South Yorkshire Core Psychiatry Training Scheme

Course Handbook 2015
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INTRODUCTION

Welcome to the South Yorkshire Core Psychiatry training scheme! This handbook provides an outline of our three year training schemes in Psychiatry setting out the educational responsibilities of the trainee and the scheme organisers.

Medical training has been evolving rapidly over the last twenty years and further changes are in the pipeline. In spite of this national instability, the South Yorkshire scheme has provided a consistently high standard of training throughout this period within a defined geographical region that loosely equates to the Sheffield city region.

The scheme is one of six within the Yorkshire School of Psychiatry, which is part of Health Education Yorkshire and Humber (HEEYH – formerly the “Yorkshire Deanery”). Within this larger regional structure we are often abbreviated to the “South” scheme and around a third of the core trainees in Psychiatry in Yorkshire (approximately fifty) are allocated to our scheme.

As former trainees of the South Yorkshire scheme it is always a pleasure to see many of our trainee colleagues and our own trainees working successfully as consultants within the region. The scheme will continue to evolve beyond the completion of this guide as we try to improve the quality of training. We hope that this guide is a useful introduction to the scheme and we would welcome comments as to how we can improve the contents for future editions.

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. Broad based trainees (BBT) will undertake two years of core Psychiatry training having already experienced six months of core training as part of BBT.

During core training each trainee will undertake six 6-month placements in a range of different psychiatric specialties. In the first year (CT1) trainees usually gain experience of general adult and old age Psychiatry within community or inpatient settings. In CT2 trainees usually undertake another general adult or old age placement, and a “developmental” 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, Rehabilitation).

Whilst undertaking the main clinical placements each trainee will develop competencies in psychotherapy, clinical governance, research and leadership; and they will be expected to complete the Membership of the Royal College of Psychiatrists examination (Core Psychiatry Training).

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 directors 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 Core Psychiatry Training or other competencies but this is at the discretion of the School of Psychiatry.

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 scheme has six local education providers (LEPs) serving a diverse population of around 1.5 million. The number of placements available during any given rotation varies slightly and in line with other schemes across the country there has been a small reduction in funded posts as a consequence of expanding Foundation year and BBT Psychiatry training.

The following numbers are therefore approximate but give an indication of the training opportunities across our scheme.

**Sheffield Health and Social Care NHS Foundation Trust (SHSC)** is the lead employer for core trainees on the scheme and the local provider of the Core Psychiatry Training Course (CPTC). The trust provides a range of 10-15 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 our scheme that provides 10-15 placements in general adult, old age, CAMHS and intellectual disability psychiatry. The placements are distributed between the main population centres of Rotherham, Doncaster and Scunthorpe.

**Derbyshire Healthcare NHS Foundation Trust** provides around 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 around five placements in general adult, old age, and substance misuse psychiatry in and around Barnsley.

**Sheffield Children’s NHS Foundation Trust (SCH)** provides four posts in community and inpatient CAMHS.

The process of allocation begins four months before each rotation. Each trainee receives a choice of placement preferences and these are considered along with specific training needs by the Training Programme Directors 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 and is released around a month before commencement of the rotation.
The geographical distribution of placements requires trainees to work across different trusts during their core training. Whilst this can cause some disruption due to commuting times 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 begin work in the August rotation and December/January for trainees who begin work in the February rotation. There are two panels:

(i) A local panel that consists of the Training Programme Director (chair) and local educational supervisors; there may occasionally be administrative support in attendance who does not form part of the formal panel. The panel may also be joined by academic, Royal College, School of Psychiatry and lay 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 welcome to attend immediately after the panel decision in order to receive feedback on their progress.

(ii) A central panel that consists of the Head of School (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

Once again trainees are invited to attend for feedback.

The ARCP understandably evokes a degree of anxiety among trainees but in all of the cases referred to the central panel the trainee will already be aware of difficulties e.g. non-completion of Core Psychiatry Training. The secrets to success are familiarization with the ARCP guidelines published by the School of Psychiatry and regular updating of the e-portfolio. The other key documents that must be submitted to the ARCP panel are the enhanced form R (renewal of registration for Postgraduate Training with the Postgraduate Dean) and the annual structured report (ASR).
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 consideration of award of a Certificate of Completion of Training (CCT) or a Certificate of Eligibility for the Specialist Registration (CESR) at the end of specialty training.

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

(i) **Personal development plan (PDP)** – this section is divided further into details of past and present personal development plans, the attainment of curriculum competencies, and a reference guide to the **intended learning outcomes (ILOs)** contained in the core psychiatry curriculum.

(ii) **Evidence** – this section is divided into multi-source feedback, workplace-based assessments, clinical experience (case log), reflection and a number of other sections, i.e. evidence of psychotherapy, clinical supervision, teaching, courses attended, management activity, audit, presentations and research.

(iii) **Assessments** – this section overlaps with the above focusing entirely on workplace-based assessments (including the Mini-PAT multi-source feedback).

(iv) **Supervision** – this section is divided into reviews (supervision meetings, supervisor reports and ARCP) and a list of supervisors who have or have had access to the portfolio.

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 annual reviews. It is important that trainees keep a log of clinical cases (particularly 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 recorded in the reflection forms.
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. If you are not receiving clinical supervision regularly, please contact the relevant Medical Education Team and/or Director of Postgraduate Medical Education in the Trust which you are based.

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 HEEYH website) and copies should be forwarded to Postgraduate services 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 develop the 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 HEEYH website and these can be uploaded onto the e-portfolio, or alternatively, the trainees can use the PDP template contained in the August 2014 revision of the portfolio. The PDP should then be reviewed at least once (usually at the CT year mid-point) before the end-year review in order to ensure the trainee is on course with their development of curriculum competencies.

The end-year review should take place at least two weeks before the local ARCP, which in practice approximates to early June 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. Once again the latest ASR form will be available on the HEEYH 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 Core Psychiatry Training 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, 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 any problems. As well as concerns about the trainee’s performance or educational development this includes 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 appraisals and documented in the ASR.

In those cases where problems cannot be resolved locally the clinical or educational supervisor will 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.
CLINICAL EXPERIENCE

Core trainees will have a range of placements in community and inpatient settings, across a range of clinical specialties. Experience of different settings and clinical presentations 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 (current South Yorkshire scheme guidelines discussed in 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 provides 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 ten assessments in each CT year, which in practice equates to one per month prior to the local ARCP panel. 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 WPBAs should include 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 (see Psychotherapy section). All trainees are required to undertake training in ECT and this is the only procedure in core training that requires 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, such as psychotherapy. 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 clearly positive points and areas for development.
Until recently the content of WPBAs has not been specified and this has led to a great deal of variability in practice. It is anticipated that trainees starting after August 2014 will be required to provide WPBA evidence on ten essential competencies as part of their mid/end placement reviews and ASR. The aim is to ensure that trainees are safe to work in less directly supervised settings after their first three months of training and identify at an early stage deficits in performance. Details of the ten essential competencies are provided in Appendix 3.
PSYCHOTHERAPY

Experience of psychotherapy is an important component of 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 scheme 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 recorded within the WPBA section of the portfolio.

In CT2/3 the trainee will usually progress to undertaking individual therapy, typically a “short case” (12-20 sessions) in cognitive behaviour therapy (CBT), followed by a “long case” (>20 sessions) in a different modality of therapy (usually psychodynamic).

Patients for therapy with trainees need to be 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 should 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 and we aim for trainees to undertake their psychotherapy training (particularly the short case) as far as possible in or near their main clinical placement. This is easier for the short case than for the long case which will extend beyond six months duration.

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.

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 during protected study leave time. The course is more than just preparation for the Core Psychiatry Training 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.

Attendance at the course is compulsory and trainees are required to register with the course at the beginning of each term and complete a study leave form.

With effect from 31st December 2014, Papers 1, 2 and 3 (written exams) were ceased and replaced by new written examinations which assess core medical knowledge underpinning psychiatric training. The Clinical Assessment of Skills and Competencies (CASC) is an OSCE-style clinical examination. 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 CASC in CT3. There are usually two opportunities to sit each part of the exam every year. The examination regulations, syllabus and calendar are updated regularly on the Royal College website. Trainees are advised not to sit a paper until they have completed a minimum of six months of teaching.

From April 2015 the structure of the Core Psychiatry Training examinations will from three to two written papers, Paper A (which combines previous papers 1 and 2) and Paper B (broadly equivalent to the previous paper 3). To reflect this change the local Core Psychiatry Training Course during the two terms September 2014 – July 2015 will be organised as:

Year 1: Paper A – Friday mornings
Year 2: Paper B and CASC– Tuesday afternoons

With effect from September 2015, an additional year will be introduced:
Year 3: CASC – alternate Wednesday afternoons
Also, with effect from September 2015, teaching will take place for a full day every fortnight at Fulwood House. The course is also currently developing bespoke e-learning modules and additional resources to support learning.

Trainees will complete each year level sequentially and will only be able to repeat year levels in exceptional circumstances, with the agreement of the Training Programme Director and Core Psychiatry Training Course Lead. Less Than Full Time trainees will undertake teaching on the course pro rata (i.e. they will attend alternate weeks). Therefore, LTFT trainees working 50% or 60% would usually take 2 years to complete each year level of the course.
Trainees who have passed Paper A (or Papers 1 and 2) and Paper B (or Paper 3) will attend CASC teaching in Year 3. As advised above, trainees who have not passed the written papers by the end of Year 2 may need to repeat a year level of the course.

The course has a website which includes excellent resources from across the Yorkshire and Humber region, which trainees registered on the course can access. The course timetable, course information and resources are all available on the website and you are encouraged to access it regularly.

**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 scheme aims to develop these competencies in conjunction with the core curriculum.

Within the ARCP there is a requirement that trainees complete at least one clinical audit project per year. The “ownership” of the project must reside with the trainee although it may be shared with a trainee colleague and it will usually be supervised by the clinical supervisor. Within the portfolio an uploaded report should include details of the project, including the: aims, rationale, standards, methodology, results and a conclusion. In addition, the reports uploaded by CT2/3 trainees should include evidence of recommendations, outcomes and re-audit.

In 2014, Dr Adrian Phillipson (Adrian.phillipson@rdash.nhs.uk) organised the first of a scheme-wide leadership and management training session that is intended to develop into an annual programme of interactive sessions for each CT year. Trainees are also encouraged to undertake representative roles within the region within local trainee committees, the BMA and the Royal College.

The South Yorkshire scheme 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), Core Psychiatry Training Course committees and Clinical Simulation Training Committees. All trainees are encouraged to provide feedback on their training through local, regional and national surveys.
TRAINING AND DEVELOPMENT

Each of the five trusts within the scheme provides an educational programme for core trainees that include: case conferences, journal clubs, supervision groups, audit meetings and taster sessions in psychiatric sub-specialties. Details of local programmes are available from local postgraduate tutors.

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

There is a priority to develop clinical simulation training in conjunction with the Core Psychiatry Training Course (CPTC) with the aim of improving communication and clinical skills at an early stage in order to eventually prepare trainees for the CASC. This has led to the adoption of Formative Assessment of Communication Skills (FACS) at the end of CT1. The trainee is filmed during a consultation with a simulated patient and given feedback from two trained assessors. In addition, CT2-3 trainees are encouraged to participate in the multi-professional RAMMPS programme, 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

The University of Sheffield Academic Clinical Psychiatry department is led by Professor Peter Woodruff. It is currently in the process of re-locating from the Longley Centre at the Northern General Hospital to refurbished accommodation within the University. The department is the home of SCANLab, the Sheffield Cognition and Neuroimaging Laboratory, which has pioneered internationally renowned research into the structural and functional neuroimaging of psychiatric disorders, psychopathology and the response to new treatments.

Since 2001 the vibrant research culture has supported the development of over 100 PhD, MPhil, MD, BMedSci, F2 Fellows, Academic Clinical Fellows, Clinical Lecturers and MSc research students. A number of trainees have participated in research projects that have led to peer reviewed publications and abstracts, and research excellence is recognised by the award of the annual Irwin Stengal prize.

Prospective trainees who are interested in run-through training as an Academic Clinical Fellow (ACF) should contact Professor Woodruff directly.
STUDY LEAVE

All core trainees must comply with the policies and procedures of HEEYH and the lead employer. Further details of on call arrangements, annual leave entitlement, unplanned leave and expenses are provided in Appendix 4. Study leave is defined as leave to participate in education and training activity away from the workplace and all trainees are entitled to a maximum of 30 days per annum. Education and training that occurs within the workplace, such as local postgraduate programmes, does 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 application form must be submitted six weeks in advance to Postgraduate Services. 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 Core Psychiatry Training Course which as noted earlier 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 Core Psychiatry Training 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/Approved clinician courses**
   Once trainees have completed the Core Psychiatry Training examination they will receive study leave and reimbursement of fees and expenses for an accredited section 12/Approved Clinician course that takes place within the Yorkshire and Humber region.

3. **Private study leave**
   A maximum of five days per CT year (August – July) prior to an Core Psychiatry Training examination (with proof of examination entry in the application) is permitted. If the examination is failed the trainee cannot take private study leave again for the same examination. The leave should not cover a weekend or bank holiday (e.g. Friday – Tuesday) since all days are counted and will be deducted from the entitlement. 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. **FACS, RAMMPs and Management Courses**
These events are free of charge to attend but are external to the Core Psychiatry Training Course (CPTC) and will therefore require study leave approval. Expense claims which relate to these courses must by 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% less than full time and extensive use is made of slot share arrangements. On call, annual leave, study leave and Core Psychiatry Training Course 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 Core Psychiatry Training Course 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 the audit 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 (LTFTT) 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 LTFTT 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.

HEEYH (Deanery) 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 LTFTT/OOP policies are available on the HEEYH website or via Postgraduate Services.
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)
Floor 4
Tower Block
Fulwood House
Old Fulwood Road
Fulwood
Sheffield
South Yorkshire
S10 3TH

Postgraduate Services Enquiry
Email: postgraduate.services@shsc.nhs.uk
Tel: 0114 226 3182
Fax: 0114 226 2758

Medical Education Manager
TBC
Email: TBC
Tel: TBC

Trainee Staffing Manager
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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
Study leave policy
Less than full time training policy
Out of placement (OOP) experience policy

Programme Support Team

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Emily Downes
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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 Core Psychiatry Training examination syllabus
- Portfolio online  
  http://www.rcpsych.ac.uk/training/trainees/traineeregistration.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. Confirm 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

<table>
<thead>
<tr>
<th>ESSENTIAL COMPETENCY</th>
<th>SUGGESTED WPBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Elicit a clinical history</td>
<td>ACE/Mini-ACE</td>
</tr>
<tr>
<td>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:</td>
<td>The trainee should be observed taking the history of a new patient e.g. acute admission, new outpatient, new community assessment.</td>
</tr>
<tr>
<td>• Introduction: name, age, current circumstances, reason for referral</td>
<td></td>
</tr>
<tr>
<td>• Presenting complaint</td>
<td></td>
</tr>
<tr>
<td>• History of presenting complaint</td>
<td></td>
</tr>
<tr>
<td>• Family history</td>
<td></td>
</tr>
<tr>
<td>• Childhood development</td>
<td></td>
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<tr>
<td>• Education</td>
<td></td>
</tr>
</tbody>
</table>
### Essential Competency

<table>
<thead>
<tr>
<th>Employment</th>
<th>Psychosexual history and relationships</th>
<th>Social history</th>
<th>Forensic history</th>
</tr>
</thead>
</table>

### Suggested WPBA

<table>
<thead>
<tr>
<th>Substance use history</th>
<th>Past medical history</th>
<th>Past psychiatric history</th>
<th>Assessment of personality</th>
</tr>
</thead>
</table>

## 2. Perform a Mental State Examination

ACE/Mini-ACE

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:

- Appearance
- Behaviour
- Speech
- Mood and affect
- Suicidal or violent thoughts
- Thought form
- Thought content
- Perception
- Cognitive function (orientation, attention/concentration, memory)
- Insight

The trainee should be observed undertaking the mental state examination, perhaps in conjunction with the clinical history.

## 3. Perform a Cognitive Screening Assessment

Mini-ACE

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.

This assessment will have specific relevance to placements in old age psychiatry or within general adult psychiatry where there are concerns about cognitive function.

## 4. Perform a Suicide Risk Assessment

Mini-ACE
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:

<table>
<thead>
<tr>
<th>ESSENTIAL COMPETENCY</th>
<th>SUGGESTED WPBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>patient in an emergency setting or following a recent suicide attempt.</td>
</tr>
<tr>
<td>Relevant mental state factors, e.g. suicidal ideation, depressed affect, hopelessness</td>
<td></td>
</tr>
<tr>
<td>Recent attempts and current intention</td>
<td></td>
</tr>
<tr>
<td>Protective factors, e.g. social support</td>
<td></td>
</tr>
</tbody>
</table>

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.

5. **Present a clinical case (with basic management plan)**

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.

This assessment could be combined with competencies 1 and 2, or separately during clinical supervision.

6. **Perform a physical examination**

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.

This assessment will be relevant to a new admission clerking or an acute assessment of a physical health problem.

7. **Prescribe safely in psychiatry**

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

The assessment could be observed in real time via a Mini-ACE but it is
example would be prescribing rapid tranquillisation 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 chart).

<table>
<thead>
<tr>
<th>ESSENTIAL COMPETENCY</th>
<th>SUGGESTED WPBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Write a clinical letter or report</td>
<td>CbD</td>
</tr>
</tbody>
</table>

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.

| 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:

- 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

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 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:

- 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

| This competency will be further assessed at the end of CT1 by way of the FACS (formative assessment of communication skills) |

<table>
<thead>
<tr>
<th>ACE/Mini-ACE</th>
<th>10. Interview skills</th>
</tr>
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<td></td>
</tr>
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</table>
APPENDIX 4: 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.