
the teams carrying out these assessments. If the EWTD means that this can only be achieved by implementing a shift system we can see our future, and this is to be supported over and above a reduction of SHOs' night commitments. Not only is this significant for SHO training, but it is of paramount importance in defining the role of the psychiatrist in the multidisciplinary team.

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## Who wants to be a specialist registrar?

From personal experience I support A. Naeem's opinion 'thinking about higher training during senior house officer (SHO) years can reap rewards' (*Psychiatric Bulletin*, November 2004, **28**, 421–424). I appreciate the importance of valid research but during SHO training I focused on developing my clinical skills and the MRCPsych examinations. As a consequence, I had no publications and was not shortlisted for specialist registrar interview.

I am currently waiting for research projects to proceed through ethics committee approval, one of the aims being to improve my shortlisting chances. However, from colleagues' experiences it seems possible that 1 h spent replying to this article may have the same desired effect.

Another concern surrounding the shortlisting process is the emphasis that seems to be placed on research and publications, while other important factors such as communication skills and clinical ability that cannot be quantified in a standardised manner on paper take a back seat. As a consequence, the system filters out too early valuable clinicians with these subjective skills but who possess less research prowess.

I do not think the quality of counter-transference you experience on looking at someone's curriculum vitae can compare to that on interview. It is these feelings you invoke in the interviewer (positive or negative) that are likely to be replicated in interactions with patients throughout your career. Perhaps it is these subjective qualities that patients will appreciate just as much as extensive research. I acknowledge the shortlisting process needs to be standardised, however, perhaps selectors could increase the numbers they shortlist.

The answer to the question: who wants to be a specialist registrar? Well, I do and I think I have a good chance once someone meets me face to face.

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## Are the College 'norms' for general psychiatry dated?

The Royal College of Psychiatrists Occasional Paper 55, published in October 2002, *Model Consultant Job Description and Recommended Norms*, is the most up-to-date current document available that sets the standards recommended for the mental health services consultant workforce in general psychiatry. One would have hoped that it would command some credence in planning the consultant workforce, yet to our dismay, recently at our local planning away day between consultants and senior managers questions were asked by the senior managers about its utility. A cloud of confusion and ignorance was created and basic questions were asked about what does a consultant psychiatrist do and what should or should not be his or her role.

An interim report in August 2004, produced by the National Steering Group formed under the auspices of NHS Modernisation Agency, the Royal College of Psychiatrists and National Institute for Mental Health in England, has issued some 'Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency context'. Appendix 3 of the document lists a summary of the hypothetical options discussed by the Royal College of Psychiatrists and in option 2 and option 3 there is mention of delegation and distribution of responsibility among other professional disciplines. Unfortunately, the document, gives guidance and talks of general principles only.

The general psychiatrist had already begun to disappear in the mist of functionalisation of services. Now the future feels even more uncertain. The College needs to respond rapidly with an updated version of its recommended norms for the new forms of general and specialised psychiatrists.

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## Impact of a nurse triage system on junior doctors' workload

We were interested in the article by Moore & Willmott (*Psychiatric Bulletin*, October 2004, **28**, 368–370) that discussed the impact of a nurse triage system on junior doctors' workload. We were involved in piloting a very similar nurse triage system at Solihull Hospital, which has a psychiatric unit based in a district general hospital.

At the time of our study the senior house officer rota was a 1:6 'on-call' system covering the four in-patient wards, accident and emergency and general practitioner referrals, and liaison referrals within the hospital.

The nurse triage system was introduced at the beginning of February 2004. Nurse practitioners were to be the first point of contact for all referrals and ward calls in order to offer advice, screen referrals and assist the doctor with certain administrative work. During the trial a nurse practitioner was not present for every on-call shift, which therefore allowed us to evaluate the impact of a nurse practitioner on junior doctors' workload. Between 17 February and 17 May 2004 the six senior house officers recorded the time and nature of the calls they received and whether there was a nurse practitioner working with them. During this period there were 44 on-call shifts with a nurse practitioner present, 39 where there was not and 8 where it was not recorded.

The average number of calls received by the junior doctors was not significantly different with a nurse practitioner present (7.25) or without (6.76) (*t*-test $P=0.53$). The type of call received was recorded in four categories: referrals/advice, admissions, psychiatric ward calls and inappropriate calls (wrong mental health team/specialty etc.). The type of call received did not differ significantly depending on whether or not a nurse practitioner was on duty (*t*-tests, $P=0.93$, $P=0.61$, $P=0.51$, $P=0.17$, respectively). When a nurse practitioner was present, junior doctors did not receive 5 h continuous rest (the minimum required to be compliant for an 'on-call' rota under the new deal) for 34% of on-call shifts, compared with 26% when the junior doctor was working alone. There was, however, no significant difference between these results ($\chi^2$ $P=0.10$).

Our results would appear to confirm the findings of Moore & Willmott that a nurse triage system had no significant impact on reducing junior doctors' workload. We felt though that having an experienced nurse on duty offered junior doctors support during assessments, improved multidisciplinary relationships and provided specific guidance for those who were newly appointed. However, these benefits must be balanced against the risk of trainees missing out on essential learning experiences in acute psychiatry as described in the recent letter by Dixon (*Psychiatric Bulletin* (Correspondence), November 2004, **28**, 426).

A carefully planned nurse triage system in fact could not only be a valuable part of service provision in the light of changes in junior doctors' working hours, but also lead to an overall improvement in care received by psychiatric patients out of working hours. Clearly there needs to be further evidence published to ascertain if



https://doi.org/10.1192/pb.29.3.115-a Published online by Cambridge University Press