

Royal College of Psychiatry Response to the Academy of Medical Royal Colleges "Shape of Training Mapping Exercise"

Service requirements

What is your perception of the future patient and service needs in your specialty and the implications of this in terms of the role of doctors in your specialty and what they should be doing - and so what they should be trained to do?

It is highly likely that there will be an increased demand on psychiatric services as a result of an ageing population, reducing stigma and an expectation that all members of society have access to high quality health services. There is also likely to be a move towards delivering psychiatric services within Primary Care but with the support of trained psychiatrists.

Given the vulnerable nature of many of the patients with whom psychiatrists come into contact, and with the knowledge that they are at increased risk of other 'physical' co-morbidities and may have a resultant shortened life expectancy, it is clear that the psychiatrists of the future ought to have a level of expertise in recognition of these difficulties and their assessment.

Current psychiatric training mandates the development of leadership and management. We feel that these skills will come ever more to the fore in psychiatric practice, where psychiatrists will take further responsibility for service development and oversight.

It is also likely that psychiatrists of the future will need to be competent in multi-psychiatric specialty cover on the out of hours rotas to ensure safe patient care.

Do your curricula currently meet the objective of producing doctors in your specialty equipped in terms of their knowledge, capability, experience, attitudes and behaviour to meet the changing needs of the patient population and flexibility to continue to meet those needs as they may evolve?

The curricula are felt to comprehensively cover those areas that are required for 'day to day' practice. However, it is clear that where psychiatrists progress through training and as their expertise narrows and deepens; trainees become deskilled in those areas in which they do not routinely practice.

One area that needs further development is that of out of hours psychiatric care, where there is an expectation that the psychiatrist covers a multi-specialty on-call. There is a need for certain competencies to be maintained that are necessary for each sub-specialty but that do not necessitate the breadth or depth required to achieve expertise in these sub-specialties alone.

Our curricula are under constant review and revision. This will need to continue to meet the evolving needs of our patient population.

More generic training - generalism and areas for joint work and training

What are the clinical pathways/areas in your specialty which require or will require cross medical specialty working? This may be particularly relevant to the boundaries between primary and secondary care

Mental ill health can and is found in all patient populations; therefore it would be naive to presume that there is not a medical specialty that requires at least some knowledge of such illness, just as there is an expectation that the psychiatrist can identify physical health needs.

That being said, there is scope for further joined up working. For example, supporting general practitioners to manage common mental health disorders, input into community paediatric settings to manage behavioural disorders, and closer work with neurology colleagues to manage complex neuropsychiatric pathology.

It is clear that mental illness within each of these areas, however, cannot simply be subsumed within individual non-psychiatric specialties.

Which other specialty (ies) could or should your specialty and curricula be combined with?

We are working with HEE on a proposed new core training programme which would offer combined training in paediatrics and psychiatry.

We are also having discussions with RCGP about shared training pathways.

What is the overall scope for more generic training in your specialty and with whom? Are there generic components in your curricula which would be useful for other specialties? This may be particularly relevant to the boundaries between primary and secondary care.

Our core training programme is already as generic as we feel it can be. If competencies were removed this would lead to an independent practitioner who was not sufficiently competent to manage the breadth and depth of psychiatric illness. If competencies from other specialties were incorporated this would either dilute experience, or necessitate the lengthening of training resulting in a lack of clarity over the ultimate role of such a practitioner.

With regards to generic components from within our curricula that would be useful within other specialties we believe that all doctors should be able to:

- Utilise a holistic model of care and undertake a basic mental state examination
- Make a basic assessment of a suicidal patient
- Understand the physical and mental effects of excess alcohol intake
- Be aware of the psychiatric consequences of physical illness
- Have an understanding of the existence of medically unexplained symptoms
- Be able to assess capacity
- Have a basic knowledge of dementia and an understanding of how to approach a person with dementia

Which other specialties could you usefully collaborate with to produce quality training?

Collaboration may be helpful with paediatricians, physicians, general practitioners and public health.

What role could dual accreditation of specialties play?

Dual accreditation already exists with some other psychiatric specialties and is popular with trainees. We are currently working on some new combinations such as CAMHs and General Psychiatry to fulfil a service need in the emerging Youth Mental Health services.

A dual programme for General Practice and Psychiatry has been suggested. We would be willing to explore this.

What specific parts of your curriculum need to be shared with or exported to other specialties? i.e. what elements of your curriculum do believe doctors from other specialties need to understand to provide the best care for their patients?

Other doctors need some knowledge of the common mental disorders.

What specific parts of curricula from other specialties need to be imported to your curriculum? i.e. What elements of the curricula of other specialties do you believe doctors in your specialty need to better understand to provide the best care for your patients?

We need to increase Psychiatrists' knowledge of physical illness.

Handling acute and emergency patients

Do your current curricula equip doctors at CST level to manage appropriate acute and emergency patients if required?

Our current curricula equip doctors to manage patients within their specialty appropriately in acute and emergency situations. However, we are aware that service needs can lead to cross-specialty working which is an area that has been acknowledged to require further evaluation and this work is currently underway. We are mapping the way in which emergency care is delivered across the UK and will then be able to define what competencies are needed to do this.

It is important to note that psychiatric patients presenting with acute medical pathology cannot be managed within psychiatric settings as a result of a lack of appropriate facilities, equipment and expertise across the breadth of the psychiatric workforce. Psychiatrists do need to be able to identify physical healthcare needs.

If they do not, how might training and curricula equip doctors at CST level to manage appropriate acute and emergency patients?

As previously described, work evaluating cross-specialty psychiatric emergency management is underway. If it is found that such cross-specialty competence in emergency settings has not been attained by CCT then it is envisaged that those competencies perceived to be necessary to ensure safe care in these settings will be incorporated in all higher specialty training curricula.

Credentialing

Are there elements of your current curricula (currently perhaps sub specialty or special interest) which you think would be suitable for undertaking as credentials outside of the current training programme? What are these and what impact would that have on the training programme?

We currently have an expansion of Liaison Psychiatry and posts are being filled by Psychiatrists who have not been trained in the specialty. HEE have funded a project to look at how a credential might work in this specialty and we will be running a pilot. We are developing a blueprint which can be used for other credentials.

Areas that we are likely to cover early on are Youth Mental Health, Perinatal Psychiatry, Eating Disorders and Neuropsychiatry.

Are there areas of your curricula that are not directly related to part of CCT that would be considered as possible areas for credentialing?

Liaison psychiatry has the advantage that there is a curriculum. This would need to be developed for the other suggested credentials.

Are there any areas of your curricula that would be a possible area for Credentialing Pre-CST or should credentialing only be post-CST

Our preference is for training to be delivered pre-CST where there is a supported, monitored and quality assured learning environment. We do accept that psychiatrists sometimes change career pathways after training is complete and therefore credentialing is needed. We therefore believe that credentialing should be post CST and only used when a training post is no longer an option.

Sub-specialty training

How do you envisage the training of sub-specialists in your specialty?

We envisage sub-specialty training remaining as it currently is, as there is no evidence that there is benefit in changing this either from a patient or service perspective.

Are there areas of the sub-specialty/special interest curricula that could be applicable to generalists within your specialty or other specialties? What are these?

We feel that there are no 'generalists' within psychiatry and each CCT holder has their area of expertise, and where service need mandates cross-specialty competence there are dual training programmes.

Academic training

What is the scope for more generic academic training across the specialties?

Academic training in teaching and research is already included in all our curricula.

A credential in teaching or research has been suggested and this is probably the one area where we would support a pre-CST credential.

Length of training

How long do you think it should take to acquire the competences to meet the overall training requirements? Should there be a prescribed length of training or an overall average length of training?

There is nothing to suggest that with the scope of the current curricula and the arguments put forward for the danger of removing competencies that the curricula could or should be delivered in less than the current 6 years. However, were additional competencies to be added, then we would envisage longer training to ensure safe and competent practitioners. We favour a prescribed length of training for each psychiatric specialty.

Is there scope for shortening the length of training? Why or why not?

No. Our training is already short compared to other specialties and if it was shortened further the psychiatric workforce would not be suitable for independent practice.

If the length of training was shortened what impact would that have? What components of the various curricula could not be delivered if training was shortened to the arbitrary time scale of a maximum of 6 years as suggested in the Shape of Training Review?

Our training is already delivered in 6 years. There is some evidence that this is too short as many trainees leave after core training without having achieved all the competencies, develop competencies in Specialty Doctor posts and then re-enter training as higher trainees.

How well does the undergraduate programme and Foundation programme prepare doctors for entry to your specialty?

It prepares them well.

How would these programmes need to be developed to incorporate aspects of your curricula should the length of training be shortened

We do not believe that our training can be shortened. We would welcome more Psychiatry in the Foundation programme as this helps doctors to become skilled in the area of whole-person care.

Description

Describe (in no more than 2/4 sides) the components of a curriculum that you would propose having considered all the issues above?

We are not at a stage when we can do this in detail. In view of our short training time and relative lack of sub-specialisation we would expect our curricula to retain their basic form with additions and alterations as necessary.

Would you be interested in piloting your possible curricula?

We would be interested in piloting a new core curriculum for paediatrics and psychiatry.