this country and the Part II in the next 6 months, contingent on their overseas training being recognised by the College. This option may not necessarily be exercised by all trainees but nonetheless needs to be there for those who think themselves ready to sit the examination.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *General Information and Regulations for the MRCPsych Examinations*. London: RCPsych.

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Predicting attendance at child and adolescent psychiatry clinics

Sir: Not all child psychiatry services have high non-attendance rates and I would suggest that the experience of Potter & Darwish (*Psychiatric Bulletin*, December 1996, **20**, 717–718) is unusual. Our service has an unnotified non-attendance rate of 13%. This compares favourably with our local paediatric services, and particularly community paediatric services. There is nothing unusual about our services. We are the main child psychiatry provider for a population of about 330 000, have a multidisciplinary clinical staff (excluding trainees) of 11 whole time equivalents and contracts to provide over 5000 appointments per annum. Steadily rising referral rates (more than 1100 new referrals in 1995/6) have caused a waiting list for non-urgent cases of 3 to 6 months.

How have we achieved low non-attendance rates?

Staff attitude: We regard an unnotified non-attendance as a waste of NHS resources and a disservice to other patients. This view is held by all clinical and administrative staff.

First appointments: All patients have to opt in to their first appointment, i.e. they are given an appointment with a date and time and named clinician but asked to confirm attendance within ten days of receiving notification. Failure to confirm automatically leads to the appointment being vacated and offered to another patient. Our patients appreciate this good management of NHS resources.

Follow-up appointments: All follow-up appointments are booked by the clinician with the family for their mutual convenience. This personal touch probably ensures the patient's realisation that the clinician's time is valuable. Patients who subsequently fail to notify non-attendance at a follow-up appointment are not sent a further appointment, but are sent a letter asking them to contact the clinic to request a further appointment.

Clinician feedback: As part of our internal contract monitoring we provide all clinicians with quarterly feedback on their own clinical activity. This includes numbers of new and follow-up appointments completed, non-attendance rates and individual clinical caseload data. Clinicians are thus aware of their own performance, and of the performance of others.

Purchaser expectations: Our purchasers do not fund patients who do not attend, either by cancellation or by unnotified non-attendance.

Meeting patient expectations: Our contracts specify that referrals have to be made via a GP or paediatrician. This has enabled us to build up a good relationship with a relatively stable group of referers who select and prepare appropriate patients for referral. It is also our impression that patients' cooperation is increased by assessment and treatment procedures which are non-blaming, easy to understand and brief.

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Job-sharing

Sir: Part-time training including job-sharing is topical in the *Psychiatric Bulletin* (Abas & Ramsay, **20**, 433; Cremona, **20**, 627–624; West & Taylor, **20**, 685–686). Having viewed the job-share policies of several Trusts in Greater Manchester, a number of pitfalls are evident, especially for training.

It is difficult in a job-share, especially at senior house officer (SHO) level, to fulfil the objective of sharing the responsibilities of a full-time post. Firstly, if each SHO works 2.5 days a week of which one day is a training course, the pair are only on the wards for three days altogether, compared to the four of a full-time employee. In addition, both partners may need to attend ward rounds or case conferences at the same time, further undermining time for clinical work.

Although all policies stated that job-sharers have the same access to training as full-timers, only one stated explicitly that double funding would be available for both job-sharers to attend the same course. Attendance at courses needs to be guaranteed for training.

During SHO training, trainees develop different clinical interests and not all will wish to do the same jobs on any rotation. If job-share SHOs are to have the same training opportunities as full timers (a College requirement), they need to have the flexibility to split from their job-share partner to experience different specialities within psychiatry. One policy stated: "Posts filled on a . . . fixed term basis will only be agreed for a job

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