South London and Maudsley NHS
NHS Foundation Trust

KING'S College LONDON

A New Strategy for Medical Education and Training in Psychiatry

February 2011

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Pioneering better health for all

The educational mission of the Maudsley is to provide an internationally renowned training in psychiatry and for the South London and Maudsley NHS Foundation Trust and King's College London School of Medicine to become a destination place to train for future psychiatrists.

Through an innovative and co-ordinated system of training that commences in the undergraduate years and continues through to Consultant/Senior Lecturer appointments, followed by appropriate opportunities for Continued Professional Development (CPD), we aim to build outstanding practitioners, critical thinkers and leaders in patient care, research, education and management.

For nearly a hundred years now the "Maudsley" has stood for training the very best clinicians and academics in the field of mental health and psychiatry. Educating the next generation was central to the mission of the hospital when it was founded and it remains central to our mission today.

The last few years have seen many changes in the scientific basis, funding streams, organisation and oversight of medical and post-graduate education. The formation of King's Health Partners provides a new impetus for us to rethink how we provide medical and post-graduate training. At our request, Prof. Simon Wessely, supported by Prof. Michael Farrell, Drs. Martin Baggaley, Teif Davies, Amy Iversen and colleagues have been taking another look at how we organise and deliver psychiatric education. We thank them for their efforts. That initial report was published in May 2010, which initiated a period of consultation.

We thank them for all the work they have done, and thank those of you who took the trouble to make your views known. The final document reflects all these inputs.

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Introduction

The "Maudsley" is an international brand name signifying excellence in psychiatric training and research. Numerous reviews and metrics continue to demonstrate our leading role in academic psychiatry. We continue to provide leading clinicians, researchers and educators across the world, and to attract amongst the best clinical and academic trainees in Europe. But it is time to consider that despite the above, the quality and indeed reputation of our teaching and training could still be improved. At the same time, our undergraduate education in psychiatry, delivered as part of the KCL School of Medicine, has never achieved the same distinction as our postgraduate training, and must also be seen in the context of a steady decline in the number of undergraduates opting for a career in psychiatry.

There is now a necessity for change, and also an opportunity. Medical education is going through a time of rapid change, as part of a new process of competitive commissioning – the Medical and Dental Education Commissioning System (MDECS). Whether we like it or not, this mandates a fresh look at what we do. We have also had the benefit of an external review of our undergraduate and postgraduate education, carried out by very senior authorities in psychiatric education (see Appendix 2), who visited us in March 2010 and shared their findings with us.

This document reviews the current status of psychiatric training at IOP, SLAM and KCL, places it in a national and international context, synthesises the key findings of the external review that was carried out earlier in the year, the responses to the period of consultation, and finally proposes a new approach.

1. New Commissioning Arrangements for Undergraduate & Postgraduate Education

1.1 It is perhaps a sign of the times that this document needs to begin with an introduction to another reform of English medical education. A new commissioning and providing structure for medical and dental education was introduced in 2010. This covered undergraduate and postgraduate education together with CPD for consultants. There are two drivers for this – first to continue the separation of purchaser and provider, and second, to ensure that education/ training is more closely aligned to service needs, reversing the trends that were established over the last two decades, and which are now seen to have "gone too far". There will also be an increased emphasis on quality management.

1.2 The first part of the programme is establishing Lead Providers, who will in turn manage the provision of education/training.

The structure will be as follows:

Lead Providers will be responsible for a number of processes, including:

- Construction and oversight of training programmes
- Recruitment (supported by a pan-London Shared Service)
- Managing trainee rotations
- Reviews of trainee progress
- Quality managing the education delivered by LEPs

1.3 The actual training and teaching, both undergraduate and postgraduate, will be delivered by Local Education Providers (LEPS). Lead Providers can also be LEPs.

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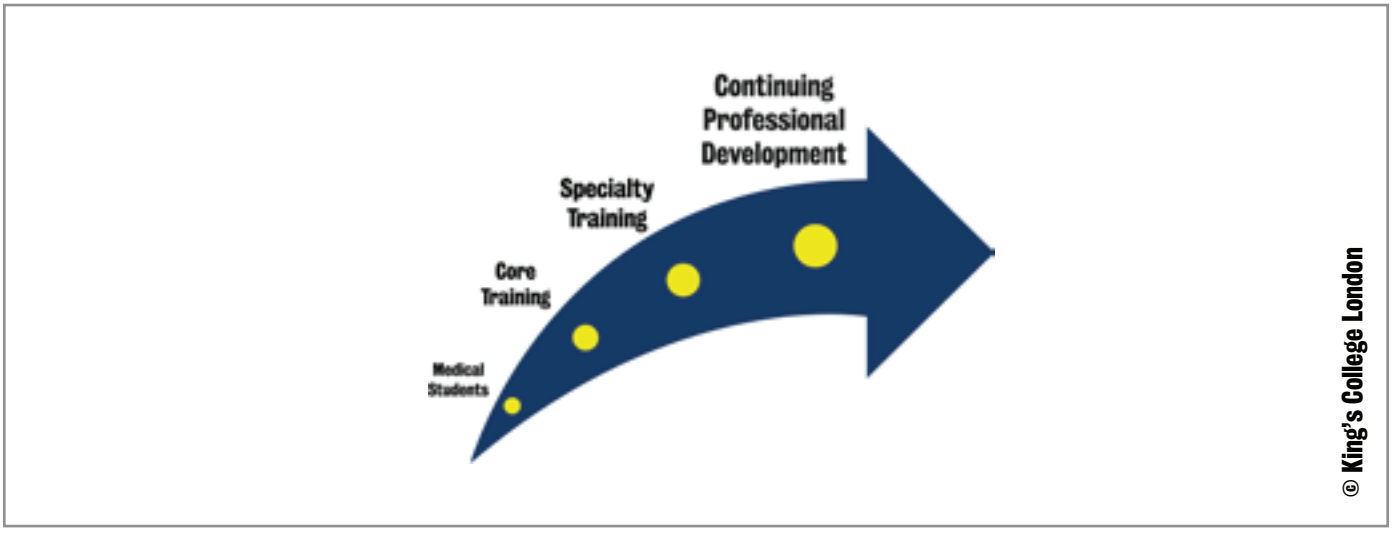

Figure 1. Career Progression

1.4 What is at risk is our undergraduate and postgraduate training, or more specifically the funding for them, known as SIFT and MADEL respectively.

1.5 SLAM successfully bid for Lead Provider status for core psychiatry training in the area currently covered by SLAM, in partnership with Oxleas NHS Foundation Trust as a Local Education Provider. Our psychiatry bid was submitted alongside similar bids for providing postgraduate education in medicine, surgery and dentistry. All these bids come under the KHP umbrella. We will continue as the Lead Provider for core psychiatry (led by SLAM and IOP), whilst offering a series of shared services within KHP. In 2011 we will be bidding for various higher training "bundles" as they are called. We have decided not to attempt to further extend the size of our training scheme by bidding to be sole provider for South London (and thus come into direct competition with St George's).

1.6 The principal strategic reason for this decision is that we are already concerned with the size of our rotation, and the problems that brings in ensuring both quality of applicants and quality of training. Over the last decade the number of postgraduate trainees has more than tripled to around 250. As far as we know we are the largest provider of psychiatric training in the world, the largest single postgraduate medical education programme in any speciality in the UK, and possibly Europe. We note the remarkable discrepancy between these numbers and the size of the residency programmes in the USA whom we wish to emulate.

1.7 As ever, these new, but relatively unknown and totally untried processes, means that what follows in the rest of this document will of necessity require continuous update and amendment.

2. Undergraduate Education

2.1 Organisation of Undergraduate Education (General)

Undergraduate education in psychiatry is currently provided by the Universities. Each medical school has considerable flexibility in the curriculum, within the overall framework laid out by the General Medical Council (GMC) in "Tomorrow's Doctors". Quality control is provided by periodic inspections by the GMC. The Royal College of Psychiatrists has a suggested curriculum, but this is advisory. In nearly all medical schools the National Health Service (NHS) plays a major role in delivery, funded by SIFT (Service Increment for Teaching).

2.2 Organisation of Undergraduate Education (Local)

Undergraduate teaching at KCLSoM is organised by the Medical Education Committee and its subcommittees (called Curriculum Committees, one for each phase of the course), and provided in a vertically integrated curriculum over the five years. The largest part of psychiatry teaching occurs in Phase 3 (Year 3 of the standard course) in Rotation B (known as NOP: Neurology-Ophthalmology-Psychiatry). Over 80% of teaching is provided by staff employed by the NHS.

2.3 Key Threats and Challenges

2.3.1. Undergraduate curriculum

Following the recent GMC QABME (quality control) visit and the revision of Tomorrow's Doctors, a review is underway of both the curriculum content and the student experience. In particular, the GMC raised concerns about the variability of teaching in different modules/ teaching firms. Our own feedback suggests this is the case in psychiatry as elsewhere. In addition we also know that many students, including some previously expressing interests in psychiatry, are unprepared for immmediate exposure to inner city inpatient psychiatry.

2.32 Recruitment

Recruitment into psychiatry is falling. This is a national problem. Less than 5% of those who recently sat the first part of the obligatory professional membership examination set by the Royal College of Psychiatrists were UK medical school graduates. At the same time the number of KCLSoM undergraduates choosing psychiatry as their speciality is the same as the national average, which given our position in UK and European psychiatry is a matter for concern.

2.33 Service Increment for Teaching (SIFT)

SIFT (Service Increment for Teaching), the principal way in which the Trusts are funded to provide medical education, has previously been a block grant that goes via the medical school to the Trust, but has not been managed by the medical school. The new provider commissioning arrangements (outlined above) will almost certainly mean that the provider will be able to shift money in a much more targeted fashion, and it will be possible to link teaching activity and outcomes more closely than before.

2.34 Data collection/quality management

We do not have robust systems in place to determine who is doing our teaching, nor to monitor the quality of the teaching that is being delivered. This is likely to have a negative financial impact unless addressed. For example, the IOP undergraduate budget comes from the KCLSoM and for KCL employees is determined on the basis of teaching time (preparation and face-to-face) according to a formula. Thus SLAM faces the risk that it will be penalised in a similar fashion to what happened in 2009 when the IOP suffered a sudden loss of funding for undergraduate teaching of £1.4 million, if we cannot fully track and report our activity.

However, this setback has concentrated minds. Thus a database has been set up by the Director of Administration (IOP) to audit the contribution of IOP staff to undergraduate teaching (in both psychiatry and neurology). Ascertainment of teaching is not yet complete but has already revealed a greater contribution by IOP-employed staff to KCLSoM than previously documented. This in turn meant a considerable increase in the 2010 award. The SIFT allocation to the NHS trusts, including SLAM (which receives currently about £1.6M annually), is based on: number of students in NHS facilities (facilities component) and number of student-hours spent in NHS placement (placement component). Currently, these data are returned by the head of phase/year on the basis of timetables submitted by the respective NHS teachers.

Obtaining feedback is a core concern of the undergraduate course. KCLSoM plans to operate a consistent process for obtaining feedback from students across the entire medical course using standard forms posted on the Virtual Campus (VC). Currently, feedback from Phase 4 students conforms to this model. It is our intention to ensure that Phase 3 will follow suit. At present, informal feedback is obtained from Phase 3 students at the mid-point and end of their Rotation B (neurology-ophthalmology-psychiatry) placement. Uptake is patchy (response rate about 10%) so, although the results are fed back to firm heads, the outcomes do not as yet form the basis for modification of the course. This needs to change – particularly if we are to improve our courses and our teaching on the basis of student feedback. This was emphasised by our external reviewers:

> *"(iii) Gather more systematic feedback from students and faculty on the psychiatric curriculum, including the third year NOP rotation which appears to be experienced by many students and faculty as fragmented, inconveniently scheduled across clinical sites in Neurology, Psychiatry and Opthalmology, and with inadequate advance preparation for learning and teaching."* [1]

Likewise, although SLAM consultants usually have in their job description and job planning time allocated to undergraduate teaching, there seems no formal way of determining if this is honoured, nor whether sanctions are imposed if it is not. To date there has been little interest in monitoring this, and at present Clinical Directors are not mandated to report to the Director of Undergraduate Teaching the numbers and disposition of Programmed Activities for teaching. This makes audit, quality management and monitoring difficult.

> *Recommendation 1.*
>
> Overall we need more robust systems of recording consultant teaching activity, which in turn will need to feedback via job planning and appraisal. This does not currently happen.

2.35 Incentives for teaching

The main "incentive" for SLAM staff to carry out medical student teaching remains that it is included in their job plans. We should be more imaginative in rewarding teaching activities by NHS staff.

> *Recommendation 2.*
>
> Investigate new ways of incentivising SLAM staff for teaching.

[1] - *indented italicised paragraphs are all verbatim quotations from the report of the external reviewers.*

2.4 Response: Undergraduate Education

2.41 KCL has 450 medical students per year. Research suggests that the potential pool for psychiatry recruitment lies between 3 and 10%. The best UK medical schools for psychiatry achieve 10% intake (historically Oxford and UCL, now Edinburgh), whilst KCL is on the mean at 4%. What this means is that we should view our students as in two groups – the 90% that need to acquire basic skills in psychiatry for the rest of their career but will never contemplate a specialist career, and the 10% for whom a career in psychiatry is at least a possibility.

2.42 Our overall strategy is to ensure that the majority have a good undergraduate experience and leave with the necessary basic skills. These are as outlined in "Tomorrow's Doctors" and largely relate to skills in general mental state examination and communication skills, recognising common mental disorders, assessing deliberate self harm, depression/anxiety, somatisation, confusional states, alcohol/drugs and some psychosis. It is important to note that this curriculum is very different from that required for those who specialise in psychiatry. The former require skills for general practice or general hospital work, in which serious mental illness plays a relatively small part, but the reverse is true for the latter.

2.43 At present our curriculum does reflect the emphasis placed in Tomorrow's Doctors, but the delivery of teaching does not. In particular, we rely on student attachments to inpatient units, dealing largely with psychosis. This has two undesirable effects. First, many students are not learning the skills they need for a career outside psychiatry. Second, the experience is also counter productive and aversive for some, including those who began the course with at least the possibility of contemplating a career in psychiatry. Our external reviewers commented on this, noting that students required exposure to a wider range of patients, specifically mentioning liaison psychiatry and patients with anxiety and depression.

> *"(vi) Monitor what is currently being done and ensure students have experiences that fulfil the requirements of log book outcomes, with exposure to a breadth of different patients, including liaison and patients with anxiety/depression."*

2.44 So a general policy shift towards settings in the general hospital, poly clinic and primary care will have two linked and desirable objectives. It will be closer to the aims of "Tomorrow's Doctors", and it will also provide a better experience for students, thus increasing the chances of recruitment. We know for example that students exposed to liaison psychiatry are more likely to follow a career in psychiatry.

Recommendation 3.

A shift of undergraduate teaching away from psychiatric inpatient settings towards the general hospital and community settings.

Recommendation 4.

We will carry out a full review of undergraduate placements, identifying those that do provide a reasonable training environment, and those that do not. It is also important that the practice of providing feedback to undergraduate teaching firms is improved, as recommended by the external review.

2.45 Our external reviewers also made two recommendations to improve the relevance and attractiveness of undergraduate psychiatry teaching, both of them using our undoubted strengths:

> *"Include lectures from inspirational, charismatic speakers (e.g. well-known psychiatrists) in the curriculum, including covering current models of psychiatric illness. The first lecture they see is particularly important. Current psychiatric scenarios covered in the first year (eating disorders) and second year (psychosis, depression) should be introduced by particularly compelling and expert lecturers who convey the vitality and relevance of contemporary psychiatry.*
>
> *"Staff in IoP with neuroscience expertise should provide some of the teaching at the undergraduate level including integrating psychiatric teaching in the second year neurosciences course, now largely taught by non-psychiatrists.*
>
> *"Consider integrating psychiatry and neurology teaching in some fashion, either via lectures or discussion of neuropsychiatric cases."*

Recommendation 5.

Review the current curriculum in the light of the external reviewers comments. Increase the integration of psychiatry and neuroscience.

2.46 To deliver this agenda will inevitably have resource implications. At present the current resources allocated to general hospital psychiatry are slender, and would be incapable of supporting any increase in undergraduate numbers/exposure, even though it is already the case that the undergraduate liaison firms receive consistently good feedback, and students like being close to the Weston Education Centre with its access to lockers, PAWs and library.

2.47 It will be necessary to bring into alignment the AHSC clinical agenda of improving the psychological care of patients in the acute sectors with the teaching/education agenda of improving the quality of student experience. In the current stringent financial climate new resource is not likely to be forthcoming, so we will require a gradual programme of shifting consultant sessions allocated for teaching in order to sustain this change in policy.

2.48 The second theme of our strategy must be to provide an enhanced experience for the minority who are contemplating psychiatry as an option, as well as also using our strength, resource and reputation in research to particularly attract those who might contemplate a career in academic psychiatry. We note the recommendation of our external reviewers to the effect that:

> *"(viii) Expand wherever possible opportunities for psychiatry training, for example via an increased number of high quality Student Selected Components.*
>
> *"(ix) Facilitate mentored research opportunities and clinical shadowing opportunities for medical students."*

Recommendation 6.

Increase the number of SSCs and opportunities for mentored undergraduate research.

Our response is to commit ourselves to increasing the number of Student Selected Components (SSC) offered by the IOP to undergraduates, to be developed as part of our policy of agreeing formal "contracts" with individual departments (see below). We have already introduced in 2010 a special "double" SSC in psychiatry research that accommodates 60 students a year. What is particularly innovative about this project is that after completing the SSC all the students will be offered six months mentorship to assist them in taking their project through to publication. All too often good projects that could be written up for publication are never taken that one stage further as the student moves on to the next hurdle.

2.49 We are in discussion with the SLAM psychotherapy department for their support to commence a pilot undergraduate psychotherapy scheme at King's, using the UCL model.

2.50 There is already a KCL Psychiatry Society, which one of our consultants was instrumental in launching, and is the largest KCLSoM society. This receives some financial support from the undergraduate teaching budget held within the old Division of Psychiatry. This must be sustained even in the current harsh climate. We will invite the Chair of the "Psych Soc" onto our undergraduate committee.

2.51 We have already hosted two successful Medical Student Summer Schools with the support of the RCPSych, and will continue to do so. Other initiatives that we should have a presence at include the RSM Speciality Careers Fair and the main BMJ-led careers fairs for undergraduates and Foundation Year doctors. Finally, innovative new ways of teaching such as "Extreme Psychiatry", singled out for special praise by our external reviewers, are a real asset to our undergraduate programme and will be encouraged and supported.

Recommendation 7.

Increase support for "Psych Soc", "Extreme Psychiatry" and continue Medical Student Summer School. Pilot a student psychotherapy scheme for undergraduates.

2.52 Medical student electives are another way of encouraging recruitment. At present there is an IOP system for managing overseas students (albeit at considerable expense to the students), but none for local students, who are more likely to be recruitable. Likewise, we need to acknowledge the key role that "tasters" now play for students and FYs in deciding career choices. SLAM needs to be incorporated into this activity. We are already taking steps to identify leads to organise "taster programmes" both for undergraduates and Foundation year trainees, and are pleased to note the first such course was successfully run by Dr Livia Martucci this summer.

2.53 One of the best ways of attracting students into psychiatry is via the intercalated BSc in Psychology. It is gratifying to note that this is over subscribed, and also is attracting students from other London medical schools. We need to review student numbers, and ensure that there is succession planning and continuity following the imminent retirement of Professor Weinman.

Recommendation 8.

A working group to plan for Professor Weinman's succession has now been set up.

2.54 The current generation of students are very keen on winning prizes/awards, because these are specifically acknowledged on the MTAS application forms for FY posts and both core and academic training. To reverse the "I'm Sorry I Haven't a Clue" catchphrase – prizes mean points. We have very few. We are currently reviewing this, and looking for new opportunities to create new markers and recognition for excellence in undergraduate psychiatry.

2.55 Finally, the external review committee noted a lack of definition of "what is the purpose of undergraduate psychiatry", that there was:

> *"no apparent longitudinal oversight over the entire student experience in psychiatry across years, with individuals only being responsible for elements of the experience."*

In response to this, and also the recommendation to better integrate neuroscience and psychiatry teaching, the committee made the following recommendation:

> *"Identify a Director of Undergraduate Psychiatry to organise and monitor the student experience in psychiatry across four years, and expand wherever possible opportunities for psychiatry training, for example via an increased number of high quality Student Selected Components. This should be at least a half time post."*

Recommendation 9.

Create a Director of Undergraduate Psychiatry.


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MRC, SGDP Centre
Portacabin on the Green
Short Term Parking
Staff Car Park
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3. Foundation Years

Background

3.1 The Foundation Year (FY) programme has replaced the old system of pre registration "house jobs". All medical graduates are required to do two years of approved FY posts before they are eligible for specialty training.

3.2 At present only 2.5% of FY posts are in psychiatry, although there is an acknowledged desire by the UK Foundation Office to increase that number. Evidence presented at the 2009 College Annual Training Meeting shows that FY trainees in psychiatry are significantly more likely to go into Core Training. The figures are startling. About 12% of those intending to study medicine indicate an interest in psychiatry. Study after study shows that during medical education this drops to around 2%, perhaps reflecting the "toxic" effects of some physicians and surgeons and/or the sometimes unattractive nature of modern inner city psychiatry. This figure does rise to around 4% later in the course, but is provisionally reported to be 12% for those schools that have Foundation Posts in Psychiatry, compared to 4% in those that do not.

3.3 In theory increasing the number of FY posts might provide one solution to the problem of core trainees and out of hours experience, which is getting increasingly difficult to deliver, but remains crucial to all training. If FY trainees undertake outpatient clinics or some of the less demanding in patient posts, core trainees may be freed up to do more out of hours experience, and come closer to satisfying the current RCPsych standards.

3.4 Much the same argument applies to the Academic Foundation Programme (AFP). We have only one AFP post per year in psychiatry. The quality of applicants has been very high indeed, and it makes sense to increase the number of these posts – another quick survey of our own ACFs already showed the impact of the AFP programme. We are well placed at KCL since our AFP programme is more developed than our competitors at the moment.

3.5 Unfortunately at present the number of FY posts is capped centrally, and discussions with the Director of the Foundation School confirm that there are at the moment no opportunities to increase these numbers. However, this is not true for Academic Foundation Posts

Response

3.6 At the moment we cannot simply increase the numbers of FY posts in psychiatry. We will however continue to lobby for such a change, with advice from the Dean of the Royal College.

3.7 What we can do is make the FY posts as attractive as possible, and ensure that we maximise the opportunities of using those posts to recruit to the profession in general, and Maudsley training in particular.

3.8 We must accept that Foundation Year doctors require more supervision, and may contribute less to service than their more senior colleagues. Thus consultants who take on FY trainees need some compensation for the "double whammy" of requiring extra supervision and getting less

service support. It is proposed that trainers with FY posts are given priority in also having ST (4-6) posts. Our limited experience already suggests that those who have taken on FY trainees have a greater commitment to teaching/ training, and thus would also be well placed to supervise a more experienced trainee as well.

3.9 After consultation with our neuroscience colleagues we will link existing FY posts in neurology with those in psychiatry, to emphasise the interdisciplinary nature of both subjects.

3.10 We will attempt to expand the numbers of AFP posts, again in consultation with neurology. The costs of these posts are not vast, but will need to be met from local resources.

Recommendation 10.

Work with the College to lobby for an increase in FY posts in Psychiatry. Look for local funding to create extra Academic Foundation Posts in psychiatry and neurology. Appoint a Director of Foundation Year Training.

4. Postgraduate Training

4.1 Background

4.11 The current system of postgraduate medical education in general and psychiatry in particular, is not simple. Currently both the commissioning and provision of education, including all the processes that support this, are provided by Deaneries. The conceptual framework is as follows: PMETB set the standards for postgraduate training; the London Deanery holds the budgets and the training is provided at Trust level coordinated by the Graduate School of Psychiatry. The GMC decides the undergraduate curriculum; the College determines the content of the postgraduate curriculum and assessment processes which are then approved by PMETB. The training is provided at Trust level and quality managed by the Deanery acting on behalf of PMETB who have responsibility for quality assuring the programmes. Meanwhile, a parallel academic track exists, in which in addition to the above, this time the NIHR holds some (but not all) of the budgets, and the University delivers the academic (but not clinical) training.

4.12 That is the theory – the practice is yet more complex. A series of changes to the structure of postgraduate medical education (PGME) have come, and occasionally gone, in rapid succession. Currently we are in a period of transition from the old style Calman training to the new MMC programmes. Old style specialist registrars are training alongside the new speciality trainee grade with the differing assessment procedures (RITAand ARCP – see appendix) processes running side by side. There is a new "Gold Guide" with recently updated regulations. PMETB, the regulator, merged with the GMC in April 2010 bringing the regulation of undergraduate and postgraduate education under the same roof for the first time. The Patel review will then advise on the overall structure and legislative framework for the merged organisation.

4.13 However, one can determine some overall strategic patterns emerging. First, there is an element of "back to the future" as Psychiatry has uncoupled and abandoned run through training and the new CT and ST grades bear a remarkable resemblance to the old SHOs and SpRs. Second, responsibility for recruitment is shifting. The Royal College of Psychiatrists now has a major role in a speciality led recruitment process at CT1 (and it is expected this will be extended to all levels of recruitment in 2010). Applications are centrally managed by the RCPsych, long listing, short listing and interviewing is undertaken at Deanery level and there is a national clearing system to maximise fill rates while minimising the amount of time spent by consultants in the recruitment process. The Royal College deserves considerable credit for these changes.

4.14 Terminology is as ever confusing in this area. Throughout this document we will use CT 1 to 3 to refer to the Core Training years, essentially the old SHO grades, and ST 4-6 to refer to Speciality training, reflecting the old SpRs.

4.15 Locally, postgraduate training and teaching is lead by the Joint Medical Education Committee (JMEC), chaired by the Director of Postgraduate Medical Education (Professor Michael Farrell). Prof Farrell will be leaving this post, and indeed country, in 2011 and we take this opportunity to pay tribute to the many years of service he has given to postgraduate education at the Maudsley and wish him well in his new position.

4.16 Overall, we are in a strong position to deliver high quality postgraduate training in psychiatry, as acknowledged by the external reviewers:

> *"There is an appreciation by the trainees of the wealth and breadth of resources and opportunities in the Academic Health Sciences Centre, including the rich variety of clinical posts."*

4.17 But we face several obstacles and threats in fully realising our potential.

4.2 Threats

We face several interlinked threats.

4.21 First, the possibility that the Department of Health will cease to fund training posts in full, but only those parts of posts that are specifically linked to education, leaving the Trusts to fund the remaining salary costs that relate to service provision. This might well have the probably intended consequence of shifting money from medical posts (expensive) to cheaper AMP (non medical) posts.

4.22 Second, quality monitoring. Monitoring the quality of postgraduate education is not easy. There are some obvious metrics, such as MRCPsych pass rate (currently unknown), and satisfaction/trainee experience. In both the 2008/09 and 2009/10 survey carried out by PMETB for all trainees in the London region, our ratings were below average, with UCL, for example, out performing us particularly in the areas of educational and clinical supervision. There are many reasons for this – large schemes tend to get worse ratings than smaller more personal schemes for example, and satisfaction is a blunt instrument. However, trainee satisfaction will continue to be a core metric. It is easy to obtain, enables direct comparisons with competitors, and already features strongly in the PMETB quality assessments, which are certain to be continued by Medical Education England.

4.23 Third– the new MDECS commissioning arrangements themselves, which have already been outlined above. Any commissioning process is a potential threat, particularly in a harsh financial climate, but, whilst mindful of the cliché, it is also an opportunity as well. At the time of writing we have just been informed that our bid to be the Lead Provider for South East London has been successful, which brings us closer to being able to put into practice some of the changes that we wish to make.

4.24 Fourth– financial. The IOP's contribution to undergraduate teaching is not evenly distributed across the organisation; it is concentrated mainly in the old Division of Psychiatry/Psychological

Medicine, solely for historical reasons. This narrow base has not served us well, reflected in the dramatic loss of income following the recent teaching audit carried by the School of Medicine. We should also note that the nature of SIFT funding is that it is fixed by the SIFT formula (ie small increases/decreases in teaching volume do not affect funding), but within IOP it is allocated by teaching hours. Increases/decreases in activity can and have had serious impacts on funding.

4.3 Postgraduate teaching: MRCPsych

4.31 On the old Maudsley rotation little attention was paid to formal MRCPsych teaching. It was assumed that our trainees would pass the admittedly not very high hurdle of the Membership by virtue of their own efforts, which most supplemented by attending one of the many short courses offered elsewhere to supply the "finishing touches". Maudsley teaching was broader, and more orientated towards critical thinking and academic preparation.

4.32 However, as the rotation expanded, this proved increasingly unsustainable. Many trainees indicated in feedback that this was also thought to be a way of avoiding our responsibilities. In response we now offer a didactic MRCPsych course, based on the acquisition of factual knowledge, followed by skills-based small group teaching, sometimes involving simulations/actors.

4.33 The didactic course itself is very popular, due in no small measure not just to the quality of the teachers, but also of the course organisers. It is at present delivered largely by lectures, almost invariably of high standard. However, as the organisers acknowledge, little use is made of modern teaching, electronic or web based formats. This means that self directed learning is difficult, and marketing the course beyond SLAM/IOP impossible. We perhaps are making too little use of problem/case-based learning, peer and self-directed learning , e-learning and simulation, and inter-disciplinary learning. However, it is pleasing to acknowledge the popularity of the current course, and the fact that trainees clearly and repeatedly appreciate exposure to senior often well known teachers. We acknowledge the popularity of locally organised skills-based teaching, especially involving the use of actors/simulators. We will build on this experience in 2011 with the introduction of a 2 day simulation-based Induction course covering the core skills of emergency psychiatry to equip new trainees for on-call work.

4.34 The other problem is that we have perhaps swung too far in teaching a traditional MRCPsych course. We need to find a balance between didactic exam orientated teaching, and equipping the trainees for the future, giving them skills that they will need post Membership. Psychiatrists are an increasingly expensive option, both to train and then to pay. There is an inexorable trend for other professions such as nursing or psychology to take over roles that have previously been restricted to psychiatry. Psychiatrists no longer have the monopoly on prescribing, and their status as RMO or legally

privileged position given by mental health legislation is likewise changing rapidly. Policy documents such as "New Ways of Working" signpost a future in which it will be far from a given that psychiatrists will be automatically leaders of the multi disciplinary team.

4.35 All this means that the next generation of psychiatrists will need to have a broader and different range of skills if they are to justify their position (and salaries).

4.4 Response (Postgraduate Training: General)

4.41 We need to acknowledge that we have not devoted sufficient resource to postgraduate training. The best US training schemes are much smaller than ours. The usual numbers of trainees ("residents") is between 40 to 60. Yet all these schemes have a full time post of Training Programme Director and at least one part-time assistant director, whose core responsibilities lie with planning, administering and developing postgraduate medical training. In the past our Training Programme Directors have always been full time consultants with major clinical responsibilities, who then have an additional role in education, usually remunerated by one, rarely two, additional sessions. It is a tribute to our TPDs that they have performed as well as they have over the years given the limited resources that have been devoted to the task. When we consider that our rotation, with upwards of 250 trainees is as large as the five leading US rotations put together, the disparity in resource becomes even more apparent.

This was perhaps the most repeated observation made by our external visitors.

> *"(iii) The greatly increased size of the programme and the process by which trainees apply pose significant challenges to the cohesiveness and quality of the training experience.*
>
> *"(iv) There is a lack of adequate administrative support to manage this increased programme size.*
>
> *"(vi) The trainees report a lack of clarity over who is responsible for education and appraisal and a lack of trust and confidence in "the system" by the trainees who feel that "no one person is looking out for them."*

4.42 We will respond to these comments in four ways. We will reorganise the management of post-graduate medical education and invest in more dedicated education sessions for our staff. We will increase the resources for the administration of our programmes. We will review all our training posts, and will make a small overall reduction in the size of the rotation.

4.43 First, we accept the recommendation of the review.

> *"(i) Professionalisation of the role of Training Programme Director. A Training Programme Director for the overall training programme should be identified, with a time allocation of four days per week."*

Recommendation 11.

We have created a new post of Director of Postgraduate Psychiatric Training.

We are delighted to announce that Dr John Moriarty has been appointed as Director of Postgraduate Psychiatric Training, and will be taking up his post early in 2011.

Dr Moriarty, who has a distinguished record as a clinician, educator and academic in clinical neuropsychiatry, will have as a primary responsibility the management of our core general training (CT1-3). Although he will continue with some clinical responsibilities in neuropsychiatry, the majority of his time will be given to postgraduate education including the implementation of the MDECS programme. This represents a shift in organisational priorities, and a break with the past. As DPPT he will be responsible for managing the network of educational supervisors who will oversee the trainees' progression through their core training. He will also oversee the organisation and governance of core and higher training through the relevant committee structures, the 6 Specialist TPDs and the Director of Academic Psychiatry (see Figure 3b).

4.44 Second, we have responded to the second recommendation of our external advisors by creating a new senior management post, to support undergraduate and postgraduate education. This person is a senior administrator with experience in education. The post holder will cover both undergraduate and postgraduate education, and will answer to the Vice Dean (IOP) and the Medical Director (SLAM). The post holder will lead and manage the currently diverse and fragmented administration of undergraduate and postgraduate education and also will guide us in the development of robust systems to quality assess and quality monitor our posts. This role will be increasingly important as we enter the new era of commissioning. We are delighted therefore to welcome Ms Denise Phillips to the new post of Manager, Psychiatric Education and Training, commencing in November 2010.

Recommendation 12.

We have created a new senior administrative/ managerial post to support undergraduate and postgraduate medical education.

4.45 Third, we have comissioned Dr Eduardo Iacoponi and Dr Elizabeth Parker to carry out a "root and branch" internal review of each of our core training posts. In the past 4 months, they have interviewed over 100 trainees and trainers in person, and visited workplaces across the rotation. Their report (due shortly) together with other feedback collected on posts previously, will be used to build on the general responses noted by our external reviewers, translating these into more local knowledge.

4.46 At the same time we also have to respond to a new directive from NHS London to reduce the size of our rotation by 15% over three years. We intend to make use of this opportunity to ensure that these reductions are used as part of our own quality improvement programme. As a matter of policy we will ensure that the reductions fall on posts with a consistently poor performance in training. We need and will respond to observations by our external reviewers that:

> "*(xiii) There were reports that trainees have experienced violent incidents and that there was no post-incident debriefing and remediation*
>
> *"(xv) There is marked and concerning variation in the frequency with which trainees meet with*

their clinical supervisors, from more than the required once weekly to no more than several times per 6 months; some trainees being asked to meet in pairs with a supervisor rather than individually."

4.47 We will also start a dialogue with the consultant body and senior leaders about the optimum size of our rotation in the future. Of course any changes will have implications for service delivery. Nevertheless, we need to rethink what it is that we are trying to achieve in training, and link this with increased emphasis on consultant-led services. This would correspond with the advice from our external reviewers:

"Some of the inpatient general adult psychiatry placements are especially unpopular because of the combination of high patient load, concerns about personal safety, and perceived lack of clinical supervision. This is all compounded by the high percentage of "bank" nursing staff on such wards."

4.48 The External Review concluded that we should:

"(ix) Consider whether a substantial reduction in the overall numbers of trainees would be the most powerful intervention to improve the quality of the training."

We will indeed begin such a dialogue, whilst acknowledging that any such change needs to take in to account the effect on clinical services, and the general manpower situation across psychiatry within the NHS

4.49 Our external reviewers made the following observation:

"The allocation of posts causes unnecessary anxiety. The process of decision making is opaque, and the decisions are made on an intermittent basis, not even allowing for knowing a yearly, much less a long-term (3 year) view of one's educational plan."

Our proposed reforms, both the streaming system for more senior trainees and the new post of Director of Postgraduate Psychiatric Training, will ensure that a trainee will have a better idea of what posts and in which locations he/she is likely to be given during their time as a Maudsley trainee. One of the principal negative feedbacks that we received from trainees, and was echoed by the external review, is that they perceive that the allocation of posts is often unpredictable and uncertain. It is difficult for them to establish links with a future trainer because they have no idea who that might be. It is not proposed however that our new system of streaming be inflexible. Swaps or specific allocations outside the nominated stream will be possible, but only with the agreement of the Director of Postgraduate Psychiatric Training.

4.6 Mentoring and Support

4.61 The evidence for the success of mentoring in assisting academic and clinical careers is strong. For that reason major funding bodies now insist on mentoring schemes being in place for academic trainees. PMETB is also introducing a new role of "educational supervisor" for all clinical trainees, which has strong overlaps with mentoring.

4.62 We are already responding to the new Deanery-mandated requirements for educational supervisors or mentors. Our numbers mean that it is impossible for the Director of Postgraduate Psychiatric Training to meet up with each trainee on a regular basis (as happened years ago)- but that the he or she will chair a committee of the educational supervisors, and will be expected also to meet with each supervisor on at least a six monthly basis to review progress of trainees and ensure good career planning.

We expect that a trainee will have the same mentor/educational supervisor during their core training, replacing the current system in which these are geographically based, and thus change as the trainee moves within the region. As specified by the Learning and Development Agreement, we will require 20-25 such educational supervisors, who will replace the old system of college and site tutors (although of course we hope that many of our existing site tutor personnel will apply for these posts). This will require a change in job plans and appropriate training to be provided for those who choose to take up these new roles.

Recommendation 13.

To press ahead with the recruitment of more Educational Supervisors, with appropriate support and training.

4.7 MRCPsych

4.71 Our MRCPsych course is well run and valued. But it can be modernised. By developing more modern teaching media for the MRCPsych course we can also reduce the time commitment to the course, thus allowing space for more imaginative and innovative teaching. Small group teaching, team-based learning, problem based learning, peer led learning and the use of actors/simulations provides a better educational experience, and is also popular.

4.72 Modernisation also assists marketing, as part of a wider strategy of marketing the "Maudsley" brand.

4.73 We accept both suggestions from the External Review:

> *"(vi) Consider developing on-line resources such as a hub wiki that organizes reading, self-assessments and other materials in parallel with the core lectures and possibly also helps the ancillary aim of preparation for the MRCPsych examinations.*
>
> *"(vii) Consider the piloting of use of some new methods of teaching such as Team Based Learning as opposed to exclusively didactic lectures."*

Recommendation 14.

Expand on the success of the MRCPsych course by promoting new learning techniques.

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5. Specialist Training

Simply providing exam based teaching will not prepare the trainee for the world of tomorrow. We need to develop more specialised training programmes, as part of developing parallel specialist tracks. A core innovation of our response is to create specific training streams, and that every trainee, by the time they reach specialty training will belong to one stream, after a period of general training. These streams will be academic, educational, management/ leadership and clinical. So those who join the educational stream will be allocated to posts where the trainer has demonstrated specific skills or interests and experience of teaching, whether it be undergraduate or postgraduate. Likewise, a person who is recruited to or joins the academic stream will therefore know which pool of posts are available to him/her, and that these posts will all have an academic slant. The managerial/ leadership stream will favour posts where the trainer has a local or national managerial/role. The largest stream will be the clinical stream. We should consider whether or not this be further divided into perhaps two or three separate streams, each containing at least one of the full range of posts that we offer (community, liaison, forensic, old age etc.).

5.1 Academic Psychiatry Training: Background

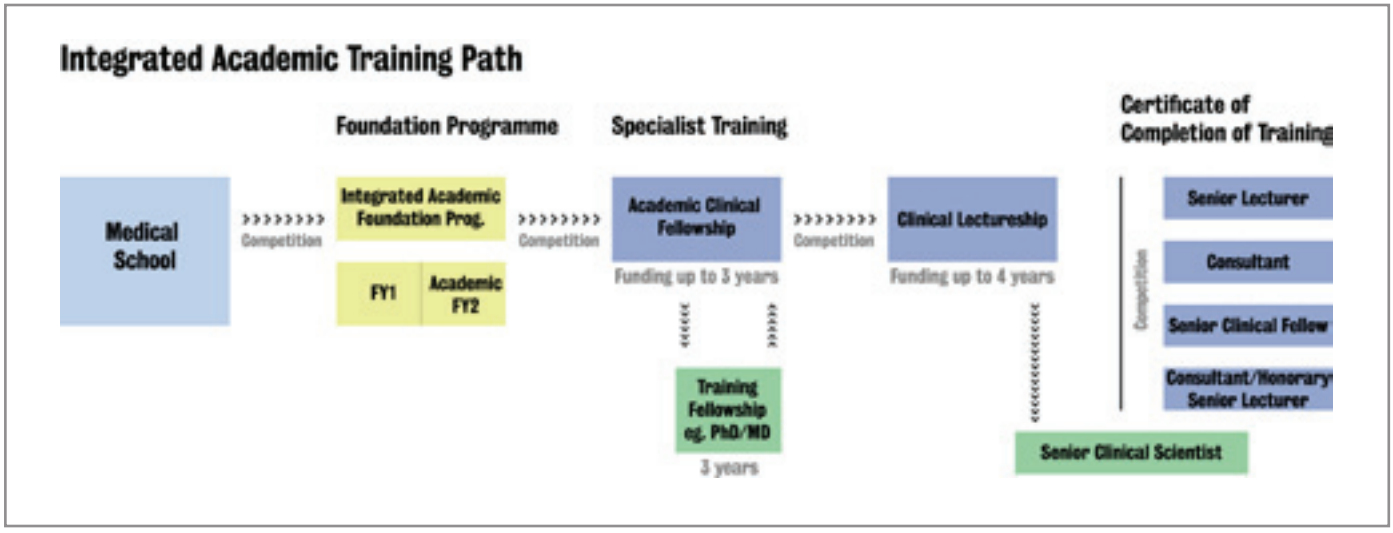

Figure 2. Outline of Academic Training Pathway. (adapted from NIHR Website)

5.11 Academic training has and should remain a core element of the "Maudsley" brand. It should be a key area in which we can and should be differentiated from other training schemes, and is one reason why mental health is at the heart of the AHSC (unlike our two principal London competitors).

5.12 Like so much else, academic training is also in a period of transition. Funding has been shifting from the university sector (via the core HEFC funding) and over to the National

Institute of Health Research (NIHR), funded via the Department of Health budget. For academic training the arrival of NIHR has been a major step forward in many ways. The above diagram summarises the proposed new career pathway for clinical academic training. People enter at the Academic Clinical Fellowship (ACF) level, iin which they have 25% protected time for research, to be taken over the three year period either with protected time each week, in a research block, or in a combination of the above. At the end of the ACF period they are expected to apply for a full time training fellowship

5.13 However, perhaps less welcome has been a change in the structure of academic careers, especially in the so called "craft" specialities including psychiatry. At its simplest, people will need to commit themselves to an academic career at an earlier stage than previously. The new timescales mean that the current generation do not have the luxury that a previous generation enjoyed of two or three years to "find their feet". Now they need to hit the ground running.

5.14 One reason is because entry to the new Academic Clinical Lecturer (ACL) grade was originally proposed to be available to only those who had completed a doctorate. An immediate switch to the new requirement would have closed further academic psychiatry training to nearly all of our current trainees. We successfully negotiated a temporary relaxation of this requirement, but only for five years, so a major priority is to ensure that we recruit future academic leaders earlier than has been the case in the past, and assist in their development.

5.2 Academic Training: Threats and Challenges

5.21 It is clear from the above that those contemplating an academic career need to do so earlier than before, and hence we, as the premier training institution for academic psychiatrists in Europe, need to respond accordingly

5.22 The three main funding bodies (NIHR, MRC and Wellcome) make it clear that they expect a formal system of academic mentorship and teaching to be in place in each host institution. At present we do not meet either requirement.

5.23 Our allocation of ACF and ACL posts by NIHR was initially by means of a formula, based on size. This has now been replaced by new metrics, which in particular reward NIHR funded activity. KCL has done well in this system, because of its successes in hosting BRCs (both general and specialist), having the highest number of NIHR Senior Investigators in the country, and a substantial programme grant income, as well as other indices of success. SLAM/IOP more than played its part in this success. This allocation will run until 2013. We do not know how posts will be allocated after that, but it is likely that there will at that stage be a greater emphasis on outcomes, such as numbers obtaining training fellowships (ACFs) or Senior Lecturer posts/intermediate fellowships (ACLs).

5.24 A further change has been that control of academic training has moved from IOP to KCLSoM, since we are not being treated as a

"special case" by NIHR, but as a medical school with a Department of Psychiatry. However, we should acknowledge that allocation of posts will continue to reflect the contribution made by SLAM/IOP to the overall numbers of posts allocated to KCL.

5.25 Some of our current academic trainees appear to have suffered from some of the recent changes. Our external reviewers noted that

> *"The current academic trainees feel that they do not have sufficient time or support to develop their research careers."*

5.3 Academic Training: Responses

5.31 Entry. Whilst it is correct that in general trainees will need to commit themselves to academic careers earlier than was the case, it does not seem to be true, as was initially believed, that all ACFs need to start in the first year of postgraduate training (CT1). Our experience, mirrored elsewhere, is that for some this is too early, and they need a year if not more to gain more experience of general psychiatry before they can decide whether or not they wish to commit to an academic career, which will inevitably extend their training, let alone their area of speciality.

5.32 We therefore propose to alter the information/advice we are currently giving out (currently also purely informally), to indicate that we welcome applications for academic training from CT1 to CT3. However, we should not insist that all trainees do our proposed foundation year of general training (CT1) before applying for ACF positions, because some will apply already with higher degrees such as PhDs and clear research plans.

> *Recommendation 15.*
> Greater flexibility in recruitment of academic trainees, coupled with improved information/ linking with potential supervisors.

5.33 Information. The previous informal ways in which trainees and potential supervisors met and interacted worked well when we were a small rotation. It is no longer satisfactory for a large rotation with over 250 trainees. We have already responded to some of the criticisms expressed by our current cadre of ACFs by comissioning the development of a regularly updated research project e-database which will be available to ACFs and ACLs as soon as they are appointed and before they start.

5.34 Metrics. We currently lack metrics on the outcomes of our academic trainees. This is being addressed urgently. The current director of academic training has now established a data base of all our academic trainees, which is being updated to include the outcome of each trainee. This is certain to be required by NIHR.

5.35 We have one clear advantage over our competitors, namely the presence of the NIHR funded BRC. The one year BRC Preparatory Fellowships (which were not reviewed by our external advisors) are proving highly successful – so far 8/8 have successfully obtained training fellowships after their year. We need to ensure that these are included in our metrics, whilst at the same time consider why they seem more successful that the ACF route.

5.36 Academic teaching/training. Our current ACFs have correctly identified a lack of basic training in research skills. This used to be part of general "Maudsley" training, but has somewhat fallen by the wayside as part of the expansion of the size of the rotation. We are addressing this. Last year we ran a very successful Summer School for ACFs and academically minded trainees across the country, funded by NIHR. We will be repeating this in 2011. However, we have also adapted and modified this course, to introduce a new KHP programme for all academic trainees across the specialities in KHP. This will cover generic skills (grant writing, ethics, statistics, RCTs etc). It will be funded by the £4.5K capital that accompanies academic NIHR trainees. This proposal was welcomed by the School of Medicine, and is now been implemented as part of our Integrated Academic Training (IAT) plan mandated by NIHR. The first such course was organised by Dr Stephani Hatch and Dr Vivienne Curtis, and ran in September 2010.

5.37 Working with our colleagues in the School of Medicine, this course will have a credit bearing framework so that it will form part of a specific research skills module, delivered across the IOP for not just ACFs, but to cater for a range of MSc and doctoral students. This will come under the responsibilities of Professor Susan Lea, our new Vice Dean for Education.

Recommendation 16.
A generic research skills taught course for all Academic Trainees within KHP has been successfully launched.

5.38 At the same time we need to make greater use of our existing and future ACLs who need, and indeed wish, to participate in teaching/ training of their junior colleagues. We recently hosted a visit from Professor Brian Hodges, a Canadian psychiatrist who founded and directs a world renowned research institution in medical education at the University of Toronto. It was encouraging to note the very high turn out by our trainees for this full day. We have now started a monthly Special Interest Group for trainees with a special interest in Medical Education Research (SIGMER), all of which supports our proposal for a formal Educational Track outlined overleaf.

5.39 Mentorship/supervision. Formal mentorship is also a condition of acceptance of training awards from our three leading funders. We need to develop this in parallel with our new proposals for educational supervisors for all trainees.

5.391 Leadership. We will create a specific role of Director of the Academic Training Scheme who will sit on both the Core and Specialty Training committees. This individual will be an experienced academic with a proven and ongoing track record of successful grant acquisition and original research.

Recommendation 17.
Appoint a Director the Academic Training Scheme (Psychiatry)

5.4 Specialty Training (Education and Management/Leadership)

5.41 At the moment we make little attempt to differentiate training experiences/needs, with the exception of higher training in specialities such as forensic, old age and child. We have the beginnings of an academic track, but nothing else. We propose that we formally create streams for academic, educational and leadership/ management, each with a course director and with specific educational objectives – these would, like the current academic streams, be competitive and prestigious, so that successful trainees would have a subsequent advantage in the increasingly competitive job market.

5.42 It is proposed that entry to these tracks begins at ST4. The first three years of training will be devoted to clinical training and core skill acquisition. these will function as "foundation years", but will not be designated as such to avoid confusion with FY1 and FY2 years

5.43 The exception will be academic training, which can begin immediately at CT1 for those appointed to ACF posts who already have a suitable background. However, our inclination will be to favour CT2 or even CT3 entrance for most academic trainees.

5.5 Educational Track

5.51 As noted above, we already have several enthusiastic trainees who are keen on education, but until now they have been working largely on their own and without direction and support. In May 2010 we were awarded a three year programme from the London Deanery to host six half year Felllowships in Medical Education (FME) in SLAM. These posts, which are nationally competitive, allow trainees to undertake a bespoke piece of educational research and participate in teaching innovation, whilst being freed from their routine clinical commitment by means of an OOPE (an Out of Programme Experience). The first post holder will start in February 2011.

5.52 In addition to the nationwide FME posts, it is proposed that we establish a small formal "Teaching and Educational Scholarship Stream" for internal candidates, who would be competitively identified in the same way that academic trainees are currently identified. Those on this stream would have specific duties with organising medical student attachments and teaching, as well as teaching core trainees, would be guaranteed an educational supervisor/ mentor interested in similar matters, and access to training posts with clinical trainers who were active in the field of medical education. They would also be encouraged to undertake an original piece of medical education research during their training and would be supported to develop this for publication, and to undertake appropriate further post-graduate studies if they wish (for e.g. an MA in Medical Education).

5.6 Management/Leadership Track

5.61 We have identified a number of senior trainees who have been Darzi Fellows, held Harkness Fellowships or otherwise shown

both interest and excellence in management/ leadership, and indeed have been identified by the NHS as future leaders. We are already using these future (and of course our existing) leaders in developing our programme.

5.62 It is proposed that we establish a small formal "Management and Leadership Stream" for trainees, who would be competitively identified in the same way that academic trainees are currently identified. Those in this stream would be mentored to apply for specific external fellowships such as the Darzi fellowships and others, would be guaranteed an educational supervisor interested in management/leadership, and access to posts with trainers who are active and experienced in management and leadership.

Trainees on this stream would be expected to undertake relevant projects both locally and perhaps nationally. Our current senior managers/executives would be expected to offer relevant opportunities and/or take part in the teaching programme and mentorship for this stream.

5.63 This would be an excellent area for inter-professional working and learning, in that some of the teaching/opportunities/learning experiences and secondments would be equally suitable for senior nurses or psychologists who wish to develop management and leadership skills.

6. General Environment

6.1 The Maudsley has a long tradition of regular teaching events, such as the Maudsley Debates, Grand Rounds, Maudsley Forum and Journal Clubs. These must continue. In the past these have been run by junior academic staff, who have usually been nominated/"encouraged" by Professor Murray and thus usually have come from the old Department of Psychiatry.

6.2 In the future it is important that these responsibilities no longer fall entirely on the shoulders of one department, as part of a general policy of widening the participation in teaching activities. As with the undergraduate teaching provision, in order to become embedded, these activities need to be formally acknowledged as important by senior staff, incentivised in the job application and promotion process, and rewarded with prizes.

7. Innovation and Leading the Educational Agenda

7.1 One of the goals of the KHP Education Academy is that all education and training should be research led. SLAM/IOP are research led institutions, except when it comes to training/education. There is no reason why this should be. Pedagogical research requires the same attention to matters such as developing hypotheses, experimental design, measurement, sample size, outcomes and so on, and the academic rigor which we already excel at can be brought to this new discipline. We should aim not only to innovate in new methods of teaching and supporting trainees in their professional development, but to design high quality intervention studies, based on sound RCT methodology, which examine the success or otherwise of what we do.

7.2 We have appointed Dr Amy Iversen to the new post of Senior Lecturer in Academic Psychiatry and Faculty Development, with responsibility for initiating research into medical/psychiatric education, and allowing us to innovate in psychiatric education for KHP and indeed the UK.

Recommendation 18.

We have created a new Senior Lecturer position in Academic Psychiatry and Faculty Development.

8. The Prominence of Teaching

8.1 It is not revealing any secrets to note that the IOP has traditionally valued research more than teaching. This is partly historical, since it is only in the past decade that IOP has had involvement in undergraduate education. This emphasis can be seen at many levels. A greater proportion of our income comes from research than in comparable organisations. Most if not all of our senior positions are filled by individuals who have achieved prominence in research. Our promotion system has traditionally placed a greater emphasis on research than teaching. The culture of the IOP has to date favoured and rewarded excellence in research more than it has teaching.

8.11 There are many reasons why this needs to change. Our reputation alone is no longer sufficient to attract the best trainees. Academic recruitment across medicine is falling as the training requirements become more arduous in terms of time and financial rewards compared to NHS career structures. There is increasing monitoring of quality in teaching, and we are sometimes found deficient. It is likely that we are reaching the ceiling in terms of research income – as it is some feel that we already have an unhealthy slice of the UK research cake. But this is definitely not the case as regards teaching/training – recent events have shown how vulnerable we are to audit of our teaching contribution, but paradoxically have also highlighted the opportunities that we are missing, for example with overseas students.

8.12 Changing the culture of an organisation, especially a successful one as the IOP undoubtedly is, is never easy. But that is what is required.

Proposals

8.2 Resource allocation: At the moment there is little incentive for IOP staff to devote much time to teaching, unless they are specifically employed for that purpose (which applies to very few). Heads of Departments (HODs) will see the benefits of developing, hosting and encouraging staff to assist in taught courses at MSc level, but there is virtually no incentive for them to support undergraduate teaching in general, nor SSCs. At present of the more than 1000 SSCs offered by the Medical School, 7 involve the IOP. The new system of resource allocation to be proposed by the new Dean will ensure that resources follow activity in a transparent fashion that has not been achieved before, and thus act as a stimulant for growth.

8.3 Promotion— needs to be clear and transparent criteria for rewarding teaching as much as research. Particular emphasis needs to be given not just to teaching time, but on teaching innovation, research and leadership.

8.31 The Harvard University promotion system deserves careful study. At Harvard candidates must select one area of excellence, representing their major area of contribution, achievement and impact – these are teaching/education,

research and clinical. Candidates can also select additional areas, which we would label "good citizenship", but include community service, administration, institutional service, public engagement, patient education and so on. However, the criteria also state that "all candidates, irrespective of their chosen area of excellence, will be evaluated for their teaching and educational contribution" and states elsewhere "given the importance of the educational mission, it is expected that with rare exception, all faculty will engage in teaching". Hence promotion is impossible for anyone who makes no contribution to teaching/education. The criteria are also detailed and explicit in the metrics that will be taken into account, and the standards that are required at each level (Lecturer, Senior Lecturer and Professor in our system). Finally it actively encourages mentorship – candidates for promotion are expected to give details of mentorship, including the careers and grants of those they have mentored.

9. International

Forming stronger links with international partners to exchange student and staff is part of the wider AHSC vision for Education and Training. We are in the process of reviving our links with Johns Hopkins Department of Psychiatry, and our first research exchange resident arrived in December 2010. IOP are intending to lead the AHSC in developing this link with Johns Hopkins, with a plan that in time this may be available to all IAT trainees. We are also exploring the possibility of exchange programmes with Harvard/Brigham and Women's Hospital in Boston and and the National Institute of Mental Health & Neurosciences, Bangalore. Finally in the developing world, we are looking to offer placements for our trainees in education in Ethiopia, Zimbabwe and Somaliland.

10. Continuous Professional Development

Probably the best areas for income generation are around consultant CPD, especially when revalidation starts to have impact. We need to consider the potential for developing our CPD training opportunites alongside our reform of our post-graduate training.

11. Web Presence

11.1 Our web presence has in the past been lamentable, indeed absent would be a better word. A doctor who wishes to train at the "Maudsley" or at SLAM would be forgiven for thinking on the basis of our web presence that we do not offer postgraduate training. Nowhere was there any information as to why a trainee would wish to come here, what posts we have, what teaching we offer, or how to apply. The trainees themselves have made a start with an internal website highlighting courses, lecturers and relevant links, but this needs to be made more professional and incorporated into the overall integrated web presence. It should also signpost to our international activities, such as the renewal of US links and the links with developing countries such as Somalia.

11.2 We have no difficulty in accepting the recommendations of the external review:

> *"viii) Develop more effective mechanisms for recruiting trainees into the training programme through web presence, advertising etc."*

11.3 We have already taken urgent steps to develop a web presence, clearly branded as the "Maudsley Training Programme", within the AHSC umbrella. In particular we are intending to develop two linked websites – the first is the front of house website, essentially for recruitment in order to explain– "Why train at the Maudsley?" and second is for our trainees, which will eventually become a resource for self directed learning. The website www.maudsleytraining.com is now under construction, with work led by Dr Steve Church and numerous colleagues.

12. New Structures

12.1 The new landscapes in psychiatric education and training, both locally and nationally, mean that it is opportune for us to review and update our structures. These should reflect both the new MEE structures, the HIEC and our own AHSC.

12.2 What is needed is better co ordination. In particular this needs to be on three levels. First, to ensure better co ordination of undergraduate/ postgraduate training, to reflect the need to offer students a coherent and integrated pathway based on the AHSC, and in which the various parts/elements work together, and not against each other, as is sometimes perceived. Second, to improve the co ordination between IOP/ SLAM and KCLSoM. Third, to co ordinate and integrate basic and speciality training, ensuring that we have tracks for specialist, academic, educational and leadership/managerial training, that also are seen as part of a coherent strategy.

12.3 The creation of the Vice Dean position is an essential first step, in bringing together strategic direction at a higher level within IOP/SLAM than before, and also working within the new Education Academy.

12.4 The new requirements of MDECS, the need to improve our monitoring and evaluation of undergraduate education, the transfer of previous roles from the London Deanery to the Lead and Local Providers, and much else, also mandate that we improve our administrative and executive capabilities in both undergraduate and postgraduate education. We have therefore already appointed to a new administrative post, Manager, Psychiatric Education and Training, jointly funded by IOP and SLAM, covering both undergraduate and postgraduate education.

12.5 In Figure 3 we propose an outline new structure.

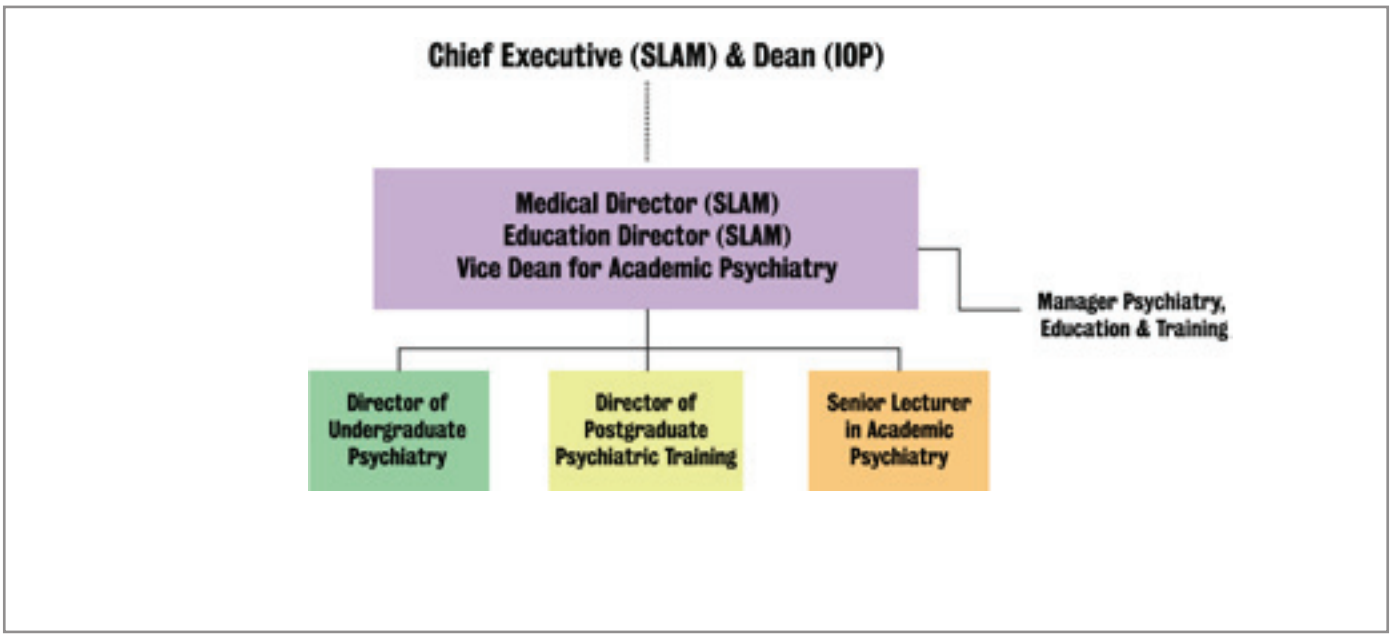

Figure 3a. High Level Structure

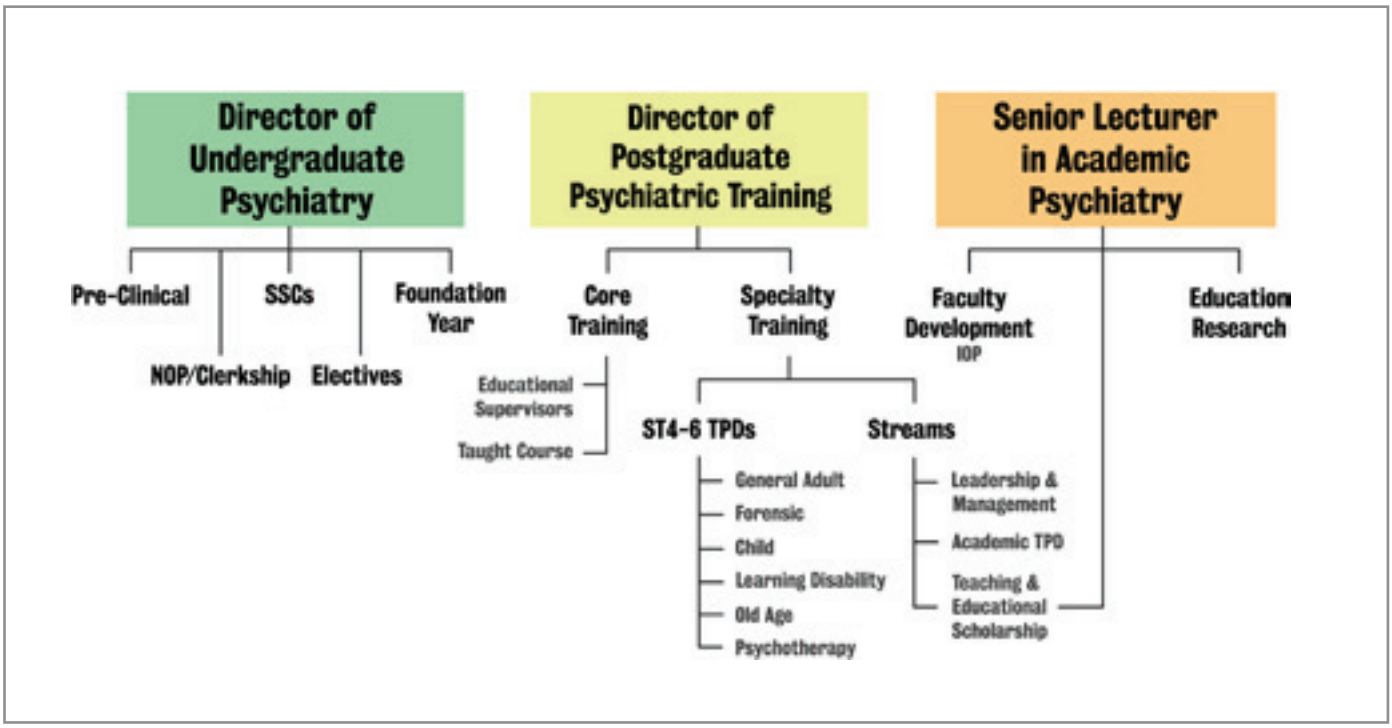

Figure 3b. Undergraduate & Postgraduate Level Structures

13. Performance Indicators

13.1 Assessing success in education is as complex as assessing success in research. But we need to devote attention to this, both as a means of monitoring our own progress, and because others will do so anyway.

13.2 In undergraduate education we need to both monitor accurately, and to increase, the number of hours of undergraduate teaching by IOP staff as monitored by TRAC. We should also monitor the division of labour, to ensure that the burden of teaching is more equitably distributed across the departments than is currently the case (and at the same time ensure that resource allocation reflects this workload, which is not currently the case).

13.3 A core outcome measure will be the proportion of our undergraduates choosing psychiatry at CT1. It is currently at the national average. We should aim to be at least in the "top three."

13.4 The core metric for postgraduate medical education is the PMETB annual survey. Our results have been disappointing, partly reflecting our size. Improving these outcome measures, such as availability of supervision, is a priority.

13.5 We will also commence monitoring our MRCPsych pass rates.

14. Next Steps

14.1 This document outlines an ambitious programme. However, we believe that the nature of the Maudsley Training Programme is to be ambitious. As what is indisputably the largest training scheme in the UK and probably elsewhere, it is incumbent on us to lead, experiment and innovate. This document outlines our general strategy to achieve this.

14.2 Various factors mean that we are already starting to implement some of these changes. The MDECS commissioning process has been a stimulus for us to reflect on our performance, and think about how we can build on our many strengths and address some of our weaknesses. Likewise, NIHR is mandating new systems of support for our academic trainees, to which we have needed to respond immediately. So we are already developing and now running new courses (for example for academic trainees across KHP), appointing to new posts (Manager, Psychiatric Education and Training, Senior Lecturer in Academic Psychiatry and Faculty Development, and Director of Postgraduate Psychiatric Training), and new programmes (for example in Medical Education and in Faculty Development).

14.3 The next stage is to ensure that our trainees, trainers, faculty and senior personnel come to share our vision, since without that support across IOP and SLAM, this will all be rhetoric. A previous draft of this document has therefore been circulated to all medical students, psychiatry trainees, consultant supervisors, and staff at the IOP as well as senior colleagues within KHP and all have been invited to comment and this has been supplemented by a series of presentations to disseminate the key ideas to relevant stakeholders. Many people took the time to share their views and make suggestions and we want to thank everyone who has taken part. This final policy document reflects these comments, as well as progress in the interim, and should be viewed as the definitive road map of the way forward for Academic Psychiatry.

14.4 At the same time we are developing a new management structure. Key elements of this include a far greater co ordination of undergraduate and postgraduate activities than previously, an increased role for professional management and clearer lines of accountability for delivery.

Dr Amy Iversen
Senior Lecturer in Academic Psychiatry

Dr John Moriarty
Director of Postgraduate Psychiatric Training

Denise Phillips
Manager, Psychiatry Education & Training

Professor Simon Wessely
Vice Dean, Academic Psychiatry, Teaching & Training

February 2011

Appendix I. Recommendations

Undergraduate Education

◊ Shift towards teaching settings that are more aligned to undergraduate curriculum and offer better student experiences. Better student experiences means either more relevant to the student who is unlikely ever to contemplate a career in psychiatry (the majority) or more likely to attract the minority who might contemplate such a career.

◊ Extra opportunities for students potentially attracted to psychiatry (double research SSC, student psychotherapy scheme, Summer School).

◊ Confirm support for Psych Soc, and "Extreme Psychiatry."

◊ More incentives for NHS staff to reward teaching.

◊ Create new post of Director of Undergraduate Psychiatry.

Postgraduate Education

◊ Introduce specific general and specialist "streams" , each containing a pool of designated posts.

◊ More educational supervisors.

◊ New post of Director of Postgraduate Psychiatric Training, who will devote majority of paid sessions to postgraduate training.

◊ New senior administrative/managerial position, with responsibility for Undergraduate and Postgraduate medical education.

◊ Review of all posts, to match posts with new streams, and improve quality.

◊ Begin discussions on optimum size of rotation.

◊ Modernise MRCPsych teaching.

Academic Psychiatry

◊ Greater flexibility in year of entry to ACF grade.

◊ Taught course and Summer School.

◊ Explore MSc options.

◊ Robust outcome data and career tracking.

◊ Single mentor/educational supervisor for period of training.

◊ Greater use of ACLs in teaching ACFs.

◊ Academic Training Director.

Others

◊ Resource allocation to become effective so that resource follows activity.

◊ A review of promotion criteria, mirroring the Harvard model.

Appendix II

ACF: Academic Clinical Fellow

ACL: Academic Clinical Lecturer

AHSC: Academic Health Sciences Centre. The generic term for the new confederation that brings together what were known as university teaching hospitals and NHS trusts. The relevant AHSC for us is KHP. There are two other AHSCs in London (Imperial and UCL) – neither include the relevant mental health trusts, unlike KHP.

AMP: Allied Medical Professions

ARCP: Annual Review of Competence Progress

BRC: Biomedical Research Centre.

CEA: Clinical Excellence Awards. National scheme for doctors that financially rewards excellence in clinical work, research and teaching over and above what is expected as part of a person's job – colloquially known as "merit awards"

CPD: Continuous Professional Development

CT: Core trainee. Junior psychiatry trainee. Replaces the old SHO grade

DPPT: Director of Postgraduate Psychiatric Training

FY: Foundation Year.

GMC: General Medical Council

HEFC: Higher Education and Funding Council

HIEC: Health Innovation and Education Cluster

IOP: Institute of Psychiatry

JMEC: Joint Committee on Medical Education

KCH: King's College Hospital. The acute trust on the Denmark Hill site, part of KHP

KCL: King's College London - ie the university

KCLSoM King's College London School of Medicine

KHP: King's Health Partners AHSC

LDA: Learning and Development Agreement. This is the agreement between SLAM and the London Strategic Authority for the delivery of multi professional learning and education across SLAM .

LEP: Local Education Providers. Will deliver undergraduate and postgraduate teaching and training under the new commissioning structures starting in 2010.

MADEL: Postgraduate medical education funding

MDECS: Medical and Dental Education Commissioning System

MEE: Medical Education England – the new regulator for all medical education

MRCPsych – the obligatory qualification for all residents in psychiatry, run by the Royal College of Psychiatrists

NIHR: National Institute of Health Research

PGME: Postgraduate Medical Education.

PMETB: Postgraduate Medical Education and Training Board. The regulator for medical education. Due to be incorporated into the GMC and reappear as Medical Education England (MEE).

SIFT: Service Increment for Teaching (funds the NHS costs of teaching)

SLAM: South London and Maudsley NHS Foundation Trust (the NHS provider for mental health, incorporating the old "Maudsley").

SSC: Self Selected Component (student chosen attachments as part of undergraduate programme – used to be called SSMs)

ST: specialist trainee. Replaces the old SpR grade.

UCL: University College London.

VC: Virtual Campus

VLE: Virtual Learning Environment

WEC: Weston Education Centre

Appendix III

External review Thursday 18th – Friday 19th March 2010

Thank you very much for taking part in this external review. We value your support and hope that the information you supply will help to make a positive difference to the future of Postgraduate Training in Psychiatry.

We have listed some information about the visit below which we hope you will find of use.

Background

As you know, an external review of our post-gradate psychiatry training provision is planned for 18th-19thMarch 2010. This visit is the beginning of process of taking stock, and rethinking the way we provide psychiatric training here at SLAM/IOP from undergraduate through to Continuing professional development for consultants in the Trust. The visit is being coordinated by Professor Simon Wessely and his team, in his new role as Vice Dean for Academic Psychiatry. More widely, the impetus for change is varied and includes a change in senior management at the IOP with our new Dean, Shitij Kapur, the crisis in recruitment to psychiatry as a speciality, and a growing awareness both within SLAM and outside, that we can do better, as confirmed by the PMETB survey results which were published last year.

Who are the Visiting Team?

- Dr Ron Rieder (Vice Chair for Education from Mount Sinai School of Medicine and previously of Columbia University),
- Dr Jon Alpert (Director of Medical Student Education in Psychiatry for Harvard Medical School),
- Dr Denis Antoine (Chief Resident, Johns Hopkins Medical School),
- Dr Andy Brittlebank (Director of Medical Education at Northumberland Tyne and Wear Health Trust)
- Dr Lindsay Thompson (Director of Undergraduate Psychiatry, Edinburgh).

The panel have received a small honorarium to participate but are essentially taking part as they are all interested and experienced in the business of psychiatry education. Their task, with a brief from us about the key areas, will be to come and hear the experiences of trainee and trainers, visit the training sites, and then to formulate their response to our questions and suggest some best ways forward.

I have agreed to take part in one of the groups, what do I have to do?

All we ask is that you come along and contribute to the discussion. Each group will be chaired by one member of the panel who will guide the discussion, explore areas, invite comments and ask questions. It might help, especially if you are escorting one of guests, for you to spend five minutes jotting down the key points or issues you feel most strongly about, so that you feel you make the most of the experience, but thatbis up to you.

What times and where are the groups supposed to meet? Who is my escort?

All group meetings will take place on Thursday 18th March 2010. Please see table below for further information and also attached spreadsheet.

What if I want to say something negative?

That is fine. It is important that trainees are as honest as possible about what their experiences of training here are; we are not trying to impress or "showcase" the rotation, far from it. During the session there will be no-one else present from the Trust except for your peers and the panel member. It is important that trainees understand that this is not like a College review where the panel come to "make sure that SLAM are ticking all the boxes." In a way, it is the complete opposite, the panel are trying to work out which boxes are repeatedly not ticked, so that we can make thing better. The visitors are visiting your training site, so if you want to show them your physical work space (or lack of it), or you current inpatient list, then go ahead – that is why we are sending them out to the places you work, including the CMHTs. Overall, it would be helpful if you focus on problems at the system level, rather than individual problems which you may be experiencing or have experienced on a personal level with a specific trainer. Please try to keep your comments broad and useful and by all means talk about other posts you have been in on the rotation, or indeed if you are an SpR and did your SHO training elsewhere, there may be useful comparisons to draw.

What we are aiming for is an honest and constructive appraisal of your training experience, without sugaring the pill. If you have an idea, a suggestion, or solution, please suggest it to the visitor.

What if I can't show up on the day?

As this visit is high profile, and a huge amount of planning has gone into the composition of each group it willbe very tricky for us if the groups are incomplete so please make every effort to attend. If you cannot, please let me know as soon as possible via email and let me know your reason. We will follow up any unexplained no shows.

What's the point, nothing ever changes?

We take your point, but this time, things are going to change. However, before we can start shaking things up we need an up-to-date, accurate picture of the current state of the rotation, and an experienced appraisal, in order to produce a mandate for change. And to do that, we need your help.

I still have questions…

You can email me simon.wessely@kcl.ac.uk or my Lecturer, Dr Amy Iversen on amy.c.iversen@kcl.ac.uk

We hope you will enjoy taking part, and thanks again for your support.

Layout: bspoken.