (Appointment of Consultants) Regulations - Good Practice Guidance (DH 2005) and replaces “Joint Guidance on the Employment of Consultant Psychiatrists” (DH 2005).

Developing a Better Role for the Consultant Psychiatrist within Teams

For the consultant psychiatrist to fulfil their role effectively within modern mental health teams, three broad sets of needs should be addressed as follows:

1. It is important that users and carers value the service, being able to benefit from the expertise and specialist skills a psychiatrist can offer them, but within the setting of an effective multidisciplinary team. They should be able to expect help *when* it is needed and at a level of *intensity* proportionate to their needs. In other words they need to see a psychiatrist *when* it is necessary, based on their current mental state and *when* those skills possessed by a psychiatrist have most impact.

2. The psychiatrist should feel that they are delivering a role which is satisfying to them from a professional point of view, in which they are having an effective influence on the well-being of the service user, and that they are valued for that role by colleagues both managerial and clinical. In short if they enjoy a job which is do-able, which others rate and which delivers care within accepted governance standards then there is usually satisfaction expressed.

3. The employing organisation should be satisfied that both of the preceding conditions are met and that there is alignment between the needs of users and carers, the professional needs of the psychiatrist and the strategic directions of the employing body. When all three of these are aligned then excellence can flourish.

Achieving alignment is sometimes difficult, however, and is lost if the psychiatrist begins to operate (for example) as a care coordinator for hundreds of routine cases rather than as a specialist resource for the team. It is also lost where the team defaults to the psychiatrist for decision-making rather than operating as a team in which there is equitable distribution of caseload and responsibilities. Conversely, alignment can occur when the consultant psychiatrist is clinically based within a team, has a specialist consultant role to the team and carries a relatively small caseload of the most complex cases under their personal supervision whilst at the same time being rapidly available to offer advice and see cases held by other team members, which are then handed back for monitoring. Teams in which there is a system of distributed responsibility in operation for clinical cases mean that no one individual has responsibility for all cases. Instead, responsibility rests at an individual care coordinator level (in line with recommendations from professional bodies including the General Medical Council).

In this model, the Consultant Psychiatrist remains responsible for their clinical work and decision-making and for their advice to others but not for the clinical decisions and work of others. Such teams develop a sense of mutual professional respect and allow the opportunity for individual professionals to demonstrate not only their profession-specific skills but also a range of new skills, such as independent prescribing, physical examination and case formulation which are becoming no longer specific to one profession. The end result for the Consultant Psychiatrist is to become a highly valued specialist member of a capable and competent team, with an enhanced skill base operating within a system of distributed responsibility. It is this model of working which the current guidance seeks to support.

National guidance on the boundaries of responsibility and accountability is available. (See refs).

Job Planning as a Quality Tool

In contemporary psychiatric practice, with functionalised teams and new patterns of multidisciplinary working, it is increasingly difficult and generally unproductive to attempt any definition of population or activity norms as a means of regulating Consultant workload and defining doable, fulfilling and productive jobs. This is why the current guidance has made no effort to produce such figures. In their absence, it is necessary to have an alternate means of achieving this end. Properly conducted, and if embarked upon in a spirit of cooperation and bilateral problem solving, job planning can provide just such a mechanism. This section offers some pointers to making best use of this tool.

Job planning within the Consultant Contract

A much enhanced job planning framework was central to the realisation of the 2003 Consultant Contract in England. Whether observing that particular contract or not, it is suggested that all employers would be well advised to adhere to an agreed and well-developed framework such as the one that this contract provides for job planning. Similar frameworks are applicable in the other UK jurisdictions.

As an exemplar, the key documents that support job planning from the English contract are:

- Terms and Conditions, Consultants (England 2003), DH
  (Particularly Schedules 3 and 4)
- Job Planning: standards of best practice. DH, April 2003

In addition, NHS Scotland has produced an excellent Job Planning handbook which provides detailed advice and practical guidance on getting the most out of job planning:

- Consultant Job Planning Handbook for Medical Managers, NHS Scotland Pay Modernisation Team, September 2005. *Available at:* http://www.paymodernisation.scot.nhs.uk/consultant/docs/jobplan/Job%20planning%20handbook.doc

Throughout these documents, the emphasis is on job planning being based on a partnership approach. It should be grounded in delivering the following mutual benefits.

For consultants, effective job planning 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 these commitments;
- prioritise work and better manage workload;
- promote flexible working; and
- support, where appropriate, a phased approach to consultant careers.

For employers, effective job planning should help in:
- planning the most effective use of overall resources;
- agreeing and providing transparency as to how consultants' work can most effectively

support wider local objectives;
- identifying priorities for changes in capacity, skill mix and/or ways of working; and
- agreeing appropriate time and resources to support clinical governance, quality improvements, teaching, education and research.

(From: Job planning: standards of best practice. DoH, April 2003)

Each organisation should have an agreed policy setting out its approach to job planning and the paperwork which supports it. Where clinical academics are employed this should account for their needs and describe how both appraisal and job planning are integrated between university and clinical duties.

The link with appraisal

In the era of revalidation, it is recognised that Consultant Appraisal cannot be a purely formative and developmental process which remains entirely confidential between the appraisee and the appraiser. Nevertheless, properly conducted, it can provide a rich account of the Consultant's working situation, the opportunities and constraints they face, and the specific impact of team factors and availability of other supporting resources. As such, the output from appraisal should feed into the job planning process. This can most readily be achieved where the same individual (eg a Clinical or Associate Medical Director) is conducting both processes. In that event, it is essential that both parties recognise and respect the differing purposes and methods for appraisal and job planning, though acknowledging how the former feeds the latter. Where such an arrangement is not in place, it is necessary to consider how learning from the appraisal process is captured in the job planning exercise.

Initial and interim job planning and subsequent reviews

Whenever a Consultant job is newly established or a Consultant is newly appointed, there should be an immediate discussion to agree the job plan. In such circumstances, it is highly advisable for an interim job plan review to be conducted at say 3 or 6 months in order to check that initial assumptions about the post and the deliverability of the plan are correct. If they are not, this provides an opportunity to agree corrective action before problems escalate.
In the ordinary course of events, when jobs are well established, annual reviews should suffice. Employers should be receptive, however, to early requests for a review if initiated by Consultants who are concerned about their working arrangements and who wish support to remedy their issues.

Dispute resolution

In the great majority of cases, with good will on both sides, job plans can be agreed to mutual benefit and without dispute. On those occasions where this is not the case, there should be the opportunity for mediation followed in the last resort by formal appeal. Mediation will usually involve the Medical Director and should be based on careful consideration of the evidence provided by both parties which is relevant to the issues under dispute. The better the evidence, the more likely it is that an agreed resolution can be found. This might include evidence such as a workload diary exercise conducted by the Consultant, or detailed information regarding supporting resources and

what steps have been or can be taken to remodel how the Consultant is working within their team. To support this process, it is strongly recommended that employers should involve the College Regional Adviser or one of their team as necessary to “broker” any areas of dispute.

Should these processes fail, there will be access to a formal appeal process. It is submitted, however, that this should be avoidable in the majority of circumstances if job planning is undertaken in good faith in accordance with agreed principles and within a sound framework such as those referred to above. It is likely that this outcome is more likely where both parties have received training in the process and employers should ensure that they have arrangements in place to support this. Effectively implemented job planning can help both practitioner and employer deliver their objectives whilst upholding high professional standards of practice within collective multi-disciplinary team working.

The Royal College of Psychiatrists:
College Regional Advisers and College Assessors

The Royal College of Psychiatrists can prove very helpful to employers in formulating consultant roles, preparing job descriptions, person specifications and job plans, and in resolving any difficulties related to consultant posts. Much of the work of the College is devolved to 'Divisions' (representing local geographical areas) and to 'Faculties' (representing the different subspecialties).

Regional Advisers and Specialty Regional Representatives

In each area of the country the College appoints a Regional Adviser and a Deputy Regional Adviser. Their roles are to be the representatives of the College on all matters relating to postgraduate education in psychiatry. They have considerable knowledge of local services and training issues, and can advise on the development of posts and services, including offering informal comments at any stage in the development of a job description. Each faculty also appoints a 'Specialty Regional Representative' in each area to support Regional Advisers in giving specialty specific advice.

Relevance to NHS Foundation Trusts and Independent Providers

NHS Foundation Trusts and independent sector providers are not bound by the 1996 Regulations and subsequent amendments when appointing to a consultant post although they can choose to follow the guidance. The Foundation Trust Network and the Academy of Medical Royal Colleges have established a Concordat agreeing that independent professional medical advice has an important role to play in enabling Foundation Trusts to make the best possible consultant appointments and that the Medical Royal Colleges can make an important contribution in relevant stages of the appointment process.

Job Descriptions, Person Specifications and Selection Criteria

Regional Advisers can be contacted at any stage of drafting a job description for their informal comments and advice. The definitive version (including person specification and selection criteria) should then be sent to the Regional Adviser for formal comment and advice. Employers should seek to respond positively to comments from Regional Advisers, although they are not compelled to act upon them. Ultimately the responsibility for job descriptions and advertising posts is that of the employing organisation. However the goal is to produce posts that are satisfying to work in, within services that meet the needs of service users and carers.

When reviewing any job description, the Adviser will liaise with the relevant Specialty Regional Representative. Their comments will focus on the balance and feasibility of the clinical, teaching, research and service management components of the post and on the arrangements and support for the Continuing Professional Development of the appointee. Providers may be seeking consultants with particular interests (e.g. in service or teaching) or certain specialisms to balance teams. The key question is whether the post represents a satisfactory consultant post in the local circumstances of the provider.

The person specification and selection criteria should outline the essential and desirable qualities required of the successful candidate including the minimum qualifications, skills and experience

required to perform the job. Doctors wishing to take up a Consultant appointment in the NHS are legally required to be on the Specialist Register of the General Medical Council. However Specialty Trainees (and Specialist Registrars) in Post-Graduate Medical Education and Training Board (PMETB) -approved training posts are able to apply for Consultant posts when the date of interview falls no more than 6 months before the expected date of the award of their CCT. It is important to be aware that doctors can obtain Specialist Registration by routes other than PMETB-approved higher training.

College Assessors & Consultant Appointment Committees

The College maintains a list (accessible to providers by a secure password protected website http://www.rcpsych.ac.uk/asp/aac/) of College approved External Assessors to participate in Consultant Appointments Committees. Assessors provide a reliable and constructive assessment of the training, qualifications and experience of a candidate, including their eligibility for inclusion on the Specialist Register. They help ensure the process of appointment is conducted fairly by providing an impartial, external opinion. As a core member of the Consultant Appointments Committee, any College Assessor should be involved in all stages of selection, including short-listing. They should also encourage employers to provide mentorship for newly appointed Consultants.

Difficult-to-fill Posts

Occasionally, innovative approaches may be required to solve persistent recruitment problems. It can be helpful to work closely with Royal College of Psychiatrists Regional Advisers, who often have experience of tackling such issues elsewhere, and Strategic Health Authorities and employer organisations, which may also be able to offer valuable advice and expertise. Long- term locum consultant appointments in such circumstances are rarely a productive solution (see RCPsych & NIMHE endorsed paper: Kennedy & Humphries (2006) A Practical Guide for Handling Consultant Vacancies:
http://www.rcpsych.ac.uk/pdf/Practical%20Guide%20for%20handling%20consultant%20vacancies%20Dec%2006.pdf

Conclusion

Employers need to have confidence in the quality of those they appoint to Consultant posts and will want those appointees to be able to work productively. College advisers and assessors are invaluable sources of expertise and experience that can help employers achieve that end. A collaborative working relationship between those two parties, based on mutual understanding, can only serve to improve standards and ensure the best possible results for service users.

The Recruitment and Selection Process

The appointment of consultants has historically been governed by the **Appointment of Consultants within the NHS** (Appointment of Consultants) **Regulations 1996**, as amended. In 2005 the Department of Health issued **Good Practice Guidance** on these regulations and it is important to note that the regulations and subsequent amendments still apply to NHS Trusts, Primary Care Trusts and Strategic Health Authorities. NHS Foundation Trusts are not formally bound by these regulations though it is suggested that there are benefits in adhering to them. The Good Practice guidance covers all aspects of the recruitment and selection process, including the role and function of the Advisory Appointments Committee and the interview process. Apart from listing potential unfair questions, however (Annexe E), the document does not address the interview process itself. Nor does it reference additional or alternative methods of selection.

The **Chartered Institute of Personnel and Development** (CIPD) has highlighted the limitations of the traditional interview as a poor predictor of a candidate's performance in the job. Information is gathered from the interview in a relatively unsystematic manner and judgements may be made on candidates for a variety of reasons. Bearing in mind their limitations, many organisations are including other selection techniques in addition to using interviews.

Whether interviews are used alone or in conjunction with other selection methods, it is essential to use a clear, rigorous and structured interview approach which assesses candidates against the clear criteria set out in a person specification and which may include the use of behavioural questions to assess competencies – generic and technical/specialty focused. The **behavioural approach** to interviewing focuses on past events in a candidate's life and is designed to focus on critical incidents or "situations", when the candidate has demonstrated the behaviours required in the vacancy – the assumption being that past behaviour is a good indicator of future performance.

It is good practice for the whole consultant team to be involved in the development and agreement of an **appropriate competency framework** which can be applied both to the selection process and all aspects of the consultant's role. A number of competency frameworks exist which can be used as a basis for further development – including the **Medical Leadership Competency Framework** jointly developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges.

All those involved in interviewing candidates must have received appropriate training and be aware of relevant legislation so that they do not ask questions or make judgements that are discriminatory.

As indicated above, a number of organisations are also including other selection techniques in addition to the interview itself. **Assessment centres** can assist the process by giving candidates experience of the job while testing them on work related activities as individuals and in groups. This can include simulation exercises in clinical and multi-disciplinary group settings, observed by the interviewer. **Psychological testing** tools are designed to measure individual difference in a number of areas, such as intelligence, team-working, sociability, resilience and ability. There are a variety of tests available which can enhance decision-making in recruitment although it is important that the right test is selected and it is implemented properly. These tests are part of the data set

only and interviewing decisions should not be determined solely by psychometric scores.

A rigorous and structured approach to selection is necessary to ensure that the process is both fair and seen to be fair. It is important that organisations adopt recruitment approaches that maintain a degree of flexibility and which are acknowledged as fair and effective in selecting the right candidate for the job.

Good practice ideas for selection from College Assessors

The following represents a range of suggestions for the selection process which have been gathered from experienced College Assessors, based on extensive experience of Advisory Appointment Committees (AACs). Employers may wish to consider adopting some of these ideas whilst also considering other best practice advice such as that offered by the CIPD.

- The employer may organise an Open Day prior to the AAC for candidates to visit sites, meet key staff and users and carers. Feedback can be given to AAC members, but the main benefit is that all candidates have a better feel for the job.

- Candidates can be asked to give a presentation on a relevant topic notified to them beforehand:
  - either to the AAC only
  - *or* to a wider audience who can then give structured feedback to AAC members.

- Candidates can be interviewed by members of the relevant service user and carer group using prepared questions and:
  - either feedback is given to the full AAC before interviews start
  - *or* an AAC member is present during the service user/carer interviews and he/she then feeds back views to AAC
  - *or* a service user/carer from the group acts as a full panel member and provides direct feedback on behalf of the group

- A Question and Answer session may be set up with say 7 – 10 service users and carers, with each candidate in the “hot” seat in turn. The service user on the AAC then gives feedback to the whole AAC prior the formal interview stage.

- All candidates may be set a specialty relevant scenario to consider beforehand, although not related to the specific local service in order to avoid bias for local candidates. Structured questions are agreed by the panel focussed on this scenario.

- An AAC may choose to agree topics for questioning beforehand, but then limit the number of panel members who ask them, to enable a more in-depth assessment of candidates on key issues, rather than everyone having “their” turn. All members, however, score on the areas covered.

Practical aspects of recruitment

The process for appointing a Consultant, from identifying a vacancy right through to commencing in post, is relatively complex. In order to ensure an efficient and effective process which is conducted in a timely manner, it is recommended that all employers clarify the procedures they will follow and the allocation of work required. To aid this, a model flowchart for Consultant appointment (courtesy of Hampshire Partnership NHS Trust) is available at **Appendix 1.**

A clear and comprehensive **Job Description** is also essential so that all parties can understand what will be expected of the post-holder, the setting in which they will work and the support they can expect to receive. A model for this is presented at **Appendix 2**.

Appointments in the Sub-specialties of Psychiatry

Employers should be aware that there are distinctive features of the roles and responsibilities of Consultants in the various sub-specialties which must be taken into account when designing and recruiting into these posts. As above, College Regional Advisers and College Assessors constitute an invaluable source of advice on these matters. They in turn will be advised by the specific faculties and specialist sections within the Royal College of Psychiatrists who have a responsibility for setting standards and supporting excellence of practice within their respective areas. Guidance notes from the faculties (which it is intended will be updated periodically) can be found at **Appendix 3.**

USEFUL WEB LINKS

CCTA – Creating Capable Teams Approach
http://www.newwaysofworking.org.uk/

10 Essential Shared Capabilities
http://www.newwaysofworking.org.uk/

Medical Leadership Competency Framework
http://www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html

NWW for Everyone
http://www.newwaysofworking.org.uk/

DH Terms and Conditions – Consultants (England) 2 003
http://www.nhsemployers.org/

The National Health Service (Appointment of Consultants) Regulations: Good Practice Guidance January 2005
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102748

(The NHS Employers website also contains a model contract for NHS Consultants).

Procedure for obtaining a College Assessor for an Advisory Appointment Committee is set out on the Royal College of Psychiatrists' website.
http://www.rcpsych.ac.uk/training/collegeassessor.aspx

Practical Guide for Handling Consultant Vacancies
http://www.rcpsych.ac.uk/pdf/Practical%20Guide%20for%20handling%20consultant%20vacancies%20Dec%2006.pdf

NHS Modernisation Agency Consultant Job Planning Toolkit - available on request.
Email: CCITEnquiries@dh.gsi.gov.uk

New Ways of Working: Responsibility and Accountability
http://www.newwaysofworking.org.uk/

ABBREVIATIONS

A

AAC: Advisory Appointments Committee

ADHD: Attention Deficit and Hyperactivity Disorder

AMRC: Academy of Medical Royal Colleges

AO: Assertive Outreach teams

ARCP: Annual Review of Competence Progression

ATU: Assessment and Treatment Unit

C

CAMHS: Child and Adolescent Mental Health Services

CASC: Clinical Assessment of Skills and Competencies (this is the final part of the MRCPsych. Exam(see). A candidate is assessed by many examiners over many 'clinical stations' for their clinical skills

CCT: Certificate of Completion of Training

CCTA: Creating Capable Teams Approach

CFS: Chronic Fatigue Syndrome (see also ME below)

CPA: Care Programme Approach

CPD: Continuing Professional Development

CIPD: Chartered Institute of Personnel and Development

CMHT: Community Mental Health Teams

CPN: Community Psychiatric Nurse

CRB: Criminal Records Bureau (disclosure and checks)

CRHT: Crisis Resolution and Home Treatment teams

D

DCC: Direct Clinical Care (type of PA)

DH or DoH: Department of Health

DoLS: Deprivation of Liberty Safeguards (part of the provision of the Mental Capacity Act of 2005)

DSPD: Dangerous and Severe Personality Disorder

E

ECM: Every Child Matters. An important Government policy paper (2004) regarding health of children

EIP: Early Intervention in Psychosis teams

EWTD: European Working Time Directive

F

FT: Foundation Trusts

G

GMC: General Medical Council. The Professional regulatory body for all doctors employed or working or eligible to work in the UK

I

IAPT: Improved Access to Psychological Therapies

IT: Information Technology (department)

L

LD: Learning Disability

M

MDT: Multi-disciplinary Team

ME: Myelo-Encephalopathy. This is usually used together with CFS (see above)

MHA: Mental Health Act

MHRT: Mental Health Act Review Tribunal

MMC: Modernising Medical Careers.

MRCPsych: Member or Membership of the Royal College of Psychiatrists. This is an examination with papers and clinical examination, after passing which, a doctor is entitled to use these initials after his / her name showing these higher qualifications. It is a post

graduate diploma.

N

NHS : National Health Service

NICE: National Institute of Health and Clinical Excellence

NSF: National Service Framework

NWW: New Way s of Working

O

OATs: Out-of-Area Treatments

OCD: Obsessive Compulsive Disorder

OPMH: Older Peoples' Mental Health (This is usually a Directorate in a Trust) The sub-speciality is called Psychiatry of Old Age or Old-Age Psychiatry

OT: Occupational Therapist

P

PAs: Programmed Activity (one session of 4 hours, morning or afternoon) (2 types: DCC and SPA: see)

PC: Personal Computer

PCT: Primary Care Trust

PD: Personality Disorder

PLD: Psychiatry of Learning Disability

PMETB: Post-Graduate Medical Education and Training Board

PSA: Public Service Agreement (targets)

R

RA: Regional Advisor

R & D: Research and Development

RCPsych: Royal college of Psychiatrists

RSR: Regional Speciality Representative

S

SPA: Supporting Professional Activity (type of PA see above)

SRR: Speciality Regional Representative (see: RSR above)

ST: Speciality Training. ST1 means first year of Speciality Training, ST2 means second year of Speciality Training and so on until ST6. ST1 to ST3 is often called Core (speciality)Training or CT-1 to CT3. ST4 to ST6 is called Higher Speciality Training

STR worker: Support Time and Recovery worker

U

UK: United Kingdom (of Great Britain and Channel Islands)

W

WEMSS: Women's Enhanced Medium Secure Service

WPBA: Work Place Based Assessment

WTE: Whole Time Equivalent

MEMBERSHIP OF REVIEW GROUP

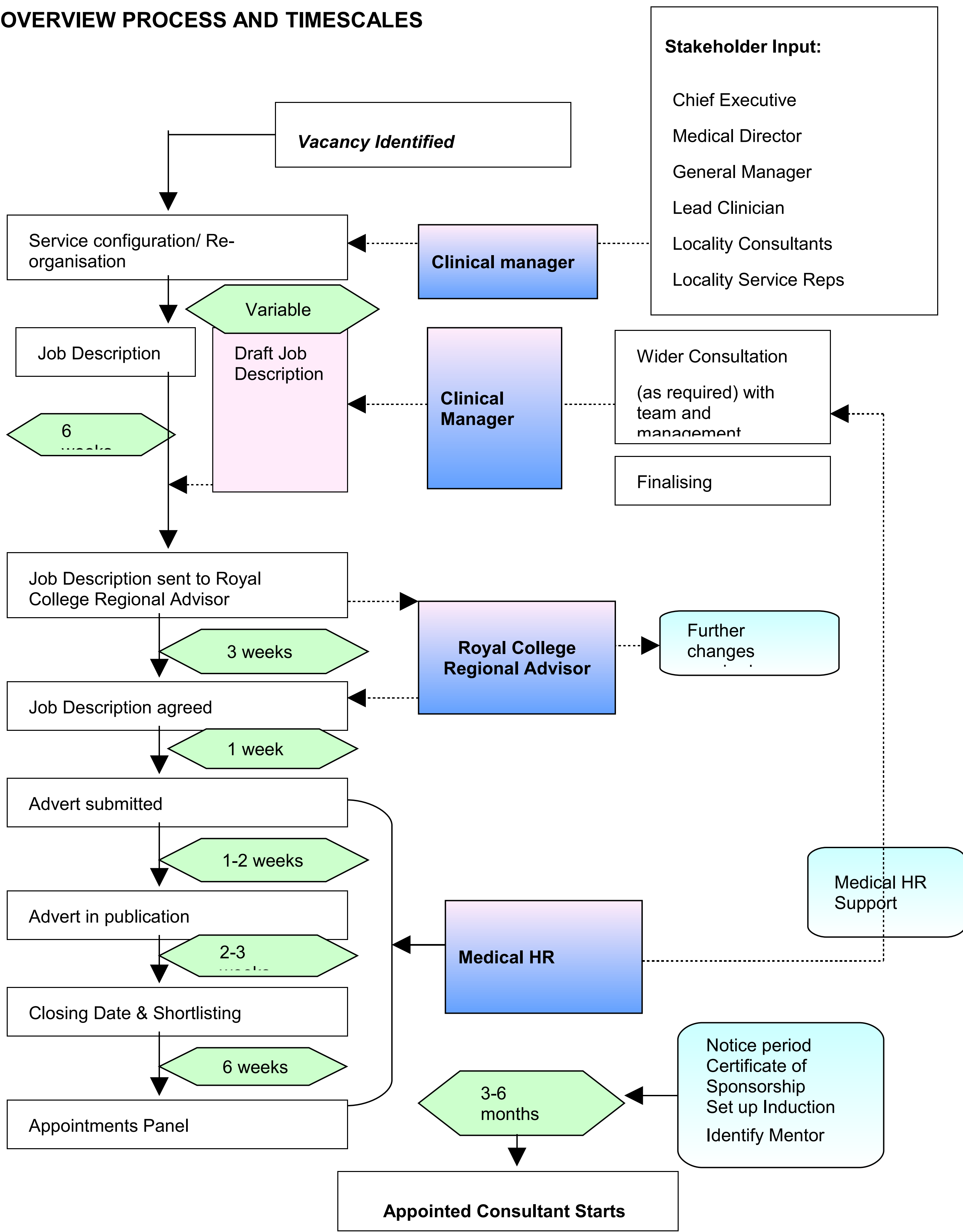
JOINT GUIDANCE REVIEW GROUP

Name	Role	Representing or from
Hugh Griffiths (Chair)	Deputy Director of Mental Health	Department of Health
Sally Pidd (Chair)	Associate Dean - Workforce	Royal College of Psychiatrists
Neil Carr	Chief Executive	South Staffordshire Mental Health Trust
Andrew Clark	Regional Advisor, North West	Royal College of Psychiatrists
Bill Davidson	Service User Involvement Lead	NIMHE National Workforce Programme
Patrick Geoghegan	Chief Executive	South Essex Partnership NHS Foundation Trust
Roslyn Hope	Director	NIMHE National Workforce Programme
Stephen Humphries	Associate Director of NWW	NIMHE National Workforce Programme
R H Kathane	Regional Advisor, East of England	Royal College of Psychiatrists
Jen Kilyon	Carer Involvement Lead	NIMHE National Workforce Programme
Liz Latham	Director of HR	Northumberland, Tyne and Wear NHS Trust
David Newby	Medical Director	Leeds Partnerships NHS Foundation Trust
Huw Stone	Regional Advisor, Hampshire	Royal College of Psychiatrists

Hampshire Partnership NHS
NHS Trust

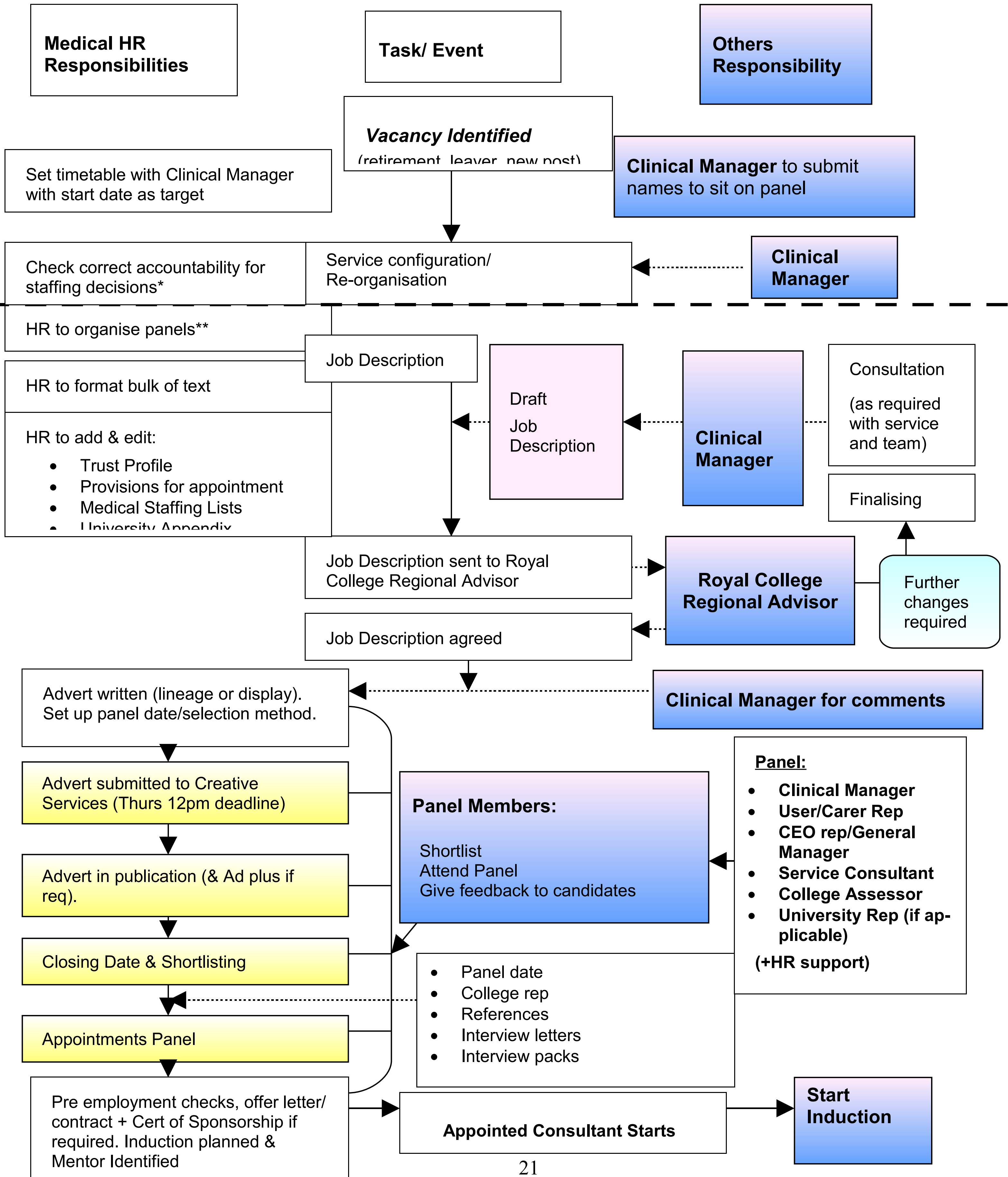
Appendix 1
CONSULTANT RECRUITMENT

OVERVIEW PROCESS AND TIMESCALES



Hampshire Partnership NHS
NHS Trust

Appendix1
CONSULTANT RECRUITMENT- SCHEDULE OF TASKS & RESPONSIBILITIES



Appendix 2

Example of a Job Description and Person Specification

JOB DESCRIPTION

The following section provides crucial information valuable to the employer and clinician in defining the nature of the post and the resources available. Entries made in *italics* are designed to be illustrative examples only. Other headings and entries are suggestions for structuring a job description and can be used as a template but are not designed to be exhaustive and should be locally amended as needed.

POST and speciality e.g. rehab ,LD	Consultant Psychiatrist in General Adult Psychiatry
BASE:	St Elsewhere's Resource Centre
CONTRACT:	Number of Programmed Activities - 10
Accountable professionally to	Medical Director
Accountable operationally to	Clinical Director and General Manager
Key working relationships and lines of responsibility	On a day-to-day basis the consultant psychiatrist will be in a close working relationship with the local management structure, particularly the team manager, locality and general manager. They will have a close working relationship on clinical matters with the community mental health team, crisis intervention, AOT and EIP services in the delivery of clinical care and local primary care services. On a more strategic level they will relate to the Clinical Director and Director of Operations. From an overall professional perspective they will relate to the Medical Director. In turn all are ultimately responsible within the Trust to the Chief Executive.

1. INTRODUCTION

2. TRUST DETAILS

3. SERVICE DETAILS

- Describe the operations of the local services to which this consultant post relates, and the expectations from the consultant of both clinical input and service developmental time.

- Make reference to the team composition, patterns of referral and system for dealing with caseload flow. Give examples of number of new referrals per week and how the team assesses and allocates referrals, expected caseload numbers per team member and the role expected of the psychiatrist within the team. Highlight any trust based examples of good clinical practice or locally based services which provide extra resources and reference on trust or SHA website, eg local specialist services and beacon sites.

- Give clear reference to the other teams and resources which relate to this service (to give a picture of how this post fits within the larger trust service strategy).

Specifically identify the following issues:

- The local population needs, i.e. deprivation indices, demographics. What sort of demand is expected?
- Availability of other local mental health services e.g. CAMHS, OPMH
- In patient facilities
- CRHT, other CMHTs, AOT, Forensic
- Addictions, Early Intervention for Psychosis
- Trust wide consultant network
- Give further detail in section 12 on clinical duties

4. LOCAL WORKING ARRANGEMENTS

An example is given below of a section which describes the service in which the consultant psychiatrist will be expected to work and the resources made available to support that work:

The Trust is seeking a consultant psychiatrist to join the St Elsewhere Community Mental Health Team. The vacancy has arisen as the result of a retirement and the Trust regards this as an opportune moment to develop the functioning of the team. The service covers the Eastern area of the town, an area of particular social deprivation with considerable drug and alcohol related difficulties in the local population. The post-holder will carry no responsibility for in-patients.

The team consists of:

1 WTE Consultant Psychiatrist
1 WTE Specialty Registrar
1 WTE Medical secretary

6 WTE CPNS- one advanced nurse practitioner with supplementary prescribing skills
0.5 WTE Social worker
0.5 WTE Senior OT
0.2 WTE Consultant Psychologist
0.8 WTE STR worker
0.5x2 WTE support workers

The team expects to receive on average 7 new referrals a week and has in place a rapid assessment triaging service which is multi disciplinary in nature allowing assessment of up to 10 cases within 48 hours of receipt of referral It is expected that all team members (apart from the support workers) carry roughly equivalent numbers of cases as care coordinators .The Consultant Psychiatrist is expected to carry a compact caseload of the most complex and unstable cases but will also be available at short notice to provide consultation and advice to other team members, though they are not required to act as care coordinator.

The St Elsewhere Team is one of 4 CMHTs providing services to the town
Consultant Psychiatrist colleagues are as follows

- *Northern team- Dr Red*
- *Western team- Dr Yellow*
- *St Elsewhere team- this post*
- *Southern team- Dr Green*

In patient services are provided in a new purpose built 40 bedded unit 4 miles from the team base. A dedicated in patient consultant psychiatrist and related team provide care whilst an inpatient.

The team is also supported by a Crisis Response Home Treatment service which deals with all crisis referrals from 9am to 9pm with an on-call service thereafter. The Crisis team deals with all emergency Mental Health Act referrals and A&E Liaison calls.

An Assertive Outreach service provides intensive care to the difficult to engage clients and accepts on average 80% of referrals from the team. The team is also supported by an Addictions team, an EIP service and Forensic services which provide a local medium secure and low secure service.

Whilst primarily responsible for delivering a quality clinical service the consultant psychiatrist is also expected to be actively involved in the strategic development of the team and broader services, being involved with the team manager and locality manager in helping to steer the development of the service in line with the strategic direction of the organisation.

5. CONTINUING PROFESSIONAL AND PERSONAL DEVELOPMENT

- Expectation to remain in Good Standing for CPD with R C Psych
- Local Arrangements for Peer Review Group
- Trust support for CPD activities, including study leave arrangements and budget

6. CLINICAL LEADERSHIP AND MEDICAL MANAGEMENT

- Trust medical management framework
- Local Clinical Leadership arrangements
- Participation in business planning for the locality and as appropriate contribution to the broader strategic and planning work of the trust

7. APPRAISAL AND JOB PLANNING

- Trust commitment to implementation of annual consultant appraisal, outlined in the NHS Executive Advance Letters AL (MD) 6/00 and AL (MD) 5/01
- Trust process, including linkage to job planning
- Links to Revalidation

8. TEACHING AND TRAINING

- Teaching commitments of post and support in place to achieve these
- Trust -wide Teaching
- Teaching arrangements in locality/team
- Participation in undergraduate and postgraduate clinical teaching.
- Participation in the training of other disciplines.
- Providing educational supervision of his/her trainees and other disciplines
- Taking part in continuing medical education within statutory limits.

9. RESEARCH

- Support facilities
- Specific R&D responsibilities expected of the post-holder

10. SECRETARIAL SUPPORT & OFFICE FACILITIES

- Specific Consultant Secretarial arrangements, including arrangements for other team members.
- Other administration support
- Office arrangements for Consultant, taking into account the need for confidentiality, security of information and supervision requirements of post
- Availability of PC with internet connection and IT support.

11. CLINICAL DUTIES OF POSTHOLDER

This should include specific details of the clinical work of the post which should be clearly linked to the indicative timetable. For example:

- For inpatient post, numbers of beds, localities/teams covered, ward reviews/ CPAs etc
- For community posts, numbers of referrals, team meetings, supervision of team members
- Management of complex cases
- Clinical Leadership of team
- Role in assessment of referrals/admissions
- Care plan and treatment formulation, guidance on evidence-based treatment and effectiveness.
- Liaison and collaborative working with other services/agencies
- Mental Health Act implementation
- Multi-disciplinary, multi-agency and partnership working
- Other clinical duties e.g. Substance Misuse

12. TRAINING DUTIES

- To participate in undergraduate and postgraduate clinical teaching
- To participate in the training of other disciplines
- To provide educational supervision of his/her trainees and other disciplines
- To take part in continuing medical education within statutory limits

13. CLINICAL GOVERNANCE

- Expected contribution to Clinical Governance and responsibility for setting and monitoring standards
- Participation in clinical audit
- To participate in service/team evaluation and the planning of future service developments

14. GENERAL DUTIES:

- To manage, appraise and give professional supervision to junior medical staff as agreed between Consultant colleagues and the Medical Director and in accordance with the Trust's personnel policies and procedures. This may include assessing competencies under the MMC framework.
- To ensure that junior medical staff working with the post holder operates within the parameters of the New Deal and are Working Time Directive compliant.
- To undertake the administrative duties associated with the care of patients.
- To record accurately and comprehensively, clinical activity and submit this promptly to the Information Department.
- To participate in service and business planning activity for the Locality and, as appropriate, for the whole Mental Health Service.
- To participate in annual appraisal for consultants.
- To attend and participate in the academic programme of the Trust, including lectures and

seminars as part of the internal CPD programme.

- To maintain professional registration with the General Medical Council, Mental Health Act Section 12 (2) approval and abide by Professional Codes of Conduct.
- To participate annually in a job plan review with the Clinical Manager which will include consultation with a relevant Manager in order to ensure that the post is developed to take into account changes in service configuration and delivery associated with modernisation.
- The post holder will be expected to work with local managers and professional colleagues in ensuring the efficient running of services and share with consultant colleagues in the medical contribution to management.
- To comply with the Trust's agreed policies, procedures, standing orders and financial instructions, and to take an active role in the financial management of the service and support the Medical Director and other managers in preparing plans for services.

15. EXTERNAL DUTIES, ROLES AND RESPONSIBILITIES

The Trust actively supports the involvement of the consultant body in regional and national groups subject to discussion and approval with the Medical Director and as necessary the Chief Executive Officer.

16. OTHER DUTIES

From time to time it may be necessary for the post holder to carry out such other duties as may be assigned, with agreement, by the Trust. It is expected that the post holder will not unreasonably withhold agreement to any reasonable proposed changes which the Trust might make.

17. WORK PROGRAMME

It is envisaged that the post holder will work _ programmed activities over _ days. Following appointment there will be a meeting at no later than 3 months with the Clinical Manager to review and revise the job plan and objectives of the post holder. The overall split of the programmed activities is _ to be devoted to Direct Clinical Care and _ to Supporting Professional Activities.

The timetable is indicative only. A formal job plan will be agreed between the post holder and Associate Medical Director or Clinical Manager 3 months after commencing the post and at least annually thereafter.

19. ON CALL AND COVER ARRANGEMENTS

- Details of on call rota, frequency, area/services covered, trainee support, other out of hour's services, eg Crisis teams.
- On call supplement
- Cover arrangements for post holder & responsibilities for covering colleagues during leave.

20. VISITING ARRANGEMENTS (Key contact numbers, Trust website Etc)

Suggested Draft Timetable:

Day	Time	Location	Work	Category	No of PAs
Monday	AM				
	PM				
Tuesday	AM				
	PM				
Wednesday	AM				
	PM				
Thursday	AM				
	PM				
Friday	AM				
	PM				
Unpredictable emergency on call work					
TOTAL PAs		Direct Clinical Care			
		Supporting Activities			

EXAMPLE PERSON SPECIFICATION/ SELECTION CRITERIA

Entries in italics are suggestions by way of example.

Requirements	Essential	Desirable	Demonstrated By
1. Qualifications & Training	*Recognised basic Medical Degree* *MRCPsych or equivalent* *Full GMC Registration* *Eligibility for inclusion on the Specialist Register* *or* *CCT in General Adult Psychiatry (or within 6 months at time of interview) or equivalent* *Eligibility for Section 12 Approval*	*Relevant Higher Degree e.g. MD, PhD, MSc or other additional clinical qualifications* *Section 12 Approval*	*Application*
2. Experience	*Experience of assessing and treating patients in acute & community psychiatric settings* *Knowledge of UK Hospital Systems (or equivalent)* *Knowledge and evidence of participation in CPD*	*Experience of working in the specific service/team* *Other relevant experience, eg specific psychological therapies.*	*Application/Interview*
3. Skills	*Ability to take a leadership role in a multidisciplinary team, ensuring high quality care and staff morale.*	*Evidence of specific achievements that demonstrate leadership skills* *Additional Clinical*	*Application/Interview/References*

	Ability to manage own time, workload and prioritise clinical work. *Ability to appraise own performance* *Excellent written and oral communication skills*	*Qualification*	
4. Knowledge	*Understanding of the management skills required to function successfully as a consultant* *Ability to use IT, including e-mail and the internet* *Knowledge of risk management*	*Knowledge of recent developments and drug advances in the psychiatry specialty applied for.* *Knowledge of NHS planning*	*Application/Interview/References*
5.Teaching	*Commitment to and experience of under graduate and postgraduate learning and teaching.* *Understand principles of teaching*	*Organisation of further teaching programmes in medical education or multi professional education*	*Application/Interview*
6. Research and Audit	*Ability to critically appraise published research* *Experience of carrying out an audit project*	*Experience of involvement in a research project and publication* *Interest in research* *Published audit project*	*Application/Interview*

7.Management	Knowledge of the management and structure of the NHS	Evidence of management training Previous management experience Evidence of a management project	Application/Interview
8. Aptitude and Personal qualities	*Ability to deal effectively with pressure* *Thoroughness and attention to detail* *Excellent interpersonal skills and the ability to communicate effectively* *Reliable and honest* *Flexible approach to working practise* *Positive approach to the job planning and appraisal process*	*Evidence of Leadership Attributes* *Motivational Skills* *Commitment to service development*	*Interview/References*
9.Other Requirements	*Able to fulfil the travel requirements of the post* *Able to fulfil all duties of post including on-call* *Satisfactory clearances from enhanced CRB disclosure and Health checks*		*Application/Interview/post interview process*

Appendix 3

Faculty submissions for the sub-specialties of Psychiatry

The following section comprises submissions which have been invited from the various faculties in the Royal College of Psychiatrists which have oversight of standards as they apply in the particular sub-specialty area. They are intended to provide an overview of relevant issues that may particularly impact on Consultant jobs in that area. As such they should help employers in planning and designing jobs to the benefit of all parties. The views and advice presented here are those of the relevant faculty alone. It is intended that they will be updated periodically.

Faculty of Old Age Psychiatry

The continuing demographic shift towards a higher proportion of people in the UK aged over 65 (particularly over 75) and a diminishing proportion of working age adults is established. People over 75 and especially over 85 are known to be proportionately high users of health and social services. 5% of people over 65 are aged over 90 but this group accounts for 10% of referrals to some Old Age Services. In addition, Old Age Psychiatry Services are expected to meet the diagnostic and ongoing management needs of working age adults who develop dementing illnesses. There is pressure in many quarters for Old Age Services to extend this remit to include people who develop challenging behaviour from non-progressive causes e.g. traumatic brain injury, stroke and alcohol. Old Age Psychiatry Services are also responsible for the range of psychiatric disorders seen in working age adults, but provide services which lack the same subspecialty expertise e.g. substance misuse, forensic issues, learning disability issues or liaison psychiatry.

In Old Age Psychiatry patients with dual and treble diagnosis are commonplace. Complex mixtures of functional illness, cognitive impairment and significant physical co-morbidity are the main caseload for Old Age Teams. Within these teams consultants fulfil a role as expert diagnostician, analysts of complex cases, key influencers of team-based case management and liaison with senior professionals in other services, together with a prominent role in the strategic planning and development of services. In this respect consultants working in Old Age Psychiatry have been familiar with "New Ways of Working" for more than a decade. However, post-modern developments of this model have been necessary to accommodate people with mild cognitive impairment and people inherited from working age services, which have seen exponential growth, people in non-psychiatric situations as general hospitals and care homes who have complex co-morbidities and increasing subspecialty problems associated with an ageing cohort of people. Consequently most consultants have redeveloped a caseload of complex and challenging individuals with enduring illnesses in addition to fulfilling the roles described by new ways of working.

Trends in the service are driven by predictable demographic change and the successful physical ageing of patients through public health and general medical interventions. The English Dementia Strategy and key strategic documents in Scotland, Wales and Northern Ireland mandate the improvement of diagnostic services, post-diagnostic counselling, intensive case management from diagnosis, improved specialist input into general hospitals and care homes, improved palliative care and more co-ordinated person-centred services for people developing dementia while of working age. In addition, the increased expectation and demand of the cohort of adults moving into old age, the need to develop age appropriate outreach and Crisis Resolution Services, together with the increasing challenge of treatment resistant patients and the development of subspecialty interests all require a substantial increase in services available to older people with mental illness.

Faculty of General and Community Psychiatry

Consultants in general and community psychiatry are vital members of multi-disciplinary teams providing a range of services, currently including comprehensive models of care and functional specialisation. The latter include Community Mental Health Teams (CMHT), day care and acute in-patient care. The National Service Framework for Mental Health and subsequent Policy Implementation Guidance led to the development of functional teams; Crisis Resolution and Home Treatment (CRHT), Assertive Outreach and Early Intervention in Psychosis Teams. Whereas in the past consultants would be involved in every part of the patient's care pathway and provided the continuity of care, now consultants often work in one or more functional teams . Further development of this approach has led to the CMHT function in many areas being subdivided into (1) primary care liaison and (2) rehabilitation and recovery teams. In addition consultants may be specifically allocated between in-patient and out-patient care teams. This requires a greater emphasis on liaison between services to be effective.

The key role of the consultant in the team is the assessment and formulation of the individual's difficulties to determine the appropriate package of care required. The broad based training of the psychiatrist is essential for this role. Thus the medical training assists in diagnosis and drug treatment of both physical and psychiatric disorder and the link between the two. Psychiatric training, which includes training in several psychotherapeutic approaches and an understanding of psychology and sociology assists in care planning. In addition to the assessment of those with complex problems, the consultant psychiatrist advises and supports other team members in their roles, particularly around issues of complexity or treatment resistance. They may also have a personal role in the provision of some therapeutic interventions.

In some areas service developments have not included adequate psychiatric input. In the case of CRHTs there is evidence of the benefit of dedicated consultant input for the effectiveness of the team's gate-keeping role. Without the full integration of psychiatrists within teams the opportunity for the early recognition and management of complexity will be lost. This will be true too of services currently being developed including services to improve access to psychological therapies (IAPT), personality disorder services and specialist care for those with Asperger's and Attention Deficit Hyperactivity Disorder (ADHD).

In the future court diversion is likely to increase the workload of the general adult psychiatrist as is improved recognition in both primary care and acute trusts of those with mental health problems. More consultant time will be required for assessments in relation to the Deprivation of Liberty safeguards and the increase in Mental Health Review Tribunals.

All trainees now require greater clinical supervision, with the new assessment processes. Expansion of foundation year and GP trainees in psychiatry will require close supervision of their clinical work and this will largely fall to adult psychiatrists. Likewise time will be required in the future to fulfil the requirements of revalidation.

The psychiatrist also has a valuable leadership role within the organisation for the development, evaluation and monitoring of services, which will develop with the renewed focus on quality indicators.

Faculty of Forensic Psychiatry

Forensic Psychiatry overlaps extensively with all of the other sub-specialities in psychiatry. Over the past decade forensic psychiatry services have changed significantly. Specialised services, including women's, adolescent secure, long term medium secure, low secure rehabilitation and personality disorder, have increased. The independent sector currently provides approx 50% of secure beds in England and Wales. New national pilot services have developed including Dangerous and Severe Personality Disorder Services DSPD, and Women's Enhanced Medium Secure Services WEMSS. National standards for secure services, such as those for medium secure units, have been introduced and are monitored by commissioners.

In whichever setting that they work, the roles of a forensic psychiatrist will include:

- treatment of offenders with mental disorders, who pose or who have posed risks to others in the community, in hospitals (particularly secure hospitals) and in prisons
- support and treatment of victims, especially those that develop dangerous behaviour
- the giving of advice and collaborative working with other psychiatrists, GPs, lawyers, police officers, prison staff and social workers, especially probation officers
- provision of evidence and reports for legal purposes.

There has been a rapid expansion in secure hospitals, in particular low secure and medium secure beds, driven by the substantial reduction in bed numbers in High Secure Hospitals. In parallel with this, extended mental health in reach to prisons continues to identify prisoners with significant mental health problems, who require transfer to secure hospitals. Leadership of multi-disciplinary teams and recognising the skills and competencies of all team members is essential and the team view is increasingly sought by stakeholders such as the Ministry of Justice and the Mental Health Review Tribunal.

In addition, the risk agenda is now more central to the function of forensic mental teams than ever before. There is an expectation that, where patients in the community demonstrate actual or perceived risk of serious harm to others, an assessment by a specialist forensic mental health team should be requested. This has increased the workload for forensic psychiatrists. Forensic psychiatrists are expected to also work with other agencies to manage risk, usually via the Multi Agency Public Protection Arrangements (MAPPA) and some posts will include dedicated time for this work.

Dedicated Community Forensic Psychiatry services are still sparse throughout the country and consequently there remains a need for local General Adult services to manage patients who pose a risk to others. Parallel forensic community services exist in most regions for higher risk offenders and but cannot provide aftercare for all patients discharged from a forensic inpatient unit. Liaison with and consultation to local services continues to be a significant component of the work load for forensic psychiatrists working in medium and low secure services. High Secure services are now provided by specialist mental health trusts, and consultants employed there may have the opportunity to take up responsibilities in a variety of services, thus avoiding past risks of professional isolation.

Increasingly, forensic psychiatrists work in prisons as part of in-reach services provided by mental health trusts. In these roles, they need to work across primary, secondary and tertiary levels of care. Prisoners under the age of twenty one are held in young offender institutions and the involvement of child and adolescent forensic psychiatrists will be appropriate, because of their developmental needs. In England, responsibility for providing healthcare to prisons sits with PCTs. Health care in prisons is provided through primary care and secondary multidisciplinary mental health teams. “Equivalence of care” for prisoners is the expectation, but due to the ongoing limitations of the prison environment, this remains an aspiration and the finite resources in the health service has resulted in some prisoners continuing to have their transfer to hospital delayed.

Faculty of Psychotherapy

Consultants in psychotherapy have expertise in at least one principal form of psychotherapy alongside a working familiarity with others. They have extensive experience of working with people requiring care through secondary mental health services, including people with personality disorders (PD) and other complex needs. Psychotherapy consultants are trained to assess the relative merits of psychological and physical treatments for these patients and like other psychiatrists are skilled in recognising the impact of physical as well as psychiatric disorders. The consultant in psychotherapy has a key clinical role in delivering psychotherapeutic treatments, advising colleagues and also in assessing patients' needs across a range of treatment and service options.

Consultants in psychotherapy also contribute to the postgraduate training of psychiatrists and other professionals. Experience of psychotherapeutic case discussion groups, and of providing psychotherapy under supervision in at least two modalities, is a mandatory training requirement for all psychiatrists during the first three years of training. Other psychiatric specialties also recognise the value of additional psychotherapeutic training for specialty registrars in order for them to become fully rounded consultants in their chosen specialty. While it is hoped to increase these opportunities as more psychiatrists completing the full training as psychotherapy specialists make them available, the numbers of trainees specialising in psychotherapy needs to grow to sustain these and other training demands.

Recent government initiatives will impact on the need for psychotherapy consultants within psychiatric services. As the Improving Access to Psychological Therapies (IAPT) programme is implemented, more patients whose needs cannot be met within primary care services will be identified. Initiatives to highlight the needs of people with personality disorders, the responsibility of mental health services for meeting them, and the confirmation by NICE of the pre-eminence of psychological treatments in doing so, means that psychotherapy consultants are ideally placed to develop new services for people with PD.

Training for psychotherapy consultants' requires substantial academic, clinical and experiential learning. Training schemes may need to join forces to ensure that training to become a psychotherapy specialist is available to doctors within each school of psychiatry. A small number of psychiatrists are continuing to train in the specific field of forensic psychotherapy. Newly appointed consultants need to continue their personal development with advice from a suitable mentor. It is essential their own clinical work allows them to continue to use and consolidate those clinical skills on which they will draw in their contributions as a supervisor of other therapists and as teachers and trainers. Psychotherapy consultants need to work with a team in which other professionals also have relevant postgraduate training in psychotherapy and to have regular contact with other consultants in the specialty. The regional representative in psychotherapy can advise Trusts on issues such as these as job descriptions are prepared.

Faculty of Rehabilitation and Social Psychiatry

Consultants in Rehabilitation psychiatry promote recovery-based practice and socially inclusive service development and take a local lead in the care of people with “treatment resistant” psychotic illnesses. Part of their function in Multi-disciplinary teams and multi agency networks is not only to bring medical expertise but also to define its limits and encourage a recovery ethos.

They work in a clinical environment which has changed markedly over the past two decades following their leading role in the hospital closure program which resulted in the development of local rehabilitation services, such as rehabilitation inpatient units, community-based rehabilitation wards, community rehabilitation teams and intensively supported housing schemes. An increasing number work in secure settings. Rehabilitation can involve long term maintenance support as well as development of skills and ability. More recently services have begun to cater for new groups of service users requiring longer term rehabilitation, including people with personality disorder and autistic spectrum disorders.

Rehabilitation psychiatrists work in a wide range of settings from the High Secure Hospital to the Community Rehabilitation Team.

Local Rehabilitation and Recovery services manage the care of people with complex and expensive care packages in supported, residential and nursing care homes, also providing training and support to third-sector and for-profit care providers. They can help commissioners manage care budgets by expert management of people supported by these budgets. The Rehabilitation psychiatrist should play a key role in decision-making around the funding of Out-of-Area Treatments (OATs) for patients with highly complex needs. They should also be involved in monitoring of OATs and any planning for the repatriation of patients within the local health and social care economy. Rehabilitation consultants require expertise in complex multi-agency liaison, including work with the Criminal Justice System, substance misuse services and local voluntary sector agencies. Good communication and management skills are essential for a Rehabilitation consultant.

Assertive Outreach Teams and Early Intervention in Psychosis Teams require competencies associated with the trained Rehabilitation psychiatrist. Forensic Rehabilitation is an emerging specialty requiring a combination of rehabilitation and forensic skills, and expertise in gender sensitive service development.

Rehabilitation consultants must be able to take an overview of the needs of their local high dependency population and 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. They will spend proportionately more of their working week on strategic development of these resources and supervision, liaison and consultation compared to some specialties.

Faculty of Learning Disability Psychiatry

Some particular roles and responsibilities of the Consultant in Psychiatry of Learning Disability (PLD) include:

- the clinical role
- the training and educational role
- the leadership, management and service development role

The Clinical role

The clinical role of the Consultant in PLD in community learning disability teams is mainly in providing assessment, diagnosis and management of individuals with complex needs with special emphasis on mental illness, behaviour disorder, pervasive & neuro-developmental disorders, dementias and epilepsy.

The clinical work is usually carried out by a multi-disciplinary team (MDT) with a Care Programme Approach (CPA) or a Care Co-ordination Approach. The MDT members include psychiatrists, community nurses, psychologists, social workers, occupational therapists, speech and language therapists and physiotherapists.

The range of responsibilities for Consultants in PLD includes the following:

1. Assessment and management of mental illness, behaviour disorder, pervasive & neuro-developmental disorders, dementias and epilepsy. The consultants also deal with offenders with LD and may provide prison in-reach services, court reports and second opinions when necessary.
2. Liaison role with other agencies such as social services, primary care and other secondary/tertiary care services.
3. Facilitating access for PLD to generic services.
4. A clinical leadership role, which can include leading the MDT and supporting the creation of capable teams (CCTA)
5. Assessment and management of patients in an acute specialist in-patient facility for PLD.
6. Acting as a Responsible Clinician for detained patients.
7. Assessment and management of other in-patients in generic mental health services who are perceived to have learning disability.
8. Supervising and advising other specialist clinical team members on clinical issues.
9. Psycho-education of families and carers.
10. Carrying out risk assessments and continuing healthcare needs assessments.
11. Conducting special interest clinics such as memory clinics, epilepsy clinics
12. Assessing the mental capacity of individuals under the framework of the Mental Capacity Act.

Most consultant psychiatrists in learning disability work with adults. However, some psychiatrists in LD may work solely with children. There are a few services which offer lifespan service though the majority offer services separately for children and adults.

Those who need urgent psychiatric assessment or treatment requiring high intensity specialist support may be admitted to Assessment & Treatment inpatient units (ATU's), usually staffed by specialised learning disability teams. In some areas, admission to generic mental health settings is possible, with the consultant psychiatrist in PLD retaining some clinical responsibility: either as the Approved/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 (low, medium and high secure services), in addition to that provided by the Independent or Voluntary sector.

Specialist service provision for people with pervasive developmental disorders & neuro-developmental disorders vary considerably in different settings, but in some areas the consultant in PLD leads the provision of care for this group of individuals.

The training & educational role

There are significant additional roles as teachers, education supervisors and trainers for Consultants in PLD. Organising and delivering a university teaching programme for medical or nursing students in Psychiatry of Learning Disability, organising Core & Specialist Training in PLD for Specialist trainees (ST1-ST6) including educational supervision, carrying out workplace based assessments, shortlisting & appointing ST1-ST3 & ST4-ST6 trainees. Participating in ARCP & portfolio reviews, involvement in MRCPsych teaching and CASC examinations, ensuring audit opportunities and psychotherapy experience are available to trainees & providing mentorship and career counselling. Chairing and participating in grand-rounds and journal clubs

The leadership, management and development role

Particular management responsibilities for Consultants in PLD include the following:

- Providing medical advice to others
- Identifying service gaps
- Helping the management team in policy development
- Providing medical input to specialist management teams and partnership board meetings
- Helping commissioners in understanding the nature of service provision
- Actively participating in developing strategy for the service development and planning

Faculty of Child and Adolescent Psychiatry

The consultant in child and adolescent psychiatry has a pivotal role in the specialist multidisciplinary team and indeed in the wider system within which child mental health is delivered.

The consultant brings to the team and hence the children, adolescents and their parents a wide range of knowledge and skills. The doctor in the team is uniquely equipped with an in depth knowledge *and* experience of working with both physical health issues and mental health issues. In addition the consultants skills in identifying and diagnosing, bringing together complex patterns of behaviour and systems into a coherent, effective and efficient management plan are crucial to the good functioning of the child mental health team.

Care Pathways: the consultant has generic and specific roles across most of the core care pathways in specialist CAMHS; in providing both direct and indirect consultative and professional liaison advice from screening of referrals, in the assessment phase through to treatment and discharge planning.

Responsibilities will include ensuring children and adolescents with mental illness and developmental disorders are not missed or misdiagnosed, providing and helping ensure the team are delivering the full range of current evidence based interventions; being called on to provide case reviews and second opinions regarding ongoing treatment by non-medical and junior medical staff.

The consultant brings a broad range of knowledge, skills and competencies across the main psychological therapeutic modalities along with the medical and psychopharmacological training, training in the use of mental health act legislation, consent and capacity assessment. The doctor in the team often has a 'meta' view, a perspective drawn from all the foregoing skills, knowledge and competences that allows clinically effective and cost effective decision making.

Forums of Delivery: The medical consultant works in any appropriate setting, usually relating to or in close relation to a multidisciplinary team; specialist services (tier 2/3/4) in the community, outpatients, day-patients and inpatient settings

The Children's NSF (2004): Government policy calls for 'comprehensive CAMHS' which should include input to universal services, specialist and targeted specialist services. The service elements detailed herein all require consultant child and adolescent psychiatry time, to varying extents.

Specialist teams: covering core services: NICE guidelines all of which require some input from child psychiatrists now include, Depression in Children and Adolescents, Deliberate Self Harm Guidelines, Schizophrenia and Early Psychosis, ADHD, Anxiety Disorders, Post Traumatic Stress Disorder, OCD, Pre & Postnatal Care, Chronic Fatigue Syndrome and ME, Bipolar disorders. There are also national guidelines from the National Autism Plan for Children (see exemplar in the Children's NSF regarding Asperger's and Autism)

Targeted specialist teams: Neuro-developmental disorders services, paediatric liaison hospital

services, looked after children's teams, substance misuse, youth offending and forensic services, learning disability teams, early onset psychosis and infant mental health teams.

Services up to age 18 years

Delivering services up to age 18 years; the majority of services have previously used a 16 or 17 year age cut off. There is a very steep increase in workload in year cohorts 16 and 17 as major mental disorder frequency, risk and severity all sharply increase at this transition.

On call-emergency & 24/7 for all CAMHS

Policy via the government PSA targets has led to *all* services needing to deliver 24/7 on call services; previously only some services provided this. There continues to be considerable reconfiguration and extra workload as a result, in many if not all parts of the country. The effects on routine services will continue as there has often been little or indeed less resource to do this with.

Universal Services Remit for CAMHS specialists: This has led to more comprehensive teaching, training, consultation and liaison with primary care agencies, education, social care and GPs, community health to deliver the 'comprehensive CAMHS' and the Every Child Matters Agendas**.** Of relevance are the NICE guidelines for the mental health and well-being of children in primary schools and that for parenting interventions for behaviour problems.

Teaching, Training Research & Development: Child Psychiatrists have a key role in teaching, training, research & development, not only to medical and non-medical CAMHS professionals, but also to paediatricians, primary care workers, and also colleagues in education and social care as they increasingly take up the management of behaviour and emotional problems in those they see. Child Psychiatrists also have important roles in the strategic development of services and innovation/leadership of change in services, with trusts looking to engage consultants in service management, change and innovation.