Psychiatric Bulletin (1990), **14**, 338–342

Training matters

The approval of psychiatric training schemes in 1988

Professor A. C. P. SIMS, Dean, Royal College of Psychiatrists

Introduction

The objects and purposes of the constitution of the Royal College of Psychiatrists in 1971 included to "advance the science and practice of psychiatry" and "to promote study and research" (Supplemental Charter and Bye-Laws, 1989).

Appropriate training should result in better clinical practice and more stringent training requirements nationally will improve the quality of the mental health service in the United Kingdom and Ireland and in other places where the training standards of the Royal College of Psychiatrists pertain. This has been particularly important for training schemes remote from Universities.

Impetus for improving educational standards in the College has come in two main ways: the MRCPsych examination which assesses the individual trainee psychiatrist, and the approval of training for the MRCPsych examination which assesses the training schemes, hospitals and groups of consultants who are providing that training. These two processes work in parallel and improvements in training standards have resulted from their combined action.

The approval at registrar and senior house officer levels of training posts to enable the occupant to sit the MRCPsych examination is carried out by visiting teams of members of the College making a detailed assessment and inspection of the training facilities and the quality of training actually provided. The details of what is looked for in a scheme are contained in the Statement on Approval of General Professional Training for the MRCPsych (1989). The visiting team consists of three psychiatrists: the convenor, who arranges and goes on all the visits from that Division of the College; another consultant; and a trainee member who is usually a senior registrar. The team comes from one College Division and makes its visit to another Division. They are usually accompanied by a representative of the Royal College of General Practitioners who is particularly concerned with general professional training for general practice. After the visit the convenor, with the assistance of other members of the team, produces an agreed report which is considered by the Central Approval Panel. The reports are finally adjudicated by the Court of Electors which is the ultimate arbiter of standards in the College. From the agreed reports at the Court is produced the 'Review of Hospitals, Units and Training Schemes for General Professional Training in Psychiatry'. This is the short final report which is sent to the Clinical Tutor, the Regional Postgraduate Dean (or in Ireland, the Irish Psychiatric Training Committee), and the local Professor of Psychiatry, and where appropriate the Regional Adviser in general practice. It is intended for communication to all interested parties, including both the involved trainees and their consultant supervisors. The report contains a statement as to whether the training scheme is approved or not, the interval before the next visit of the team (normally between one and five years), mandatory requirements for future approval of the scheme, and recommendations for improving the quality of training.

The approval of psychiatric training schemes for registrars and senior house officers to be eligible to sit the MRCPsych examination is a form of professional audit: for audit to be effective, the information ascertained must be fed back. This obviously is the chief purpose in sending reports to the clinical tutors of training schemes. However, it seemed that to make widely available the standards that the Central Approval Panel and the Court of Electors were aiming for nationally could be a more effective method of disseminating information to a wider readership.

The aim of this article is to review all the reports on training schemes made by the Court of Electors in 1988, analysing the commonly demanded mandatory requirements and the most frequent recommendations, and from this to try and draw some conclusions as to what is currently looked for to establish a training scheme to be of high quality. The reports were deliberately drawn from a time before the document *Achieving a Balance – Plan for Action* was operative as it was thought that the implementation of this document would distort the reports, at least for a time.

Background

All the 49 reports dispatched from the College in 1988 are assessed. All approved posts are now within training schemes which vary in their number of posts

from three to about 50 posts. Solitary posts, not part of a training scheme, would not be approved, and on the whole very small schemes are only approved for a limited duration of training. Records for training schemes and their approval status are maintained at the College.

At the time of previous approval visits the interval to the next visit would have been stated. When this becomes due the convenor responsible for that visit is notified by the College. The convenor is appointed by the executive of that College Division in collaboration with the Dean and has a term of office of five years during which he would co-ordinate and go on all the visits from his Division. Visits are made to another Division in a different geographical area and the convenor works with another consultant and a senior registrar member of the team. Arrangements for the visit are made with the receiving tutor who is the training scheme organiser. The receiving health authority is responsible for the costs of the visit. Visits generally take between half and four days, depending upon the size and complexity of the scheme. The Statement of Approval is used as a yardstick to measure the quality of training available. This concentrates on the people involved in training, both trainers and trainees, the programmes, courses and arrangements for training, and the accommodation involved which includes both teaching accommodation such as libraries, lecture rooms etc, and also residential and office accommodation for junior staff.

Before the visit, the tutor is asked to prepare a detailed document on the training scheme and this is made available to the team. The convenor of the visiting team has this document and also all previous full reports with recommendations and other supporting papers. The team makes a detailed visit; they pool their individual findings during the visit, and they feed back their findings to the relevant people involved in the training scheme at the end of the visit. The convenor then writes a full report and circulates this to members of the team, and after incorporating their improvements the report is sent to the College for consideration at the Central Approval Panel, and thence to the Court of Electors. From the time of the visit to the tutor receiving the written report will take between six and ten months.

This final report is quite short with an introductory statement, the decision on status concerning approval and any limitation of approval. If there is limitation there will be a time limit for the permitted period of training given. Limitation is most commonly given because there is only a small range of sub-specialty experience available. The interval given before the next visit is due is determined to some extent by the degree of satisfaction of the visiting team, Central Approval Panel and Court of Electors with training standards. However, there are other reasons for recommending a more rapid revisit, such as the knowledge that substantial administrative changes are proposed for the scheme in the relatively near future.

In 1988, 49 reports were sent out by the College on training schemes that had been visited in all parts of the United Kingdom and in Ireland. These reports recorded the duration since last visit, the number of hospitals and units visited, the decision on approval status and any limitation, the interval until the next visit, a list of mandatory requirements and a further list of recommendations. The implication from mandatory requirements is that if they have not been fulfilled by the next visit then approval cannot be given. Recommendations for improvement to a training scheme are made either when the improvement is not seen as being quite so important as a mandatory requirement or when the improvement is not within the power of the training scheme and its consultants and cannot reasonably be demanded. For this reason the Central Approval Panel try to limit mandatory requirements as much as is consistent with achieving high standards.

Findings from approval visits

Duration since last visit (see Table I)

Most schemes (78%) had been visited between one year and five years before. Those that had never been visited before had not wished previously to have approved trainees; those with a very long duration since the last visit had been unapproved and were now seeking re-approval.

TABLE I
Duration since last visit

	No. of schemes
Never visited before	3
Visited less than 1 year before	3
Visited 1–2 years before	10
Visited 2–3 years before	9
Visited 3–4 years before	3
Visited 4–5 years before	16
Visited 5–6 years before	2
Visited 6–7 years before	1
Visited 9 years before	1
Visited 13 years before	1
Total	49

Forty-nine training schemes took place in 224 hospitals and units; that is a mean of $4\frac{1}{2}$ and a range from 1 to 14 units and hospitals per scheme.

https://doi.org/10.1192/pb.14.6.338 Published online by Cambridge University Press

Of the 49 schemes visited, 48 were approved and 1 not approved.

Limited approval was given to 17 schemes (35%): 3 schemes were limited to 6 months, 4 to 1 year, 1 to 18 months and 9 to 2 years of training.

Interval before next visit (see Table II)

Of 48 schemes approved, the interval before the next visit showed a mean of 2 years 3 months and a range from 1 to 4 years. Although 5 years interval could be granted, it was not in 1988.

TABLE II
Interval before next visit

Time interval	*No. of schemes*
0 (not approved)	1
1 year	12
1½ years	4
2 years	14
3 years	15
4 years	3
5 years	0
Total	49

Mandatory requirements and recommendations (see Table III)

In the 49 schemes visited, 197 mandatory requirements were made. This represents a mean of 4.0 requirements per training scheme with a range from 0 to 16 per scheme. There were 284 recommendations, with a mean of 5.8 per scheme and a range from 0 to 27.

It can readily be anticipated that the larger the size of the training scheme, that is the more hospitals and units that were included within it, the more mandatory requirements could be expected. In practice, there was a positive correlation coefficient between number of hospitals and units and mandatory requirements, $r=0.38$, $P<0.01$.

With various exceptions, the better the scheme is found to be by the visiting team, the longer the interval will be given until the next visit. However, the negative correlation coefficient between the number of mandatory requirements and interval to next visit was only $r=-0.20$, not significant.

As the size of the scheme was correlated with number of requirements, a correction was introduced for size when correlating requirements with interval. The negative correlation coefficient between interval to next visit and number of mandatory requirements divided by number of hospitals and units was $r=-0.40$, $P<0.01$, thus correcting for size of scheme there was a correlation between the interval given and the number of mandatory requirements.

It is quite difficult to categorise the somewhat idiosyncratic requirements and recommendations made for different training schemes. However, an attempt is made in Table IV in which the frequency of mandatory requirements are listed.

TABLE III
Mandatory requirements and recommendations

No. of requirements or recommendations	*No. of schemes in which that no. of mandatory requirements occurred*	*No. of schemes in which that no. of recommendations occurred*
0	3	4
1	3	4
2	8	2
3	14	3
4	4	5
5	8	9
6	4	2
7	0	9
8	1	2
9	2	2
10	0	2
11	0	3
13	0	1
14	1	0
16	1	0
27	0	1
Total	49	49

https://doi.org/10.1192/pb.14.6.338 Published online by Cambridge University Press

TABLE IV
Frequency with which individual mandatory requirements are requested

Availability of and full use of multi-disciplinary opportunities, i.e. structure of training, sufficient training in specific sub-specialties: 19
Induction of trainees, including introduction to Mental Health Act and supervision/training in ECT. Named consultant to supervise ECT: 19
Standard of case note recording and medical records: 18
Clinical supervision: 11
Day/half-day release for MRCPsych examination course or a recognised academic course: 11
Trainees' Committee and Training Committee with formal structure, responsibilities etc: 11
Office and domestic accommodation and secretarial help sub-standard: 9
More involvement in community work: 8
Assessment of trainees/training – feedback between consultant and trainee: 8
More funding for library/journals: 5
Formalised teaching programme: 5
Recognised case conferences and Journal Club (contact with peers): 4
Sufficient back-up/assistance regarding trainees' workload. i.e. use of clinical assistants, balanced workload: 4
Teaching of interview skills: 4
One consultant designated as principal tutor: 3
Improvement of special areas of experience to make them acceptable for recognition: 2
Attendance by consultants at teaching activities: 2
Educational opportunities to take priority over primary care needs: 2
Co-ordination of/and funding of study leave: 2
Job description/contracts for trainees: 2
Closer links with local university/other hospitals: 2
Limit of number of patients that trainee can be responsible for: 2
There were also 16 requirements which were only made once.

Frequency with which individual mandatory requirements are requested (see Table IV)

Mandatory requirements can be considered as communications from the approval team to an individual or group of people in the locality of the training scheme. In Table V the intended recipient of this message is listed. It is always ascertained that these requirements are possible locally before asking for implementation. Most often mandatory requirements are directed at the tutor or training consultants in the scheme (71% of requirements). Requirements are also made of the employing authority (19%) and the local academic department (8%).

TABLE V
Frequency of recipient of mandatory requirements

Directed to:	
Tutor and training committee	50
Tutor	40
Training consultants	29
Employing authority	31
Academic department	14
Other	3
Total	167

Frequency of recipient of mandatory requirements (see Table V)

Comment

Forty-nine schemes were visited in 1988 out of 171 training schemes in the United Kingdom and Ireland, 29% of all schemes visited in this one year. If that is the current rate of carrying out visits then the mean duration between visits is at present $3\frac{1}{2}$ years.

We do not at present have figures for the number of trainees in each scheme. However, we know that in all approved training schemes in the UK and Ireland there are at present 1030 registrars and 950 senior house officers; therefore, 29% would probably represent approximately 570 training posts approved in one year.

The mean duration since the last visit for all these schemes was 3.5 years while the recommended interval until the next visit was 2.1 years. The acceleration of visits is partly explained by delays in arranging visits and partly by the more recent introduction of using shorter interval to improve standards. In the past full approval automatically meant revisit in 5 years whereas now a sliding scale for the interval until the next visit is used for schemes which are fully approved.

The number of hospitals and units visited is partly related to the size of the scheme and the number of

https://doi.org/10.1192/pb.14.6.338 Published online by Cambridge University Press

trainees involved, but it also indicates the degree of dispersal of psychiatric facilities into the community. It is not surprising that the number of hospitals and units correlates positively with the number of mandatory requirements.

Of the 49 schemes, 48 were approved and one was not.

It is of interest to know if the interval until the next visit is being used as a form of quality control. Correlation between the interval until the next visit and the number of mandatory requirements divided by the number of hospitals and units would suggest that this is in fact taking place. However, many other factors are also involved, including imminent changes in the training scheme such as linking up with other schemes, changes in personnel such as the appointment of key new consultants, and changes in buildings such as the planned closure of an old mental hospital. Sometimes the organisers of the training scheme themselves may request a rapid return visit. New schemes or schemes that have previously been unapproved and now are requesting further approval will always require and receive a rapid return visit.

Mandatory requirements are mostly directed at the consultant psychiatrist including the tutor. The two key elements in training remain consultant supervision and an emphasis on practical clinical training. Clinical supervision by the consultant requires individual contact and teaching, discussion of in- and out-patients, ensuring a satisfactory level of case note recording and other ward activities. Practical training in the hospital or unit requires an induction course for new trainees, good training in and supervision of ECT and provision of training in interviewing, with case conferences and journal meetings.

The Approval mechanism was initially established by Professor Rawnsley, the first Dean of the College. Over the subsequent years it has made an important contribution to improving training standards in psychiatry, raising clinical standards in hospitals and hence improving the care of patients.

Acknowledgement

I would like to acknowledge the great help of Annette Harris in the preparation of this report.

References

DEPARTMENT OF HEALTH (1988) *Achieving a Balance*.
ROYAL COLLEGE OF PSYCHIATRISTS (1989) Approval of General Professional Training.
—— (1989) Supplemental Charter and Bye-laws.

Psychiatric Bulletin (1990), **14**, 342–345

Clinical tutors' survey 1988

Registrars and senior house officers in psychiatry

SURYA BHATE, Consultant in Adolescent Psychiatry, Sir Martin Roth Young People's Unit, Newcastle General Hospital, Newcastle upon Tyne NE4 6BE

The Government's proposals in the White Paper have given rise to exceptional controversy and concern not only among professional groups working in the NHS but also among the general public. It is therefore not surprising that the medical profession has somewhat lost sight of the significance of the radical proposals in the report issued in October 1987. The report *Hospital Medical Staff: Achieving*