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Hospital in Liverpool, I held the post of pre-registration house physician in psychiatry for 9 months. Next, I moved to Walton Hospital, also in Liverpool, where I was a pre-registration house surgeon in neurosurgery and following this, in the same hospital, I held the post of senior house officer in neurology. From then on, I did nothing but psychiatry. I have never held a general medical or a general surgical post and I have never regretted this. Even as an undergraduate, I was passionately interested in psychiatry, and I took every opportunity that came my way to gain additional experience in it. I have always held the view that psychiatry is a profession in its own right, and that its true foundations are psychology and neurology. Psychiatry is becoming ever more influenced by these two areas of study, and we should be directing prospective psychiatrists towards them and away from general medicine.

John Birtchnell Honorary Senior Lecturer, Institute of Psychiatry, De Crespigny Park, London SE5 8AF

the college

Remedies for work overload of consultant psychiatrists

Consultant psychiatrists and specialist registrars – your views are invited

Dear Member,

The Royal College of Psychiatrists and the Department of Health have jointly set up a steering group and two sub-groups to develop the mental health workforce so that it is able to deal with modern service conditions. The task of one sub-group (co-chaired by Professor Richard Williams for the College and Mr Barry Foley of the National Institute of Mental Health Changing Workforce Programme) is specifically related to the future roles of consultant psychiatrists. Also, the College has set up a Scoping Group on the Roles and Values of Psychiatrists, chaired by Richard Williams with Professor Bill Fulford as its Secretary.

The President and senior officers of the College, who are involved in these discussions, are convinced that these are not-to-be-missed opportunities to address the serious work overload of many consultant psychiatrists. The GMC is listening and has signalled that it is willing to consider developing guidance. This may allow consultants a wider range of options about the ways in which they work. We think that this is likely to be better for patients, and could give consultants more fulfilling jobs.

Negotiations are starting on what realistic options are available, so please take the opportunity to let us know what you and your colleagues (in all disciplines) think, and help to shape the negotiations. The Scoping Group would be grateful if you would draw this article to the attention of your colleagues, so that as many members as possible have an opportunity to comment before this consultation closes, early in February.

Richard Williams

Please e-mail comments to awoolf@rcpsych.ac.uk
or send a hard copy to Andrea Woolf, Royal College of Psychiatrists,
17 Belgrave Square, London SW1X 8PG

Introduction

The Royal College of Psychiatrists' Scoping Group on the Roles and Values of Psychiatrists has initiated five main strands of exploration or 'action research'. One of them is to consider the way forward with clarifying and developing what is meant by 'consultant responsibility'. In the spring, the Group will report to the Council of the College.

The College Scoping Group is also feeding its work into the project on 'New Ways of Working in Mental Health' set up jointly by the National Institute for Mental Health in England (NIMHE) in the Department of Health and the College.

Background

The purpose of this paper

This paper has been prepared on behalf of the College's Scoping Group with the intention of getting closer to the experience and opinions of members of the College. We would like your views so that we can base our conclusions on members' wishes for the future.

The Scoping Group has found that many consultant psychiatrists are overburdened and under stress (Rathod *et al*, 2000). Many consultants report that their case-loads are too large and still rising (Tyrer *et al*, 2001). A range of other tasks has been added in recent years. Time to deal adequately with emergencies and high-risk situations is compressed as expectations for risk avoidance increase (Kennedy & Griffiths, 2001). The pressures on consultants are compounded by recruitment and retention problems with high vacancy levels (Kendell & Pearce, 1997). Many members think that services for patients are suffering because, in these conditions, psychiatrists cannot do a good job.

Everyone agrees that people with mental health problems should have help from professionals who are working in conditions that allow them to operate competently and maintain their own good health. But plainly, this is not the present position.

This consultation paper identifies a key issue and the realistic choices that are available. It applies to all psychiatric specialties, and aspects that are particular to one are elaborated in Appendix 1. The main consequences of each option are spelled out. Thus, this paper attempts to make clear what are the main elements for debate, so that the views of all concerned can inform the conclusions of the Scoping Group and lead to a transparent rationale for the negotiating stance of the College.

The role of the College

The foundation charter of the Royal College of Psychiatrists (Royal College of Psychiatrists, 2001) requires it 'to promote amongst its members and others working in allied and related disciplines the achievement and maintenance of the highest possible standards of professional competence and practice'. Therefore, the College has an obligation to ensure that

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solutions are found to the problem of work overload.

Relevant legislation, policy, and guidance

Legislation in England and Wales defines that all patients who are subject to compulsion must have a 'responsible medical officer' (RMO), but the Mental Health Act 1983 is under review and, in future, other professions may also take on the new role of 'clinical supervisor' that was proposed in the draft Mental Health Bill for England & Wales.

Recent government policies in England and in Wales identify multi-disciplinary working to provide patient-centred services as two fundamental values underpinning the NHS Plan (Department of Health, 2000), the National Service Frameworks (NSFs) for adults of working age in England and Wales (Department of Health, 1999; Welsh Assembly Government, 2002) and the Welsh strategy for child and adolescent mental health services (National Assembly for Wales, 2001).

General Medical Council (GMC) guidance makes it clear that consultants are medically responsible for in-patients and GPs for out-patients (General Medical Council, 1998) (Appendix 2). Consultant responsibility may be delegated to another doctor but not abrogated. Consultant responsibility also extends to ensuring that referrals are to professionals who are competent.

Previously, Guidance from the College (Appendix 3) recognised lack of clarity about consultant responsibility for patients who receive assessment, intervention and care from professionals in community mental health teams though it did make clear that consultants cannot be responsible for patients of whom they do not have 'specific knowledge'.

Relevant actions and developments

The governments in the UK have recognised the shortage of doctors and are increasing medical school outputs. But, it will take more than a decade for this to have a significant impact on consultant numbers. There is evidence that students' choice of specialty depends on the morale of their teachers.

Also, in England, the attrition rate from the psychiatric training grades is high. In Wales, the attrition rate is lower, and there is evidence, to date, that the majority of trainees remain in psychiatry. However, a substantial proportion of those who train in Wales do not become consultants but, instead, deliberately opt to take on the lesser managerial, administrative and out-of-hours responsibilities of non-consultant career grade appointments for shorter or longer periods. The qualitative interviews conducted as a part of a research project on recruitment and retention in Wales identified that consultant posts have become unpopular and revealed some of the reasons why.

On the positive side, some consultants are selecting much smaller caseloads comprising the more complex cases (although not exclusively), thereby releasing more of their time for better risk management, more involvement in service development, and consultancy relationships with other professionals who take responsibility for the majority of referrals to secondary care. There is evidence that they are more satisfied with their jobs, less stressed by overwork, and more influential on service development and the other professions, than those consultants who work in more traditional ways (Pajak *et al*, 2003). Also, the Trust Boards that employ these consultants have generally endorsed this change in practice and, when asked, chief executives have interpreted delegation of clinical responsibility as coming from the Board rather than from the consultants.

On the other hand, some Trusts continue to insist that every patient referred to their services has a named consultant responsible for their care. Nonetheless, the Scoping Group thinks that changes in the present arrangements are inevitable and some are taking place *de facto*. For example, some psychiatrists are capitalising on scarcity by opting for 'careers' and high salaries as locums. Trusts are concerned that locum costs are producing financial deficits that delay investment in worthwhile service developments and de-motivate consultants with substantive appointments who are committed to the local service, but paid less.

The British Medical Association, National Institute for Mental Health in England, the College, the General Medical Council and the English Department of Health have recently sponsored two national conferences to explore new roles for psychiatrists.

The issue

The law and the requirements relating to in-patients are clear – every in-patient is the ultimate responsibility of a consultant. In this paper, we are primarily concerned with the way in which out-patients are managed and, therefore, with the manner in which responsibility for their care is distributed. Arising from all of the considerations that we have summarised so far, the outstanding issue seems to be:

Whether or not redefinition of the responsibilities of a consultant psychiatrist is required to improve mental health services for those who use them and those who provide them.

The options

The Scoping Group has identified three options. These are listed below along with a summary of the main consequences of each.

Option 1: No change in consultant psychiatrists' responsibilities

The main features of this option are that:

- Consultants continue to be responsible for very large numbers of patients in secondary care;
- Consultants accept continuing workload problems and the likelihood of further increases in demand;
- Consultants hope that more colleagues will be recruited from the increased output of medical schools – this is likely to require us to wait a decade or more for any significant impact on consultant numbers; and
- There is a much lesser requirement for professionals from other disciplines to developing greater clinical autonomy.

Option 2: Smaller and selected consultant caseloads with responsibility for other patients delegated to other professional disciplines in the community mental health teams (CMHTs) that provide services for adult patients (or the equivalent multi-disciplinary teams that provide community and outpatient services in other psychiatric specialties)

The main features of this option are that:

- Consultants have reduced personal caseloads but continue to be responsible for very large numbers of patients;
- There is a named consultant for all patients in secondary care whether they are in-patients or out-patients;
- Consultants develop supervisory relationships with other professionals;

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- The other professional disciplines need to develop competencies so that they can accept greater clinical autonomy; and
- There is no need to negotiate with the GMC with the aim of developing its current guidance.
- There would be the need to develop guidelines to define the meaning, nature and range of 'complexity' and the training required to address it.

Option 3: Smaller and selected consultant caseloads with responsibility for other patients distributed among other professionals in CMHTs (or the equivalent teams in other psychiatric specialties)

The main features of this option are that:

- Consultants have reduced caseloads and direct responsibility for fewer patients in secondary care
- Consultants have clinical primacy (in which the 'buck' stops with the consultant) for high risk or complex cases
- Consultants need to develop consultancy relationships with other professionals
- Professionals from other professions need to develop competencies for more clinical autonomy
- There is need for the College to request the GMC to develop guidance on the responsibilities of consultants (Appendix 3)
- There would be the need to develop guidelines to define the meaning, nature and range of 'complexity' and the training required to address it.

Please let us have your views on the options

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Appendix 1

Responsibility of consultant child and adolescent psychiatrists in child and adolescent mental health services (CAMHS)

Discussion and review of the limits of consultant responsibility in CAMHS has been going on for much longer than in other specialties in psychiatry and there may be much for others to learn from it.

As regards in-patients, the law requires the same allocation of responsibility for child patients to consultants as it does for adult patients.

As regards out-patients, neither the professionals themselves nor their employers would accept that work they are doing with children in multi-disciplinary collaboration with consultants is in any way delegated responsibility by a consultant to a teacher or social worker, for example. Nor would most consultants wish that. Teachers and social workers are autonomous professionals who are accountable to their, usually non-NHS, employers.

Health visitors and practice nurses work in the NHS, but the former are generally regarded as autonomous professionals and the latter see their medical leadership as coming from general practitioners.

Thus, many consultant child and adolescent psychiatrists have long accepted and worked with distributed responsibility. Sometimes, the situation has been testing or uneasy or accompanied by anxiety about the formal position. Also, many specialist CAMHS operate formal or informal systems in which consultants have clinical primacy (in that the 'buck' stops with the consultant) for young people who present the most complex and high-risk needs.

Often, in these circumstances, psychiatrists are consulted by other professionals. Presently, there is anxiety within the discipline of child and adolescent psychiatry about wider acceptance outside psychiatry of the limited responsibility that is usually accepted by 'consultants' when consultation models are used. Many professionals in specialist CAMHS think that clarification would be helpful.

What is now being considered is whether:

- The relationships between psychiatrists and nurses, psychotherapists and occupational therapists, for example, in teams should become similar to the relationships that exist in many places between child and adolescent psychiatrists and clinical psychologists. All these professions have grown in recent decades to be capable of, and flourish within, such a working context; and
- There should be negotiations with the GMC so as to achieve explicit and clear understandings about the ways in which many Specialist CAMHS handle professional responsibility for out-patients.

Appendix 2

Delegation and referral

Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment, you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually, you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that such health care workers are accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of each patient.

For further information, see the General Medical Council *Good Medical Practice*, 1998, and the Royal College of Psychiatrists *Good Psychiatric Practice* 2000

Appendix 3

Responsibility for care

Consultants have a responsibility towards the community they serve through GPs,

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who must be kept fully informed about matters relating to their patients' care. Consultant psychiatrists retain the ultimate responsibility for all aspects of medical care of an in-patient under their care, including discharge. This includes ensuring that effective on-call arrangements are in place for medical cover, including the prompt availability of a consultant at all times, at least for consultation by telephone. Consultants must ensure that there is appropriate staffing at all times for the unit concerned to ensure safe delivery of patient services, taking into account local variations with respect to the siting of units. Appropriate medical staff must be available at all times in any environment where acutely ill psychiatric patients are treated. It may be necessary for inadequacies in medical cover to be brought to the attention of the managers who are responsible.

Consultants should collaborate in ensuring that comprehensive mental health services are provided by co-operating agencies with clear responsibilities. Community services should be coterminous, so that social services, psychiatric services and GPs can function together. Clear lines of clinical and medical responsibility for patients referred from the community to secondary care services must be carefully maintained; it is desirable that all such patients should be under the care of a named consultant psychiatrist.

The Royal College of Psychiatrists' publication *Caring for a Community* offers comprehensive guidance on community psychiatric care and how best to maintain standards of good practice. This builds on recommendations made in the care programme approach, which was produced to provide a framework for the care in England of mentally ill people outside hospital. The essential elements are:

- systematic assessment of health and social care needs;
- an agreed care plan;
- allocation of a key worker;
- regular review of the patient's progress.

The medical care of out-patients remains the on-going responsibility of GPs, with consultants acting in an advisory capacity or providing specialised treatment.

A copy of this paper is posted on the College website at http://www.rcpsych.ac.uk/members/membership/workOverload.htm

The Royal College of Psychiatrists Winter Business Meeting

27 January 2004, 4.30 p.m., to be held at the Royal College of Psychiatrists following the meeting of Council. Chaired by the President, Dr Mike Shooter.

Agenda

1. To approve the Minutes of the previous Winter Business Meeting, held at the Royal College of Psychiatrists on 28 April 2003
2. Obituary
3. Election of Honorary Fellows

HRH The Princes Royal

Her Royal Highness is the seventh holder of the title, The Princess Royal. In 1987, The Princess Royal was made a Fellow of the Royal Society and in 1994, The Queen appointed her a Knight of the Most Noble Order of the Garter. In 2000, to mark her 50th birthday, The Princess Royal was appointed to the order of the Thistle in recognition of her work for charities.

The Save the Children Fund, of which she has been President since 1970, was the first major charity with which she became closely associated, and it has given her great insight into the needs of children worldwide. This association, and her love of equestrian sports, have been the starting point for the development of a very wide range of charitable appointments, to all of which she devotes a large part of her working life. The Princess was also closely involved with the creation of some charities, notably The Princess Royal's Trust for Carers, Transaid and Riders for Health. She also serves as President of the Register of Engineers for Disaster Relief. She succeeded her late grandmother, Her Majesty Queen Elizabeth The Queen Mother, as Chancellor of London University in 1981.

The Princess Royal is President or Patron of some 222 organisations, including:

Riding for the Disabled
Royal College of Anaesthetists
Royal College of Midwives
Royal College of Paediatrics and Child Health
Save the Children
The Princess Royal Trust for Carers
The Queen Victoria Hospital NHS Trust

In addition to working for her many charities and regiments, both at home and overseas, the Princess carries out up to three overseas tours each year for the Foreign and Commonwealth Office in support of British interests. She also carries out a very wide range of official duties and visits in the United Kingdom in support of regional authorities and local institutions.

From her early days, riding was the Princess's great passion, and she soon proved herself an expert horsewoman. She regularly took part in the Horse of the Year Show at Wembley and the Badminton Horse Trials. In September 1971, she won the individual European 3-Day Event at Burghley, and was nominated Sportswoman of the Year by the Sports Writers' Association, the *Daily Express* newspaper and *World Sport* (the journal of the British Olympic Association). She was also voted the BBC Sports Personality of 1971.

In 1973, The Princess was a member of the British team in the European 3-Day Event Championships at Kiev in the Soviet Union. Two years later, in the same contest in Germany, she won silver medals as an individual competitor and as a team member. The Princess also competed in the 1976 Montreal Olympic Games as a member of the British 3-Day Event team. This led in 1983 to her becoming President of the British Olympic Association. In 1988, she became one of the two UK members of the International Olympic Committee. The Princess has been an enthusiastic supporter of the British Olympic teams at successive games since 1983, including the highly-successful games in Sydney in 2000.

For her life-long support of many charities and organisations in the area of health, The Princess Royal is highly commended for the Honorary Fellowship, and her acceptance would be an honour for the College.

The Lord Bragg

The work of Melvyn Bragg, FRSL, DLitt, MA, FRTS, television presenter, novelist and broadcaster, and currently President of MIND, will be very familiar to most people. Lord Bragg's name is synonymous with the arts in general. Lord Bragg has worked in broadcasting since 1961 and is currently Controller of Arts and Features at LWT, Editor and Presenter of the South Bank Show and Executive Producer of several other Arts strands. He also writes for numerous publications. He is President of the National Campaign for the Arts, a Governor of the LSE and Chancellor of Leeds University. He was made a Life Peer in 1998. In 2001, he won the Prix Italia Special Award for 25 seasons of The South Bank Show and, among many other achievements, has received numerous Honorary Doctorates and Fellowships from academic organisations.

Lord Bragg has been involved with MIND in Carlisle for 16 years, and became President of MIND in 2001. His awareness of the distress that mental illness sufferers experience and of the stigma surrounding mental health has strengthened his

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