Outline

• Educational Principles and Programme (John)
  – Aims
  – Pedagogy
  – Structure
  – Outcomes
  – Syllabus
    • General
    • Mental Health

• Practice and Posts (Alex)
Aims and Outcomes of the Programme

• Enable and manage a safe and efficient **Transition** from good Student to good Doctor
• **Gateway** to Specialism
• **Whole Person** and **Patient Centered** Approach
• Delivers **Broad and Generic** Clinical Skills
• Facilitates **Professionalism** in Leadership, Supervision and Team Working
• Supports **Career Choice** through exposure to a variety of specialties and work place settings
Pedagogy of the Programme

• Work Based but Safe
  – Clinically Supervised at all times
• Learner Centered
  – Learning Plan
  – Educational Supervision
  – Supervised Learning Events SLEs
• Evidenced and Progressive
  – E Portfolio
• Outcome Based
  – Only 2 Modules (F1 and F2) with indicative competencies
• Managed and Assured
  – Professional Requirement
    • Registration (F1 Outcome)
    • Specialty Gateway (F2 Outcome)
  – Final Summative Assessment
    • FACD (Foundation Achievement of Competency Documents) and ARCP
  – UK Office and Regional Foundation Schools, Directors and Tutors
  – Regulated by the GMC
Structure of the Programme

• Lasts 2 years
• After Medical School
• Before Specialty Training
• National Recruitment
• Only 2 Overarching Modules – F1 and F2 – with associated Tutors, both subject to ARCP
• Typically 6 Placements each lasting 4 months in a variety of specialties
• Special Induction at outset
Modular Outcomes

• **F1**
  – *Consolidation* of Medical School Knowledge and Skills
  – Able to take *supervised responsibility* for Pt Care
  – Demonstrates *Self Management*
  – Leads to *GMC Registration* on successful completion

• **F2**
  – *Increasing autonomy* but still under supervision
  – Makes basic *patient management decisions*
  – Shows *Leadership*
  – Make a *Career Choice* (SL and Tasters)
  – Leads to FACD – Foundation Achievement of Competencies Document
Syllabus Content

• 88 Pages
• 2 Modular Outcomes – F1 and F2
• 10 Sections (3 Groups)
  – Professionalism
  – Communication
  – Safety
  – Ethical and Legal
  – Teaching
  – Maintaining GMP
  – Good Clinical Care
  – Acute Patient
  – Resuscitation
  – Long Term Conditions
  – Investigations
  – Procedures
Mental Health and Disorder – Last Reviewed 2014

• 22 references to ‘Mental’ in Sections on
  – Contents (1)
  – Communication (3)
  – Ethical and Legal (3)
  – Good Clinical Care (3)
  – Acutely Ill Patient
    • Sub-section Managing Acute Mental Disorder and Harm (9)
  – Long Term Conditions (2)
  – Bibliography (1)
Specific MH Competencies (1) - Indicative

– Communication
  • Considers any acute or chronic mental or physical condition that may have an impact on communication or understanding p21 [ ] or consent p22

– Legal and Ethical Framework p25
  • Demonstrates the knowledge and skills to cope with ethical and legal issues that occur during the management of patients with medical problems or mental illness
  • Recognises the need for restraint of some patients with mental illness according to the appropriate legal framework
  • Initiates restraining orders against some patients with mental illness according to the appropriate legal framework

– Good Clinical Care
  • Performs a mental state assessment p31
  • Considers mental illness or disturbance as being a factor in patients’ presentation, as well as the impact of physical illness in patients’ mental health p32
Specific MH Competencies (2) - Indicative

– Acute p41
  • Recognises Acute Mental Disorder
  • Able to perform an MSE
  • Recognise and Assesses Risks to Pt and others
  • Acts to protect Pt and Others and seeks help appropriately
  • Considers underlying cause of acute mental disturbance
  • Initiates appropriate special investigations
  • Aware of acute management and care pathways
  • Understands pathways to longer term and community care
  • Understands roles of different disciplines and agencies

– Chronic
  • Recognises the interplay between long-term physical illness, psychological factors and mental disorder
Section 2

Overview

• Role of clinical supervisor and educational supervisor
• Educational experiences in psychiatry for foundation doctors
• Competency checklist
• Assessment – formative and summative
• Specific issues in psychiatry
Role of the CS

- Ensuring adequate local induction
- Setting up educational contract with foundation doctor at start of placement
- Ensuring clinical experience is available, appropriate and safe (i.e. sufficiently supervised)
- Undertaking SLEs and having oversight of overall progress in these
- Overall monitoring, supporting and assessing of progress throughout placement
- Providing regular feedback to trainee and obtaining feedback from trainee regarding quality of post
- Raising concerns with both the trainee and named ES
- Completing end of placement report
Principles of the CS role

- Needs adequate resource and support from the LEP including job planning
- E&D training
- Appropriate training in supervision
- Trained in using ePortfolio and SLEs
- Never allow FD to work outside competence
- Set up ‘placement supervision group’
- Will need to understand UG education at a broad level
- Be familiar with curriculum and map experiences accordingly – there are very few that cannot be assessed in psychiatric placements
- Otherwise principles are very similar to CT
What should be expected of an FD and their CS?

- Particularly F1, broad principles of ‘becoming a doctor’
- Professional behaviours, time management etc.
- Emphasis on future career choices
- Increased supervision compared to CT
- Posts are not intended to provide competences in ‘psychiatry’ but they are expected to be gained in ‘mental health’
- Balance between recognising limitations and not infantilising
Role of the ES

• In NWTFS, not envisaged that psychiatrists will take this role on in the first instance, will remain with acute trust
• Overall supervision and management of educational progress
• Identifying educational aims for each placement
• Completion of SLEs where appropriate
• Completion of appropriate placement forms and end of year sign-off for ARCP
• Support of TIDs
Educational experiences in psychiatry

• This should be planned in advance of taking on an FD and reflected in the job description
• In line with principles of BTFP, educational experiences should highlight multidisciplinary and holistic practice (including physical health wherever possible)
• F1s generally should not be seeing patients in the community
• F2s may undertake community work but should be closely supervised (e.g. not undertaking DVs in isolation)
• All experiences should be supervised, either directly or discussed with senior
• Not necessarily the CS, although must maintain overview including workload
Examples of suitable experiences

• F1
  – Joint initial assessments in liaison with PLN or doctor
  – Follow-up liaison assessments with appropriate post-review supervision e.g. Response to antidepressants etc.
  – Supervised clerking and mental state reviews on in-patient units, as well as physical health reviews
  – Assisting with running of MDT/ward round, carrying out ward work under appropriate supervision
  – Preparing discharge summaries with appropriate support and supervision
  – Prescribing on in-patient charts under supervision
Examples of suitable experiences

- F2
  - Joint home visits in community with senior doctor/nurse
  - Follow-up assessments in out-patient clinics with appropriate post-review supervision and patient selection
  - Presenting cases and formulations at MDTs
  - Supervised involvement in other community work (observing MHAs, best interests and network meetings etc)
  - Undertake Section 5(2) assessments under close supervision
  - Writing outpatient scripts under supervision
  - Discussions with patients and families about diagnosis, BBN etc under supervision
Other educational experiences

• Psychiatry academic programmes
• Acute site teaching with peers – extremely important
• Local team teaching and MDTs – using FD knowledge to benefit of team
• Bespoke foundation psychiatry programmes within MH LEPs?
The competency checklist

- Adapted from CT competency checklist
- Currently 6, may be expanded to include 7th competency (capacity)
1. Eliciting a clinical history
2. Performing a mental state examination
3. Performing a cognitive screening assessment
4. Perform a risk assessment
5. Present a clinical case
6. Write a clinical letter or report
Competency checklist

• Now available on ePortfolio at NWTFs
• Most should be achievable in all placements (and this should be the aim)
• If not, consider taster sessions to improve exposure and curriculum coverage (e.g. Old age taster for cognitive assessment)
Formative assessment

• The ePortfolio
• Supervisors will need to be familiar with this
• ‘Bible’ for foundation training
• Contains WPBAs (SLEs etc) as well as reflective logs, supervisor reports etc
• Pretty intuitive
• Much more ‘white box’ and formative than scored system of RCPsych WPBAs
Formative assessment

• Supervised learning events
  – Similar to WPBAs
  – Should use ‘just in time’ principles
  – Feedback is integral
  – CS should perform majority, others (trained) may contribute
  – 4 types:
    • Mini-CEX (3 min)
    • DOPS (harder to achieve in psychiatry)
    • CBDs (2 min)
    • DCTs – developing the clinical teacher (similar to AoT)
Other formative assessments

• TAB – team assessment of behaviour (= mini-PAT)
• At least 10 responses, done at least once a year (pref at end of first post)
• Core procedures – less relevant to psych (but may be achievable on wards etc?)
Summative assessments

• Clinical and educational supervisor reports
  – Multiple trigger points
  – Initial and end of placement reviews mandatory
  – Mid-placement review strongly encouraged

• ARCP
  – Similar principles to specialty training
  – Beyond scope of today!
Specific issues in psychiatry for FDs and supervisors

- Unwillingness!
- Isolation
- On-calls
- Pay!
- ‘Deskilling’ and achieving sign-off
- Service provision versus safe training