TPDs Induction Booklet for Core Trainees in Psychiatry

West of Scotland

August 2019

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Dr Debby Brown (North)

This booklet lets you know what is available in the West of Scotland with respect to your Core Training and outlines what your training expectations are for the next three years.

Overview of the Training Scheme

The West of Scotland Core Psychiatry training scheme consists of two halves:

North division
TPD
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Location	Educational Supervisors
North East Glasgow (Stobhill Hospital)	Dr Rosemary McCaffery & Dr Caroline Leeming
West Glasgow (Gartnavel Royal Hospital)	Dr Jonathan Dourish & Dr Sean Dornan
Lochgilphead (Argyll & Bute Hospital)	Dr Paul Morrison
Forth Valley (Stirling & Falkirk Royal)	Dr Lisa Conway
Lanarkshire (Monklands, Wishaw and Hairmyres hospitals)	Dr Rehka Hegde & Dr Andrew Donaldson

South division
TPD
Dr Euan Easton,
Riverside CMHT, 547 Dumbarton Road, Glasgow,
G11 6HU
Tel: 0141 211 1445
Email: euan.easton@ggc.scot.nhs.uk

Location	Educational Supervisors
South Glasgow (Leverndale Hospital)	Dr Emma Lewington & Dr Stephen Byers
Dumfries & Galloway (Midpark Hospital)	Dr Shiona MacDonald
Paisley (Dykebar Hospital, Leverndale & RAH)	Dr Lorna Harris

Inverclyde (Inverclyde Royal and Ravenscraig)	Dr Chris Haxton
Ayrshire (Ayrshire Central Hospital Irvine)	Dr Partha Gangopadhyay & Dr Omer Rashid

Child and Adolescent Core Training Advisor – Dr Kim Lim

Learning Disability Core Training Advisor – Dr Dipali Mantry

Deputy TPD Psychological Therapies – Not yet appointed

LTFT Core Training Advisor (South) – Dr Lucy Carrick

LTFT Core Training Advisor (North) –

LTFT Associate Postgraduate Dean – Dr Andrea Caldwell (West of Scotland Region)

Associate Postgraduate Dean Psychiatry - Dr Seamus McNulty (West of Scotland Region)

Core Psychiatry Training Administrator – Ms Sarah McNeil sarah.mcneil @nes.scot.nhs.uk (West of Scotland Region) 0141 223 1409

As of 2015, Scotland moved to being one deanery. West of Scotland is one of 4 deanery regions.
There is a local West of Scotland Specialty Training Committee chaired by Dr McNulty which meets every 3 months to oversee all aspects of delivery and quality management of postgraduate psychiatry training.

There are separate north and south core training committees chaired by Drs Brown and Easton which meet every 3 months.

There is a psychotherapy subgroup committee overseeing core and advanced postgraduate psychotherapy training in psychiatry which meets every 4 months.

Core trainee representation on all of the above committees is important – please check with colleagues to ensure that there is appropriate representation.

2. Academic Programmes:

Each area will have a local teaching Programme usually on a Thursday morning, running in tandem with the MRCPsych Regional Teaching Programme. The Programme for each semester will be available via your local Educational Supervisor.

At your local programme you will have the opportunity to do a WPBA Case Presentation (CP) and a Journal Club (JC) which you require for your portfolio. You need one CP and one JC each year. We suggest you tell your supervising consultant about the date for your presentation so that they can help you work on it. There should always be a senior medic to assess your presentation and

input the WPBA to your portfolio. (In the unlikely event that you fail to meet the standard for your WBA for either your JC or your CP then please arrange a slot with your Educational Supervisor for another date).

This local teaching Programme alternates with the morning Regional MRCPsych teaching Details of both the morning and afternoon Regional Teaching Programme (including timetables and reading material) is available on the MRCPsych website or via Tracy Aitken.

Whilst one of the objectives of the MRCPsych teaching is to help you to pass you MRCPsych exam, this is not the sole purpose and the programme is also organised to give you a good, broad foundation in the basics of psychiatry and also depth of knowledge in certain subjects. Trainees are asked to consider, understand and appreciate the dual purpose of the programme.

Trainees in a CAMHs placement should attend the CAMHs teaching and will be assessed at their mid-point by the Speciality Educational Supervisor in CAMHS.

There may also be opportunities to attend local Learning Disability teaching or Forensic teaching depending on your individual post; it is suggested that you agree with your Clinical Supervisor and Educational Supervisor what would be the most appropriate teaching for you to attend each 6 months.

Essential information on Exams, Training and the Curriculum are in the Trainees Section of the Royal College of Psychiatrists web site and trainees should make sure they are familiar with this site http://www.rcpsych.ac.uk/specialtytraining/trainees.aspx
and with the handbook OP69 in particular.

3. Training Objectives:

We expect trainees to complete Training Objectives and Learning Outcomes for each 6-month post. These should be completed in the PDP section of the College e-portfolio.
The aim of this training agreement is for the trainee and trainer to agree a set of learning objectives for each six-month placement. Remember to make objectives SMART – Specific, Measurable, Achievable, Realistic and Time considerate.
Each objective should be linked to Intended Learning Outcomes from the curriculum and should over time be linked to evidence to support objectives being met.
Expectation is for approximately 4-6 PDP items for each 6 month placement. Each item should be separate with appropriate linkage and mapping.

Training agreement - The objectives should be agreed during an appraisal or induction interview (conducted during a supervision session) within the first month of placement.

The trainer and trainee should consider the trainee's previous experiences and achievements (using the trainees portfolio/ previous ARCP information as a guide), the stage/ level of the trainee e.g. with respect to exams/ career and what the placement has to offer e.g. special interests available. Both trainee and trainer should formally review the objectives at 3 and 6 months at a specified supervision session. The Educational Supervisor will ask to see the agreement at mid-point and end-point assessment interviews.

4. Emergency Psychiatric Experience:

You are expected by the College to see a minimum of 50 emergency cases with a range of diagnoses where you draw up and implement the first line management plan in your three years. You are also required to complete the equivalent of 55 first on call shifts of out of hours emergency work. You should use the MRCPsych portfolio and keep a record of these cases in the e-portfolio.
You can use any urgent clinical situation arising from daytime page holding rotas, Out of Hours rotas or any other day time work where on an urgent and unplanned basis you are asked to assess a specific patient.
The emergency case log should contain a **brief** description of the clinical situation but the main focus should be on a) recording / describing your own evidence of reflection on being directly involved in this urgent clinical situation and b) how this will direct future learning and / or reinforced previous learning.
All clinical information MUST be anonymised. These cases must be discussed with your psychiatric supervisor.
As a guide you are expected to describe approximately 15-20 cases for each year with, over course of 3 years core training, a total of 50 cases described with appropriate reflection and learning evidenced.

RECORD OF CLINICAL ACTIVITIES

The assessment and management of urgent and emergency cases is seen as a vital part of core training. Cases can be gathered from a variety of sources – many will be seen during daytime on-call duties or on out-of-hours on-call duties, but you may also include cases of unscheduled care you have seen on the ward, in the clinic or elsewhere.

It is expected (as outlined above) that the 50 emergency cases will be spread out evenly over the 3 year period, i.e. approximately **15-20** cases a year. Other cases are optional but are recommended to broaden your learning experience and provide evidence of this at ARCP.

By the end of the 3 years the generic case log should reflect the full range of mental disorders including organic disorders, psychotic disorders, mood disorders, anxiety disorders and disorders of personality. Most of the cases will come from General Adult Psychiatry, but there should be a proportion of cases from each of the other Psychiatric Specialties including Old Age, Addictions, Liaison, Learning Disability, Child & Family and Forensic.

Most of the cases should be picked up in routine day-to-day page holding/ OOH on-call. However if, by the end of the three years there are no cases from one or more of the Specialties, then this should be discussed with the Educational

Supervisor to explore how this experience might be obtained, e.g. spending a day with the CAMHS self-harm team.

Each case should be of a reasonable degree of complexity to allow some reflective learning. Prior to going to see the patient, some time should be spent thinking about what the learning objectives could be for the case. The objectives set will depend on what stage the trainee is in their training and what their previous experience has been. In CT1 these objectives might just be to e.g. learn to take a good alcohol history or improve mental state examination, but by the end of CT3 the trainee's objectives may be more complex, or related to their specialist interests/ research.

After completing the clinical assessment and management of patient or situation, a brief write up of the case should be completed, to include any extra reading, research or discussions that have taken place to allow completion of learning outcomes.

The cases should be mapped to the RCPsych curriculum or to the RCPsych WPBAs Guide for Trainees which identify specify WPBA competencies that should be practised in every speciality throughout training in order to prepare them for the CASC exam.

The case should be discussed at the time or afterwards e.g. with the Consultant-on-Call or the Clinical Supervisor, or at the Doctor-Patient Relationship Group (whichever is most appropriate and convenient) and the log entry should be read by the supervisor on the e-portfolio. Note - the Consultant is confirming that they have discussed the case from an educational perspective, but it does not mean that they are necessarily assuming any clinical responsibility.

The up-to-date record should be kept in the trainees Portfolio, and made available at mid-point and end-point assessments, and at ARCP.

5. Psychotherapy experience:

The College has recently updated its guidance on what is to be expected from trainees with regard to their psychotherapy training. This guidance is available on the College web site.

For Core Trainees:
Training in psychotherapy is an essential component in the training of future psychiatrists. All psychiatrists need basic psychotherapeutic skills and knowledge of the psychological mechanisms that underpin psychiatric illness.

"The public and professional colleagues expect that all psychiatrists along with other mental health professionals should have a basic understanding of psychotherapy theory, be able to treat patients safely with specific psychological treatments, to use psychological understanding as part of an overall treatment plan, and to know when to refer for specialist treatment. Psychotherapies carried out incompletely or unethically can be harmful to patients". (Requirements for psychotherapy training as part of basic specialist psychiatric training – Royal College of Psychiatrists, June 2002).

In addition to theoretical instruction (obtained through the West of Scotland postgraduate day release course and personal reading), each psychiatric scheme is responsible for the provision of training and supervised experience in the

various forms of psychotherapy. This basic training should take place over the initial 3 year period of work (CT1 – 3).

Progress in obtaining psychotherapy experience will be reviewed regularly at the 3-monthly meetings with your local Educational Supervisor and annually at your ARCPs. Evidence of the necessary psychotherapy experience and training will be necessary for career progression. Trainees will not achieve CT3 competencies without a completed ACE in psychotherapy for both a short and long case and will not be able to progress to ST4, even if they have passed their exams and have a job.

Essentially there are two components to be completed during core training (CT1 – 3).

1. Reflective Practice Group – Years 1 – 2.

A Reflective Practice Group will be run locally in each area. **All** psychiatric trainees (CT1 and usually CT2) are expected to attend and to present cases to the group. Trainees can also write up these presentations (see guideline, Appendix I) and submit these write ups to the Group supervisor.

An attendance sheet should be kept as trainees will need to provide evidence that they have attended at least **thirty** groups by end of core training in order to pass this component of the training. Also trainees are expected to have a satisfactory outcome for two Case based Discussion Group Assessments (CbDGA), the first one is usually completed after 6 months and the second one must be done by the time of the first ARCP. You can find this on the College web site. The trainee must also provide evidence of attendance at 30 meetings by the end of CT3.

Progression to supervised individual psychotherapy cases is dependent upon trainees displaying competence within the Reflective Practice Group which is evidenced by a satisfactory CbDGA. If after six months a trainee is making satisfactory progress in the CbDGA they can progress to start individual cases.

It is the trainee's responsibility to ensure that appropriate evidence of satisfactory attendance and WPBAs are contained within e-portfolio

2. Supervised Psychotherapy Practice – Years 2 – 3.

All trainees must undertake to see two supervised psychotherapy cases in two different modalities over two different durations of time. One of these cases should be a long case (defined as at least 20 sessions) and the other of a more brief (at least 12 sessions) duration. In general, you should seek to have begun both cases in Year 2, provided your Reflective Practice supervisor reports are satisfactory. Remember it will take 12-18 months to undertake a long case in dynamic or supportive modalities: as this must be completed before ST4 progression, you would need to have begun, at least possible identification of a case, by midpoint of CT2. Long cases in CBT will usually be of less duration than this however.

A range of options are acceptable including psychodynamic, cognitive analytic (CAT), CBT, family therapy, group therapy, etc. Whichever modality is chosen the work must be supervised by an adequately trained supervisor under the overall direction of a medical psychotherapist. For CBT and Psychodynamic Psychotherapy there are local courses/ supervision available which the trainees are advised to access prior to taking on a case.

It is the trainee's responsibility to approach a supervisor to discuss whether or not they are ready to take on a case and also whether there is likely to be a space in a supervision group.

We would strongly recommend that you discuss your thoughts about the psychotherapy experience you are proposing with the local Educational Supervisor in your review towards the end of your first year of training.

Assessment of Supervised Psychotherapy Cases

By the end of the second year, trainees will be expected to present evidence of a completed case. A psychotherapy ACE should be completed for each of the 2 psychotherapy mandatory cases, consisting of 2 SAPEs, a 500 word write up and a marked viva with an external supervisor. The psychotherapy ACE assessment marking sheet should be used (see College website for more details) and at the end of the third year trainees should present full evidence to the ARCP of completion of the second case.
Note that the PACE is additional to your yearly minimum ACE requirements**. A satisfactory outcome is necessary for progression to ST4.**

As a minimum, two SAPEs should be completed for all psychotherapy cases (one at mid point and one at end of therapy).

6. Audit / Research experience:

You are expected to complete at least one complete Audit in CT2 and to have x2 completed audits by end of CT3.
"Complete audit " is initial cycle with intervention and then re-audit.
You may choose to do initial cycle and re-audit from separate audit projects but ideally you would undertake full audit cycle for 1 specific topic.
By end of CT3 your portfolio has to have evidence of x2 initial audit and x2 closing loop audit.

We suggest you discuss this with your Clinical Supervisor quite early on. There may be Audits that have been started by other trainees, where you can complete the 2nd cycle or you may be able to link in with the departmental Clinical Governance Programme.

Each audit should be clearly identifiable as audit and not for example a survey. There should be clearly defined gold standard, clear evidence of all of recognised audit principles, be of a reasonable size ie minimum 15-20 cases / subjects being audited as part of project, and clear documented proposed intervention.

If there are 2 or more trainees jointly undertaking audit, roles of each trainee should be made explicit, although the expectation is that audits will be done individually, there are certain larger multi source audits where more than one contributor will be deemed necessary and accepted. If you have any uncertainty as to whether your proposed audit project meets requirements for ARCP then please check with your educational supervisor.

Alternatively in CT3 you can do a research project and/or Quality Improvement Project instead of audit if your Educational Supervisor is in agreement with this. Your Educational Supervisor must agree if you are competent in Audits and can move on to research.

Copies of your completed Audits or Research should be included in your Portfolios. For any Audits that are still "in progress", please include project plan, data collection sheets, etc. It is unacceptable to submit no evidence for audits in progress – this will lead to an unsatisfactory ARCP outcome

7. Workplace Based Assessments:

There is a requirement that trainees complete WPBAs each year, in order to progress through training. This is also a requirement for sitting the MRCPsych exam.

Trainees must register with the Royal College of Psychiatrists Portfolio/ Assessments on-line service, found at https://training.rcpsych.ac.uk/ You will require to have previously registered with the College. **Ensure that you add your current Clinical Supervisor, Educational Supervisor and TPD when you are invited to register individuals who have access to your assessments online.**

This allows trainees to see what the WPBA requirements are for them each year. It also allows them to register for rounds of mini-PAT, which provide the trainees with 360 degree appraisal for their teams and colleagues.

The ***minimum*** requirements at present are:

Year	**WPBA**
CT1	2 ACE 4 CbD 4 mini-ACE 2 mini-PAT 1 JCP 1 CP 1 DOPS ECT 2 CbDGA
CT2-3	3 ACE 4 CbD 4 mini-ACE 2 mini-PAT 1 JCP 1 CP Psychotherapy WPBAs

Please note that for LTFT trainees, table highlighting expected minimum numbers of required satisfactory WPBAs has been produced and will be used from August 2018, this can be found at end of this document

The WPBA are to be satisfactory (i.e. a score of 4 or above for the scoring criteria "at this stage of training ") and WPBA where the minimum standard is not met, whilst useful for training purposes, are not to be counted in the above figures. It is to be expected that some trainees, at the start of a placement, may well "fail" a WPBA, especially in the specialities, but then should be able to show progress over the duration on the post. **All WPBAs should be included in your Portfolio for ARCP purposes and withholding WPBAs will be viewed as unprofessional conduct.**

Note that the WPBA can be completed by other clinicians, nurses, etc, but at least one of each type of clinical WPBAs for each post should be completed by your own Psychiatric Supervisor.

For purposes of counting towards ARCP, clinical WPBAs can be done by SAS grade doctors, provided your Educational Supervisor is satisfied that the SAS grade doctor is suitably qualified and experienced to do so. ST4 -6 advanced trainees at least 2 grades above trainee performing assessment may also undertake clinical WPBAs to count towards ARCP requirements
Also note that nurses and other Allied Health Professionals have to be Grade 7 or above to complete any assessment that you wish to count towards your minimum numbers. **If a nurse or Allied health professional does complete a WPBA please record the band of professional performing the assessment.** It is also expected that there will be a number of WPBAs from both six month posts (not all just done in the first post) to show that competencies have been met in both areas.

As well as the above minimum recommended WPBAs, trainees in CT1 will be expected to have a DOPS or equivalent demonstration of competency in ECT and trainees in CT2 – 3 will be expected to have an AOT completed for any teaching.

Trainees are encouraged to complete more WPBAs than are recommended as a minimum to practice and achieve competencies in the various areas of each speciality. The College WPBA Guide for trainees (a comprehensive document looking at how WPBAs can be more focussed towards helping trainees prepare for the MRCPsych exams, especially the CASC) can be found on the College website under training and is useful in this regard.

All necessary WBAs must be visible on the trainee's e-portfolio by the deadline for ARCP submissions each year. You will be given this date in an e-mail from NES outlining the ARCP process each year. It will be two weeks before the ARCP panel and is usually mid May. Please make sure NES has your up to date e-mail address so you receive important communications.

8. Teaching experience:

It is expected that trainees will obtain teaching experience throughout **each** year of their training. In addition to the CP and the JCP at local teaching, trainees should endeavour to obtain teaching experience with at least one audience group: medical students, foundation doctors, nurses, AHPs, carers, patients, other hospital staff, voluntary organisations, etc.

Again, please speak to your Clinical Supervisor about opportunities. Evidence of talks given should be put into your Portfolio, e.g. power-point slides, handouts, programme, etc.
Where possible the use of feedback forms from audience members is encouraged as is a formal Assessment of Teaching WPBA.

As you progress through your training, try to teach to different audiences, increasing your repertoire, with the aim of speaking at a College meeting or similar by the end of CT3.

9. Management Experience:

All trainees are expected to achieve some management experience during **each** year of their training. This can include making up on call rotas, shadowing one of your managers, attending MHD&T or Clinical Governance meetings, attending courses or representing your colleagues as Junior Doctor Representative at any level. **Evidence for this activity, e.g. minutes of meetings, should be within your Portfolio.**

10. Examination Progress:

The College provides a clear framework for sitting the MRCPsych examinations over a three year period. It is suggested that trainees start to think about studying for the exam from early on in their training, as the exam timetable for CT1 - CT3 is tight. Joining a Study Group is often helpful, for support and sharing of useful resources. The Regional MRCPsych teaching programme has been adapted to be helpful to those sitting the exam, and full advantage should be made of this course, both morning and afternoon sessions.
Trainees should ensure that they attend the appropriate level of tutorial, as outlined in the course guideline, for example Interview Skills Training is essential for CT1s.
Information on the course can be found on the MRCPsych site.

Examination progress will be considered at ARCP. A pass in all written papers and the CASC is required before trainees can move into ST4 posts (subject to satisfactory ARCP outcome).

11. Mandatory Courses:

It is expected that trainees will participate in the following mandatory training courses;

- Medical Emergency
- Management of Aggression
- Child Protection

It is expected that the trainees will update this in line with specific Health Board guidelines, and update as required. Certificates should be held in the Portfolio as evidence.

12. Educational Supervision & Competencies:

Each trainee will have a named Psychiatric Supervisor who should meet with you for one-one supervision on a weekly basis (where possible). The main purpose of supervision is development of learning, checking competencies & skills, feedback on progress and future career planning.

Supervision can have a number of formats (e.g. case based discussions, topics, exam practice, etc) but we would suggest that early on the trainee identifies their training objectives and that these objectives are worked through in subsequent supervision sessions. WPBAs may also be completed in supervision, especially Case Based Discussions. The formats for these are to be found on the College website.

As well as the trainee's individual objectives, GMC good clinical practice competencies will have to be signed off at the end of the year, in order for the trainee to progress with training. It would therefore be sensible to address these competencies throughout the year with your Educational Supervisor, especially if there is any concern that you are having difficulties in any of the areas. This means that problems can be identified early and addressed before it is too late.

If there are ongoing difficulties (including adverse events/complaints) then you should continue to try to address them with your Psychiatric Supervisor, but you may also find it helpful to speak to your Educational Supervisor as soon as possible.

If you feel you are being undermined or bullied at any stage in you training, by anyone, please discuss this with your supervisor – but also bring this up with your

Educational Supervisor or TPD. You have a duty to your colleagues and patients to highlight these issues so that they can be addressed. It is not enough that you comment on this in the GMC trainee survey, as the information in the survey is not traceable to individuals and so no direct action can be taken.

13. Supervisor Reports and Reviews:

The Educational Supervisors will arrange to meet with the trainees every three months, to **formally** look at your progress and address any concerns. Trainee feedback forms will be sent out to you. One Psychiatric Supervisor's report should be completed by your supervising consultant for each six months post and both of these need to be completed in advance of the ARCP submission date. Your Educational Supervisor will complete a Educational Supervisor Report once the two PS reports are available. All of these reports are then submitted in advance of your ARCP. All reports should be completed on the e-portfolio.

Trainees will take part in the ARCP process May / June every year. Dates and full information for this will be sent out by NES. Online ARCP reports are completed and these are standardised across all of Scotland Deanery.
Please note it is highly likely that the submission date for all evidence for ARCP will be approximately mid May – this means that all evidence for training year needs to be within your portfolio by this time.

If any remedial training objectives are identified at ARCP it is strongly suggested that the trainees discuss these with their Psychiatric Supervisor and Educational Supervisor, so that they can be addressed during subsequent placements. These objectives are something to be considered as helpful to training and trainee should not be ashamed or disenfranchised if this occurs.

The Training Programme Directors will meet individually with all trainees during February / March. This will allow the opportunity to review progress to date, to discuss any relevant issues and allow for discussion on preferences for future core training placements.

NB: Trainee Feedback - During the course of your training you will receive both positive and negative feedback in various ways both formally and informally. The following is a helpful summary of what you should expect and how to integrate feedback into your training experience in a helpful way.

Formal feedback -This tends to be structured and documented, providing you with written evidence of your progress and objectives for further improvement.

* Workplace based assessments
* Review of training Objectives
* Supervisor Reports
* ARCP
* Exam results
* Exam courses
* Video skills/ interview skills feedback sessions

You must obtain formal feedback to provide evidence for your ARCP, so this is what tends to be focussed on. However informal feedback is also very important.

Informal feedback - This can take place in different *settings*, and tends to be more opportunistic and less structured. It can also come from a number of different *sources.*

Some examples are:

* Weekly 1:1 hour of supervision
* On the ward/ in the car/ over coffee
* During/after ward round
* CMHT
* Clinic/ Home visits
* Clinical / Educational Supervisor
* Other consultants/ senior staff/ GPs
* Other Junior staff
* Nurses/ AHPs/ admin staff
* Patients/ carers
* Exam/ interview practice
* Discussing on-call cases/ completing on-call log
* At teaching/ journal club/ Balint group

If you are not getting informal feedback at all, then you may have to seek it and ask people how you are doing. Do not be afraid to ask patients and carers. To lead into this you may want to ask at the end of an interview "Have I covered everything you wanted to know?", "Are you happy that we leave things there for now or is there anything else you would want me to discuss?" or "Are you happy to see me again?" and then see what they say.

Difficult situations - When feedback is positive then it is easier to accept. If you receive what you feel is negative feedback then try to remember that it is for your benefit as much as positive feedback – in fact negative feedback, handled correctly, is often more useful.

If someone gives negative feedback they should do it in a sensitive fashion. You should be asked what you feel about a situation, e.g. "How do you think the interview went today with Mr McGee's wife?"

If you identify anything, such as "It was really difficult, I found her to be quite awkward" then this provides a basis for further discussion, into what maybe went wrong.

You should then be asked how you think you might want to handle a similar situation next time, and further helpful discussion should ensue, with advice from your Supervisor as to what techniques they find are helpful.

However sometimes feedback comes out-of-the-blue and you can't think what you did wrong – you might even think things went quite well. In this case you must ensure that you enquire what the problem was, discuss what *you* thought, and look for advice regarding future training objectives to address the issue in the future. Don't ever go away from a negative feedback situation without a clear idea of how to learn from the situation and take things forward.

If you feel upset and unable to discuss it at the time, bring it back to your next Supervision session. Similarly if the feedback was from a patient, carer or from another staff member, again discuss it in Supervision.

Conflict - A number of conflict situations appear to arise in the context of trainees' availability. The nurses in the ward will want you on the ward, A&E want you down seeing patients, your consultant will want you in the clinic and your Educational Supervisor will want you at teaching. Sometimes you will receive negative feedback about this. Try to ensure that people know where you are and know what your timetable and on-call commitments are. Also ensure they know how to contact you and exactly when you will next be available be to see them – often that is enough.

Hints - If you are going to miss the ward round, try to see the patients sometime in the week prior to the ward round, and provide your consultant with a brief summary of their progress.

If you are going to miss teaching or Reflective Practice Group, make sure you let people know. Arrange swaps for presentations and journal clubs.

If you follow this advice it will help people to realise you are keen and interested. If you do receive feedback about you being unavailable, try to find out what would help e.g. provide a contact number or make sure people know who is covering if you are away. These are all skills you will need for Advanced Training and for being a Consultant.

Who can you turn to? - If you feel a situation cannot be resolved in Supervision with your Clinical Supervisor, then you can speak to your Educational Supervisors or if it is a service issue you can speak to your Line Manager.

You will also have Trainee representatives that can bring issue to the Junior Doctors Working Group, the Training Committee or the Division of Psychiatry.

Please do not worry about any situation and try to handle it yourself as there is support. We would rather hear from you early on. It is much easier to help you individually than to try to identify a problem highlighted in the GMC survey but not reported at the time.

14. Reflective Practice

Trainees are expected to show evidence of attainment of the competency in reflective practice. This may be a challenging clinical case, a difficult meeting with relatives, disagreement with another member of the clinical team, having made an error etc. It is likely that such situations occur for most of us most weeks. Reflective practice allows you to analyse the situation, outline what occurred, how you managed it and, importantly, what you learned from the situation. Your recording should be sufficiently detailed such that there is clear evidence of self reflection.

We recommend that you evidence competence in reflective practice by completion of reflective notes in each 6 month post. You can use the framework in the College portfolio, the SEA format that GP trainees use or your own method of capturing brief details of the event, what the outcome was, what you learned and what has been changed. The purpose of these reflections is to demonstrate that you are developing critical self awareness and the ability to constantly analyse and improve your practice. These reflections should therefore be about your **own practice** not observations of others. We have attached guidance on writing reflective notes which we think is helpful. It is however not mandatory to use this structure. The crucial element required is that you demonstrate the ability to analyse when you did not perform well and think about how you can improve your practice. This can be a difficult skill to acquire and you should regularly discuss these reflections with a supervisor to help you improve this skill.

Formal reflective notes are not however mandatory; they are one means by which you can demonstrate attainment of competency reflective practice.

Reflective practice can also be demonstrated by reflections in clinical case / emergency case write ups, WPBAs and through discussion at formal supervision. . Your ability to demonstrate this skill will be assessed by your Psychiatric Supervisor and recorded in the Psychiatric Supervisor reports.
It is important that your portfolio has available the evidence used by your Psychiatric Supervisor to acknowledge your competence in this learning outcome.

15. Portfolio:

Trainees will be expected to register and use the RCPsych e-portfolio available on the College website in the Trainee Section:

Only e-Portfolio will be used. All reviews/ARCPs will be based on e-Portfolio and no other evidence will be considered so it is imperative that all your training activity is recorded there.

We suggest you use this adding any other relevant documents as appropriate. You must also remember to upload all supporting evidence of other aspects of training eg audit/research/ teaching/management etc

Your e-portfolio should be reviewed as part of supervision, mid-point and end-point assessments. Educational Supervisors and TPDs will review your portfolio before the ARCP each year with the aim of identifying and resolving any potential problems.

You should nominate your Psychiatric Supervisor, Educational Supervisor and TPD to obtain access to your portfolio, so that they can monitor your progress as required.

15. Study Leave guidelines:

Current Study Leave guidelines are to be found on the NES website. All study leave applications must be made electronically via Turas, the NES information system.

In addition to guidance provided by NES the following points are important:

Budget – Study leave funds are not "ring-fenced" per trainee, but there is an approximate budget of £500 per year for each Trainee in years 1-3. There is no additional funding for trainees who require an extra 6 months in Core training to reach CT3 competencies and move to ST4. The majority of the study budget over the three years is taken up by the regional MRCPsych course, with the fees for this course as follows:

CT1	£550
CT2	£375
CT3	£375
CT3+ (i.e. additional training required)	free

This means that CT1 trainees will effectively have no additional funding for study out with the MRCPsych course, and years 2-3 will have a maximum of £100 per annum (as the course fees in year 1 exceed the £500 per year budget, money in years 2-3 is reduced by £25 per year).

Approved uses of Study Leave - please review the guidance from NES. Please note that exam preparation courses and exam sitting expenses are specifically excluded from study leave funding.

In essence this means that trainees in years CT2-3 will have a relatively small amount of money available to allow reimbursement of attending, for example, a Scottish RCPsych meeting. It is recognised that additional activities are likely to require some self-funding. However, the study leave budget tends to remain underspent, and trainees are advised to submit requests for study leave funding, as there is often money available over and above these levels.

Duration of Study Leave - Specialty trainees are permitted up to 30 days study leave per year, commencing each August**. Not more than 5 consecutive working days may be claimed for exam revision ("Private Study"), and this is subject to Service requirements and explicit service approval.**

The MRCPsych course uses the following amount of leave:

CT1	24 days
CT2	16 days
CT3	16 days

Study leave application has recently changed. From approximately autumn 2015 the application process has been done on line through the NES website "Turas". This is a standardised process across the Scotland deanery and across all medical training specialities. As part of this process, you will be required to state that you have checked with your local service and obtained service agreement for study leave. Under the new system, no retrospective claims will be considered.

Note that compulsory training such as Management of Aggression, Child Protection training, Medical Emergency and AMP training, which is available locally does not require study leave from NES and is funded by the local service.

16. ARCP

The Annual Review of Competency and Progression (the "ARCP") is an annual process and acts as the means for assessing trainee progress. The evidence for assessing trainee progression is all contained with the e-portfolio. Trainees will be asked by NES to submit paperwork in relation to absence and ensure that all relevant supervisor reports are available on trainees' e-portfolio in relation to their Annual Review of Competency Progression (ARCP). **Dates for submission are usually mid May time.**

In CT2-3, your Portfolio should include documentation of how your ARCP objectives from the year before have been met.

Your Portfolio should also contain evidence of Training Objectives (and how they were met), Audit, Teaching, On-call log, Management activity, Mandatory Courses, Exam Progress Reflective Practice, WPBAs and Psychotherapy training.

The ARCP outcomes are as follows

1) Outcome 1 - satisfactory progress
2) Outcome 2 - unsatisfactory progress, no additional training time needed
3) Outcome 3 - unsatisfactory progress, additional training time needed
4) Outcome 4 - release from training, competencies not met
5) Outcome 5 - insufficient evidence – 5 working days to explain absence of evidence
6) Outcome 6 - satisfactory completion of core training

We strongly recommend that you aim to have met the minimum requirements for WPBAs by the time you submit your ARCP paperwork at the beginning of May – failure to do so will result in you being issued with an unsatisfactory outcome.

The ARCP is based solely on review of your e-Portfolio. It is therefore important that your e-Portfolio contains all relevant documentation and evidence to support training undertaken.

Should there be any evidence missing from the e-portfolio at time of ARCP then an outcome 5 may be awarded - note this is to allow solely for the uploading of any missing or incomplete evidence. Trainees have 5 working days to give a written explanation to the panel of why evidence is missing. If the panel accepts this explanation they will then give the trainee a short period of time to upload the missing evidence. At this stage the definitive ARCP outcome will be awarded.

Following on from the ARCP, any trainees who receive anything other than a satisfactory outcome (an outcome 1) will require to attend for formal deanery interview.
Approximately 10% of all outcome 1s will also be asked to attend for interview.

17. SOAR and Revalidation

Each year at the time of ARCP you are also required to complete the health and probity sections of the SOAR website for revalidation purposes. You must ensure that the entire scope of your medical practice is declared at ARCP and to SOAR. This must include things such as locum work and fee paying medico-legal reports. Failure to do this will be considered a serious probity issue.

17. Other useful links

http://www.nes.scot.nhs.uk/http://www.rcgp.org.uk/

http://www.mwcscot.org.uk/mwc_home/home.asp

We hope that this booklet will be helpful. If you have any other questions please do not hesitate to contact your TPD or Educational Supervisor.

Debby Brown& Euan Easton
August 2019

APPENDIX 1
REFLECTIVE NOTES

LEARNING FROM EXPERIENCE

We do not all approach learning in the same way and we do not all learn as much as we could from our experiences. There may be occasions were the time and effort of looking in detail at what happened and trying to do this in a way that is structured will enable learning. For this reason Sheffield VTS would recommend that when there has been a particularly important incident that this rather detailed framework is

used. With significant incidents it may be important to address the incident in several different ways, in these difficult situations the educational response and suggestions are important and separate from any disciplinary or other responses, and undertaking an educational response can appropriately be expected of any person involved in a training programme!

Different learners learn in different ways. We have presented the reflective exercise before the theory explaining why this is likely to be helpful, some people may prefer to read this before doing the exercise whilst others will just want to get on, do the exercise and then read and think about why this is relevant to them.

This framework aims to enhance your learning from specific experiences. The questions in the left hand column are designed as prompts to help you structure your thoughts – you don't necessarily need to answer everyone of them. The main questions help you to focus on key aspects of the incident you are reflecting on, and to learn as a result of your reflection.

The main things to think about are:

- what happened?
- how did you feel?
- how did others react?
- what was good?
- what needed improvement?
- what have you learnt?

1. What happened?
   Begin by simply writing down exactly what happened without thinking about how you felt – that comes later. Try and write this so that someone reading it would be able to get a fairly clear picture of what happened

Questions to ask yourself include	**Your record**
What happened? What was the context? What were the main points or stages, in what order, when, did one thing follow from another? What were you responsible for? What other information would help you describe the experience, eg how long did it take, who else was involved, what costs were involved etc? Are other people's views relevant? What were they?	.

2. How did you feel?
   Now write down how you FELT about what happened at the time and also later on.

Questions to ask yourself include	**Your record**

What was your initial gut feeling? What might that tell you? What were your subsequent feelings? What do they tell you?	

3. How did others react?
What about other people involved – how did they react, how do you think they felt?

Questions to ask yourself include	**Your record**
Did others react like you? Did they react differently? How? Who reacted the same? Who reacted differently? What does this suggest?	

4. Identifying the positives
What were the good things about the experience – there are always some!

Questions to ask yourself include	**Your record**
What pleased/interested you? What was good? Did you succeed in something difficult? What? How? Why? What/who was helpful? What points were made? What were your findings? What skills/qualities/ abilities did you use? What was important to you?	.

5. Identify the negatives
What were the things that you think could have been better?

Questions to ask yourself include	**Your record**

What made you unhappy/ concerned? What was poor/didn't work well? Were there difficulties? Did you fail to do something? What/who was unhelpful? What need improvement?	

6. Identifying common themes/generalising

Questions to ask yourself include	**Your record**
What were the main points to emerge from the detail? What common aspects are there between this and other experiences? What caused them? Were there any differences between this and other experiences? What caused them? What might happen in the future which could be the same? What would make a difference?	

What are the 2 or 3 key things you learnt form this experience?

And now for some theoretical back ground on why this is appropriate and relevant to you!

The following diagrams give you suggestions on some of the theory about learning that may be relevant here, as well as a reference for each one which you could use to find out more.

Alternatively you can look at a brief summary on our website on some of the theories of adult learning prepared for trainers (and registrars). This is available through the following hyperlink http://www.sheffieldvts.co.uk/trainer/SIMPLEEDUCATIONALTHEORYFORGPTRAINING04.doc

DEVELOPING THE REFLECTIVE PRACTITIONER - SCHON

Reflection on action:	retrospective analysis
Reflection in action:	intuitive, based on accumulated previous experience
Reflection on reflection in action:	research in practice, leading to new ways of reviewing own practice and developing new strategies

Schon D (1987) Educating the Reflective Practitioner, Jossey Bass, San Francisco

KOLB'S LEARNING STYLES

Accommodators Opportunity seeking Risk taking Adapting to immediate circumstances (Business, health workers)	**Divergers** Examine many perspectives and organise into a meaningful whole (Historians, political scientists)
Convergers Need to find answers Decision making Practical application Problem solving (Nurses, engineers)	**Assimilators** Create theoretical models (Mathematicians, economists)

"SURFACE" APPROACH TO LEARNING

Intention simply to reproduce parts of the content

Accepting ideas and information passively

Concentrating only on assessment requirements

Not reflecting on purpose or strategy

Memorising facts and procedure routinely

Failing to distinguish guiding principles or patterns

Entwistle N (1992) The impact of teaching on learning outcomes in Higher Education. Sheffield: Committee of Vice-Chancellors and Principals

"DEEP" APPROACH TO LEARNING

Intention to understand material for oneself

Interacting vigorously and critically with the content

Relating ideas to previous knowledge and experience

Using organising principles to integrate ideas

Relating evidence to conclusions

Examining the logic of the argument

Entwistle N *(1992)* The impact of teaching on learning outcomes in Higher Education Sheffield: Committee of Vice-Chancellors and Principals

ASSUMPTIONS ABOUT ADULT LEARNERS KNOWLES

Self-concept:	adults see themselves as self-directed individuals, and their learning is connected to their own concept of their identity and how this might change
Experience:	an individual's experience becomes an educational resource, and provides a basis for new learning
Readiness to learn:	individuals are more prepared to learn if they can see relevance to their own needs
Learning orientation:	adults tend to learn better if they are ''solving problems rather than absorbing new information without seeing how it can be applied

Knowles M (1970) 'Andragogy: an emerging technology for adult learning', in M Tight (ed) Adult learning and Education

Explore the "criticality" of this incident from the point of view of each of the participants:

what is going on for each person?

why might they see this as critical?

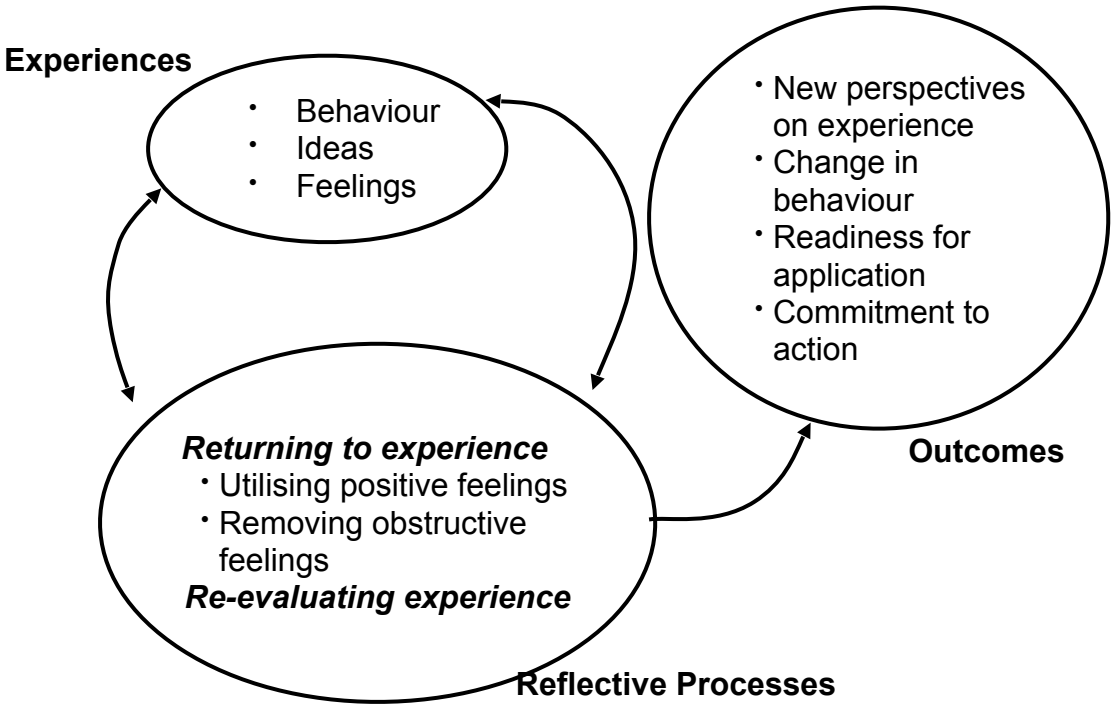
where might the situation go from

AIMS

To introduce the use of critical incidents and reflection in learning

To outline the educational rationale for using critical incidents in reflection

To fit the use of critical incidents and reflection within the professional development programme!



Adapted from: Drew, S (1997) Reflection on Experience, Starter Pack, Sheffield Hallam University