

South Yorkshire Training Rotation in Core Psychiatry

Course Handbook 2018



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INTRODUCTION

Welcome to the South Yorkshire core psychiatry training rotation! This handbook provides an outline of core psychiatry training in our region, setting out the educational responsibilities of the trainee and the trainers.

The South Yorkshire rotation has provided a consistently high standard of training since its inception almost twenty five years ago. It is the largest of the six rotations within the Yorkshire School of Psychiatry (Health Education England Yorkshire and Humber) with forty to fifty trainees at any one time.

As a former South Yorkshire trainee it is always a pleasure to see many of my trainee colleagues and trainees working successfully as consultants in the region. The rotation will continue to evolve beyond the completion of this guide as we try to improve the quality of training. I hope that this guide is a useful introduction to the rotation and I am grateful to Dr Sidra Chaudhry (CT1) and Dr Sahar Basirat (CT3) for their helpful comments.

Darran Bloye
Training Programme Director



CORE PSYCHIATRY TRAINING

Core psychiatry training is a three year programme sandwiched between the two year Foundation Programme and the three to five year higher training programmes in psychiatry.

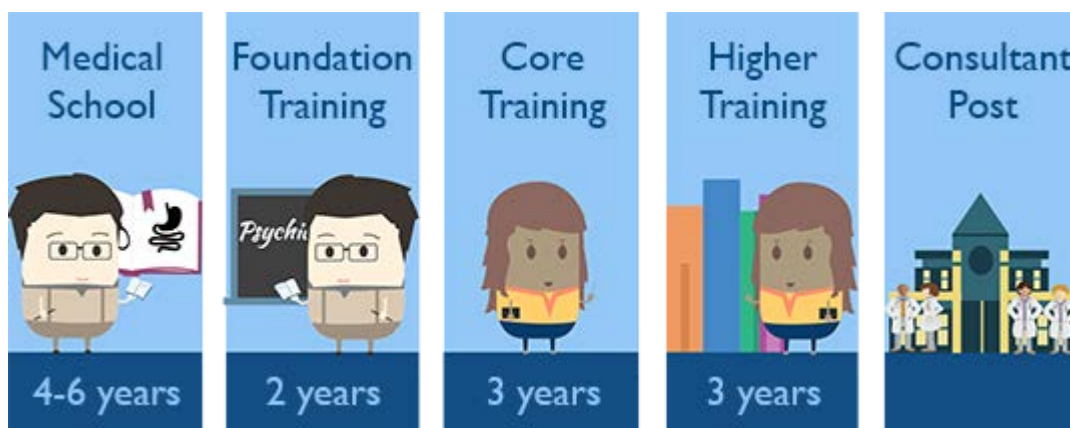
During core training each trainee will undertake six 6-month placements in a range of different psychiatric specialties. In the first year (CT1) trainees gain experience of general adult and old age psychiatry within community or inpatient settings. In CT2 trainees undertake another general adult or old age placement, and a “developmental psychiatry” placement in Child and Adolescent Mental Health (CAMHS) or Intellectual disability. Finally, the CT3 year offers at least one placement in one of the other psychiatric specialties (Forensic, Liaison, Substance Misuse or Rehabilitation).

Whilst undertaking clinical placements trainees will develop competencies in psychotherapy, Quality Improvement, professional development, research and leadership; and they will be expected to complete Membership of the Royal College of Psychiatrists exam (MRCPSych).

Each placement will be subject to mid- and end-placement reviews by the *clinical supervisor* who directly supervises clinical work, and at the end of each year the trainee will have an annual structured report (ASR) completed by their *educational supervisor*, who provides continuity of educational supervision throughout core training.

The ASR and electronic portfolio are then considered by the *training programme director* and other representatives at the Annual Review of Competency Progression (ARCP). This assessment determines whether the trainee is able to progress through the CT year and ultimately complete core training. In some cases an additional six to twelve months can be added to core training in order to facilitate attainment of MRCPSych or other competencies.

We will now look at the various components of core training in a little more detail. Key references and contact details are summarized in Appendix A.



THE ROTATION

The South Yorkshire rotation has six local education providers (LEPs) serving a diverse population of around 1.5 million.

Sheffield Health and Social Care NHS Foundation Trust (SHSC) is the lead employer for core trainees on the rotation and the local provider of the Core Psychiatry Training course (CPTC). The trust provides fourteen placements across the city of Sheffield in general adult, old age, liaison, forensic low secure, substance misuse and rehabilitation psychiatry. It is also the main centre for psychotherapy training and research activity.

Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) is a large trust in the heart of South Yorkshire that provides twelve placements in general adult, old age, CAMHS and intellectual disability psychiatry. The placements are distributed across the main population centres of Rotherham, Doncaster and Scunthorpe.

Derbyshire Healthcare NHS Foundation Trust provides eight placements in general adult and old age psychiatry across Chesterfield and much of the Peak District.

Nottinghamshire Healthcare NHS Trust provides two general adult placements in Bassetlaw (North Notts) and four forensic medium secure placements at Wathwood Hospital RSU (Rotherham).

South West Yorkshire Partnership NHS Foundation Trust (SWYFT) provides four placements in general adult, old age, and liaison psychiatry in and around Barnsley.

Sheffield Childrens NHS Foundation Trust (SCH) provides four posts in community and inpatient CAMHS.

New CT1 trainees are allocated to their first two placements by the Training Programme Director and the majority will spend their first full year in the same Trust to promote continuity. Thereafter, trainees are able to express a preference for subsequent placements at CT2 and CT3. The process of allocation begins six months before each August rotation and each trainee receives a choice of placement preferences and these are considered along with specific training needs by the Training Programme Director and the Directors of Medical Education for each Trust at an allocation meeting. The final allocation is subject to approval by the School of Psychiatry in line with national policy.

The geographical distribution of placements requires trainees to work across different trusts during their core training. This can cause some disruption due to commuting times but the diversity of training providers enables a depth of experience that is difficult to replicate in the smaller schemes.

ANNUAL ASSESSMENT

The Annual Review of Competency Progression (ARCP) takes place towards the end of the training year in June/July for trainees who join the August rotation and December/January for trainees who join the February rotation.

All trainees are reviewed at ARCP at least once a year.

Members of ARCP panels must be allowed access to portfolios and an ARCP can only take place if there is an up to date Annual Structured Report (ASR) signed by the educational supervisor and an enhanced Form R (renewal of registration for Postgraduate Training with the Postgraduate Dean).

There are two panels:

(i) A **local panel** that consists of the Training Programme Director (chair), local educational supervisors and a lay representative. The panel may also be joined by academic, Royal College or School of Psychiatry representatives.

This panel is able to decide on the following outcomes:

- 1 satisfactory progress
- 5 incomplete evidence presented (with no more than two weeks to complete outstanding tasks)
- 6 completion of the core training programme

Trainees out of programme (e.g. maternity leave) will still have an ARCP but may not receive a formal outcome. South Yorkshire trainees are encouraged to attend immediately after the panel decision in order to receive feedback on their progress. Particularly impressive achievement leading to outcome 1 or 6 is recognized with a commendation.

(ii) A **central panel** that usually consists of the Head of School/Associate Postgraduate Dean (chair), representatives from the School, local TPDs and a lay representative. This panel considers trainees who are identified by the local panel as providing *unsatisfactory evidence* and three additional outcomes are available:

- 2 development of specific competencies required (additional training time not required)
- 3 inadequate progress by the trainee (additional training time required)
- 4 release from training with or without specified competencies

Trainees are expected to attend for feedback.

The secret to success is adherence to the *latest* ARCP guidelines published by the School of Psychiatry on the HEE YH website. Further guidance and advice will be provided by the TPD two months before the local panel.

PORTFOLIO

All trainees must register with the Royal College of Psychiatrists in order to create an electronic portfolio and access to College publications, journals and library services. Registration also ensures that eligible trainees can be recommended to the GMC for award of Certificate of Completion of Training (CCT).

Once established the portfolio allows the uploading of evidence pertaining to each CT year under the categories:

- (i) **Personal development plan (PDP)** - this can be mapped to curriculum learning objectives.
- (ii) **Activities** - this section lists all activities added to the portfolio, including Workplace-based assessments, clinical experience (case logs), reflective practice, supervisor reports, quality improvement activity and presentations.
- (iii) **Assessments** - this section overlaps with the above containing all workplace-based assessments (including the Mini-PAT multi-source feedback).
- (iv) **ARCPs** - this section contains all ARCP panel assessments.

Trainees are required to give their clinical supervisor, educational supervisor, Training Programme Director and members of their ARCP panel access to their portfolio. Supervisors are then able to document workplace-based assessments, induction meetings and placement/annual reviews. It is important that trainees keep a log of psychiatric emergencies, other achievements, and details of complaints or serious untoward incidents. The latter should be discussed with clinical or educational supervisors and should be reviewed as part of reflective practice.



PORTFOLIOONLINE

EDUCATIONAL SUPERVISION

The South Yorkshire scheme pioneered the development of educational supervisors who work alongside clinical supervisors and Training Programme Directors in the provision of training and supervision.

Clinical Supervisors are responsible for providing direct clinical supervision of core trainees at a level appropriate to their competence and experience. He or she will be involved in workplace-based training and will undertake the majority of workplace-based assessments. They are responsible for providing one hour of clinical supervision per week, which should take place away from the main clinical area and should be focused on the individual trainee's learning needs. The supervision time may be used to discuss specific clinical cases, on call experience or specific clinical topics. It is recommended that trainees and supervisors keep a record of the supervision.

The clinical supervisor and trainee will agree and document a job plan at the beginning of each placement and this will both reflect and inform the educational PDP agreed with the educational supervisor at the beginning of each CT year. The clinical supervisor will need to complete the **mid and end placement appraisal forms** (use only latest copies available on the HEE YH website) and copies should be forwarded to the Medical Education Department and the educational supervisor, and uploaded to the portfolio.

Educational supervisors oversee the educational development of trainees throughout their core training and the role necessitates a combination of mentoring, coaching, appraising and assessment functions. The educational supervisor is appointed at the beginning of training and will provide continuity throughout the core training period in the majority of cases. He or she will meet the trainee at least three times a year for initial, mid-point and end-year reviews.

In the initial review meeting the educational supervisor and trainee will complete the annual learning agreement and PDP based on the intended learning outcomes (ILOs) set out in the curriculum framework for core training. Templates for the annual learning agreement and PDP are available on the HEE YH website and these can be uploaded onto the e-portfolio, or alternatively, the trainees can use the PDP template contained in the portfolio. The PDP should then be reviewed at least once (usually at the CT year mid-point) before the end-year review.

The end-year review should take place at least two weeks before the local ARCP, which in practice approximates to late May or late November for June and December ARCPs respectively. The educational supervisor should have access to the e-portfolio and copies of clinical supervisor reports. He or she will complete the **annual structured report (ASR)** which will have a pivotal role in the ARCP assessment. The latest ASR form will be available on the HEE YH website.

Doctors at risk or in difficulty

It is recognised that a small proportion of trainees will encounter difficulties during their training and this is usually a consequence of poor MRCPsych exam progression, health problems or concerns about performance. The structure of clinical and educational supervision aims to identify problems at an early stage in order to offer a range of supportive interventions according to the circumstances. For instance, some trainees require more targeted training, some trainees require adjustments to their working patterns (often on the advice of occupational health), and some trainees require an extension to training time.

Clinical supervisors should work closely with the educational supervisor, local College Tutor and local Director of Medical Education in order to highlight problems with performance or educational development, or conversely any problems in the provision of adequate training and supervision. In the first instance the clinical supervisor should clearly document any problems that do arise and liaise with the educational supervisor to try and establish a mutually agreed action plan. The progress of the action plan should be reviewed at subsequent reviews and documented in the ASR.

In those cases where problems cannot be resolved locally by the clinical or educational supervisor then it will be necessary to liaise with the Training Programme Director in order to review or directly supervise the action plan. In all cases where trainees are identified as “at risk” or “in difficulty” the action plans are discussed at regular intervals with the Head of School.

Training calendar

	Supervision	ARCP	MRCPsych
August – new trainee induction	Meet educational supervisor review PDP		
September			CASC
October	Mid placement review		Paper B
November	Complete ASR (February starters)		
December		Local panel (February starters)	Paper A
January	End placement review	Central panel	CASC
February – new trainee induction	Meet educational supervisor review PDP		
March			
April	Mid placement review		Paper B
May	Complete ASR (August starters)		
June		Local panel (August starters)	Paper A
July	End placement review	Central panel	

CLINICAL EXPERIENCE

Core trainees will have a range of placements in community and inpatient setting. Experience of different settings and specialties is the key to developing the clinical competencies necessary to progress to higher training. Trainees are advised to keep a log of cases during each placement and this is particularly important in respect of the curriculum requirement of a minimum of fifty emergency cases with first line management plans (Appendix 2).

The curriculum also specifies a minimum of fifty five nights on call (or equivalent) during core training, which is usually easy to attain unless there are restrictions on working hours. As trainees gain more experience and competence the degree of autonomy in respect of undertaking unsupervised assessments and formulating management plans should increase.

The portfolio should also contain evidence of reflective practice (uploaded as “Reflection Forms”), which provide the opportunity for trainees to record notable clinical or non-clinical experiences and reflect in more depth on the learning experience. This section can be a helpful forum for reflection on difficult or emergency cases, and the learning points that arise from any complaints or serious untoward incidents.



WORKPLACE-BASED ASSESSMENT

Workplace-based assessments (WPBAs) have been developed by the Royal College to enable continuous formative assessment of a trainee's progress and are a mandatory requirement of ARCP. The current guidance requires a minimum of sixteen (ten clinical assessments) in each CT year. They are categorised as follows:

Assessment of Clinical Expertise (ACE) – the assessor observes the whole clinical encounter, enabling assessment of history taking, mental state examination and interview skills.

Mini-Assessed Clinical Encounter (mini-ACE) – the assessor rates a specific section of the clinical encounter, for example, cognitive examination.

Case-based Discussion (CbD) – the assessor discusses a case enabling assessment of clinical knowledge and formulation skills.

The minimum ten clinical WPBAs should equate to a minimum of four CbDs, one/two ACE and four/five mini-ACE.

In addition, **trainees are required to complete two Mini-Peer Assessment Tools (mini-PAT)** – a form of 360 degree appraisal – per year, which equates to one per placement. A minimum of six responses from eight or more members of the clinical team are required.

Further workplace-based assessments can be rated following journal club presentations (JCP), case presentations (CP), teaching sessions (AoT) and psychotherapy sessions. All trainees are required to undertake training in ECT and this is one of the only procedures in core training that require a Directly Observed Procedural Skills (DOPS) assessment.

In most instances the assessor will be the consultant supervisor but trainees may also approach other consultants, higher trainees and specialty grade doctors within their service who are familiar with the core training curriculum. Band 7 or above non-medical professionals may also be approached where there is direct supervision of practice. The weight given to rating scores remains contentious since it is inevitable that they will be taken into consideration at the summative ARCP assessment. Some assessors are “hawks” whereas others are “doves” (and many in between). It is therefore important that WPBAs are spaced out across the CT year, rather than bunched up towards the end, and that a range of assessors are sought. Assessors should also be encouraged to write detailed feedback, setting out positive points and areas for development.

Until recently the WPBA clinical scenarios have not been specified and this has led to a great deal of variability in practice. CT1s are now required to provide WPBA evidence on **ten essential competencies** as part of their mid/end placement reviews and ASR (Appendix 3).

PSYCHOTHERAPY

Experience of psychotherapy is central to the core curriculum enabling the trainee to learn psychotherapy principles and processes, and deliver at least two therapies. Within South Yorkshire there is a dedicated psychotherapy tutor, Dr Harriet Fletcher, who oversees the development of psychotherapy training in the rotation and the progress of individual trainees. There are also a number of approved psychotherapy supervisors, who have experience in a range of different therapies, and who are able to directly supervise trainees within supervision groups.

Each trainee will be allocated to a weekly case-based discussion (Balint) group in Sheffield, Rotherham or Chesterfield at the beginning of their training. Towards the end of CT1, after approximately 30 sessions, the trainee's progress will be assessed by the supervisor using the case-based discussion group assessment (CBDGA), which is available within the WPBA section of the portfolio.

In CT2/3 the trainee will progress to individual therapies, namely, a "short case" (12-20 sessions) in cognitive behaviour or psychodynamic therapy and a "long case" (>20 sessions) in a different therapy modality.

The psychotherapy patients are assessed by an experienced therapist as being appropriate training cases. The trainee should not be asked to carry out the assessment themselves, although they may wish to observe the assessment. Trainees need to receive some induction sessions in the model of therapy (often by observing their peers in the supervision group) and they will be supervised by an accredited therapist. There are a number of approved supervisors across the scheme and further information about finding a supervisor will be provided by the Psychotherapy Tutor. Many trainees do their cases in the Specialist Psychotherapy Service in Sheffield but there are also a number of opportunities available elsewhere, preferably in or near their main clinical placement.

The short case is assessed by the supervisor using the Structured Assessment of Psychotherapy (SAPE) and the psychotherapy tutor using the Psychotherapy Assessment of Clinical Expertise (PACE).

The long case differs in respect of requiring two SAPEs around the beginning and end of therapy, and is similar in respect of requiring a single PACE after therapy has been completed. A 2000 word essay is required mid-therapy, followed by the 500 word written summary of the case when the therapy is completed.

The training time required to complete psychotherapy competencies is extensive and needs to be protected from other clinical duties within the placement. It is therefore important that psychotherapy time is clearly documented in job plans and that psychotherapy competencies are referenced in the PDP.

CORE PSYCHIATRY TRAINING COURSE

All core trainees attend the School of Psychiatry Core Psychiatry Training Course (CPTC) during protected study leave. The majority of sessions are at Fulwood House in Sheffield and the others are shared with the University of Leeds Centre, on occasion using video-technology to reduce travelling time. The course has a website which includes excellent resources from across the Yorkshire and Humber region.

The course is more than just preparation for the MRCPsych examination; it has a wider role that aims to develop the knowledge base and technical skills necessary for a core trainee to successfully progress to a higher training or specialty doctor post.

The theory Papers A and B are usually taken in the first two years of core training, and their successful completion enables core trainees to sit the OSCE-style clinical examination, Clinical Assessment of Skills and Competencies (CASC), in CT3.

There are two opportunities annually to sit each part of the exam. The examination regulations, syllabus and calendar are updated regularly on the Royal College of Psychiatrists website.

Attendance at the course is compulsory and trainees are required to register with the course at the beginning of each term using a study leave form. A minimum 75% attendance per annum is expected and attendance will be reviewed at ARCP. The following timetable has been established:

CT 1: Paper A - alternate Fridays

CT 2: Paper B - alternate Tuesdays

CT 3: CASC - alternate Wednesday afternoons

Trainees will only be able to repeat year levels in exceptional circumstances, with the agreement of the Training Programme Director and CPTC Course Lead.

Less Than Full Time trainees will undertake teaching on a pro rata basis, for instance, LTFT trainees working 50% or 60% would usually take 2 years to complete each year level of the course.

LEADERSHIP AND CLINICAL GOVERNANCE

Doctors who enter psychiatry core training in South Yorkshire will be tomorrow's clinical leaders, responsible for managing and leading clinical teams, service development and evaluation, and promotion of psychiatry within the wider community. The rotation aims to develop these competencies in conjunction with the core curriculum.

Within ARCP there is a requirement that trainees complete at least one Quality Improvement (QI) project annually. A wide range of projects are encouraged, including clinical audit, service development and procedure development; and more academic trainees may undertake a supervised research project over a two year period instead of two QI projects. The "ownership" of the project must reside with the trainee (sometimes in collaboration with another trainee) and it will usually be supervised by the clinical supervisor.

Within the portfolio an uploaded report should include details of the project, including: aims, rationale, standards, methodology, results and conclusion. A structured reflective template has been devised to evaluate project impact and learning points. For the latest QI project Guidance see Appendix 4.

Trainees are also encouraged to undertake representative roles within the region within local trainee committees, the BMA and the Royal College.

The South Yorkshire rotation and the Yorkshire School of Psychiatry work collaboratively with trainees to improve the quality of training. Trainee representatives are invited to the local Specialty Education Committee (SEC), regional School Management Committee (SMC), and CPTC committees. All trainees are encouraged to provide feedback on their training through local, regional and national surveys. Completion of Yorkshire and Humber training survey and GMC national training surveys are compulsory and evidence of completion of these surveys must be upload to e-portfolio prior to ARCP.

TRAINING AND DEVELOPMENT

Each of the six trusts within the rotation provide an educational programme that include: case conferences, journal clubs, supervision groups, audit meetings and taster sessions in psychiatric sub-specialties.

A regional *North Trent Grand Round* for all trainees takes place once a month in Sheffield at Fulwood House. The morning usually includes a case conference and trainee committee meetings.

There is a priority to develop clinical simulation training in within the CPTC with the aim of improving communication and clinical skills from an early stage to prepare trainees for the CASC and higher training. This has led to the adoption of Formative Assessment of Communication Skills (FACS1) at the end of CT1 and Formative Assessment of Clinical Skills (FACS2) at the end of CT2. Trainees filmed during a consultation with two simulated patient scenarios in each FACS and receive feedback from two trained assessors. The CPTC also provides a biannual mock CASC examination for eligible CT2 and CT3 trainees, and there is an evening CASC club for trainees sitting the examination.

In addition, core trainees are encouraged to participate in the multi-professional RAMMPS course, which provides clinical simulation experience of physical healthcare emergencies in psychiatric settings.

For those trainees interested in teaching there are ample opportunities to become involved with the undergraduate medical students on clinical placements from the University of Sheffield. Feedback forms, Assessment of Teaching (AoT), Case Presentation (CP) and Journal Club (JC) WPBAs should be added to the portfolio in each CT year.

RESEARCH

Professor Scott Weich, at the The University of Sheffield Centre for Health and Related Research (SchARR), is able to provide support for core trainees interested in undertaking research projects.

The rotation is also able to accommodate run-through training as an Academic Clinical Fellow (ACF) and prospective applicants are advised to contact Professor Weich directly (s.weich@sheffield.ac.uk).

CURRICULUM DELIVERY

All core trainees must comply with the policies and procedures of HEE YH and the lead employer. Further details of on call arrangements, annual leave entitlement, unplanned leave and expenses are provided in Appendix 5. Curriculum Delivery (study leave) is defined as *leave to participate in education and training activity away from the workplace* and all trainees are allowed a maximum of 30 days per annum. Education and training that occurs within the workplace, such as local postgraduate programmes, do not count against the study leave entitlement. Approval for study leave must be agreed by the clinical supervisor (with appropriate clinical cover), Training Programme Director and Director of Postgraduate Medical Education, and the electronic application form must be submitted six weeks in advance to the Medical Education Department. Retrospective applications will not be supported and any leave taken will be deducted from the annual leave entitlement or salary.

Study leave must be relevant to the core curriculum and the majority of the entitlement will be subsumed within the CPTC, which as noted previously requires completion of a study leave application form at the beginning of each term. The School of Psychiatry does not support applications for external courses or events where the content can be delivered in local educational programmes. The remaining study leave entitlement should therefore be used for the following:

1. **Examination leave**

Attendance at an MRCPsych examination will be approved as study leave but examination fees are not reimbursed. Travel and overnight expenses are reimbursed for first attempts but are not reimbursed for subsequent attempts of each paper. Proof of examination entry should be enclosed in the application.

2. **Mandatory s12 approval courses**

Once trainees have completed the MRCPsych examination they will receive study leave and reimbursement of fees and expenses for an accredited section 12 approval course.

3. **Private study leave**

A maximum of five days per CT year (August – July) prior to an MRCPsych examination (with proof of examination entry in the application) is permitted. The study leave application must have an attached revision timetable.

4. **External conferences**

Trainees may use study leave to attend the School of Psychiatry annual conference. Fees and travel expenses are reimbursed.

5. **RAMMPs and Management Courses**

These events are free of charge to attend but are external to the CPTC and will therefore require study leave approval. Expense claims which relate to these courses must be applied for using a study leave expenses claim form.

Applications for other external training events, such as Royal College conferences, may be considered where the trainee has a direct interest (e.g. presentation of a research project).

LESS THAN FULL TIME TRAINING

At the time of writing approximately one quarter of South Yorkshire core trainees are 50/60/80% less than full time and extensive use is made of slot share arrangements. On call, annual leave, study leave and CPTC attendance is undertaken on a pro-rata basis. For instance, a trainee working 50% LTFT will spend two years at each year level and will have half the number of annual leave days and half the number of CPTC sessions per annum. Similarly, he or she will do half the number of WPBAs per annum. However, all trainees have at least one ARCP per annum and certain single or odd number curriculum requirements, such as QI project or case presentation, require “rounding up” to one per annum.

Core training posts are offered on a full time basis and a request for less than full time training does not guarantee that a placement will be available for the start date. New applications must be submitted three months in advance of the start date. A trainee may be eligible for LTFT training for the following reasons:

1. **Category 1** – disability, ill health, responsibility caring for children/dependent relative
2. **Category 2** –
 - a. Unique opportunities for personal/professional development
 - b. Religious commitment
 - c. Non-medical professional development

Category 1 applications are prioritised and the application process differs slightly according to the reasons given.

HEE YH may also approve unpaid leave to take time out of programme (OOP), either in relation to clinical training (OOPT), clinical experience (OOPE), research (OOPR) or a career break (OOPC). The trainee should have already completed twelve months of training and the application should be considered at least six months before commencement.

Application forms and the latest LTFT/OOP policies are available on the HEE YH.

HIGHER SPECIALIST TRAINING

Successful completion of core training will equip trainees for higher training in psychiatry and the Yorkshire School is able to provide higher training in all of the psychiatric specialties:

- General adult psychiatry
- Old age psychiatry
- Child and adolescent psychiatry (CAMHS)
- Forensic psychiatry
- Intellectual disability psychiatry
- Psychotherapy

The larger specialties (general adult, old age, CAMHS) have locality schemes in South Yorkshire whereas the smaller specialties are organised across the Yorkshire region with individual placements in South Yorkshire.

APPENDIX 1: CONTACTS

Sheffield Health and Social Care (Lead Employer)

Fulwood House
Old Fulwood Road
Fulwood
Sheffield
South Yorkshire
S10 3TH

Medical Education Department: 1st Floor Tudor Building, Fulwood House
Tel. 0114 22 61585

Medical Education Manager: Jo Wilson

Payroll Department

Victoria Pay Services
Coleridge House,
Northern General Hospital
Herries Road
Sheffield, S5 7AU

Training Programme Directors

Dr Darran Bloye – TPD Core Psychiatry
Darran.Bloye@nottshc.nhs.uk
Tel. 01709 870818

Dr Grace Warren – TPD Specialty Training General Adult Psychiatry
Grace.Warren@rdash.nhs.uk

Dr Claire Young – TPD Specialty Training Old Age Psychiatry
Claire.Young@shsc.nhs.uk

Dr Harriet Fletcher – Psychotherapy Tutor
Harriet.Fletcher@shsc.nhs.uk
Or psychotherapy training administrator aimee.buck@shsc.nhs.uk
0114 271 6944/6920

Directors of Postgraduate Medical Education (or equivalent)

SHSC NHS FT

Dr Abhi Shetty
Director of Postgraduate Medical Education
Abhijeeth.shetty@shsc.nhs.uk

RDASH NHS FT

Dr Sunil Mehta
Director of Medical Education
Sunil.mehta@rdash.nhs.uk

Derbyshire NHS FT

Dr Ritu Gupta
Associate Director of Medical Education
Ritu.gupta@derbysft.nhs.uk

Nottinghamshire Healthcare NHS Foundation Trust

Contact Dr Bloye (Wathwood) as above or Dr Rajesh Alex (Bassetlaw)
rajesh.alex@nottshc.nhs.uk

SWYFT

Dr Anil Karan
Clinical tutor
Anil.karan@swyt.nhs.uk

SCH

Dr Joy Owens
Clinical tutor
Joy.owens@sch.nhs.uk

CPTC Course

Antony Baker – Course Administrator
Antony.baker@shsc.nhs.uk

Dr Alex Pavlovic – CPTC lead
Alex.pavlovic@shsc.nhs.uk

Health Education Yorkshire and Humber – Yorkshire School of Psychiatry

The website yorksandhumberdeanery.nhs.uk/psychiatry/ provides comprehensive links to the latest forms, policies and guidance, including:

ARCP guidance

Mid-/end-placement and ASR forms

Annual learning review, PDP and PDP progress forms

Curriculum Delivery policy

Less than full time training policy

Out of placement (OOP) experience policy

Royal College of Psychiatrists

www.rcpsych.ac.uk

The Royal College website has comprehensive links to:

The core psychiatry curriculum: *A Competency Based Curriculum for Specialist Core Training in Psychiatry 2013*

WPBA Guide for Core Psychiatry Training 2010

The MRCPsych examination syllabus

Portfolio online <http://www.rcpsych.ac.uk/training/trainees/traineeeregistration.aspx>

Online college publications

Workplace-based assessment guidance

General Medical Council

www.gmc-uk.org

The GMC sets standards and outcomes for medical education and training. The postgraduate education and training section has useful links to reports from Postgraduate Deaneries and National Training Surveys.

The **Reference Guide for Postgraduate Training in the UK** (“Gold Guide”) may be accessed via www.specialtytraining.hee.nhs.uk

APPENDIX 2: EMERGENCY PSYCHIATRY

Emergency psychiatry experience

The curriculum guidance states:

Emergency Psychiatry

Trainees must gain experience in the assessment and clinical management of psychiatric emergencies and trainees must document both time spent on-call and experience gained (cases seen and managed) and this should be “signed off” by their Clinical Supervisor/Trainer.

*A number and range of emergencies will constitute relevant experience. During Core Psychiatry training, trainees must have experience equivalent to participation in a first on call rota with a minimum of 55 nights on call during the period of core specialty training (i.e. **at least 50 cases with a range of diagnosed conditions and with first line management plans conceived and implemented.**) (Trainees working part time or on partial shift systems must have equivalent experience.) Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes Core Psychiatry trainees from the initial assessment of deliberate self-harm patients or DGH liaison psychiatry consultations, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.*

It is important that exposure to emergency cases occurs in all core trainee posts irrespective of setting and subspecialty. The 50 cases specified are considered an **absolute minimum**. The following guidance summarises local interpretation of the curriculum with reference to the following domains:

Acute clinical presentations

Acute clinical syndrome e.g.

- Delirium
- Substance related e.g. delirium tremens
- Psychosis (first episode, acute relapse or acute on chronic)
- Major affective disorder (first episode, acute relapse or acute on chronic)

Psychotropic related e.g.

- Acute dystonia
- Lithium toxicity
- Neuroleptic malignant syndrome

- Clozapine-associated neutropaenia
- Prolonged QTc interval on ECG

Acute risk e.g.

- Self harm and Suicidal behaviours
- Violence
- Severe neglect e.g. malnutrition
- Firesetting

Service setting

Inpatient e.g.

- Emergency admissions without prior assessment by a psychiatrist
- Initial assessment following seclusion
- Section 5(2) assessments
- First psychiatric response to acute clinical presentations (see above)
- Assessment of capacity to consent to urgent treatment

Community e.g.

- First psychiatric assessment following urgent referral (i.e. within 24 hours)
 - Domiciliary
 - Outpatient
 - Accident and emergency (including capacity assessments)
 - General medical liaison (including capacity assessments)
 - Custodial

Rota arrangements e.g.

- Out of hours on call
- Working hours crisis/emergency cover

First line management plan

To include:

- Diagnostic formulation
- Risk assessment
- Immediate treatment and risk management plan
- Evidence of discussion or collaboration with other members of multidisciplinary team

All first line management plans should be discussed with a senior or experienced psychiatrist at higher trainee, specialty doctor or consultant grade level. Specific arrangements for supervision will vary according to trainee experience and competence, and local service protocols, and must be agreed with the clinical supervisor during initial job planning meetings.

Evidence

It is recommended that all emergency cases are logged on to the electronic portfolio (with management plans documented) and a proportion is assessed by WPBAs.

APPENDIX 3: ESSENTIAL COMPETENCIES

The Yorkshire School of Psychiatry CT1 Essential Competencies (applies to all core trainees starting after Aug 2014)

Introduction

Within the Yorkshire School of Psychiatry there are a number of factors driving the change to a more focussed delivery of the core curriculum. The introduction of workplace-based assessments provided a process for regular formative assessment of clinical and other professional competencies but the variability in implementation and standards has led to ARCP recommendations in respect of the minimum number of assessments (≥ 10 CbD/ACE/mini-ACE) per year and the seniority of the assessor ($>50\%$ by consultant).

The next stage is a clearer definition of the objectives and content of the learning outcomes that are being assessed. These are difficult to specify for each sub-speciality or CT2/3 year levels. Having considered the Royal College guidance on WPBAs and the London Competency Checklist the Yorkshire School have identified ten essential clinical competencies that will need to be assessed during CT1. These competencies provide a framework to clinical assessment that is a fundamental to all future psychiatric practice:

- Elicit a clinical history
- Perform a mental state examination
- Perform cognitive screening assessment
- Perform a suicide risk assessment
- Present a clinical case (with basic management plan)
- Perform physical examination
- Prescribe safely in psychiatry
- Write a clinical letter or report
- Assessment of capacity
- Interview skills

It is expected that the early stages of the first CT1 placement would include close review of these areas with necessary coaching and intervention to address any immediately identified issues. Acquisition and portfolio demonstration of the competencies would be reviewed initially by the clinical supervisor, educational supervisor and TPD at the first mid-placement review, and then subsequently by the clinical and educational supervisor in cases where there are no concerns (plus TPD where there are concerns) at six and nine months.

The new standards require at least ten WPBAs to cover each of the competencies in the first three months of training (one per competency). This may appear daunting at first glance but a number of competencies could be assessed simultaneously in a single assessment (e.g. an observed long case could provide a mini-ACE each for: eliciting a clinical history, performing a mental state examination, performing a cognitive assessment, interview skills and presenting a clinical case).

The aim of the three month assessment is threefold:

1. Ensure the new CT1 doctor has the psychiatric competencies equivalent to those expected of a doctor with foundation competencies who is entering core psychiatric training.
2. Identify any gaps in knowledge or skills that require early remediation.
3. the CT1 doctor is able to work without direct supervision.

Subsequent WPBAs will continue to match the essential competencies in order to chart progress over the course of the first year of training. Evidence of attainment will be recorded on revised mid/end placement and annual structured reports.

Further details of the essential competencies and their assessment are outlined in table 1.

Table 1 CT1 Essential Competencies: summary guidance

ESSENTIAL COMPETENCY	SUGGESTED WPBA
<p>1. Elicit a clinical history</p> <p>This assessment will examine the trainee’s ability to take a full psychiatric history and present a summary of the findings to the assessor. The order may vary according to the patient’s particular presentation or narrative but there should be satisfactory enquiry into the following areas:</p> <ul style="list-style-type: none"> • Introduction: name, age, current circumstances, reason for referral • Presenting complaint • History of presenting complaint • Family history • Childhood development • Education • Employment • Psychosexual history and relationships • Social history • Forensic history 	<p>ACE/Mini-ACE</p> <p>The trainee should be observed taking the history of a new patient e.g acute admission, new outpatient, new community assessment.</p>

ESSENTIAL COMPETENCY	SUGGESTED WPBA
<ul style="list-style-type: none"> • Substance use history • Past medical history • Past psychiatric history • Assessment of personality 	
<p>2. Perform a mental state examination</p>	ACE/Mini-ACE
<p>This assessment will examine the trainee’s ability to observe and enquire about the common signs and symptoms of psychopathology, and present the findings to the assessor. The examination should include:</p> <ul style="list-style-type: none"> • Appearance • Behaviour • Speech • Mood and affect • Suicidal or violent thoughts • Thought form • Thought content • Perception • Cognitive function (orientation, attention/concentration, memory) • Insight 	<p>The trainee should be observed undertaking the mental state examination, perhaps in conjunction with the clinical history.</p>
<p>3. Perform a cognitive screening assessment</p>	Mini-ACE
<p>This assessment will specifically examine the trainee’s ability to undertake a more detailed assessment of cognitive function, to include for instance: frontal lobe signs, language and communication, and general intellectual abilities. Use of a standardised screening assessment of cognitive function e.g. MMSE or ACE-R can be incorporated. The trainee should present their findings to the assessor.</p>	<p>This assessment will have specific relevance to placements in old age psychiatry or within general adult psychiatry where there are concerns about cognitive function.</p>
<p>4. Perform a suicide risk assessment</p>	Mini-ACE
<p>This assessment will also focus on a specific area of the history and mental state in more detail. The trainees will be expected to elicit:</p>	<p>The trainee can be observed assessing a</p>

ESSENTIAL COMPETENCY	SUGGESTED WPBA
<ul style="list-style-type: none"> • Relevant historical factors, e.g. history of suicide attempts, psychiatric history, life events, substance misuse, social isolation or recent separation, personality traits (e.g. impulsivity) • Relevant mental state factors, e.g. suicidal ideation, depressed affect, hopelessness • Recent attempts and current intention • Protective factors, e.g. social support <p>Once again the trainee should present their findings to the assessor, demonstrating that they have analysed the level of immediate/short term/long term risk.</p>	<p>patient in an emergency setting or following a recent suicide attempt.</p>
<p>5. Present a clinical case (with basic management plan)</p>	<p>CbD</p>
<p>This assessment will examine the trainee’s ability to coherently present the history and mental state of a patient they have assessed. A sophisticated formulation is not expected but the trainee should be able to discuss differential diagnosis, relevant aetiological factors, immediate investigations and a basic management plan.</p>	<p>This assessment could be combined with competencies 1 and 2, or separately during clinical supervision.</p>
<p>6. Perform a physical examination</p>	<p>Mini-ACE</p>
<p>This assessment will ensure that the trainee can complete a full physical examination. The examination will include cardiovascular, respiratory, gastrointestinal, musculoskeletal and neurological systems, and the assessment will include discussion of any relevant findings and the quality of documentation.</p>	<p>This assessment will be relevant to a new admission clerking or an acute assessment of a physical health problem.</p>
<p>7. Prescribe safely in psychiatry</p>	<p>CbD/Mini-ACE</p>
<p>This assessment will focus on a trainee’s ability to prescribe psychotropic medication in a setting where they will not necessarily be directly supervised. An important example would be prescribing rapid tranquilisation according to recognised local/national guidelines in an emergency situation. The assessment would review the trainee’s assessment of clinical need, discussion with other professionals, explanation given to the patient, and the quality of documentation (including legibility/accuracy of the prescription</p>	<p>The assessment could be observed in real time via a Mini-ACE but it is more likely to be undertaken retrospectively in clinical supervision. Alternatively, the</p>

chart).	assessment could take place as a simulation exercise.
ESSENTIAL COMPETENCY	SUGGESTED WPBA
8. Write a clinical letter or report	CbD
This assessment will examine the trainee's ability to write a letter or a report to another healthcare professional or as part of the clinical team's assessment. Examples include: admission summaries, discharge letters, outpatient letters or assessment letters following an emergency assessment. The quality of written communication will be assessed in respect of: structure, grammar, spelling, relevance and clarity of conclusions/recommendations. Trainees should be confident of using a Dictaphone at an early stage.	This assessment will usually be undertaken retrospectively as the clinical supervisor proof reads a report or evaluates a selection of letters.
9. Assessment of capacity	CbD/Mini-ACE
This assessment will examine the trainee's understanding and approach to assessments of a patient's decision-making capacity. The specific assessment can vary, but will usually involve capacity to consent to a medical treatment or investigation. Trainees will be expected to: <ul style="list-style-type: none"> • Assess the patient's ability to understand the decision in question • Assess the patient's ability to comprehend information relating to the decision in question • Assess the patient's ability to evaluate the decision in question • Assess the patient's ability to communicate the decision in question 	This assessment may be discussed retrospectively following an emergency assessment or observed directly by the assessor
10. Interview skills	ACE/Mini-ACE
This assessment is integral to the observed ACE/Mini-ACE clinical assessments that evaluate the majority of the essential competencies. Good communication skills are a foundation for the acquisition of	This competency will be further assessed at the end of CT1 by

ESSENTIAL COMPETENCY	SUGGESTED WPBA
<p>higher level clinical skills and can be developed through regular assessment and coaching. Trainees should obtain at least one WPBA in the first three months that focuses specifically on interview skills. In particular, trainees should demonstrate the ability to:</p> <ul style="list-style-type: none"> • Introduce their role and the purpose of the interview • Gain consent • Establish rapport and demonstrate empathy • Use appropriate open/closed questions • Avoid jargon and repetition • Control and guide the interview • Handle and reflect on emotionally laden information • Clarify ambiguous information • Summarise findings • Explain options and advice • Allow time for further questions • End the interview appropriately 	<p>way of the FACS (formative assessment of communication skills)</p>

APPENDIX 4: QUALITY IMPROVEMENT PROJECT GUIDANCE

Quality Improvement Project Guidance for Core trainees

Yorkshire School of Psychiatry standards (from August 2016 – for summer 2017 ARCPs)

The trainee must demonstrate evidence at each ARCP of involvement in a Quality Improvement Project.

The specific curriculum learning objectives of *develop the ability to conduct and complete audit in clinical practice* (ILO12) and *develop an understanding of the implementation of clinical governance* (ILO13) are relevant to this section but the ARCP panel will also be looking for evidence of attainment in related ILOs, namely: *leadership skills, time management and decision making, teach, assess and appraise, research methodology and critical appraisal, habits of lifelong learning and reflective practice.*

Most trainees will have undertaken clinical audit prior to CT1 and there is little value in repeating the same project methodology during each year of core training. It is important that clinical governance expertise is developed by exposure to different Quality Improvement methodologies in order to enable a deeper understanding of the way in which healthcare systems influence clinical outcomes.

A minimum of three projects are required over the three year period of core training, there should be a minimum of one clinical audit project and a minimum of one other project format. Two projects over the course of core training would be acceptable where a trainee undertakes a supervised research project (the other project would be a clinical audit). The following list of potential projects is a non-exclusive guide:

- Service evaluation e.g.
 - Clinical audit project
 - Service evaluation survey or review
- Service development e.g.
 - Clinical guidelines
 - Policy / procedure development
 - Application of specific Quality Improvement methodologies to a service
- Risk management e.g.
 - Involvement in critical incident review
 - Analysis of incidents or near misses
- Research and development e.g.
 - Involvement in research project
 - Literature review
- Education e.g.

- Organisation of teaching or training programme
- Development of teaching materials (including for patients and carers)

For each project there should be:

1. A written report of the project e.g. Word document, Powerpoint presentation, Poster presentation, submission for publication. A certificate denoting project involvement would not be sufficient. The report should address: rationale, aims, standards (where applicable), literature review (where applicable), methods, results, conclusions, outcomes and clinical impact.
2. Attached reflective template countersigned by project supervisor (Appendix 1).

Darran Bloye
Paul Rowlands
June 2016

Appendix 1 – Reflective template for Quality Improvement project

Project title:

Project supervisor:

What is the question or problem this project attempts to solve?

What was the method I used to solve the question or problem?

What was my role in the project?

What was the outcome of the project?

How was the project outcome disseminated?

What has been the response within my service to the project?

Has the project led to a change in practice?

Were there any barriers to change?

What have I learned from the process of undertaking this project?

What would I do differently if I did this project again?

Project supervisor comments:

Supervisor

.....

Date

.....

APPENDIX 5: EMPLOYMENT DETAILS

On call rotas

- 1. Sheffield Health and Social Care**
Non-resident, 1 in 20, two trainees on call each night, banding 1B
- 2. Sheffield Children's Hospital**
Non-resident, 1 in 7, 1A banding
- 3. RDASH - Rotherham**
Non-resident, 1 in 11, banding 1A
- 4. RDASH - Doncaster**
Non-resident, 1 in 10, banding 2B
- 5. RDASH - Scunthorpe**
Non-resident, 1 in 8, banding 2B
- 6. Chesterfield**
Resident, full shift, 1 in 13, banding 1B
- 7. Barnsley**
Resident and non-resident, hybrid shift, 1 in 7 and 1 in 14, banding 1B
- 8. Bassetlaw**
Non-resident, partial shift, 1 in 7, banding 1A
- 9. Wathwood RSU**
Non-resident, 1 in 6, banding 1A

Annual leave

Entitlement depends on the point of the Medical and Dental Pay scale i.e.

- Points 0,1,2 - 27 days per annum
- Point 3 - 32 days per annum

All leave should be taken pro-rata in each placement and must not be carried over into the next placement (or brought forward) unless there are exceptional circumstances. Similarly, lieu days should be taken in the placement where the leave was accrued (the calculation of lieu days varies according to local trust policy). LTFTT annual leave is presented in hours rather than days because they are calculated on a pro-rata basis.

Requests for annual leave must be submitted to Postgraduate Services at least one month before the commencement of leave and it is the trainee's responsibility to arrange clinical cover. A maximum of five days can be carried over pro rata subject to the prior agreement of the new clinical supervisor and Postgraduate Services.

Unplanned leave

It may be necessary to take sick, compassionate or carers leave. As well as informing the local clinical supervisor or medical manager the trainee must inform Postgraduate Services with details of the circumstances and the anticipated return to work date. Sickness absence for 4-7 days requires self-certification (SC2) and sickness absence for more than 7 days requires a medical certificate. There are a maximum of 9 days carers/compassionate leave at the discretion of Postgraduate Services.

Postgraduate Services must be informed of the return to work date and in the case of sickness absence a return to work interview and form must be completed.

Travel Expenses

The local procedure is in the process of being updated and trainees should contact Postgraduate Services for the latest guidance.

Study Leave Expenses

A study leave expenses claim form should be submitted within 28 days of the leave with proof of attendance and relevant receipts. Expenses will only be paid at the cheapest rate and overnight accommodation will not be funded for events in the Yorkshire and Humber region.

Car travel will be reimbursed by the most direct route at the public transport rate. Receipts are required for car parking and toll fares. Standard class rail fares should be booked in advance.

For accommodation an overnight allowance of £55.00 per night is allowed plus £20.00 for meals over 24 hours. A night allowance of £25.00 is allowed for non-commercial properties (e.g. staying with family or friends) but there is no meal allowance. Course dinners, telephone calls, alcoholic drinks and newspapers will not be reimbursed.

For day courses or events a day meal allowance of £5.00 for lunch and £15.00 for an evening meal are allowed where the duration of absence away from home is more than five and ten hours respectively