working with the community
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Appendix 2: RANZCP BOE Governance Chart
Appendix 3: Proposed New Governance Structure
Appendix 4: BOE Regulations and By Laws
Appendix 5: BOE List of Committees
Appendix 6: CBFP Working Parties
Appendix 7: CBFP Project Management Plan
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Appendix 10: Review of College Proposal
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Appendix 17: Current Training Regulations - Basic
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Appendix 23: Scholarly Project Regulations
Appendix 24: Scholarly Project Marking Criteria
Appendix 25: Transition Plan and Documents
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Appendix 27: RANZCP Promotional Material
Appendix 28: The syllabus for learning for Stage 1, the Stage 1 curriculum blueprint and the syllabus for Stage 2.
Appendix 29: The information to be provided to Trainees on the CBFP (the training program handbook).
Appendix 30: WBA Materials and Examples
Appendix 31: Communication Plan
Appendix 32: List of Consultation Visits
Appendix 33: Remediation Flowchart
Appendix 34: Written Exam Feedback Letter(s)
Appendix 35: Case History Feedback Letter(s)
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Appendix 37: Osce Feedback Letter
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Appendix 39: CSIMGE Summary and Flowchart
Appendix 40: IMG Trainee Handbook
Appendix 41: RANZCP Submission to Commonwealth OTD Hearing
Appendix 42: Train-the-Trainer Resources – (Three files)
Appendix 43: Trajectory to Fellowship Congress Presentation
Appendix 44: Draft Feedback Form
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Appendix 75: Remediation Outline
Governance Structure Recommended by General Council

RANZCP Members

- Branches
- Faculties
- Sections
- TRC
- OTPRC

Members’ Advisory Council (MAC) x 26 Members
- Chair, Branch Committee x 8
- Chair, NZ National Committee
- Chair, Faculty Bi-national Committee x 3
- Chair, Section Bi-national Committee x 5
- Chair, Trainee Representative Committee
- Chair, Overseas Trained Psychiatrists Representative Committee
- Chair, Te Kaunihera
- Chair, Aboriginal and Torres Strait Islander Mental Health Committee
- Education Committee Representative
- Practice and Partnerships Committee Representative
- Governance, Nominations & Remuneration Committee Representative
- Finance, Audit & Risk Committee Representative
- Community Member Representative x 1

RANZCP Board

- Minimum of 7 Board Directors + 2 co-opted (optional) Board Directors
  - President, President Elect and x 5 Fellows

  4 of the 5 Fellows will respectively chair one of the committees of the RANZCP Board
  At least 1 Director will be from Australia and 1 from New Zealand
  The President Elect and other Board Directors will be elected by the MAC

SIGs
- Networks
- Publications Committee
- Awards Committee
- Appeals Committee

Administration/Management

CEO

Governance, Nominations & Remuneration Committee (GNRC)

Finance, Audit and Risk Committee

Education Committee (EC)

Practice and Partnerships Committee (PPC)

Primary College Membership Structures

Community
- Consumer, Carer, Maori and Aboriginal people
1. PURPOSE

The purpose of these By-laws is to provide structure for governance of the Fellowships Board (also to be known as "the Board of Education") and its sub-committees - in these By-laws referred to as "the Board".

2. RESPONSIBILITIES

2.1. Pursuant to the Constitution of the RANZCP the Board shall be responsible to General Council for:

2.1.1 Formulating and developing strategic education policy advice for General Council on all matters relating to Fellowship and the award of certificates of advanced training in those special areas of psychiatric practice as General Council may approve;

2.1.2 Liaising with the Secretariat in implementation and monitoring of such policy;

2.1.3 Overseeing all activities of the Board Committees and any other bodies established by the Board in terms of their respective composition, function, and budget;

2.1.4 Advising General Council regarding decisions taken about suitably qualified persons for admission as Fellows and advising General Council on the award of certificates related to training in special areas of psychiatry;

2.1.5 Identifying appropriate measures for assessment of specialist international qualified medical graduates and for determining requirements for further training, assessment, examination or exemption which may be appropriate to achieve Fellowship;

2.1.6 Formulating advisory policy, programs and procedures for continuing medical education for Fellows and fostering on-going participation therein; wider Congress involvement; and standards in continuing professional development activities;

2.1.7 Endorsing proposed education projects as may advance and strengthen outcomes for participants, to ensure delivery of quality standards and maintain cost effective budget compliance;

2.1.8 Providing advice to relevant external authorities and bodies on all matters relating to the regulation of training, assessment and examination required to achieve Fellowship and professional development in Australia and New Zealand, and establishing liaisons and alliances with those entities;

2.1.9 Ensuring that the several activities and responsibilities of the Board Committees are directed to ensuring a collaborative approach;

2.1.10 Maintaining links with other specialist medical colleges and in particular, continuing the dual fellowship training program and its requirements;

2.1.11 Establishing sub-committees and working parties to advise and assist in carrying out its responsibilities and functions from time to time;

2.1.12 Providing an appropriate level of delegated authority for the Fellowship Attainment Committee;

2.1.13 Instituting an appropriate level of monitoring of committee activities and outcomes to facilitate both quality and financial reporting at regular intervals.
3. **POWERS AND DELEGATION**

3.1. Subject to these By-laws and the Constitution of the College, the Board shall have and exercise the following power:

3.1.1 Determine requirements for admission to Fellowship;

3.1.2 Ratify the admission of eligible candidates to Fellowship subject to recommendation from the Fellowship Attainment Committee;

3.1.3 Assess specialist international medical graduates for admission to Fellowship and/or determine requirements for them to achieve Fellowship;

3.1.4 Monitor, assess and accredit all aspects of education functions and activities;

3.1.5 Monitor, assess and deal with progression of candidates in training (including examinations);

3.1.6 Consider and determine applicable exemptions;

3.1.7 Conduct and monitor CME activities and programs;

3.1.8 Consider, assess and monitor education projects;

3.1.9 Report as appropriate to and liaise with external bodies and authorities;

3.1.10 Such other decisions or determinations necessary or desirable to carry out its responsibilities in these By-laws.

3.2. In the exercise of these powers:

3.2.1 The Board shall observe any regulations or directions that may from time to time be set by the General Council.

3.2.2 The Board shall have the power to establish sub-committees and working parties to advise and assist in carrying out its responsibilities and functions, with such powers, procedures and purposes as the Board determines and the General Council approves.

3.2.3 The Board (and its Executive) may meet via teleconference and otherwise, as determined by the Chair, deliberate and decide on matters within the framework of prior policy decisions. The Executive of the Board will not consider matters requiring a change in policy or a full vote of the Board.

4. **STRUCTURE AND COMPOSITION**

4.1 The Board shall comprise:

(a) Chair, Board of Education

(b) Deputy Chair, Board of Education

(c) Deputy Chair, Board of Education

(d) Chair, Committee for Training

(e) Chair, Committee for Examinations

(f) Chair, Committee for Specialist International Medical Graduate Education

(g) Chair, Committee for Continuing Medical Education

(h) Chair, Committee for Education Projects

(i) Chair, Committee for External Liaison and Reporting

(j) Relevant Secretariat Directors responsible for Board of Education portfolios (non-voting)

(k) Representative, Registrar Representative Committee (non-voting)
4.2 The Chair and Deputy Chairs of the Board shall be elected or otherwise appointed by General Council from among the Fellows of the College and shall hold office from the conclusion of the Annual General Meeting next following for a term of 3 years. The Chair and Deputy Chairs of the Board must be willing to serve a minimum period of one year and shall be eligible for re-appointment to serve for a maximum of two consecutive terms.

4.3 The members of the Board are appointed as Ex-officio’s in their position as Chair of each of the six parent Committees which sit under the Board.

4.4 Voting Membership of the Board is restricted to Fellows of the College appointed pursuant to these by-laws.

4.5 The Chair shall be an ex officio member of each of the Board’s Committees and shall act as the official representative of those Committees with authority also to serve, either personally or through a nominee, on RANZCP working parties as may be required. The Chair will be a voting member of General Council.

4.6 The Board shall appoint one Deputy Chair to chair the Fellowship Attainment Committee and to assume responsibility for co-ordinating the functions of the:
- Committee for Training
- Committee for Examinations
- Committee for Specialist International Medical Graduate Education

and the other Deputy Chair shall be appointed to assume responsibility for co-ordinating the functions of the:
- Committee for Continuing Medical Education
- Committee for Education Projects
- Committee for External Liaison and Reporting.

4.7 In the event of the resignation of either the Chair of the Board or a Deputy Chair (or a consequent vacation of his or her position pursuant to this by-law) prior to having served a full term, the Executive Officers shall appoint an interim chair.

4.8 The term of office of ex officio members of the Board shall coincide with their term on their constituent committee. In no case shall any member serve a term longer than three years with a maximum of two consecutive terms.

4.9 In the absence of an ex officio member of the Board representing a committee, the Chair may co-opt a replacement for that member from the relevant committee.

4.10 The Chair may co-opt additional persons with particular specified knowledge/expertise, including Fellows of the College, consumers, carers and indigenous persons. Such co-options shall not exceed three in number. Co-opted members of the Committee will not have voting rights.

5. FELLOWSHIP ATTAINMENT COMMITTEE

5.1 The Fellowship Attainment Committee shall comprise:
- Deputy Chair, Board of Education
- Chair, Committee for Training
• Chair, Committee for Examinations
• Chair, Committee for Specialist International Medical Graduate Education
• Ex-officio-Chair, Board of Education
• Ex-officio-Deputy Chair, Board of Education
• Director Education (non-voting).

The Fellowship Attainment Committee will carry out the functions and, under delegated power from the Board which shall include that of appointing or electing the non Chair members of the Pre Fellowship Committees, make and determine the matters set out in clauses 3.1.1 to 3.1.6 inclusive of these By-laws, subject to ratification by the Board.

5.2 The Deputy Chair first referred to in clause 4.6 will Chair meetings of the Pre-Fellowship Committee. In the absence of the Deputy Chair, the Members of the Fellowship Attainment Committee shall appoint another of their number to chair meetings.

5.3 A quorum for meetings of the Fellowship Attainment Committee shall be one half of the members (excluding ex-officio members).

5.4 Decisions of the Fellowship Attainment Committee shall be determined by majority vote. In the case of an equality of votes, the Deputy Chair shall have a second or casting vote.

5.5 The Fellowship Attainment Committee may co-opt, either generally, or to deal with specific matters, other Fellows, including members of the committees of the Board.

5.6 Members of the Fellowship Attainment Committee must declare any conflicts of interest to the Chair of the meeting. Once a conflict of interest has been declared, the individual concerned may be excluded from the discussion and/or voting, at the discretion of the Chair of the meeting.

5.7 The Fellowship Attainment Committee shall report regularly to the Board, and particularly notify of all decisions or determinations made by the Committee.

5.8 Supervision of the day to day business of the Committee shall be the responsibility of an Executive comprising the Chair and Deputy Chair, to be responsible for carrying into effect the resolutions and directions of the Committee and to act on its behalf between meetings.

6. COMMITTEES

The following Committees shall be established and report to the Board, in accordance with by-laws approved by General Council and in accordance with the attached chart:

• Committee for Training;
• Committee for Examinations;
• Committee for Specialist International Medical Graduate Education;
  each of which shall also report to the Fellowship Attainment Committee
• Committee for Continuing Medical Education;
• Committee for Education Projects;
• Committee for External Liaison and Reporting.

7. OPERATION OF THE BOARD

7.1 The Board shall meet regularly as necessary to carry out its functions as determined by the Chair, and in any case shall meet at least twice per year face to face. Meetings of the Board may be in person, by telephone or other telecommunications or electronic means at the discretion of the Chair.

7.2 Meetings of the Board shall be chaired by the Chair. In the absence of the Chair, the most senior Deputy Chair of the Board will chair the meeting.

7.3 A quorum for meetings shall be one half of the members.

7.4 Decisions of the Board shall be determined by majority vote. In the case of an equality of votes, the Chair shall have a second or casting vote.
7.5 Members of the Board, Associates and co-opted persons, must declare any conflicts of interest to the Chair. Once a conflict of interest has been declared, the individual concerned may be excluded from the discussion and/or voting at the discretion of the Chair.

8. FINANCES

8.1 The Board is required to operate within its budgetary constraints as determined by General Council. Any spending above and beyond the allocated budget requires explicit authorisation by the Executive Officers of the College or General Council, as appropriate.

9. REPORTING RELATIONSHIPS

9.1 The Board shall report on its activities and the activities of its Committees to each meeting of General Council.

9.2 The Board shall be represented on the General Council by the Chair of the Board as an ex officio member of the General Council.

9.3 The Chair may appoint another member of the Board as substitute for any such meeting, who shall have the same rights and powers at that meeting as the Chair of the Board.

10. INTERPRETATION

10.1 For the purposes of these By-laws and the operation of the Board, and until the members of the College may amend the Constitution of the College, affecting the identity and operation of the Fellowships Board, the identity of the Board and its references made in these by-laws shall be read and construed as referring to the Fellowships Board, as if that Board was exercising the powers and responsibilities of the Board set out in these by-laws.

10.2 The by-laws shall be known as the “By-laws Relating to the Board of Education of the RANZCP”.

10.3 The General Council rescinds the “By-laws Relating to the Fellowships Board of the RANZCP” as amended from time to time.

10.4 Acts and decisions of the previous Fellowships Board or its committees and sub-committees, including the Joint Training Committee of the Dual Fellowship Training Program and the Committee for Exemptions, from time to time and not otherwise prescribed in by-laws, shall to the extent permitted by these by-laws, remain in force and effect and shall be read and applied with all necessary and consequent changes in terminology consistent with these by-laws as the context permits.

10.5 "Associate" means a person who is an Associate of the College.

10.6 "Member" of the College means Fellow, Honorary Fellow, Corresponding Fellow or Retired Fellow of the College, but does not include Associates of the College.

10.7 The term “Trainees” refers to all membership categories related to participation in RANZCP Training and Assessment activities and includes trainee, fellow in training and exemption candidate.

10.8 “College” or “RANZCP” means The Royal Australian and New Zealand College of Psychiatrists.

10.9 “Majority of vote” means that decisions are determined based on at least half the quorum votes plus one.

10.10 The term “Branch Training Committees” includes the New Zealand National Training Committee.
10.11 “Education activities and functions” means basic and advanced training and in-training assessment, examinations and assessment of trainees, fellows in training, specialist international medical graduates and continuing medical education.

10.12 The term “Examinations” includes, but is not limited to, assessments and examinations as defined in the RANZCP Training and Assessment Regulations.

10.13 These by-laws will commence with effect from 24 May 2008.

11. REVIEW

These by-laws shall be reviewed after one year from commencement.
13. GOVERNANCE STRUCTURE

BOARD OF EDUCATION

STRATEGY & POLICY

DECISION MAKING

FELLOWSHIP ATTAINMENT COMMITTEE

LIAISON & IMPLEMENTATION

COMMITTEE FOR TRAINING

COMMITTEE FOR EXAMINATIONS

COMMITTEE FOR SPECIALIST IMG EDUCATION

COMMITTEE FOR CONTINUING MEDICAL EDUCATION

COMMITTEE FOR EDUCATION PROJECTS

COMMITTEE FOR EXTERNAL LIAISON & REPORTING
# RANZCP Board of Education Committees

**Description and structure Correct as of March 2012**

<table>
<thead>
<tr>
<th>Committee/Board</th>
<th>Description</th>
<th>Membership</th>
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<tr>
<td><strong>Board of Education</strong></td>
<td>The Board of Education (BOE) was established in May 2007 and provides a sustainable governance structure for the College’s education program. The BOE brings together the education-related activities of the RANZCP and is responsible for formulating and developing strategic education policy for the College’s General Council. The BOE provides an integrated approach to all aspects of College education through overarching governance of existing committees dealing with training, assessments, exemptions and continuing medical education, along with newly established committees concerned with education projects and quality reporting.</td>
<td>Chair, Deputy Chair x 2, plus Chairs of all BOE committees, OTP, representative, TRC representative, community representative</td>
</tr>
<tr>
<td><strong>Fellowship Attainment Committee (FAC)</strong></td>
<td>The role of the BOE is complimented by the formation of the FAC, devised as a liaison body organisationally positioned between the committees dealing with pre-Fellowship matters on behalf of the BOE. The three committees under the collective oversight of FAC are: CFT CFE, and CSIGME. The FAC is chaired by one of the Deputy Chairs of the BOE and the Chairs of CFT, CFE and CSIGME are ex officio committee members. FAC is the intermediary support and decision making body between committees dealing with pre-Fellowship matters and the BOE. FAC replaced the operational role of the pre-existing Fellowship Board. As such, FAC provides oversight of all pre-Fellowship training and assessment matters and has responsibility for advising the BOE on candidates’ completion of requirements for Fellowship, dealing with reconsideration and remediation requests, and providing supportive information to the Appeals Committee as required.</td>
<td></td>
</tr>
<tr>
<td><strong>Committee for Training</strong></td>
<td>CFT regulates and coordinates the Basic and Advanced Psychiatry Training programs. It provides policy advice on training matters, ensures that the training experience received by the trainees is commensurate with the requirements outlined in the regulations and processes of the College, and is responsible for training activities including formative in-training assessments and trainee records. It monitors and conducts the accreditation of the College’s training programs.</td>
<td></td>
</tr>
<tr>
<td>Committee for Examinations</td>
<td>CFE is responsible for developing policy in relation to examinations. It conducts the assessments and examinations, including case history submissions, written and clinical examinations and is responsible for appointing examiners and assessing trainees’ eligibility to sit the exams.</td>
<td>Chair, Committee for Examinations Up to twenty-five members, Trainee representative, A Deputy Chair of the Board of Education (Chair FAC, ex officio), Chief Examinations coordinator (non member advisor to the Committee),</td>
</tr>
<tr>
<td>Committee for Specialist International Medical Graduate Education (CSIMGE)</td>
<td>The CSIMGE provides advice and recommendations on the training and assessment requirements of exemption candidates and endorses area of need positions and occupational visas. The remit of CSIGME also extends to include a broad range of educational needs of Overseas Trained Psychiatrists (OTPs) such as ECE preparation workshops, mentoring, IMG on-line orientation, support and infrastructure for OTPs, and reporting.</td>
<td>Chair, Committee for Specialist International Medical Graduate Education, A Deputy Chair of the Board of Education (Chair FAC, ex officio), 2 Representatives, Committee for Training, 2 Representatives, Committee for Examinations, 3 Members, one of whom is a Specialist International Medical Graduate.</td>
</tr>
<tr>
<td>Committee for Continuing Medical Education (CCME)</td>
<td>The CCME was moved from BOPS oversight on the establishment of the BOE; this realignment is consistent with the substantial educational role of this Committee. As such, the CCME is responsible for policy development around continuing medical education and professional development activities. It monitors participation in, and ensures availability of, continuing education activities. The committee also has an advisory role for annual congress, conferences and other educational events.</td>
<td>A Chair, Committee for Continuing Medical Education, A Deputy Chair of the BOE, At least one member nominated from each State and Territory of Australia and from New Zealand. Trainee representative, OTP representative</td>
</tr>
<tr>
<td>Committee for Educational Quality and Reporting (CEQR)</td>
<td>The CEQR, also a newly constituted committee, is responsible for strategic links with external entities and agencies; it undertakes quality system reviews and monitors and reports on processes across the education portfolio. CEQR is responsible for forming ad-hoc working groups to support its quality assurance activities</td>
<td>A Chair, Deputy chair, A Deputy Chair of the BOE, Trainee representative, OTP representative, CFT representative, CSIMGE representative, CFE representative, Community representative.</td>
</tr>
</tbody>
</table>
Committee for Education Projects (CFEP)  
This CFEP was established to facilitate the expansion of the College’s education activities by providing policy advice on education projects, evaluating project proposals and outcomes and overseeing projects such as the Expanded Training Settings Project (ESTP) and the CBFP (See appendix X for the regulations/by-laws).  
A Chair, Committee for Education Projects, A Deputy Chair of the BOE, Further members as determined by needs of Committee, Trainee representative, OTP representative, Community member

Board of Education Organisation Chart March 2012

- General Council
- Board of Education
  - Fellowship Attainment Committee
  - Committee for Educational Quality and Reporting
  - Committee for Educational Projects
  - Committee for Continuing Medical Education
  - Committee for Training
  - Committee for Exams
  - Committee for Specialist International Medical Graduates
    - Sub-committees and working groups
Introduction

This paper outlines the CBFP working parties involved in the development of the training program and the relevant assessments. A number of working parties have been finalised and no longer meet. Table 1 shows those that are still working and provides a short description of their focus.

Working Parties – Completed

- Project Management Group (PMG)
- WBAs (to precede Feasibility Studies)
- Stage 1 Syllabus Development Group
- Learning Outcomes
- Stage 1 Assessment (CBFP PMG Sub-Group)
- Program Pathway
- Education Content and Quality Group
- Training in CBFP (Now being completed by CFT and BOE Exec)

Working parties in progress

Table 1 CBFP working parties

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<th>Working party</th>
<th>Description</th>
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<td>Recognition of Prior Learning Remediation Processes</td>
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<tr>
<td>WBA Feasibility Studies</td>
<td>Produce and run the WBA feasibility study</td>
<td>Pania Whibley (secretariat), Michelle Orkin, M Cohen</td>
</tr>
<tr>
<td>Entrustable Professional Activities (EPAs)</td>
<td>Establish the EPAs for each stage of the CBFP</td>
<td>Bronwyn Evans (secretariat), Wayne de Beer, Kym Jenkins, Stephen Jurd, Martin Cohen, SAT Representatives</td>
</tr>
<tr>
<td>Scholarly Project</td>
<td>Establish the Scholarly Project including format, polices, and marking criteria.</td>
<td>Bronwen Evans (secretariat), Helen Slattery, Anne Buist, Matt Coleman, Roger Mulder, Judith Stone</td>
</tr>
<tr>
<td>Indigenous Competency Working Group (ATSIMHC)</td>
<td>Develop indigenous competencies.</td>
<td>Cathy Schapper (secretariat), David Hartman</td>
</tr>
<tr>
<td>Working Party</td>
<td>Tasks</td>
<td>Members</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
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</table>
| Psychotherapies Long Case                                         | Establish the Psychotherapy Long Case including format, polices, and marking criteria. | Kathleen Ryan  
Ms Ana Sokratov  
Ms Ivy Trevallion  
Jason Leo  
Marshall Watson  
Michelle Orkin (secretariat)  
Marina Vamos (Chair)  
Beth Kotze  
Kate Wood  
Jenny Randle  
Aletsa Stephan (NZ)  
Bronwen Evans (secretariat)  
Jonathon Adams  
Paul Cammell  
Terry Chong  
Kym Jenkins  
Joanna MacDonald  
Chris Ryan  
Helen Slattery  
Fran Varghese |
| Stage 2 and Stage 3 Syllabus                                      | Develop and refine the Stage 2 syllabus. Develop Stage 3 syllabus.     | Bronwen Evans (secretariat)  
Jonathon Adams  
Paul Cammell  
Terry Chong  
Kym Jenkins  
Joanna MacDonald  
Chris Ryan  
Helen Slattery  
Fran Varghese |
| Blueprinting/Assessment Working Party                             | Blueprint the assessments and training program to the CanMEDs Competencies for Stages 1,2 and 3. | Elaine Halley (Secretariat)  
Martin Cohen  
Wayne de Beer  
Kym Jenkins  
Stephen Jurd  
BOE exec and CFT  
Elaine Halley |
| FEC Accreditation (Consultation)                                  | Develop policies and procedures for FEC accreditation                  | CBFP team                                                              |

**Other collaborations and cross college linkages**

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<tr>
<th>Group</th>
<th>Description</th>
<th>Who</th>
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<tbody>
<tr>
<td>Social and Cultural Psychiatry interest group</td>
<td>Lease with interest group to develop relevant material for EPAs.</td>
<td>Michelle Orkin and Bronwyn Evans</td>
</tr>
<tr>
<td>Te Kaunihera</td>
<td>NZ Maori committee. Liaise with to develop cultural competencies material and EPAs.</td>
<td>Cathy Schapper and Bronwyn Evans</td>
</tr>
<tr>
<td>Sub-committees of Advanced training (SAT)</td>
<td>CBFP project members work with SAT for each specialty to assist in developing advanced certificate material including EPAs.</td>
<td>CBFP team</td>
</tr>
<tr>
<td>Rural Special Interest Group</td>
<td>Liaise and develop rural EPAs and support material.</td>
<td>CBFP team</td>
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The Royal Australian and New Zealand College of Psychiatrists

Project Management Plan

Competency-Based Fellowship Program

PROJECT

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<td>26 November 2010</td>
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Document compiled by:
Sharon Holloway
Education Developments Manager,
RANZCP

Document Approved for Issue:
Dr Nigel Prior, Chair CBFP Project
Management Group

___________________________
(Signature)

Document Approved for Issue:

___________________________
(Signature)
### Document Version History

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<td>Initial Draft</td>
<td>S Holloway</td>
<td>April 2010</td>
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<td>Revised draft from GC Submission paper information and two-day Training Program/Assessment Pathway Recommendations (July 2010)</td>
<td>S Holloway</td>
<td>July 2010</td>
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<td>0.3</td>
<td>Revised draft following PMG Meeting on 17th July</td>
<td>S Holloway</td>
<td>Aug 2010</td>
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<tr>
<td>1.0</td>
<td>Revised draft following PMG acceptance of Key Deliverables against timeframe</td>
<td>S Holloway</td>
<td>Aug 2010</td>
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<td>1.1</td>
<td>Review of PMP following GC resolution to extend timeline by one year</td>
<td>S Holloway</td>
<td>Oct 2010</td>
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<td>S Holloway</td>
<td>Nov 2010</td>
</tr>
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<td>2.0</td>
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### Document Review and Distribution List

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<tr>
<th>Name</th>
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<th>RANZCP Stakeholder Group</th>
<th>Role</th>
<th>Date Approved/Reviewed</th>
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<tr>
<td>Dr Nigel Prior</td>
<td>Chair, CBFP PMG</td>
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<tr>
<td>Dr Richard Astill</td>
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<tr>
<td>Prof Fiona Judd</td>
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<td>Dr Bill Kingswell</td>
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<tr>
<td></td>
<td>Chair, CFT</td>
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<td>Dr Wayne de Beer</td>
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<tr>
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<tr>
<td>Dr Ben Sketcher</td>
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<tr>
<td>Dr Brad Hayhow</td>
<td>Ex-officio Member CBFP PMP Chair, TRC</td>
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<tr>
<td>Dr Stephen Jurd</td>
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<tr>
<td>Dr Kym Jenkins</td>
<td>Ex-officio Member CBFP PMP Chair, FAC</td>
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<tr>
<td>Dr John Crawshaw</td>
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<tr>
<td>Prof Phil Boyce</td>
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<td>Dr Jimsie Cutbush</td>
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<td>A/Prof John Allan</td>
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<td>Andrew Peters</td>
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<tr>
<td>Ms Elaine Halley</td>
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<tr>
<td>Mr Shaun Bowden</td>
<td>Manager, Training &amp; CME</td>
<td>Head Office</td>
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<tr>
<td>TBA</td>
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<td>Dr Anne Ellison</td>
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<td>Dr Mirco Kabat</td>
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<tr>
<td>Name</td>
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<tr>
<td>Jon Cullum/Kirrily Johns</td>
<td>Manager, Membership Services</td>
<td>Head Office</td>
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<tr>
<td>Roger Linney</td>
<td>Manager, IT</td>
<td>Head Office</td>
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1 Purpose of this Document

This document provides a definitive scope, the aims, objectives and project planning for the Competency Based Fellowship Program (CBFP) encompassing a range of sub-projects. This document will provide for each of these CBFP sub projects

✓ project objectives;
✓ scope;
✓ deliverables for completion of sub projects

The CBFP will be described in the first part of this document and the sub-projects will be described as ‘Schedules’, attached to this document, as they are developed.

The objectives of this document are to:

- inform all internal and external stakeholders, CBFP Project Management Group, CBFP Education Content and Quality Group, respective Board of Education constituent Committees and its members, Working Parties about the overall project, the sub-projects, their respective deliverables and the intended approach to successfully manage it;
- assist in securing support, commitment, and agreement from the stakeholders of the respective Projects;
- provide a basis for completion of detailed work plans;
- facilitate clear assignment of roles and responsibilities; and
- define a baseline for measurement and control of the project deliverables against which each project will be signed off against

2 Associated Documents

- Dr C Spratt and Ms S. Dick. Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program (Submission to General Council 2009/3)
• DOHA Structural Reform of Training and Assessment Funding Agreement with the Royal Australian and New Zealand College of Psychiatrists, (Variation, March 2008)

• DOHA Structural Reform of Training and Assessment Funding Agreement with the Royal Australian and New Zealand College of Psychiatrists, (Agreement March 2007)

• Minimal Training Requirements (ratified by GC 2010/4)

• Assessment Program (ratified by GC 2010/4)

• Resolutions approved by BOE 2011/4 to inform Regulation, Policy and Procedures
3 Background

In 2007 the Department of Health and Ageing (DoHA) funded the RANZCP (the College) to undertake an extensive five-year curriculum improvement project as part of the federally-funded Structural Reform of Psychiatry Training Project. A variation to this agreement was signed in March 2008. The Competency-Based Fellowship Program Project (formerly ‘Curriculum Improvement Project’) is principally concerned with the redevelopment of the College’s five-year Fellowship training program underpinned by international best practice benchmarks in specialist medical education.

In August 2008, General Council approved the Board of Education’s submitted paper, ‘Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program’1. This proposal (the proposal) recommended a competency-based curriculum model, drawing on the strengths and broad international acceptance of the Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS as the best-evidence framework for the training of medical specialists.

The aims and objectives of the Competency Based Fellowship Program have been summarised from the proposal.

The development of the structure and content for training under the CBFP provides the foundation and boundaries from which subsequent project activity will be built.

A Project Management Plan was approved by the CBFP Project Management Group in August 2010 (version 1.0). In October 2010, General Council in an out-of-session vote, approved the following resolutions:

1. That General Council approves to extend the Competency Based Fellowship Program (CBFP) implementation date in New Zealand by 12 months from December 2011 to December 2012.

---

1 Dr C Spratt and Ms S. Dick. Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program
2. That General Council approves to extend the Competency Based Fellowship Program (CBFP) implementation date in Australia by 12 months from January 2012 to January 2013.

CBFP Recommendations for the Minimum Training Requirements and Summative Assessment Program were re-presented to the RANZCP Board of Education (5-6/11/10) for further ratification from General Council. General Council met on the 20th – 21st November 2010, where they:

- ratified the proposed minimum training requirements for Fellowship according to the Competency Based Fellowship Program
- ratified the proposed summative assessment program for Competency Based Fellowship Program

Subsequent to the above approval and resolutions, the Project Management Plan was reviewed by the CBFP Project Management Group (version 1.2) on the 13 December and approved for issue as version 2.0.

The Project Management Plan was updated (version 2.1) by S Holloway following her resignation from the College effective from beginning of December 2011. This update has not been approved as at 1st December 2011 and the incoming Project Manager may make changes and seek appropriate approvals.
3.1 Competency Based Fellowship Program Aims and Objectives

The primary objective of the redeveloped program is that it is informed by a more effective and efficient outcome-oriented framework than is currently the case and which better reflects the College’s commitment to continuous improvement as ‘fitness-for-purpose’ in its educational undertakings.

The College deems that postgraduate medical education must prepare specialist psychiatrists to be creative problem-solvers – critical thinkers capable of innovative practice and who are committed to accepted professional and societal standards of patient-centred care. The Fellowship curriculum must be informed by defensible educational approaches that promote self-regulation and responsibility for one’s own professional development across the lifetime of professional practice.

In order to define ‘competence’ to accommodate these principles, an holistic or qualitative approach to competence is required which better reflects the complexity of the contemporary professional practice of specialist psychiatrists rather than the behavioural approach to competence which is largely concerned with the aggregation of objectifiable skills, as technicist, simplistic and narrow.

This project will develop the competency based curriculum framework for the CBFP, including the structure of the overall program, defining the outcomes of training for gaining Fellowship of the RANZCP and identifying how these outcomes will be defensibly recognised and assessed.

The project will integrate the concept of ‘competent performance’ as the underpinning educational philosophy to guide the curriculum framework, wherein the training program will encourage the preparation of specialist psychiatrists who are creative problem-solvers and critical thinkers, capable of innovative practice and committed to accepted professional and societal standards of patient-centred care. The Fellowship curriculum will be informed by defensible educational approaches that promote self-regulation and responsibility for one’s own professional development across the lifetime of professional practice.
### 3.2 Objectives and Benefits

The CBFP project has the following agreed Objectives and Benefits:

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>An aligned curriculum developed with learning objectives, teaching and learning strategies and assessment requirements</td>
<td>Clarity for education stakeholders regarding the integration between learning content, methods and assessment</td>
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<tr>
<td>Integrate the concept of competent performance into the College’s educational philosophy</td>
<td>The college’s educational philosophy aligned against international best practice in specialist medical education</td>
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<tr>
<td>Integration of contemporary concepts of best practice in adult education into the training program</td>
<td>Promotion of the concepts of adult education, lifelong learning and self reflection in trainees and in the broader Fellowship</td>
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<tr>
<td>Competency-based educational framework, developed in line with international specialist medical education best practice</td>
<td>Educational framework benchmarked against international best practice in specialist medical education</td>
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<td>Clarity for education stakeholders regarding the integration between learning content, methods and assessment</td>
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<tr>
<td>Workplace Based Assessments align to and assess the development of competencies</td>
<td>Training progression is mapped against developmental trajectory and competencies are linked to performance as a medical professional</td>
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<tr>
<td>Training provision that better reflects the complexity of contemporary professional practice of specialist psychiatrists (medical expert; Holistic approach to competence allowing for the preparation of psychiatrists able to meet professional and societal expectations in all aspects (not only medical expertise) of</td>
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<tr>
<td>Objectives</td>
<td>Benefits</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>communicator; collaborator; manager; health advocate; scholar and professional)</td>
<td>psychiatric practice.</td>
</tr>
<tr>
<td>The provision of a broad range of clinical experience during training,</td>
<td>Demonstrable competencies in a range of clinical settings and psychiatric/medical modalities, with a broad patient demographic, recognising the fundamental importance of experiential learning</td>
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<tr>
<td>Streamlining training requirements to enable timely completion of the training program</td>
<td>Increased flexibility in training, through opportunities for recognition of prior learning and lateral entry</td>
</tr>
<tr>
<td>Address issues associated with competing demands for service provision and training requirements for trainees</td>
<td>Sustainable workforce planning, emphasising the importance of the workplace in preparing psychiatrists for socially responsive competent practice</td>
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### TABLE 1: Objectives

<table>
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<tr>
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<th>Education Benefits</th>
<th>Measurement</th>
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<td>Promotion of the concepts of adult education, lifelong learning and self reflection in trainees and in the broader Fellowship</td>
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<td>O5</td>
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<td>Workplace Based Assessments align to and assess the development of competencies</td>
<td>Training progression is mapped against developmental trajectory and competencies are linked to performance as a medical professional</td>
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<td>O6</td>
<td>BOE</td>
<td>Training provision that</td>
<td>Holistic approach to competence</td>
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### TABLE 1: Objectives

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<th>Education Benefits</th>
<th>Measurement</th>
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<td>The provision of a broad range of clinical experience during training,</td>
<td>Demonstrable competencies in a range of clinical settings and psychiatric/medical modalities, with a broad patient demographic, recognising the fundamental importance of experiential learning</td>
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<td>Sustainable workforce planning, emphasising the importance of the workplace in preparing psychiatrists for socially responsive competent practice</td>
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# 4 Key Milestones

Note: The following Key Milestones is an updated version of the current milestones and scheduled dates. This is derived from the latest (7th November 2011) monthly status report. These status reports are provided to the CBFP Project Management Group (monthly); the Board of Education Executive (monthly) and the Board of Education (quarterly).

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<th>Baseline Planned COMPLETION date</th>
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<tr>
<td>CBFP Minimum Training Requirements Approval</td>
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<td>Completed</td>
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<td>CBFP Assessment Summative Program Approval</td>
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<td>Completed</td>
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<td>Program structure (curriculum framework)</td>
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<td>Fellowship Competencies</td>
<td>Mar 2011</td>
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<tr>
<td>Competence Developmental Trajectory</td>
<td>20 Dec 2010</td>
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<td>Developmental Descriptors</td>
<td>Apr 2011</td>
<td>June 2012</td>
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<td>Developmental Descriptors sign-off by ECQG</td>
<td>6 Apr 2011</td>
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<tr>
<td>Developmental Descriptors (in principle) sign-off by BOE</td>
<td>12th Aug 2011</td>
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<tr>
<td>Review of Developmental Descriptors by CFE Exec and other stakeholders (via website)</td>
<td>10 October 2011</td>
<td>29 November 2011</td>
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<tr>
<td>Final Review and Amendments following Feasibility Study</td>
<td>31 March 2012</td>
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<td>Approval by BoE</td>
<td>June 2012</td>
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## Key Milestones

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<td>Working Group established</td>
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<td>Learning Outcomes review/signoff by ECQG</td>
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<td>Learning Outcomes review/sign off BOE</td>
<td>16th July 2011</td>
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<td>Readiness for Mapping Process</td>
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<td>Specific Learning Outcomes for Stages II and III by SATs</td>
<td>March 2012</td>
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<td><strong>CBFP Generalist Training Pathway (Program Pathway Working Party)</strong></td>
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<td>Stage I / II</td>
<td>Apr 2011</td>
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<td>Stage III Generalist Requirements (Program Pathway working party review)</td>
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<td>31st Oct 2011</td>
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<td>BOE Approval</td>
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<td><strong>Entrustable Professional Activities</strong></td>
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<td>June 2011</td>
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<td>EPAs Stage 1, 2</td>
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<td>EPAs Stage 3 Generalist</td>
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<td>August 2011</td>
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<td>EPAs SAT first iteration/development</td>
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<td>Stage 1 EPAs; Stage 2 EPAs approval by BOE</td>
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<tr>
<td>Stage 3 EPA development, approval by BOE</td>
<td>12 November 2011</td>
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## Key Milestones

### Phase I: Competency Based Fellowship Program

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<th>REVIEWED DUE DATE</th>
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<tr>
<td>Final review and amendments by reconvened EPA Working Party</td>
<td>January 2012</td>
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<td>Further iteration, development work by SATs on respective EPAs</td>
<td>February 2012</td>
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<tr>
<td>Final Approval (ECQG)</td>
<td>March 2012</td>
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<tr>
<td>Final Approval (BoE)</td>
<td>May 2012</td>
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### Workplace Based Assessment Tools

- WBA Tools sign-off (ECQG)                                            | 13 May 2011                      | Completed        |
- WBA Tools sign-off BoE to proceed to Feasibility Studies             | 16 July 2011                     | Completed        |

### Feasibility Studies: Workplace Based Assessment

- Working Party established                                           | 1 April 2011                     | Completed        |
- Working Party convened                                              | 13 May 2011                      | Completed        |
- Feedback from DOTs                                                   | 3 June 2011                      | Completed        |
- WBA Feasibility Study methodology & evaluation recommendations       | 8 July 2011                      | Completed        |
- Research tools finalised                                             | 29 July 2011                     | Completed        |
- BOE face-to-face introduction to feasibility study & consultation    | 28 July 2011                     | Completed        |
- Methodology & evaluation approval (BoE)                              | 12 Aug 2011                      | Completed        |
- DOT Survey complete – Survey Monkey                                 | 9 Sept 2011                      | Completed        |
<table>
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<th>Key Milestones</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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<tbody>
<tr>
<td><strong>Support resources determined and produced</strong></td>
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<td>- Webinars</td>
<td>31 Oct 2011</td>
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<td>- Other materials</td>
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<td><strong>Webinars</strong></td>
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<td>12 Dec 2011</td>
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<td>End week 16 rotation 1 2012</td>
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<tr>
<td><strong>Data input &amp; analysis</strong></td>
<td>9 June 2012</td>
<td>9 June 2012</td>
</tr>
<tr>
<td><strong>Final Feasibility Studies Report</strong></td>
<td>29 June 2012</td>
<td>29 June 2012</td>
</tr>
<tr>
<td><strong>CAP pilot – WBA Feasibility Study</strong></td>
<td>28th Feb 2012</td>
<td></td>
</tr>
<tr>
<td><strong>CAP WBA pilot design &amp; consent form finalised</strong></td>
<td>27 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>CAP WBA pilot Study takes place</strong></td>
<td>Rotation 2 2011 (from July/Aug 2011)</td>
<td>Oct/Nov 2011</td>
</tr>
<tr>
<td><strong>Focus groups undertaken</strong></td>
<td>Dec 2011 – Jan 2012</td>
<td>Dec 2011 – Jan 2012</td>
</tr>
<tr>
<td><strong>Data collected (Questionnaire, WBA monitoring form &amp; Focus Group questions)</strong></td>
<td>31 Jan 2012</td>
<td>31 Jan 2012</td>
</tr>
<tr>
<td><strong>Data analysis</strong></td>
<td>28 Feb 2012</td>
<td>28 Feb 2012</td>
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</table>
### Key Milestones

<table>
<thead>
<tr>
<th>Phase I Competency Based Fellowship Program</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report complete</td>
<td>28 Feb 2012</td>
<td>28 Feb 2012</td>
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</table>

#### Stage 1 Assessment of Knowledge

<table>
<thead>
<tr>
<th>Stage 1 Syllabus</th>
<th>June 2011</th>
<th>Completed</th>
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<table>
<thead>
<tr>
<th>Stage 2 Syllabus</th>
<th>TBC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration of requirements by BOE</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Establishment of Stage 2 Syllabus Working Party</td>
<td>June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage 2 syllabus working party convened</td>
<td>July/August 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage 2 syllabus scoping</td>
<td>July/August 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage 2 syllabus development (1&lt;sup&gt;st&lt;/sup&gt; Draft)</td>
<td>September 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage 2 syllabus stakeholder review</td>
<td>September 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Additional development requirements (as identified in review)</td>
<td>October 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Stage 2 syllabus review and sign off by ECQG</td>
<td>20 January 2012</td>
<td></td>
</tr>
<tr>
<td>Stage 2 syllabus sign off by BOE Exec</td>
<td>30 January 2012 (out-of-session)</td>
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#### Stage 1 Assessment removed from CBFP Project Management Plan

- August 2011 (GC meeting)

#### Accreditation of Formal Education Course providers

- TBC
<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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</thead>
<tbody>
<tr>
<td>Consultation with Formal Education Course providers on Stage 1 and 2 Syllabus</td>
<td>TBC</td>
<td></td>
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<tr>
<td>Scoping, Planning and Development</td>
<td>TBC</td>
<td></td>
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<tr>
<td>Further consultation with FEC providers</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Implementation by FEC Accreditation Committee</td>
<td>TBC</td>
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<tr>
<td><strong>Summative OCA (OCI) CFE Ownership – removed from CBFP Project Management Plan</strong></td>
<td>BOE August 2011 meeting</td>
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</tr>
<tr>
<td><strong>Psychotherapies Long Case Assessment</strong></td>
<td>To be confirmed</td>
<td></td>
</tr>
<tr>
<td>Psych. Long Case working party established</td>
<td>28 September 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Psych. Long Case working party convened</td>
<td>2 November 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Psychotherapies assessment scoping complete</td>
<td>2 November 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Psychotherapies assessment draft forms and protocols</td>
<td>15 November 2011</td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment draft forms and protocols review</td>
<td>22 November 2011</td>
<td></td>
</tr>
<tr>
<td>Additional development requirements (as identified in review)</td>
<td>12 December 2011</td>
<td></td>
</tr>
<tr>
<td>Key stakeholders review of Psychotherapies assessment</td>
<td>11 January 2012</td>
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## Key Milestones

### Phase I Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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</thead>
<tbody>
<tr>
<td>Psychotherapies assessment requirements approval (ECQG)</td>
<td>10 February 2012</td>
<td></td>
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</table>

**Scholarly Project**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch Project working party established</td>
<td>Sept 2011</td>
<td>1st December 2011</td>
</tr>
<tr>
<td>Sch Project working party convened</td>
<td>June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Finalise draft Scholarly Project requirements</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Consultation cycle of Scholarly Project draft</td>
<td>Sept 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Additional development requirements (as identified in review) for final draft</td>
<td>28 November 2011</td>
<td></td>
</tr>
<tr>
<td>Scholarly Project Approval (ECQG)</td>
<td>20 January 2012</td>
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### In Training Records – Tracking Trainee Progress

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document current processes</td>
<td>Aug 2011</td>
<td></td>
</tr>
<tr>
<td>Develop future processes</td>
<td>14 Jun 2011</td>
<td>Aug 2011</td>
</tr>
<tr>
<td>Review and develop Supervisor Forms (mid and end of year rotations) (first draft)</td>
<td>November 2011</td>
<td>December 2011</td>
</tr>
<tr>
<td>Wider review/consultation of proposed Supervisor Assessment Forms</td>
<td>24th September 2011</td>
<td></td>
</tr>
<tr>
<td>CBFP Assessment Blueprinting (Mapping)</td>
<td>February 2011</td>
<td></td>
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</table>

**CBFP Assessment**

**Blueprinting (Mapping)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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</thead>
<tbody>
<tr>
<td>CBFP Assessment Blueprinting (Mapping)</td>
<td>February 2011</td>
<td></td>
</tr>
<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Identify appropriate expertise (external) to undertake Blueprinting work (including contract negotiation)</td>
<td>30 November 2011</td>
<td></td>
</tr>
<tr>
<td>Mapping learning objectives/competencies against formative and summative assessments (Stages 1 – 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mapping Competencies against formative and summative assessments approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regulations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training and Assessment Regulations Scoping working party established</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Training and Assessment Regulations Scoping working party convened</td>
<td>1 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Restructure current regulations</td>
<td>June/July 2011</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>Gain endorsement of restructured current regulations by appropriate governance (GRC and GC)</td>
<td>Aug 2011</td>
<td>Nov 2011</td>
</tr>
<tr>
<td>Review current Regulations against change requirements of the CBFP (high level)</td>
<td>Sept 2011</td>
<td>December 2011</td>
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### Key Milestones

**Phase I  Competency Based Fellowship Program**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development Working Groups nominated/established (if required)</td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td>Develop draft new Regulations</td>
<td>TBC</td>
<td>January 2012</td>
</tr>
<tr>
<td>New Regulations Approval</td>
<td>2012 (TBC)</td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>Transition / Sunset clauses (proposal)</strong></td>
<td>September 2011</td>
<td></td>
</tr>
<tr>
<td>Convene Working Party to develop Transition policy, guidelines and processes</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Approval Transition policy, guidelines and processes</td>
<td>November 2011</td>
<td>January 2012</td>
</tr>
<tr>
<td><strong>Recognition of Prior Learning Policy</strong></td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td>RPL Working Party convened</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Review of first draft by key stakeholders and feedback received</td>
<td>January 2012</td>
<td></td>
</tr>
<tr>
<td>Approval RPL policy, guidelines and processes</td>
<td>November 2011</td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>Training and Assessment Policies</strong></td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td>Review current Training and Assessment Policies, Guidelines and Links</td>
<td>September 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Phase I Competency Based Fellowship Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop change requirements to Training and Assessment Policies/guidelines/links against outcomes of the CBFP (Draft)</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Remediation Processes</strong></td>
<td>February 2012</td>
<td></td>
</tr>
<tr>
<td>Review current Remediation processes</td>
<td>TBC</td>
<td>February 2012</td>
</tr>
<tr>
<td>Develop changes to Remediation processes against outcomes of the CBFP</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td><strong>Training Program</strong></td>
<td>Jun 2012</td>
<td></td>
</tr>
<tr>
<td>Training Model/Program Working Party convened</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Model/Program Scoped, Planned and Developed for Supervisors</td>
<td>7 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Model/Program Scoped, Planned and Developed for Trainees</td>
<td>24 Jan 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Planning for Train the trainers</td>
<td>3 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Planning for Supervisor training</td>
<td>24 Mar 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Planning for Trainee training</td>
<td>22 June 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Tender Selection Process for external provider to develop and deliver Train the Trainer Model</td>
<td>April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Successful tenderer Agreement signed</td>
<td>May 2011</td>
<td>Completed</td>
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### Key Milestones

#### Phase I: Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Resource Pack (Workplace-based assessment and feedback) developed and published</td>
<td>15 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Package developed by provider</td>
<td>30 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Support Resources developed</td>
<td>7 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Deliver 5 Facilitator Programs</td>
<td>30 Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Set up of TELL Centre Facility (online support)</td>
<td>7 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Roll-out Supervisor workshops by trained Trainers</td>
<td>July 2012</td>
<td></td>
</tr>
<tr>
<td>Roll-out Trainee workshops</td>
<td>Aug 2012 (TBC)</td>
<td></td>
</tr>
</tbody>
</table>

#### Implementation (Stages I and II)

**Stage I**

- **CBFP Resource Package**
  - TBC (2012)
  - Draft publishing of CBFP resource package complete: March 2012
  - CBFP resource package documentation review complete: April 2012
  - CBFP resource package approval (ECQG/PMG - BOE): May 2012

**Stage II**

- New Zealand Implementation: Dec 2012
- Australia Implementation: Jan 2013

**Post Go Live (Completion Dates)**

- TBC

**Post Implementation Review**

- TBC
<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase I  Competency Based Fellowship Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Milestones</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase II  ICT Systems and Support Development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish ICT Steering Committee for CBFP</td>
<td>10 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Convene ICT Steering Committee</td>
<td>June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Engagement of Project Manager</td>
<td>March 2011</td>
<td>Completed (part-time)</td>
</tr>
<tr>
<td>Project Management (Scope) Plan</td>
<td>May 2011</td>
<td>Aug/Sept 2011</td>
</tr>
<tr>
<td>Detailed Plan</td>
<td>Sept 2011</td>
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### 4.1 Associated Working Parties

<table>
<thead>
<tr>
<th>In-Scope No.</th>
<th>Name of Work Package</th>
<th>Working Party to be convened by</th>
<th>Work of Working Party to be completed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.5</td>
<td>Development of Learning Objectives</td>
<td>End Feb 2011</td>
<td>Apr 2011</td>
</tr>
<tr>
<td>4.1.6</td>
<td>Development of Workplace Based Assessment Tools</td>
<td>End Aug 2010</td>
<td>13 Apr 2011</td>
</tr>
<tr>
<td>4.1.7</td>
<td>Feasibility Studies – Workplace Based Assessments</td>
<td>7 Jun 2011</td>
<td></td>
</tr>
<tr>
<td>4.1.8</td>
<td>Feasibility Evaluation Report</td>
<td></td>
<td>Jul 2012</td>
</tr>
<tr>
<td>4.1.9</td>
<td>Development of Entrustable Professional Activities</td>
<td>6 Apr 2011</td>
<td>5 Aug 2011</td>
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<tr>
<td>4.1.10</td>
<td>Mapping Learning Objectives and Competencies against formative and summative assessments</td>
<td>7 Dec 2011</td>
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<tr>
<td>4.1.12</td>
<td>Develop (In house Records) processes and requirements for tracking trainee progress</td>
<td>1 Sept 2011</td>
<td>27 Oct 2011</td>
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<tr>
<td>4.1.13</td>
<td>Development of Assessment Program (Stage 1)</td>
<td>Feb 2011</td>
<td>July 2011</td>
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<tr>
<td></td>
<td>Syllabus</td>
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<td>FEC provider consultation</td>
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<td></td>
<td>Stage 1 Examination</td>
<td></td>
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<td>4.1.14</td>
<td>Stage 2 examination proposal:</td>
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<td></td>
<td>Potential Written Examination changes</td>
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<td>4.1.15</td>
<td>Stage 3 examination proposal:</td>
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<td>OCI changes</td>
<td></td>
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<td></td>
<td>Psychotherapy Long Case assessment changes</td>
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<td>4.1.18</td>
<td>Recognition of Prior Learning Policy</td>
<td>Mar 2011</td>
<td>Oct 2011</td>
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<tr>
<td>4.1.21</td>
<td>Training Model/Program</td>
<td>25 Oct 2010</td>
<td>Feb 2011</td>
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<td>5.1.13.1.1</td>
<td>Stage 2 Syllabus</td>
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<td>5.1.6</td>
<td>Scholarly Project</td>
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</tr>
<tr>
<td>In-Scope No.</td>
<td>Name of Work Package</td>
<td>Working Party to be convened by</td>
<td>Work of Working Party to be completed by</td>
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<td>-------------</td>
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<tr>
<td>5.1.9</td>
<td>EPA</td>
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</table>
5 Project Scope

The overall scope of the CBFP is described below. Schedules for the main components of work, will be attached to this Project Management Plan providing detail on scope, deliverables and timeline.

5.1 In-Scope

PHASE I:
5.1.1 Program structure (curriculum framework)
- Alignment of overall framework based on development work to date
- Gap analysis: development work to date/overall framework
- Recommendations from gap analysis

5.1.2 Development of Training Pathway
- Stages 1, 2 and 3 (formerly Basic and Advanced Training)
- Determine mandatory and non-mandatory rotations/areas of practice for each stage
- Determine length of rotations for each stage
- Determine Areas of Practice (formerly sub-specialities) for Stage 2 and Stage 3
- Determine Advanced Certificate areas for Stage 3
- Determine Progression Requirements

5.1.3 Development of Competence Developmental Trajectory
- Entry - Novice
- End of Stage 1 – Basic
- End of Stage 2 – Proficient
- End of Stage 3 – Advanced
5.1.4 Development of Fellowship Competencies against Developmental Trajectory

5.1.5 Development of learning objectives (specific competencies) for each stage of training against:
- Stage 1 – determined mandated rotations (basic core psychiatry)
- Stage 2 – determined mandated and elective Areas of Practice (consolidate core competencies)
- Stage 3 – determined elective Advanced Competencies (development of advanced competencies)
- Development of ‘Generalist’ requirements

5.1.6 Development of Workplace Based Assessment Tools
- Determine Workplace Based Assessment Tools for all stages
- Determine assessment criteria
- Finalise rating scales
- Develop rating anchors
- Develop assessment protocols
- Develop assessment outcomes learning plan

5.1.7 Undertake Feasibility Studies – Workplace Based Assessments
- Develop study methodologies
- Develop support resources for studies
- Train assessors
- Train participants

5.1.8 Feasibility Study Evaluation Report
- Develop study protocol
- Develop evaluation study points
- Develop evaluation study methods

5.1.9 Development of Entrustable Professional Activities
- Determine Entrustable Professional Activities requirements for all stages
- Develop specific Entrustable Professional Activities against rotations and competencies for Stage 1
- Develop specific Entrustable Professional Activities against areas of practice and competencies for Stage 2
- Develop specific Entrustable Professional Activities against Advanced Competencies for Stage 3

5.1.10 Mapping of Learning Objectives and Competencies against formative and summative assessments
- Stage 1
- Stage 2
- Stage 3

5.1.11 Develop Developmental Descriptors against Fellowship Competencies
- Stage 1
- Stage 2
- Stage 3

5.1.12 Develop processes and requirements for tracking trainee progress (In Training Records)
- Document current processes
- Develop future processes
- Review and develop Supervisor Forms (mid and end of year rotations)

5.1.13 Development of Assessment Program (summative)
  5.1.13.1 Stage 1 Assessment of Knowledge Requirements
    5.1.13.1.1 Syllabus
      - Scope, plan, develop and implement Syllabus for Stage 1
      - Scope, plan, develop and implement Syllabus for Stage 2 (outcome of development work for Stage 1 Syllabus)
      - Development of syllabus and other documentation requirements identified, developed and published
      - FEC provider consultation
      - Development of Accreditation process for Formal Education Courses against Syllabus

    5.1.13.1.2 Assessment (Examination proposal)
5.1.14 Stage 2 examination proposal
   ○ potential Written Examination changes

5.1.15 Stage 3 examination proposal
   ○ OCI changes
   ○ Psychotherapy Long Case assessment changes

5.1.16 Scholarly Project

5.1.17 Review current Training and Assessment Regulations
   ➢ Develop change requirements to Training and Assessment Regulations against the outcomes of the Competency-Based Fellowship Program
   ➢ Transition and Sunset Clauses

5.1.18 Develop policy for Recognition of Prior Learning
   ➢ Review current Retrospective Learning policy, guidelines and processes
   ➢ Develop Recognition of Prior Learning policy, guidelines and processes

5.1.19 Review current Training and Assessment Policies/Guidelines/Links
   ➢ Develop change requirements to Training and Assessment Policies against the outcomes of the Competency-Based Fellowship Program

5.1.20 Review and develop Remediation processes against outcomes of the Competency-Based Fellowship Program changes

5.1.21 Training in the CBFP

5.1.2.1 Stage 1: CBFP Preparation (Early Education)
   ○ Develop resources

5.1.2.2 Stage 2: Core CBFP Training Part I (Pre workshop preparation)
   ○ Develop resources
   Stage 3: Core CBFP Training Part II (Workshops)
   ○ Develop Workshop Modules
5.1.2.3 **Stage 4: Continual Professional Development**

- Develop Training Modules

**Phase II  ICT Systems and Support**

5.1.22 Develop, determine, and implement Information Technology/System Requirements

- Functional requirements
- Non-functional requirements
- Request for Tender process (if appropriate)
- Selection of IT system
- Negotiate Health Service/Jurisdictional firewall requirements
- Configuration of software application

- Full Testing of system
- Training of all end-users
- Identification of ongoing and sustainable IT support requirements

5.1.23 Information and Communication Technology Training for Training Directors, Supervisors and Trainees

- Training in (chosen) electronic software application

The following potential deliverables, **require approval** before scoping, planning, development and implementation

5.1.24 Development of Competency Credits
5.1.25 Diploma in Psychiatric Medicine

### 5.2 Out-of-Scope

5.2.1 SIMG Substantially Comparability (WBAs) Feasibility Study
5.2.2 Changes to Advanced Certificates
5.2.3 Establishment of RANZCP Academy for Supervisors
5.2.5 Accreditation Review of Training Programs and Training Posts
Assumptions

The following table (Table 2) describes the assumptions that have been made in scoping, development and planning for Supervisor Training only. All other assumptions are within the individual Schedules that accompany this Project Management Plan.

<table>
<thead>
<tr>
<th>Schedule #</th>
<th>Assumption</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>DOTs will have ownership of the training of Supervisors.</td>
<td>Culture change: The College needs to have a more prominent role in leading the culture change and to not rely on DOTs for this. Training should take place when Supervisors and Trainees have been educated on the CBFP. This process was considered a PR and marketing exercise which should use many different forms of communication to engage. Buy-in from the services: The focus should be on the gains for the health service: improved motivation from Trainees, harder working with increased productivity. Quality feedback will support the growth of the Trainee. The new CBFP is built into current daily routines.</td>
<td>Project activities involve DoTs and Supervisors at appropriate times. Communication Strategy and activities facilitate awareness of CBFP, reasons and drivers for change and outcomes.</td>
</tr>
<tr>
<td>R</td>
<td>Supervisors will continue with the current allocated supervisor time of 4 hours, of this time a minimum of 1 hour individual supervision time.</td>
<td>A reasonable assumption and approved the notion of maintaining the current time based component.</td>
<td>In collaboration with Health Services/Jurisdictions – all parties have an understanding of requirements of new changes.</td>
</tr>
<tr>
<td>R</td>
<td>Formative assessment (work-place based assessment) can be completed in the one hour of one-on-one supervision time.</td>
<td>The WBAs have been designed with this time in mind. All sites will be in a position to offer this. Providing structure and guidelines to supervision is a positive outcome for trainees and supervisors.</td>
<td>In collaboration with Health Services/Jurisdictions – all parties have an understanding of requirements of new changes. CBFP with a documented Framework is published. Training resources provide guidelines and tools.</td>
</tr>
<tr>
<td>R</td>
<td>Time will be required for DOTs and</td>
<td>Different groups will have different requirements;</td>
<td>In collaboration with Health Services/Jurisdictions – all</td>
</tr>
</tbody>
</table>
| R | Supervisors to complete training in the new CBFP - either out of hours or release time. | flexibility is required.  
- Many supervisors will want training within working hours  
- Private practice may require out of hours training  
- Online training options will provide more flexibility even though face-to-face should be a required component of training. | parties have an understanding of training requirements of new changes |
<p>| R | Health services will continue to release supervisors to attend training and other relevant professional development sessions. | Release time for training will need to be raised with health services, with supporting arguments that Trainees will have realistic assessment, will be more motivated and productive. Only a fraction of the workforce can be released at any one time. DOT workload needs to be considered. | In collaboration with Health Services/Jurisdictions – all parties have an understanding of training requirements of new changes |
| R | The anticipated initial training will be a one-day workshop. | Training must be focused and practical and this may be best achieved through a shorter workshop. DOTs do not want to be providing background information. The need for supervisors (and some Trainees) to receive background education/information prior to any training was again reiterated; suggestions included journals, newsletter updates, road show. | Planning and development of training in CBFP provide appropriate information and resources. Communication Strategy and activities facilitate awareness of CBFP, reasons and drivers for change and outcomes. |
| R | Accredited Supervisors can be trained in 5 new workplace based assessment tools to a level of competence, in one day. | One day was probably not sufficient but equally the suggestion was that this is not completed in the one day. Information can be sent in advance via DVD or alternative (similar to the examiner panel process). DOTs can make use of existing meetings, case conferences and Journal club sessions to share materials. There was a | Planning and development of training program (in conjunction with Health Services/DoTs/Supervisors) in CBFP considers the aspects raised – one model will not fit all. |</p>
<table>
<thead>
<tr>
<th>Request</th>
<th>Response</th>
<th>Acceptance</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training will be completed in the following order - DOTs, followed by Supervisors followed by Trainees.</td>
<td>Agreed, even though the training of Trainees could occur concurrently with Supervisors. ‘Trainee led’ is a major focus, so is an important part of the process. Receiving Feedback is a potential module for Trainees.</td>
<td>Planning and development of training program (in conjunction with Health Services/DoTs/Supervisors) in CBFP considers the aspects raised – one model will not fit all.</td>
<td></td>
</tr>
<tr>
<td>Training will not start until the CBFP program is fully developed. It must be assumed that the CBFP program will be complete according to the current timelines (16/09/11).</td>
<td>Generic ideas about the CBFP can begin before the final program is complete as could some modules such as 'providing negative feedback'.</td>
<td>Training will be staged and appropriate support resources available.</td>
<td></td>
</tr>
<tr>
<td>The train-the-trainer model is a suitable method to complete all training, i.e. the DOTs will train Supervisors.</td>
<td>For this to work the groundwork must be complete; it is not the work of the DOTs to gain buy-in. DOTs are part of the training, but not the key to the training. Other ‘educators’ could be considered to support the process. This would need to be carefully considered. The use of DOTs working across regions was supported.</td>
<td>Planning and development of training program (in conjunction with Health Services/DoTs/Supervisors) in CBFP considers the aspects raised – one model will not fit all.</td>
<td></td>
</tr>
<tr>
<td>Training of Trainees will be included in induction/orientation programs for Trainees.</td>
<td>Induction sessions are organised by DOTs or Services and vary by region. Each region will need to be considered independently. For example, SA is initiating an Orientation weekend and this could be an appropriate opportunity for training. Trainees receive a lot of information from the services at these meetings and any training may be lost. It was suggested that material is online and the Trainee involvement in their learning is clearly explained for sign up, with a declaration that material has been read. The interview panel could ask about familiarity with program. Online resources should be</td>
<td>Planning and development of training program (in conjunction with Health Services/DoTs/Supervisors) in CBFP considers the aspects raised – one model will not fit all.</td>
<td></td>
</tr>
</tbody>
</table>
### Project Management Plan

#### Competency Based Fellowship Program v2.1  November 2011

- **R** Trainees will have a more significant role in directing their learning such as organising WBAs, maintaining training records, etc.  
  - Documentation for tracking trainee progress must be concise.  
  - Full scoping, planning and development of this work will ensure a clear and concise understanding of requirements.

- **R** Training will occur face-to-face.  
  - A mixture of forums; face-to-face, online, DVD etc. but face-to-face was considered an essential part of the training model.  
  - Planning and development of training program (in conjunction with Health Services/DoTs/Supervisors) in CBFP considers the aspects raised – one model will not fit all.

- **R** Completion of training in the CBFP requirements will result in 'accreditation' as a Supervisor.  
  - Agreed.  
  - This will also include DOATs, even though their training is most likely to occur in 2016.  
  - Engage with the appropriate Board of Education Committees for operationalisation

- **R** Some form of professional development will need to be demonstrated annually to maintain accreditation.  
  - How do supervisors maintain accreditation? Possible use of the CPD program, with some form of compulsory requirement.  
  - Engage with the appropriate Board of Education Committees for operationalisation

- **R** Supervisors have experience in providing formative feedback.  
  - No – many will require additional training.  
  - 10/27/2010 To be included as a Module in the CBFP Training Program

- **R** A cultural change is required to the Supervisors approach to supervision, in particular around the formalisation of supervision and undertaking assessment tasks.  
  - Agreed  
  - To be investigated further on appropriate training and resources

- **R** The College will provide resources such as training resources and professional staff to run training but will not cover costs to attend training.  
  - Agreed  
  - In collaboration with Health Services/Jurisdictions – all parties have an understanding of expected financial contribution

- **R** The current supervisor training resource (Felicity Plunkett's CD-ROM) can be modified and used as a resource for the CBFP training.  
  - Agreed, even though it was recognised that significant changes will be required.  
  - Within Module development

- **R** Feedback, comments and recommendations  
  - DOTs need to be included within this process.  
  - Established and will be continued
<table>
<thead>
<tr>
<th>R</th>
<th>from this working group will be sent to CFT and be managed by the CBFP project management group.</th>
<th>Continued communication with DOTs is required prior to face-to-face meetings and during teleconferences.</th>
<th>Specific project personnel appointed to develop the full requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>There will be no IT system in place at the start of implementation.</td>
<td>This system will not work unless the IT system is in place.</td>
<td>Informal mentoring is a frequent occurrence during supervision. Many supervisors see their role as a mentor. Careful consideration should be given to the way to handle this in group development work/training. There is a risk that supervisors will not continue this responsibility if required to ‘assess’.</td>
</tr>
</tbody>
</table>
Dependencies

The following table (Table 3) describes the dependencies currently identified. Dependencies are described in the Schedules that accompany this Project Management Plan.

6 CBFP Phases and Deliverables
The project is divided into two phases. Phase I is the Competency Based Fellowship Program and Phase II is the ICT systems and support required. Each phase has stages and has formal sign off of check points. Entry into a new stage is determined by satisfactory completion of the deliverables and sign off of the previous stage.

6.1 Planning Stage

The CBFP and the respective sub-projects will have a scoping, planning and development phase.

6.2 Implementation Stage

The CBFP will have an implementation phase, with identified key product deliverables and milestones. The implementation phase also has two stages. Stage I includes final approvals and completion of all training requirements. Stage II is described as ‘Go Live’.

In this stage, there will be under the guidance and support of the Project and in collaboration with the Operations to transition into operation level. There will be ongoing monitoring and review during this stage.

6.3 Closing Stage

The CBFP in its closing phase will have the following deliverables:

- All Product Documentation Revised
- Handover to Operations (where applicable)
- Post Implementation Review

6.4 Deliverables

The deliverables for the CBFP are listed in the tables below.
- Process-related Deliverables – ie documentation associated with the framework and processes of project management

- Product-related Deliverables – ie documentation which represents the products and outputs of the project

<table>
<thead>
<tr>
<th>PROCESS-RELATED DELIVERABLES: Phase I and II</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Plan v2.1</td>
<td>1\textsuperscript{st} Dec 2011</td>
<td>EDM</td>
</tr>
<tr>
<td>Detailed Project Plan (including subsidiary plans)</td>
<td>13 Dec 2010</td>
<td>EDM</td>
</tr>
<tr>
<td>CBFP Project Management Group; CBFP Education Content and Quality Group, all Working Parties Agendas, Reports &amp; Minutes</td>
<td>As identified</td>
<td>Project Team</td>
</tr>
<tr>
<td>Project Team Agendas and Action Items</td>
<td>Weekly and as required</td>
<td>Project Team</td>
</tr>
<tr>
<td>Project Status Reports</td>
<td>Monthly</td>
<td>EDM;Project Team</td>
</tr>
<tr>
<td>Risk &amp; Issues Register</td>
<td>Weekly (Project Team) Monthly (PMG)</td>
<td>Project Team; EDM</td>
</tr>
<tr>
<td>Change Request Register</td>
<td>Monthly</td>
<td>EDM</td>
</tr>
<tr>
<td>Communication Plan</td>
<td>17 July 2010</td>
<td>EDM;Project Team</td>
</tr>
<tr>
<td>Phase I: CBFP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I: Development and Planning (PMP v2.0)</td>
<td>13 Dec 2010</td>
<td>EDM;Project Team</td>
</tr>
<tr>
<td>Stage II: Implementation</td>
<td>Dec 2012 (NZ) Jan 2013 (Aust)</td>
<td>EDM;Project Team</td>
</tr>
<tr>
<td>Stage III: Project Implementation Review</td>
<td>TBC</td>
<td>EDM;Project Team</td>
</tr>
</tbody>
</table>
## Phase II: CBFP ICT systems and support

| Stage I: Development and Planning | Mar 2011 | EDM; Project Team; IT |
| Stage II Implementation | | EDM; Project Team; IT |
| Stage III: Project Implementation Review | TBC | EDM; Project Team; IT |
| Project Objectives and Benefits Report | TBC | EDM; Project Team |

Note: Dates may change as a result of Detailed Project Plan

### Legend:

- **GC**: General Council
- **BOE**: Board of Education
- **DOE**: Director of Education
- **EDM**: Education Developments Manager
- **PT**: Project Team
- **PO**: Project Officer
- **CBFP PMG**: Competency Based Fellowship Program Project Management Group
- **PMG WP**: Project Management Group approved Working Party
- **CBFP ECQG**: Competency Based Fellowship Program Education Content and Quality Group
- **CFT**: Committee for Training
- **CFE**: Committee for Examinations
- **IT**: Information Technology
## Key Milestones

<table>
<thead>
<tr>
<th>Phase I Competency Based Fellowship Program</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CBFP Minimum Training Requirements Approval</strong></td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>CBFP Assessment Summative Program Approval</strong></td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Program structure (curriculum framework)</strong></td>
<td>20 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Fellowship Competencies</strong></td>
<td>Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Competence Developmental Trajectory</strong></td>
<td>20 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Developmental Descriptors</strong></td>
<td>Apr 2011</td>
<td>8 July 2011</td>
</tr>
<tr>
<td>Draft Developmental Descriptors</td>
<td>4 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Consultation and feedback</td>
<td>22 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Developmental Descriptors sign-off by ECQG</td>
<td>6 Apr 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Developmental Descriptors (in principle) sign-off by BOE</td>
<td>12th Aug 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Review of Developmental Descriptors by CFE Exec and other stakeholders (via website)</td>
<td>10 October 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>Apr 2011</td>
<td></td>
</tr>
<tr>
<td>Working Group established</td>
<td>3 Feb 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes Stage 1 complete</td>
<td>15 Feb 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes Stage 2 complete</td>
<td>18 Feb 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes Stage 3 complete</td>
<td>23 Feb 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Learning Outcomes Stage 3 (APAT) complete</td>
<td>May 2011</td>
<td>August 2011</td>
</tr>
<tr>
<td>Learning Outcomes Review by BOE</td>
<td>28 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes consultation/ review</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes review/signoff by ECQG</td>
<td>Aug 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Learning Outcomes review/sign off BOE</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Readiness for Mapping Process</td>
<td>Nov 2011</td>
<td></td>
</tr>
<tr>
<td>Specific Learning Outcomes for Stages II and III by SATs</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td><strong>CBFP Generalist Training Pathway (Program Pathway Working Party)</strong></td>
<td>Apr 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage I / II</td>
<td>Apr 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Stage III Generalist Requirements (Program Pathway working party review)</td>
<td>Apr 2011</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; Oct 2011</td>
</tr>
<tr>
<td>BOE Approval</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; November 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Entrustable Professional Activities</strong></td>
<td>May 2011</td>
<td>June 2011</td>
</tr>
<tr>
<td>EPAs Stage 1, 2 &amp; 3 (mandatory)</td>
<td>7 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>EPAs Stage 2 &amp; 3 Generalist (non-mandatory)</td>
<td>11 Mar 2011</td>
<td>August 2011</td>
</tr>
<tr>
<td>EPAs SAT first iteration/development</td>
<td>November 2011</td>
<td></td>
</tr>
</tbody>
</table>
### Key Milestones

#### Phase I: Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 EPAs; Stage 2 EPAs approval by BOE</td>
<td>12 November 2011</td>
<td></td>
</tr>
<tr>
<td>Stage 3 EPA development, approval by BOE</td>
<td>12 November 2011</td>
<td></td>
</tr>
<tr>
<td>Further iteration, development work by SATs on respective EPAs</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Workplace Based Assessment Tools</strong></td>
<td>13 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>WBA Tools sign-off (ECQG)</td>
<td>13 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>WBA Tools sign-off BOE to proceed to Feasibility Studies</td>
<td>16 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Feasibility Studies: Workplace Based Assessment</strong></td>
<td>29 June 2012</td>
<td></td>
</tr>
<tr>
<td>Working Party established</td>
<td>1 April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Working Party convened</td>
<td>13 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Feedback from DOTs</td>
<td>3 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>WBA Feasibility Study methodology &amp; evaluation recommendations</td>
<td>8 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Research tools finalised</td>
<td>29 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>BOE face-to-face introduction to feasibility study &amp; consultation</td>
<td>28 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Methodology &amp; evaluation approval (BOE)</td>
<td>12 Aug 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>DOT Survey complete – Survey Monkey</td>
<td>9 Sept 2011</td>
<td>Completed</td>
</tr>
</tbody>
</table>
### Key Milestones

**Phase I  Competency Based Fellowship Program**

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support resources determined and produced&lt;br&gt; - Webinars&lt;br&gt; - Other materials</td>
<td>31 Oct 2011</td>
<td>31 Oct 2011</td>
</tr>
<tr>
<td>Webinars</td>
<td>30 Nov 2011</td>
<td>12 Dec 2011</td>
</tr>
<tr>
<td>WBA Feasibility Studies&lt;br&gt; First part rotation 1 2012*</td>
<td>First part rotation 1 2012</td>
<td></td>
</tr>
<tr>
<td>Data collection deadline&lt;br&gt; End week 16 Rotation 1 2012*</td>
<td>End week 16 rotation 1 2012</td>
<td></td>
</tr>
<tr>
<td>Data input &amp; analysis&lt;br&gt; 9 June 2012</td>
<td>9 June 2012</td>
<td></td>
</tr>
<tr>
<td>Final Feasibility Studies Report&lt;br&gt; 29 June 2012</td>
<td>29 June 2012</td>
<td></td>
</tr>
<tr>
<td><strong>CAP pilot – WBA Feasibility Study</strong>&lt;br&gt; 28th Feb 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAP WBA pilot design &amp; consent form finalised&lt;br&gt; 27 June 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>CAP WBA pilot Study takes place&lt;br&gt; Rotation 2 2011 (from July/Aug 2011)&lt;br&gt; Oct/Nov 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research tools finalised (Questionnaire, WBA monitoring form &amp; Focus Group questions)&lt;br&gt; 31 Oct 2011</td>
<td>31 Oct 2011</td>
<td></td>
</tr>
<tr>
<td>Data collected (Questionnaire, WBA monitoring form &amp; Focus Group questions)&lt;br&gt; 31 Jan 2012</td>
<td>31 Jan 2012</td>
<td></td>
</tr>
<tr>
<td>Data analysis&lt;br&gt; 28 Feb 2012</td>
<td>28 Feb 2012</td>
<td></td>
</tr>
</tbody>
</table>
### Key Milestones

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Competency Based Fellowship Program</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 Assessment of Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage 1 Syllabus</strong></td>
<td>June 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td><strong>Stage II Syllabus</strong></td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consideration of requirements by BOE</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; May 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Establishment of Stage II Syllabus Working Party</td>
<td>June 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus working party convened</td>
<td>July/August 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus scoping</td>
<td>July/August 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus development (1&lt;sup&gt;st&lt;/sup&gt; Draft)</td>
<td>September 2011</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus stakeholder review</td>
<td>September 2011</td>
<td>October 2011</td>
<td></td>
</tr>
<tr>
<td>Additional development requirements (as identified in review)</td>
<td>October 2011</td>
<td>November 2011</td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus review and sign off by ECQG</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage II syllabus sign off by BOE Exec</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stage 1 Assessment removed from CBFP Project Management Plan** August 2011 (GC meeting)
<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase I Competency Based Fellowship Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST1 Assessment of Knowledge requirements / recommendations (PMG subgroup)</td>
<td>18 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>ST1 Assessment of Knowledge requirements recommendations endorsement by CBFP PMG</td>
<td>June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>ST1 Assessment of Knowledge recommendations review and sign off BOE</td>
<td>July 2011</td>
<td>11 August 2011</td>
</tr>
<tr>
<td>ST1 Assessment of Knowledge requirements removed – approved by GC approval</td>
<td>Aug 2011</td>
<td>August 2011</td>
</tr>
<tr>
<td><strong>Accreditation of Formal Education Course providers</strong></td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Consultation with Formal Education Course providers on Stage 1 and 2 Syllabus</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Scoping, Planning and Development</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Further consultation with FEC providers</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Implementation by FEC Accreditation Committee</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td><strong>Summative OCA (OCI) CFE Ownership – removed from CBFP Project Management Plan</strong></td>
<td>BOE August 2011 meeting</td>
<td></td>
</tr>
</tbody>
</table>
## Key Milestones

### Phase I Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Psychotherapies Long Case Assessment</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych. Long Case working party established</td>
<td>28 September 2011</td>
<td></td>
</tr>
<tr>
<td>Psych. Long Case working party convened</td>
<td>2 November 2011</td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment scoping complete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment draft forms and protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment draft forms and protocols review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional development requirements (as identified in review)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key stakeholders review of Psychotherapies assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapies assessment requirements approval (ECQG)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scholarly Project</th>
<th>Sept 2011</th>
<th>1st December 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sch Project working party established</td>
<td>June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Sch Project working party convened</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Finalise Scholarly Project requirements</td>
<td>July 2011</td>
<td>21 Sept 2011</td>
</tr>
</tbody>
</table>
## Key Milestones
### Phase I  Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation cycle of Scholarly Project draft</td>
<td>Sept 2011</td>
<td>October 2011</td>
</tr>
<tr>
<td>Scholarly Project Approval (ECQG)</td>
<td>TBC</td>
<td></td>
</tr>
</tbody>
</table>

### In Training Records – Tracking Trainee Progress

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop future processes</td>
<td>November 2011</td>
<td></td>
</tr>
<tr>
<td>Review and develop Supervisor Forms (mid and end of year rotations) (first draft)</td>
<td>24th September 2011</td>
<td></td>
</tr>
<tr>
<td>Wider review/consultation of proposed Supervisor Assessment Forms</td>
<td>November 2011</td>
<td></td>
</tr>
</tbody>
</table>

### CBFP Assessment  
**Blueprinting (Mapping)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify appropriate expertise (external) to undertake Blueprinting work (including contract negotiation)</td>
<td>30 November 2011</td>
<td></td>
</tr>
<tr>
<td>Mapping learning objectives/competencies against formative and summative assessments (Stages 1 – 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mapping Competencies against formative and summative assessments approval</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Draft Curriculum Framework Package

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 Oct 2011</td>
<td></td>
</tr>
</tbody>
</table>
### Key Milestones

#### Phase I  Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Team consolidation of Curriculum Framework components</td>
<td>October/November 2011</td>
<td></td>
</tr>
<tr>
<td>Draft Curriculum framework expert advisor review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional development requirements (as identified in review)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Curriculum framework stakeholder review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Curriculum framework recommendations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Regulations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and Assessment Regulations Scoping working party established</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Training and Assessment Regulations Scoping working party convened</td>
<td>1 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Restructure current regulations</td>
<td>June/July 2011</td>
<td>Oct 2011</td>
</tr>
<tr>
<td>Gain endorsement of restructured current regulations by appropriate governance</td>
<td>Aug 2011</td>
<td>?Status to be confirmed</td>
</tr>
<tr>
<td>Review current Regulations against change requirements of the CBFP (high level)</td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Development Working Groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nominated/established (if required)</td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Develop draft new Regulations</strong></td>
<td></td>
<td>TBC</td>
</tr>
<tr>
<td><strong>New Regulations Approval</strong></td>
<td>2012 (TBC)</td>
<td></td>
</tr>
<tr>
<td><strong>Transition / Sunset clauses (proposal)</strong></td>
<td>September 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Convene Working Party to develop Transition policy, guidelines and processes</strong></td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Approval Transition policy, guidelines and processes</strong></td>
<td>November 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Recognition of Prior Learning Policy</strong></td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td><strong>RPL Working Party convened</strong></td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Approval RPL policy, guidelines and processes</strong></td>
<td>November 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Training and Assessment Policies</strong></td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Review current Training and Assessment Policies, Guidelines and Links</strong></td>
<td>September 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Develop change requirements to Training and Assessment Policies/guidelines/links against outcomes of the CBF (Draft)</strong></td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Remediation Processes</strong></td>
<td>To be confirmed</td>
<td></td>
</tr>
<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Review current Remediation processes</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Develop changes to Remediation processes against outcomes of the CBFP</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td><strong>Training Program</strong></td>
<td>Jun 2012</td>
<td></td>
</tr>
<tr>
<td>Training Model/Program Working Party convened</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Model/Program Scoped, Planned and Developed for Supervisors</td>
<td>7 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Model/Program Scoped, Planned and Developed for Trainees</td>
<td>24 Jan 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Planning for Train the trainers</td>
<td>3 Mar 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Planning for Supervisor training</td>
<td>24 Mar 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Planning for Trainee training</td>
<td>22 June 2011</td>
<td>November 2011</td>
</tr>
<tr>
<td>Tender Selection Process for external provider to develop and deliver Train the Trainer Model</td>
<td>April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Successful tenderer Agreement signed</td>
<td>May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Information Resource Pack (Workplace-based assessment and feedback) developed and published</td>
<td>15 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Training Package developed by provider</td>
<td>30 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Support Resources developed</td>
<td>7 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Deliver 5 Facilitator Programs</td>
<td>30 Nov 2011</td>
<td></td>
</tr>
</tbody>
</table>
### Key Milestones

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Competency Based Fellowship Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up of TELL Centre Facility (online support)</td>
<td>7 July 2011</td>
</tr>
<tr>
<td>Roll-out Supervisor workshops by trained Trainers</td>
<td>July 2012</td>
</tr>
<tr>
<td>Roll-out Trainee workshops</td>
<td>Aug 2012 (TBC)</td>
</tr>
</tbody>
</table>

### Implementation (Stages I and II)

<table>
<thead>
<tr>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBC (2012)</td>
<td>TBC</td>
</tr>
</tbody>
</table>

#### Stage I

**CBFP Curriculum Framework**

<table>
<thead>
<tr>
<th>Curriculum Framework documentation complete</th>
<th>TBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft publishing of Curriculum Framework documentation complete</td>
<td></td>
</tr>
<tr>
<td>Curriculum Framework documentation review complete</td>
<td></td>
</tr>
<tr>
<td>Curriculum Framework documentation approval (ECQG/PMG - BOE)</td>
<td></td>
</tr>
</tbody>
</table>

#### Stage II

- New Zealand Implementation: Dec 2012
- Australia Implementation: Jan 2013

### Post Go Live (Completion Dates)

<table>
<thead>
<tr>
<th>TBC</th>
</tr>
</thead>
</table>

### Post Implementation Review

<table>
<thead>
<tr>
<th>TBC</th>
</tr>
</thead>
</table>

### Key Milestones

<table>
<thead>
<tr>
<th>Phase II</th>
<th>ICT Systems and Support Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish ICT Steering Committee for CBFP</td>
<td>10 May 2011</td>
</tr>
<tr>
<td>Convene ICT Steering Committee</td>
<td>June 2011</td>
</tr>
</tbody>
</table>
### Key Milestones

#### Phase I  Competency Based Fellowship Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement of Project Manager</td>
<td>March 2011</td>
<td>Completed (part-time)</td>
</tr>
<tr>
<td>Project Management (Scope) Plan</td>
<td>May 2011</td>
<td>Aug/Sept 2011</td>
</tr>
<tr>
<td>Detailed Plan</td>
<td>Sept 2011</td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates may change as a result of Detailed Project Plan

### Legend:
- **GC**: General Council
- **BOE**: Board of Education
- **DOE**: Director of Education
- **EDM**: Education Developments Manager
- **PT**: Project Team
- **PO**: Project Officer
- **CBFP PMG**: Competency Based Fellowship Program Project Management Group
- **PMG WP**: Project Management Group approved Working Party
- **ECQG**: Education Content and Quality Group
- **CFT**: Committee for Training
- **CFE**: Committee for Examinations
- **CSIMGE**: Committee for Specialist International Medical Graduates Education
7 Supplementary Management Plans

These plans will be used throughout the project and describe how the CBFP will be monitored and managed. As circumstances change throughout the project the individual project plans must be updated to reflect these changes.

<table>
<thead>
<tr>
<th>SUPPLEMENTARY PLANS</th>
<th>PURPOSE</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope Management Plan</td>
<td>Used to monitor changes in scope</td>
<td>Attachment A, page</td>
</tr>
<tr>
<td>Project Schedule</td>
<td>Used to monitor changes in schedule</td>
<td>Attachment B, page</td>
</tr>
<tr>
<td>Cost Management</td>
<td>Describes how cost variances to cost baseline will be monitored and managed</td>
<td>Attachment C, page</td>
</tr>
<tr>
<td>Quality Management</td>
<td>Describes how the project team builds quality into the project deliverables and processes</td>
<td>Attachment D, page</td>
</tr>
<tr>
<td>Project Team Management</td>
<td>The Project Team management plan describes the roles and responsibilities of the project team. Outlines the Project Organisation/ Governance and Reporting Structure</td>
<td>Attachment E, page</td>
</tr>
<tr>
<td>Communication Management</td>
<td>Describes the process required to ensure timely and appropriate generation, collection, dissemination, storage and ultimate dispersion of project information</td>
<td>Attachment F, page</td>
</tr>
<tr>
<td>Risk Management</td>
<td>Describes the procedures for the monitoring and</td>
<td>Attachment G, page</td>
</tr>
<tr>
<td>Change Request Process</td>
<td>Describes the procedures for the steps by which official project documents will be changed</td>
<td>Attachment H, page</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Key Stakeholders</td>
<td>Nominates the key stakeholder groups that will be considered in the change management plan</td>
<td>Attachment I, Page</td>
</tr>
</tbody>
</table>
ATTACHMENT A

7.1 Scope Management Plan

The scope of the each of the CBFP is defined in the body of the Project Management Plan. Scope has been defined in terms of both Product Scope and Project Scope. The scope definition has been refined in terms of both Product-related deliverables and Project-related deliverables.

Proposals for changes to any elements of scope will be managed as per the Change Request Process. It should be noted that scope changes almost invariably lead to changes in cost and/or schedule and sometimes to changes to other project parameters.

To ensure a single point of contact, all perceived scope changes must be directed to the Education Developments Manager who will initiate the scope change process according to the table below.

<table>
<thead>
<tr>
<th>Step Description</th>
<th>EDM/DOE</th>
<th>PO</th>
<th>PT</th>
<th>CBFP PMG</th>
<th>BOE</th>
<th>GC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate scope change process</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Change Request Log</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Team meeting to discuss requested change and its implication and impact on the Project management elements of time, cost and quality</td>
<td>P</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forward recommendations to CBFP Project Management Group</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approve/Reject scope change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>Agreed change documented and communicated (including defined responsibilities)</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify all project documents as necessary, to reflect scope change</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Legend:
P  Has primary responsibility for completion of the Task
A  Assists in the performance of the Task
C  Should be consulted during the performance of the Task
S  Responsible for approval, or Sign-off, of the Task deliverable

GC  General Council
BOE  Board of Education
DOE  Director of Education
EDM  Education Developments Manager
PT  Project Team
PO  Project Officer
CBFP PMG  Competency Based Fellowship Program Project Management Group
## ATTACHMENT B

### 7.2 Project Schedule

The Work Plan for Phase I, Phase II and Phase III is outlined in the following table. Each of the major stages is discussed below.

**WORK PLAN – PHASE I, II and III – SUMMARY**

<table>
<thead>
<tr>
<th>Planning and Development Phase I and Phase II</th>
<th>Implementation Phase II Stage I</th>
<th>Stage II</th>
<th>Closing Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Detailed Project Plan (including subsidiary plans)</td>
<td>✓ Approved Training and Assessment Regulations – Competency Based Fellowship Program</td>
<td>✓ Implementation New Zealand</td>
<td>✓ Handover to Operations (where appropriate) Complete</td>
</tr>
<tr>
<td>✓ Communication Plan</td>
<td>✓ Approved Policy for Recognition of Prior Learning</td>
<td>✓ Implementation Australia</td>
<td>✓ Post Implementation Review Complete</td>
</tr>
<tr>
<td>✓ Program Structure (curriculum framework)</td>
<td>✓ Approved Training and Assessment Policies</td>
<td>✓ Information Technology systems</td>
<td></td>
</tr>
<tr>
<td>✓ Development of Training Pathway</td>
<td>✓ Feasibility Studies - WBAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Fellowship Competencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Developmental Descriptors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Development of Competence Developmental Trajectory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Development of learning objectives/specific competencies for each Stage of training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Development of EPAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Development of WBA Tools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Feasibility Studies - WBAs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Mapping of learning objectives/Competencies against formative and summative assessments
- Stage 1 Assessment of Knowledge
- Stage 2 potential written examination changes
- Stage 3: OCI / Psychotherapy Long Case Assessment
- Development of Scholarly Project requirements
- CBFP Assessment Blueprinting (Mapping)
- In Training Records – Tracking Trainee Progress
- Draft Curriculum Framework Package
- Review current Training and Assessment Regulations
- Develop policy for Recognition of Prior Learning
- Review current Training and Assessment Policies
- Review and develop Remediation processes
- Develop, determine and implementation of Information Technology / Systems Requirements (Stage II Implementation)

Progress with respect to the schedule will be monitored weekly. All baseline planning activities are expected to be completed by 30 November 2010. All implementation (excluding roll-out of the new Regulations) activities are expected to
be completed by November 2012. Completion is signalled by achievement of a milestone.

PROJECT PLANNING PHASE

The Education Developments Manager is to develop the overall Project Management Plan in consultation with the Project Team and the CBFP Project Management Group and other key stakeholders.

ESTABLISH PROJECT RESOURCING

The RANZCP Education Department and the Education Developments Manager have engaged all project resources. Other Project Team resources as required and as approved will be engaged as the project scope requires. A Project Manager for the IT phase has not yet been engaged.

DETAILED PROJECT PLANNING

The Project Team became familiar with the scope of the project from the time of their engagement and will be familiar with the Project Management Plan. Project Team members will explore issues that will be encountered in the planning and implementation processes and will develop a high-level approach to address them. Work plans will be developed for each deliverable and team members will produce the Detailed Project Schedule/Plan, in accordance with their role and responsibilities.
7.3 Cost Management Plan – **To be developed by Project Team**

The estimated costs for the CBFP Projects are as follows:

<table>
<thead>
<tr>
<th>PROJECT PHASES COST</th>
<th>AMOUNT (000's) excl GST</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Spend to end 2010</em></td>
<td>$348,000</td>
</tr>
<tr>
<td><em>Estimated 2011</em></td>
<td>$1,246,000</td>
</tr>
<tr>
<td><em>Estimated 2012</em></td>
<td>$1,057,265</td>
</tr>
</tbody>
</table>
### RE-ESTIMATING AND RECORDING OF CHANGES

To ensure a single point of contact, all perceived cost changes must be directed to the Education Developments Manager. The Education Developments Manager will initiate the change according to processes outlined in the table below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Officer</th>
<th>$000 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of authority for expenditure</td>
<td>Education Developments Manager</td>
<td>$5</td>
</tr>
<tr>
<td>Level of authority for expenditure</td>
<td>CEO / Director of Education</td>
<td>&gt;$5</td>
</tr>
<tr>
<td>Monitoring of budget</td>
<td>Project Officers</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiate cost change process</th>
<th>EDM/ DOE</th>
<th>PO</th>
<th>PT</th>
<th>CBFP</th>
<th>BOE</th>
<th>RMC</th>
<th>GC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Change Request Log</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Team meeting to discuss requested change and its implication and impact on the Project management elements</td>
<td>P</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forward recommendations to CBFP Project Management Group</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approve/Reject cost change</td>
<td>A/C</td>
<td>S</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreed change documented and communicated (including defined responsibilities)</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify all project documents as necessary, to reflect cost change</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**

- **P**: Has primary responsibility for completion of the Task
A  Assists in the performance of the Task
C  Should be consulted during the performance of the Task
S  Responsible for approval, or Sign-off, of the Task deliverable

GC  General Council
BOE  Board of Education
RMC  Resource Management Committee
DOE  Director of Education
EDM  Education Developments Manager
PT  Project Team
PO  Project Officer
CBFP PMG  Competency Based Fellowship Program Project Management Group
ATTACHMENT D

7.4 Quality Management Plan

This document, together with other referenced documents, defines the responsibilities and procedures, control mechanisms and assurance standards to be adopted by the CBFP Project Management Group for the purpose of Quality Management.

There are two components to project quality assurance: Product Assurance and Process Assurance. Product Assurance ensures that the systems and data established as a result of the CBFP are reliable, fit for purpose and consistent with the documented objectives and deliverables. Process Assurance ensures the project adheres to its agreed plans and processes. Since these components address different aspects of the project and require different procedures, the Product Quality Assurance and Process Quality Assurance are described separately below.

QUALITY STATEMENT

The project will be managed in accordance with the methodologies of the RANZCP Education Department.

QUALITY PROGRAM

All changes to the baseline project plan will be documented on the Change Register by the Project Officers. The change process is then followed in accordance with the Change Register Process.

All issues raised from the project will be documented in the Issues Register. Issues are discussed at the project team meetings and those which result in recommendations or change to project baselines or to key deliverables are forwarded to the Education Development Committee for appropriate action.
Supplementary Management Plans for scope, cost, human resources, communication, risk and training describe the processes that will be followed for performance monitoring, management and reporting during the project.

**PROCESS QUALITY MECHANISM**

The RANZCP Education Department will provide a quality review function with respect to the project management processes and deliverables. The Education Department will resolve issues pertaining to Process Assurance directly with the Education Developments Manager and will report any unresolved issues directly to the Director of Education. Process-related deliverables to be reviewed by the RANZCP Education Department are documented on a Quality Review Schedule at the end of this Quality Plan.

The CBFP Project Management Group (and other internal governance groups as appropriate) will receive a monthly Status Report.

**PRODUCT QUALITY MECHANISM**

Product Assurance is principally the responsibility of the Education Developments Manager, Project Officers, the Chair of the CBFP Project Management Group and other relevant stakeholders. The CBFP Education Content and Quality Group will be established to give final quality assurance and sign-off the education content deliverables. The Chair of the CBFP Education Content and Quality Group will report to the Chair of the CBFP Project Management Group.

The role of the Education Department in relation to Product Assurance is only to confirm that:

- Documentation pertaining to each product-related deliverable has indeed has been signed-off by the relevant parties

**PROJECT REVIEW**

The project will be reviewed by the CBFP Project Management Group, in consultation with the Education Developments Manager:

- Monthly, via the Project Status Report
TRANSITION MANAGEMENT

All and any identified transitional arrangements from Project to Operations will be managed by the (to be developed) Change Management Plan.

POST IMPLEMENTATION REVIEW

Following the conclusion of Phase II of the projects, a formal review will take place as follows:

Project Control Review

This review occurs within .... of the completion of CBFP.. It is documented in a report. The review assesses the success of the processes used to manage the project and contains lessons learned and any outstanding issues.
## Quality Review Schedule for Project Deliverables

<table>
<thead>
<tr>
<th>Process-Related Deliverable</th>
<th>Approved by</th>
<th>Scheduled Completion</th>
<th>Actual Completion</th>
<th>Sign-off Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Plan v2.0</td>
<td>CBFP PMG; Chair, BOE</td>
<td>13 Dec 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed baseline Project Plans (including subsidiary plans)</td>
<td>EDM; DOE</td>
<td>30 Nov 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBFP Project Management Group; CBFP Education Content and Quality Group, all Working Parties Agendas, Reports &amp; Minutes</td>
<td>Chair, CBFP PMG</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Team Agendas and Action Items</td>
<td>EDM</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Status Reports</td>
<td>CBFP PMG</td>
<td>Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk &amp; Issues Register</td>
<td>EDM</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Request Register</td>
<td>EDM</td>
<td>Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Management Plan</td>
<td>EDM</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication Plan</td>
<td>CBFP PMG</td>
<td>July 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase I: Development and Planning</td>
<td>CBFP PMG</td>
<td>13 Dec 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase II: Implementation Plan</td>
<td>CBFP PMG</td>
<td>13 Dec 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I and Stage II</td>
<td>BOE; CBFP PMG</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Implementation and Review</td>
<td>BOE; CBFP PMG</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Completion Report</td>
<td>BOE; CBFP PMG</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Objectives and Benefits Report</td>
<td>GC; BOE</td>
<td>TBC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Scheduled dates may change as a result of Detailed Project Plan
## Quality Review Schedule for Product Deliverables

<table>
<thead>
<tr>
<th>Product-Related Deliverable</th>
<th>Approved by</th>
<th>Scheduled Completion</th>
<th>Actual Completion</th>
<th>Sign-off Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE I:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellowship Competencies</td>
<td>ECQG; PMG</td>
<td>Mar 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence Developmental Trajectory</td>
<td>ECQG; PMG</td>
<td>20 Dec 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Descriptors</td>
<td>ECQG; PMG; BOE Exec</td>
<td>Apr 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Objectives</td>
<td>ECQG; PMG; BOE Exec</td>
<td>Apr 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBFP Training Pathway</td>
<td>ECQG; PMG</td>
<td>Apr 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entrustable Professional Activities</td>
<td>ECQG; PMG</td>
<td>May 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace Based Assessment Tools</td>
<td>ECQG; PMG</td>
<td>May 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feasibility Studies: Workplace Based Assessment</td>
<td>ECQG; PMG</td>
<td>July 2012 (to be confirmed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1 Assessment of Knowledge</td>
<td>ECQG; PMG</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I Syllabus</td>
<td>ECQG; PMG; BOE Exec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage II Syllabus</td>
<td>ECQG; PMG; BOE Exec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1 Examination Proposal (including Accreditation of Formal Education Course providers)</td>
<td>ECQG; PMG</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summative OCA (OCI)</td>
<td>ECQG; PMG</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product-Related Deliverable</td>
<td>Approved by</td>
<td>Scheduled Completion</td>
<td>Actual Completion</td>
<td>Sign-off Date</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Psychotherapies Long Case Assessment</td>
<td>ECQG; PMG</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scholarly Project</td>
<td>ECQG; PMG</td>
<td>Sept 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blueprinting (Mapping): mapping learning objectives/competencies against formative and summative assessments</td>
<td>ECQG; PMG</td>
<td>Nov 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Training Records – Tracking Trainee Progress</td>
<td>ECQG; PMG</td>
<td>Aug 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Curriculum Framework Package</td>
<td>ECQG; PMG</td>
<td>15 Oct 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulations</td>
<td>PMG; BOE</td>
<td>May 2011 (to be confirmed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognition of Prior Learning Policy</td>
<td>PMG; BOE</td>
<td>Sept 2011 (to be confirmed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training and Assessment Policies</td>
<td>PMG; BOE</td>
<td>Sept 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remediation Processes</td>
<td>PMG; BOE</td>
<td>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Program/Model</td>
<td>CBFP PMG; CFT</td>
<td>Jun 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curriculum Framework documentation</td>
<td>ECQG; PMG</td>
<td>Jun 2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHASE II: Stage I**

- Feasibility Study Evaluation Report
  - Approved by: BOE
  - Sign-off Date: TBC

- Approved Training and Assessment Regulations – Competency Based Fellowship Program
  - Approved by: GC; BOE
  - Sign-off Date: TBC

- Approved Policy for Recognition of Prior Learning
  - Approved by: GC; BOE
  - Sign-off Date: TBC

- Approved Training and Assessment Policies
  - Approved by: BOE
  - Sign-off Date: TBC

- CBFP Curriculum Framework
  - Approved by: BOE
  - Sign-off Date: TBC

**PHASE II: Stage II**

- Information Technology systems
  - Approved by: ?
  - Sign-off Date: TBC
<table>
<thead>
<tr>
<th>Product-Related Deliverable</th>
<th>Approved by</th>
<th>Scheduled Completion</th>
<th>Actual Completion</th>
<th>Sign-off Date</th>
</tr>
</thead>
</table>

Note: Scheduled dates may change as a result of Detailed Project Plan
### 7.5 Governance and Project Team Management Plan

#### E1 ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Council</td>
<td>• Responsible for authorising the project, providing resources, including financial resources and bears the ultimate responsibility for the project's success.</td>
</tr>
</tbody>
</table>
| Board of Education                             | • Owners of the project, approves the project approach at each check point and the process design (Project Management Plan)  
  • Responsible for resolution of major project issues and mitigation for project risks.  
  • Provides governance and direction to the CBFP Project Management Group and the Project Team |
| CBFP Project Management Group (CBFP PMG)       | • Provides a Project Management Plan to the owners of the project  
  • Executes with the Project Team, the project management plan with project scope and organisational change requirements in accordance with the approved Project Management Plan and other associated project documents  
  • Identifies and manages risks |
| Chair, CBFP PMG                                | • Provide project leadership, recommendations on project resources and ensure that project objectives and benefits are met  
  • Resources the Development and Implementation Phases recommending to the Board of Education appropriate expert working parties to ensure that project objectives and |
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
|      | benefits are met  
|      | • Develop and execute with the Project Team, a communications plan in accordance with the requirements of change and the approved Project Management Plan  
|      | • Reports to the Board of Education  
| CBFP Education and Content Quality Group | • Provides expert education content and quality assurance at the final stages of the development of education deliverables  
|      | • Signs off (quality assurance) education deliverables  
|      | • Reports to the CBFP PMG  
| Working Parties | • Provides expert education content in developing the educational outcomes, delivering specific key education milestones against the schedule timelines of Phase I (Development and Planning) of the Project in accordance with the approved Project Management Plan  
| Education Developments Manager | • Leads the project team and reports to the respective governance committees, Chief Executive Officer and Director of Education  
|      | • Manages the overall project, allocates and manages resources, budget and project timeline in accordance with the approved Project Management Plan, identifies and manages project risks.  
|      | • Develop and execute change management plan in accordance with project scope and organisational change requirements in accordance with approved Project Management Plan, identifies and manages risks  
|      | • Develop and execute a communications plan in accordance with the requirements of change and the approved Project Management Plan  
|      | • Reports project status and risk resolution to the CBFP Project Management Group and other internal stakeholder groups as required, conducts project team status meetings.  
|      | • Assists the project Team Members to develop plans for
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Project Officers            | • Supporting the Education Developments Manager  
• Coordinating the design, development planning and implementation of CBFP assigned sub-project responsibilities  
• Responsible for the maintenance of project management plan, detailed plan, risk and issues register, communication plan, change request register and project status reports.  
• Responsible for providing committee support e.g. scheduling of meetings, preparation of minutes, agendas. |
| Director of Education       | • Manages the change interventions and other change processes as identified and required                                                                 |
| Finance                     | • Oversight of the CBFP budget                                                                                                                  |
E2 PROJECT ORGANISATION / REPORTING STRUCTURE

General Council

Board of Education
Chair: John Crawshaw
(Adjudicator if required between CBFP PMG & ECQG – to manage potential change of scope against educational imperatives/policy setting)

CBFP Project Management Group (CBFP PMG)
Chair: Nigel Prior
What
When
How

Working Parties
Development of agreed scope of work

Education Content and Quality Group (ECQG)
Chair: Phil Boyce, to be confirmed
Quality Assurance of What
Quality Assurance of Why
E3 CBFP PROJECT MANAGEMENT GROUP

The CBFP Project Management Group function, roles and responsibilities are guided by its Terms of Reference. The membership of the CBFP Project Management Group is:

Dr Nigel Prior, Chair
Dr John Crawshaw
Dr Kym Jenkins
Dr Bill Kingswell
Dr Stephen Jurd
Dr Prue McEvoy
Dr Wayne de Beer
Dr Richard Astill
Prof Fiona Judd
Dr Ben Sketcher
Dr Murray Patton
Dr Jimsie Cutbush

CBFP EDUCATION CONTENT AND QUALITY GROUP

The CBFP Education Content and Quality Group function, roles and responsibilities are guided by its Terms of Reference. The membership of the CBFP Education Content and Quality Group is:

TO BE CONFIRMED

RANZCP Secretariat Support

- Andrew Gosbell, Director of Education
- Sharon Holloway, Education Developments Manager
- Mark Davies, Education Project Officer
• Adi Glancy, Education Project Officer
• Bree Waters, Education Project Officer

Working Parties

The CBFP Project Management Group will at time to time establish subject matter expert Working Parties to assist with the Phases of the project. The known working parties are identified in Section 3.
7.6 Communication Management Plan

The primary purpose of the Project communications strategy is to facilitate a smooth implementation of the CBFP by:

- Informing stakeholders of the implementation activities and any changes that will occur as a result of the CBFP
- Reporting project status to stakeholders on a regular basis
- Establishing methods to communicate among those participating in the project
- Managing all project documentation

The Communications Management Plan outlines the mechanisms by which this will be achieved for the CBFP and its deliverables

**Meeting, Status and Governance Progress Report Distribution Structure**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>How Often</th>
<th>What</th>
<th>When</th>
<th>Who</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOE</td>
<td>3-Monthly</td>
<td>Status Report</td>
<td>10 days prior to meeting</td>
<td>EDM / PO</td>
<td>P Drive</td>
</tr>
<tr>
<td>CBPF PMG</td>
<td>Monthly</td>
<td>Status Report</td>
<td>10 days prior to meeting</td>
<td>EDM / PO</td>
<td>P Drive</td>
</tr>
<tr>
<td>Chair, CBFP PMG</td>
<td>Weekly</td>
<td>Update</td>
<td>Wednesdays</td>
<td>DOT/EDM</td>
<td>Telephone / Face to Face as required</td>
</tr>
</tbody>
</table>
Project Organisation Structure
The project organisational structure and project team roles and responsibilities are identified in the Governance and Project Team Management Plan.

Minutes and Agenda
All formal and informal meetings are minuted, with Action Items documented, according to the Project Agenda and Minute template and stored in the Education Department files: Competency Based Fellowship Program

Reports
A status report, prepared by the Project Officers, according to the status report template, will be sent to Education Developments Manager on a regular monthly schedule. A summarised status report will be sent to the CBFP PMG members at the end of each month.

Document Storage
All documents will be stored electronically in the Education Department’s Project folder. The Education Developments Manager will hold endorsed documents.

Archiving of Project Documents
Project documents are to be archived following completion of the project according to the RANZCP’s policy governing archiving. The location of all official project documentation (ie documentation requiring a signature) will be identified in the Project’s Document Register.

Lessons Learned
All lessons learned throughout the project will be documented in the Closure sub-directory for the project and compiled into the Project Completion Report.


ATTACHMENT G

7.7 Risk Management Plan

Risks are events which, if they occurred, would have a negative effect on the project outcomes. Risks may be internal to the project – ie those which the project processes can control or influence – or external to the project – ie those which are beyond the influence of project processes. Risk Management refers to the processes used to identify, assess, prepare for and respond to risk events pertaining to this project.

Planning for Risk Events

Risk will be managed as a continuous process because existing risks are constantly changing and new risks are emerging. Review of strategies for existing risks or the development of new strategies emerging risks is an inherent part of risk management. The risk methodology consists of ongoing activities involved in identifying, assessing, treating, monitoring and reporting on risks as possible future events that can impact upon meeting strategic and operational objectives.

The Risk Management Register at the end of the Risk Management Plan details the areas of risk within the project. The register contains ‘trigger’ dates which indicate when a risk event is likely to occur. The register will be used as a tool to plan for and manage identified risks, and to eliminate or reduce their threat to the project.

Identification of Risks and their Management

Strategic Level Risks

At this level, there are drivers (such as political pressures, emerging technologies and new initiatives) arising while the program is underway which may alter the program scope and lead to changes in direction – a source of further risk to the program.
Changes at the strategic level, such as new initiatives that organisation must quickly respond to, can affect program interdependencies and the associated risks.

**Program Level Risks**

A major area of risk to the program is where project interdependencies change, giving rise to new sources of risk. The realisation of the program benefits may be frustrated if such risks are not managed.

In the context of *program risk management*, consider those risks which may not directly relate to a project but are events that could impact the program objectives. The Project teams may contribute to the identification of these risks, but management responsibility resides with the Program Management Team (including governance groups).

In defining program risks consider the events that will impact delivery in accordance with approved baselines along with those events that may impact the achievement of business benefits.

**Project Level Risks**

Much of the focus of risk management within programs is at the project level. In the context of *project risk management*, risk is considered as a future event that may impact the delivery of a project (in accordance with approved baselines) OR the benefits to be realised from the projects implementation. The risks are within the scope boundaries of the project and are managed by the project governance groups but in particular, the CBFP Project Management Group.

Risks should reflect the project or program objectives, scope, business case, project approach, assumptions, constraints, acceptance (operational adoption), interdependencies and relationships.

In defining project risks consider the events that will impact delivery in accordance with approved baselines along with those events that may impact the achievement of business benefits.

**Operational level Risks**

As project delivers their outputs of products and services, the transition to new ways of working and new systems can lead to further sources of risk. For example, during a handover process, risks could arise from the need to maintain ‘business as usual’ as well as the integrity of the systems, infrastructure and support services.
RISK OWNERSHIP AND REVIEW

Program Risk Management is primarily the responsibility of the Education Developments Manager or Project Officer. However each risk should be allocated to an individual who is best placed to monitor it and manage any treatment plan.

The process of risk identification and management will continue through the project. Risks will be reviewed weekly at the project team meeting and any significant changes will be reported monthly to the steering committee meeting.

To ensure a single point of contact, all identified risks must be directed to the Project Officer, who will initiate the appropriate action as per the table below.

<table>
<thead>
<tr>
<th>Identified Risk Reported</th>
<th>EDM / DOE</th>
<th>PO</th>
<th>PT</th>
<th>CBFP PMG</th>
<th>BOE</th>
<th>GC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting to discuss identified risk:</td>
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<tr>
<td>• Where and when it will occur</td>
<td>A/C</td>
<td>P</td>
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<tr>
<td>• Its expected impact to the project</td>
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<tr>
<td>• Appropriate risk mitigation measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document details in Risk Register</td>
<td>P</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assign monitoring and management of risk to relevant officer</td>
<td>P</td>
<td>A/C</td>
<td>C</td>
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<td></td>
</tr>
<tr>
<td>Forward notification/recommendations to Education Development Committee (only if required)</td>
<td></td>
<td></td>
<td></td>
<td>S</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>Approval for risk mitigation processes to proceed</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Modify project documents as necessary to incorporate risk</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Legend:
P Has primary responsibility for completion of the Task
A Assists in the performance of the Task
C Should be consulted during the performance of the Task
S Responsible for approval, or Sign-off, of the Task deliverable
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GC</td>
<td>General Council</td>
</tr>
<tr>
<td>BOE</td>
<td>Board of Education</td>
</tr>
<tr>
<td>DOE</td>
<td>Director of Education</td>
</tr>
<tr>
<td>EDM</td>
<td>Education Developments Manager</td>
</tr>
<tr>
<td>PT</td>
<td>Project Team</td>
</tr>
<tr>
<td>PO</td>
<td>Project Officer</td>
</tr>
<tr>
<td><strong>CBFP PMG</strong></td>
<td>Competency Based Fellowship Program Project Management Group</td>
</tr>
</tbody>
</table>
7.8 Change Register Process

In the course of the project, it is highly likely that some elements of the planned work of the project will be subject to change. ‘Change’ refers to the processes for anticipating and managing these changes. Expecting change does not mean submitting helplessly to all and any changes. Conversely, change does not mean steadfastly resisting all changes (although some changes are best dealt with by resistance).

The change process is concerned with identifying and evaluating change requests, controlling how approved changes are made to the project, and tracking and reporting the status and effect of those changes. It is about ensuring that the project remains responsive to the need for change and that, where warranted, changes are applied in a disciplined fashion.

Change Register Process

From time to time, issues are identified in the form of questions, problems, or suggestions raised by the project team, management, users or other stakeholders. All issues raised in relation to the project will be documented in the Issues Register.

In order to ensure the project plan is responsive to changing circumstances, the weekly project team meetings will review all issues, discuss the need for change to the project plan and decide on appropriate action. These decisions will be recorded in the minutes of the project team meeting.

A change request pertaining to a product-related deliverable will be passed onto the Change Register Process only if the change will impact a previously agreed and documented feature of the deliverable. Those change requests which do not result in a recommendation for change are recorded in the Change Request Log as rejected. Those which result in recommendations for change to the project baseline are forwarded to the Education Development Committee for a decision. The result is recorded in the Change Request Log.
Approved change requests are then forwarded to the relevant party for appropriate action. The Project Team will continue to monitor the progress of the change request and when completed its status will be updated in the Change Request Log.

**Change Management Roles and Responsibilities**

To ensure a single point of contact, all changes which have the potential to impact the project are directed to the Education Developments Manager. The Project Officer will then initiate the change request process according to the steps outlined in the table below.

The Project Team will act as the Change ‘Management’ Group, which will ensure all steps in the process are complied with, assess the impact of all changes on the project and act as the Change Assessment Team and Review Group for changes to all project baselines.

The Education Development Committee will act as the Change Control Board with the authority to approve or reject recommended changes to project baselines.

<table>
<thead>
<tr>
<th>Action</th>
<th>EDM / DOE</th>
<th>PO</th>
<th>PT</th>
<th>CBFP</th>
<th>BOE</th>
<th>GC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate change process</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Change Request Log</td>
<td>A/C</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Team Meeting to discuss changes and implications and the potential impact on the Project</td>
<td>P</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forward recommendations to the Education Development Committee</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approve/reject change</td>
<td></td>
<td></td>
<td></td>
<td>S</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>Agreed change documented and communicated (including defined responsibilities)</td>
<td>A/C</td>
<td>P</td>
<td></td>
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</tr>
<tr>
<td>Modify project documents as necessary, to reflect change</td>
<td>P</td>
<td>A/C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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BOE  Board of Education
DOE  Director of Education
EDM  Education Developments Manager
PT  Project Team
PO  Project Officer
CBFP PMG  Competency Based Fellowship Program Project Management Group
ATTACHMENT I

7.9 Key Stakeholders

The key stakeholders include:

- Department of Health and Ageing (DoHA)
- RANZCP General Council members
- RANZCP Chief Executive Officer
- Board of Education
- Board of Practice and Partnerships
- Committee for Training
- Committee for Examinations
- Committee for SIMGE
- CBFP Project Management Group and respective Working Parties
- CBFP Education Content and Quality Group
- Training Directors, Supervisors, Trainees, SIMGs
- Respective Working Parties
- Fellows
- Health Services/Jurisdictions
8 Sign Off

This Project Management Plan has been reviewed and endorsed by and on behalf of the Board of Education and CBFP Project Management Group.

Key signatories will be:

Dr John Crawshaw  
Chair, Board of Education  

Dr Nigel Prior  
Chair, CBFP Project Management Group  

Date
Background

The Board of Education (BOE), and Committee for Examinations (CFE), has sought to develop and maintain a high quality assessment system as an important component of the College's fellowship attainment processes. The CFE is aware of a number of issues and difficulties with the College’s examinations and has been taking steps to address these through a range of continuous improvement strategies. External expertise has been engaged on a regular basis, in attempting to ensure that the College assessments are informed by, and improved according to educational best practice. During 2006-2007, monitoring and quality assurance of College examinations identified that pass rates were reducing; this was of significant concern to the CFE and BOE, and has driven a number of quality improvements during 2008.

In late 2008 the College also became aware of the various concerns regarding its written examination standard setting and issues of sustainability regarding its clinical examinations. Therefore, in keeping with the BOE’s established continuous quality improvement strategy within its education portfolio, the College commissioned an external review of examination processes. In March 2009 an international expert, Dr Gareth Holsgrove, was engaged to undertake an independent assessment of the College’s examinations. Further expert advice, to critique and develop the recommendations provided by Dr Holsgrove, was commissioned from Prof Brian Hodges, equally renowned and a C-L Psychiatrist, in July 2009.

The BOE has now received reports and recommendations from both Dr Holsgrove and Prof Hodges. The BOE, in consultation with the CFE, is currently considering the recommendations provided by these experts, mindful of the current continuous improvement activities in the education portfolio and future developments through the Curriculum Improvement Project (CIP). In this context, the BOE provides the reports from Dr Holsgrove and Prof Hodges to inform the College membership on these recent review processes.

Holsgrove Review (Attachment 1)

Dr Gareth Holsgrove, a medical educationalist and psychometrician specialising in curriculum and assessment, was commissioned to undertake an independent assessment of the RANZCP examinations processes, with a particular focus on standard setting methodology and statistical/psychometrical analysis of examination components. Recommendations to improve current examination processes and guide future developments were an anticipated outcome of this assessment.

Hodges Critique (Attachment 2)

Prof Brian Hodges, Director of the University of Toronto Donald R Wilson Centre for Research in Education, Vice Chair of Education in the Department of Psychiatry at the University of Toronto and Chair of the Evaluation (Assessment) Committee of the Royal College of Physicians and Surgeons of Canada. He is a key advisor to the College on curriculum and assessment developments being undertaken through the CIP.

Prof Hodges was commissioned to critically evaluate Dr Holsgrove’s report, in particular providing a psychiatrist content-expert point of view on the broad range of recommendations proposed. The BOE

1 http://cip.ranzcp.org/
2 Dr Holsgrove was the Medical Education Advisor to the Royal College of Psychiatrists (UK), Jan 2003- Jul 2008
considered that this approach would provide valuable and appropriate triangulation of the advice and expert opinion provided by Dr Holsgrove.

Prof Hodges report provides a critique of Dr Holsgrove’s examination review report and its recommendations along with further recommendations for improvements to the College’s examination system particularly as related to quality assurance and assessment developments anticipated to be implemented through the CIP.

**Recommendations summary**

<table>
<thead>
<tr>
<th>Recommendations in Holsgrove Report</th>
<th>Critique and additional recommendations from Hodges Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 At present, no component of the examinations, in either the written or clinical parts, has sufficient testing time to generate adequate reliability. Since extending testing time might not be feasible, the number of components must be reduced.</td>
<td>Overall, this is a useful recommendation. Reducing over time the number of different tools and combining them into a smaller number of formats will improve reliability. This is a worthwhile goal. The pacing of these changes however should be incremental and take into consideration the effects on registrars' examination preparation and the implementation of assessment tools during training in the workplace. Roughly speaking, 3 hours of testing per question type should generate reasonably reliable test scores.</td>
</tr>
<tr>
<td>2 Map assessments clearly to the curriculum.</td>
<td>This is a very worthwhile task, and is a key goal of the CIP. The assessment blueprint should not be limited to the high-stakes examinations however, and should include all forms of assessment used during the training program, including workplace-based assessment tools.</td>
</tr>
<tr>
<td>3 a) Keep marking simple and straightforward. b) Do not aggregate marks to allow compensation between components – each component should be passed in its own right.</td>
<td>This is a useful recommendation. As discussed, it is important for the CFE to determine the best approach – be it compensatory, non-compensatory (as recommended by Drs. Holsgrove) or partially compensatory (as used by the RCPSC). Should partially or fully compensatory models be used, Dr. Holsgrove’s recommendations (eg. conversion to z-scores, rendering scaling equivalent, etc) are important.</td>
</tr>
<tr>
<td>4 Candidates should re-sit ONLY the components they fail.</td>
<td>Again, the CFE and the College as a whole must consider the implications of a stepped series of examinations hurdles, each of which must be passed (as with the American Board of Psychiatry and Neurology, or the United States Licensing Authority) or a Comprehensive Examination (as with the RCPSC). The primary determinants here are not psychometric, but related to impact on learning, progression through the training program, resources, etc.</td>
</tr>
<tr>
<td>5 Withdraw the KFCs immediately and examine the same material with EMQs and, if you choose, MCQs and SAQs.</td>
<td>This is a useful recommendation and has already been implemented.</td>
</tr>
<tr>
<td>6 EMQs should be redesigned on the standard template and ensure that they test the application of knowledge rather than merely factual recall.</td>
<td>A challenge of all examinations is a tendency to drift from higher order tasks to recall. Recall-based questions are easier to write. This is a danger in all formats. An annual quality assurance process and period reviews of the entire question bank are good approaches to make sure the balance between recall questions and higher order questions is maintained.</td>
</tr>
<tr>
<td></td>
<td>Recommendations in Holsgrove Report</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>7</td>
<td>If retained, the SAQs should be redesigned – in particular to improve the marking schedule and also to provide more accurate information to candidates.</td>
</tr>
<tr>
<td>8</td>
<td>Withdraw the CEQ immediately.</td>
</tr>
<tr>
<td>9</td>
<td>If retained, CAPs should be revised to include more questions and have a longer testing time. Alternatively (and probably more realistically) explore other ways to assess this material such as the Structured Clinical Reasoning examination.</td>
</tr>
<tr>
<td>10</td>
<td>Develop the MEQs to include more items and allow them longer testing time.</td>
</tr>
<tr>
<td></td>
<td>Recommendations in Holsgrove Report</td>
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</tr>
<tr>
<td>11</td>
<td>Increase the number of OSCE stations, aiming at around 18 stations of up to 10 minutes’ duration – a few double length stations can be used.</td>
</tr>
<tr>
<td>12</td>
<td>Consider removing the OCI into the workplace, increase the number of cases observed to at least 6 full-length encounters, and assess them using the ACE, mini-ACE or similar instruments.</td>
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</table>
Current situation and next steps
The CFE and BOE are currently considering the reports and recommendations provided by Dr Holsgrove and Prof Hodges. This has been augmented by recent consultative face-to-face meetings with Prof Hodges in June 2009 and Dr Holsgrove in August 2009.

The CFE and BOE appreciate the merit in many of the recommendations provided and anticipate that implementation of appropriate recommendations will assist in improving the reliability, validity, feasibility, fairness and sustainability of the College assessments.

The CFE is already considering a number of the issues identified by Dr Holsgrove and Prof Hodges and, as part of continuous improvement processes, is planning and progressing steps to address some of these issues. The CFE and BOE are also aware of other difficulties with the College examinations and appreciate the advice and recommendations that have been provided as this will assist in resolving some of these complex issues.

While the CFE and BOE have responded swiftly to address a small number of these recommendations, i.e. removing the KFC from the August 2009 written paper, a measured and paced approach to addressing the remaining suggestions and recommendations is anticipated. Linkages to the current continuous improvement activities in the education portfolio and future developments through the CIP are important considerations. Timely communication with trainees, exemption candidates, supervisors and DOTs regarding implementation of changes flowing from these recommendations is expected.

Abbreviations
ACE Assessment of Clinical Expertise
BOE Board of Education
CAP Critical Analysis Problem
CEQ Critical Essay Question
CFE Committee for Examinations
CIP Curriculum Improvement Project
CSE Clinical Skills Examination
EMQ Extended Matching Question
KFC Key Feature Case
OCI Observed Clinical Interview
OSCE Objective Structured Clinical Examination
MEQ Modified Essay Question
RCPSC Royal College of Physicians and Surgeons of Canada
SAQ Short Answer Question
STACER Standardized Assessment of a Clinical Encounter Report
Gareth Holsgrove Ltd

Report

for the

RANZCP

on the

2008 Examinations

Dr Gareth Holsgrove
Consultant in Medical and Dental Education
Cambridgeshire, UK

May 2009
Introduction

The RANZCP is committed to developing and maintaining its examinations to the highest standard and has engaged experts from within the College as well as external consultants to advise on and contribute to this ongoing process.

Exam development has already begun using local expertise and I was commissioned to bring an external, international perspective to this work, drawing on best practice from the UK and elsewhere. In particular, I was asked to look at the current College examinations, report on my findings, and make suggestions for further improvements. My remit was to scrutinise the Trainee Examinations held in 2008.

As would be expected in an early stage of a major overhaul of an examination, some components of the examination now perform considerably better than others and, although they might have served their purpose adequately in the past, there are components that should be withdrawn from future examinations because it is very unlikely that they can be further improved to the high standard that the College now seeks to achieve.

There are additional issues such as the ways in which marks are currently calculated and combined, and how borderline candidates are identified and treated, that I shall discuss in more detail elsewhere. However, the way in which these procedures are currently undertaken can all be improved. For example, I shall recommend that marks from separate components of the examination should not be added together to produce an overall mark, but that candidates should be required to pass each component in its own right. This is partly because it is generally accepted as the correct thing to do, and partly because the procedures that are currently used by the College would need to be improved. Since different components of the examination are testing different things, it makes much more sense to develop them as independent components and require candidates to pass each one in its own right. Agreeing on this simple strategy would immediately eliminate many of the potential mathematical problems that might be encountered.

It is important to note that until recently, a clear distinction was recognised between formative and summative assessment – the former being assessment for learning and the latter assessment of learning. This distinction is now becoming more blurred, with some predominantly formative assessments (such as workplace based assessment) contributing somewhat towards pass/fail decisions or eligibility to take examinations and summative assessments (such as high stakes examinations) as well as providing feedback to candidates. The College already provides this kind of feedback and will be developing it further in future.

Another contemporary development is concerned with the psychometric performance of examinations. Traditionally, this has been reported mainly in terms of reliability (accuracy) and validity (testing the right things in the right way). While both of these remain important characteristics, contemporary approaches are now expanded to include other issues. “In 1996 van der Vleuten proposed a conceptual model for defining not just the reliability or validity, but the utility of an assessment. This proposed that the utility could be determined by multiplying a number of factors that included not only reliability and
validity, but also educational impact, acceptability to the major stakeholders and investment required in terms of resources. He proposed, and followed up in other papers such as van der Vleuten and Shuwirth (2005), that even assessments with poor characteristics in one or more of the components, could still have utility and, thus, play a useful part in the overall assessment programme. However, since the expression for utility is a multiplication sum, if one of the values falls to zero, then the overall utility itself will be zero. Nevertheless, a perfectly useful assessment system can be developed where different components have different strengths and weaknesses, as long as none are completely deficient in any of them.” (Holsgrove, 2009, p10). Even taking this into account, high-stakes assessments such as the College examinations must have good reliability and validity, but the utility concept does serve to remind us of other important qualities that the examinations must possess and is, therefore, a helpful model for the examination development process.

Summary of recommendations

- At present no component of the examinations, in either the written or clinical parts, has sufficient testing time to generate adequate reliability. Since extending the testing time might not be feasible, the number of components must be reduced
- Map assessments clearly to the curriculum
- Keep marking simple and straightforward. Do not aggregate marks to allow compensation between components – each component should be passed in its own right
- Candidates should re-sit ONLY components they fail
- Withdraw the KFCs immediately and examine the same material with EMQs and, if you choose, MCQs and SAQs
- EMQs should be redesigned on the standard template (see Annex 2) and ensure that they test the application of knowledge rather than merely factual recall
- If retained, SAQs should be redesigned – in particular to improve the marking schedule and also to provide more accurate information to candidates
- Withdraw the CEQ immediately
- If retained, CAPs should be revised to include more questions and have a longer testing time. Alternatively (and probably more realistically) explore other ways to assess this material such as the Structured Clinical Reasoning examination.
- Develop the MEQs to include more items and allow them longer testing time
- Increase the number of OSCE stations, aiming at around 18 stations of up to 10 minutes’ duration – a few double-length stations can be used
- Consider removing the OCI into the workplace, increase the number of cases observed to at least 6 full-length encounters, and assess them using the ACE, mini-ACE or similar instruments.
General comments

There are various quality issues that apply to the College Examinations in general. These are:

- the mathematical treatment of marks;
- the identification and decision making about borderline candidates;
- mapping assessments to the curriculum; and
- the reliability of the assessments.

These are often inter-related. However, a general problem with reliability is that there are too many components and none is allowed sufficient testing time to attain adequate reliability. Testing time and item design are common threads running throughout the examination.

Marks from the component parts of the examinations are currently aggregated to produce total marks for the written and the clinical examinations. The aggregated mark out of 180 for written Paper 1 is added to the aggregated marks for Paper 2, which is also marked out of 180, to produce an overall mark for the written papers. The clinical examination also aggregates marks from its two components, but these are not combined with those from the written papers. Although this might at first sight appear to be fair and rational, in fact there are two particular problems with doing this. The first is a general point, the second was identified in the written examination, although might be found in other exams, too.

Firstly, aggregating marks in this way is unnecessary. It is also mathematically far more complicated than might at first be thought because simply adding the marks together is not the psychometrically valid method for aggregating marks. This is because different components have different weightings, different passmarks, and the marks have different Standard Deviations (SDs). This means that, unless these factors are taken into account, different components will carry unintended different weightings, which will vary from candidate to candidate, into the final aggregated total.

Furthermore, there is no educational justification in combining numbers derived from different components of an assessment programme, and there are potential patient care and safety issues in allowing sub-standard performance in one component to be compensated by better performance in another. It could be argued that this applies even in an intermediate assessment such as this, rather than a final exit exam, because this is a high-stakes assessment in which candidates pass or fail. It might not be safe to allow candidates to pass when they are below standard in some important areas.

It is correct to compensate between different questions in the same part of the examination, of course, as long as candidates who pass that component have reached the overall standard required. It is an important principle of test design that different components should be testing different things; otherwise there is no point in having different components. Therefore there should not be compensation between them. However, candidates failing one or more components should not have to re-sit the whole examination, but only the component(s) they have failed. The procedure of aggregating marks and thereby allowing compensation between components is incompatible with this principle.

The second point is that this examination has still to attain adequate reliability levels for a high stakes postgraduate examination (where a benchmark value of at least 0.8 is required for all components) and
this could compound other issues such as identifying and making pass/fail decisions about borderline candidates.

At present there appears to be no summary document that compares the content of the examinations with the curriculum. This is done in some components such as the Critical Analysis Problems (CAP) in the Written Exam and OSCE, but appears not to be done uniformly across all components. However, this should be done routinely in future because it is important to be able to demonstrate three key principles in high-quality assessments:

1. that the curriculum is thoroughly assessed;
2. that essential and important aspects of the curriculum feature very strongly in the assessments;
3. that the assessments cover only material that is in the curriculum – in other words, if it is not in the curriculum, then it should not be in the examinations.

My preliminary overview of the material I received suggests that these three criteria might not be adequately met at present, though I am not a content expert and others might be able to demonstrate issues of curriculum coverage that are not immediately apparent to a lay person. Nevertheless, some stakeholders will be lay people and so the mapping of the assessments to the curriculum must be clear and transparent. In passing, I would note that there is a modified version of the Ebel method of standard setting that considerably helps in relation to criterion 2 above (Holsgrove and Kauser Ali, 2004, more easily found on the web in PMETB, 2007).

My main priority at this stage was to identify areas which require attention in the short to medium term. There are a number of these. Of greatest concern is that none of the components of the Written Exam Papers 1 or 2 in either March or August 2008 reached the required standard for reliability in a high stakes examination. Some components were quite close and, with further development, could prove to be very reliable, but other components had very poor reliability. I have produced a short paper on reliability and attach this as Annex 1, and another on essay-type questions attached as Annex 3.

There are two main points concerning reliability in the RANZCP written examinations. Firstly, by splitting the total testing time between three different component question-types for each Paper, none of them is allocated enough testing time to achieve acceptable reliability (one of the factors in reliability being testing time). Potentially, though, three of the components used would be quite capable of reaching the required reliability threshold given more testing time (and their performance could be improved yet further – probably substantially - with changes to their design and construction). These are the Extended Matching Questions (EMQs), Short Answer Questions (SAQs) and Modified Essay Questions (MEQs). However, the EMQs in this exam are not yet fully developed, but could be improved very considerably with good item design. The SAQs are also potentially reasonably reliable, but this type of item does have the disadvantage of being manually marked, which brings several problems of its own. More work would be required to bring the MEQs up to standard, but here too it would be quite possible to achieve acceptable reliability. However, a great deal of the material in these three components could all be examined in improved EMQs. My analysis shows that the Key Feature Case (KFC) is very unreliable and therefore currently contributes nothing of importance to the assessment, but it takes up valuable time and other resources. The Critical Essay Question (CEQ) is also open to similar criticism and that, too, is probably impossible to raise to the required standard with the resources available. The College should seriously consider the ongoing use of these two components.
Written Paper 1

Written Paper 1 consists of three components. The Extended Matching Questions (EMQs) contribute 54 marks and consist of approximately 48 questions. Key Feature Cases (KFCs) have approximately 9 items and also carry 54 marks. The third component is approximately 18 Short Answer Questions (SAQs) that carry 72 marks. This makes a total of 180 marks and the time allowed is 180 minutes. Candidates are advised to apportion their time in relation to the marks available (1 mark per minute).

In my opinion, all of the material tested in Paper 1 could be assessed (potentially very reliably indeed) by well-designed EMQ’s. There is no clear advantage in dividing the assessment in either Paper into three separate components because this simply compounds potential problems, whilst also compromising reliability. A single, well designed EMQ would be a far better option than the present three components in Paper 1 and the College should consider this very seriously indeed because it is probably one of the most effective steps that could be taken at present to improve the written examinations. However, there is also a case for retaining and further developing the SAQs, should the College wish to do so. I do not see a case for retaining the KFCs.

Extended Matching Questions (EMQs)

As I suggested above, EMQs are potentially very reliable examination items, yet those I have seen in the 2008 Papers currently have lower than expected reliability coefficients. The three most obvious issues contributing to low reliability are the format, content and testing time/number of items. There is a standard format for EMQs, but the College items do not yet conform to this. With regard to content, EMQs were developed to replace SAQs as a means of testing the application of knowledge, yet much of what the College EMQs test appears to be factual recall. Moreover, Paper 1 contains both EMQs and SAQs. This is unnecessary and contributes to the third problem of inadequate testing time because the 180 minutes available is divided between three different methods.

Ideally, all of this could be allocated to EMQs or a paper combining EMQs with Single Best Answer (SBA) multiple choice questions (MCQs). As well as improved design, the EMQs would benefit from having more items and a longer allocation of time. This would enable them to achieve good reliability.

In my opinion, with informed redesigning the EMQs can be developed as a valuable and very reliable component of the College examinations. Moreover, because single best answer (one from five) MCQs and EMQs are in the same family of item types (they are technically both select-response items) they can be combined in any sensible proportion in the same exam component (there are precedents for this). This gives the advantages of greater curriculum coverage, because MCQs require less testing time than EMQs. For further information I have attached a short paper on EMQs and MCQs as Annex 2.
Reliability

The College statistician reported a reliability of 0.625 (although this is more usually reported to 2 decimal places) and my calculation agreed completely with this. A small number of questions reduced the overall reliability. When removed from the calculation the reliability improved to 0.67. While this is quite a considerably improvement (and is further evidence that attention is needed to item design), it is still short of the value one would aim for in an EMQ paper in a high stakes exam, where a Cronbach alpha of 0.85 or even better would be expected. I am sure that this problem is due to the design of the College EMQs and insufficient testing time, so attention to both should substantially improve Paper 1.

Material tested

When working with examiners in designing new test items, I often pose the question “so what?” in respect of what is being tested, in order to challenge whether the assessment is testing relevant things. There are questions in the 2008 Part 1 examinations that might benefit from challenge on these lines and this highlights one of the two main design issues with the current EMQs. One might ask “are these really key requirements of a safe, competent and caring Psychiatrist? Are they specified in the curriculum? If not, why use up valuable resources assessing it?” If the material is important, then a well designed EMQ (or a single-best answer MCQ) could test this at the higher level of ‘application of knowledge’ rather than the low ‘factual recall’ level and this would considerably improve validity and negate the “so what?” challenge.

Key Features Cases (KFC)

In the light of recent developments in examination design, the College has identified the KFCs as an exam component that should be improved or replaced. I very much agree with this view. It performed poorly in the Written Exams in 2008 with reliability coefficients well below the benchmark. They also have construction errors and inadequate, imprecise instructions to candidates such as “write up to FOUR answers only”, when it would have been preferable to have been more specific (‘give FOUR answers only’).

Since the KFCs have such poor characteristics and much of what they assess can probably be covered in the EMQ component, there is little value in trying to improve the characteristics of the KFCs. Therefore I recommend that the KFCs are withdrawn immediately and replaced by additional EMQs.

Short Answer Questions (SAQ)

Short answer questions have been in use for many years and, if properly constructed, they can be reasonably reliable and have good validity. Those in August 2008 had a reliability coefficient of 0.78, which is very close to the benchmark value. It is likely that it was not reached mainly because of inadequate testing time, but possibly also because it has some design features that could be improved.
It is generally recognised that the main drawbacks with SAQs are that they use free-written responses and are manually marked. We know from experience that free-written responses are not necessarily particularly legible and manual marking is prone to examiner error of various kinds. For these reasons EMQs were developed as an alternative to SAQs, allowing the same domains of application of knowledge to be tested, but without the disadvantages of free-response answers and manual marking. They have done this job very well (when properly designed and administered) and are now in widespread use. It is therefore unusual to see both formats featuring in the same examination. This jeopardises reliability because the testing time is split between different methods and, in the case of SAQs and EMQs, that test almost exactly the same things but in two different ways.

**Particular features of the SAQs**

The SAQ element of the Written Exam has some unusual characteristics. For example, each question in the SAQ awards only 1 mark for the first two correct answers, but beyond this one mark is awarded per correct answer (up to a point, which I shall return to in a moment). This is not an acceptable procedure. The simplest solution is to give one mark for each correct answer and allow for this in setting the passmark. Alternatively, some answers could carry more than one mark, depending on their importance, and again this would be reflected in the passmark. The marking scheme currently used does almost the opposite to this, in that candidates are likely to give the most important answers near the beginning of their lists, yet receive only one mark for the first two, while possibly gaining a full mark for subsequent and less important answers.

The second area for attention, following on from the first and also found in the KFCs, was that the instructions to candidates are not sufficiently specific. They only state the number of marks available, but not how they are awarded. For example, it is possible that candidates answering a question where they are told that 3 marks are available will therefore give only three answers and, even if all three are correct and they knew more but did not list them, would gain only 2 marks. By the same token, candidates giving several answers and listing them correctly could gain no more than 3 marks for the question even though the scoring key lists 5 possible answers. This pattern of giving candidates inadequate information about how marks are awarded and how many answers are required appears throughout the SAQs. This impairs reliability, validity and fairness to candidates.

Most of these problems could be eliminated by using EMQs instead of SAQs, and this would also bring logistical advantages by being optically, rather than manually marked. However, it is possible that SAQs could be retained in the short to medium term and, if so, then the marking schedule and information for candidates must be revised and testing time increased.
Summary of recommendations for Written Paper 1

- Keep marking simple and straightforward. Do not aggregate marks to allow compensation between components – each component should be passed in its own right
- Candidates should re-sit ONLY components they fail
- Withdraw the KFCs immediately and examine the same material with EMQs and, if you choose, MCQs and SAQs
- EMQs should be redesigned on the standard template (see Annex 2) and ensure that they test the application of knowledge rather than merely factual recall
- If retained, SAQs should be redesigned – in particular to improve the marking schedule and also to provide more accurate information to candidates
- At present there is inadequate testing time for any component to achieve adequate reliability. Both EMQs and SAQs require at least 2 ½ hours of testing time. If both are to be retained for the time being, I suggest that testing time is divided equally between them but on the understanding that reliability might still not reach the required standard (though it should still improve on the values calculated for the 2008 examinations).
Written Paper 2

Written paper 2 consists of a Critical Essay Question (CEQ) Critical Analysis Problems (CAPs) and Modified Essay Questions (MEQs) contributing 40, 40 and 100 marks respectively. These marks are aggregated with the marks from Paper 1 to give a total mark.

Critical Essay Question

The CEQ consists of just one single essay based on a quotation from the psychiatric literature. All candidates attempt the same question. If the time is used proportionately between the three elements of Paper 2 according to the marks available, as candidates are advised to do, they would spend about 40 minutes on the CEQ.

Although the College has made efforts to develop this component (for example, by designing clear marking schedules and training examiners) it still has some fundamental problems that might prove impossible to overcome. In particular, it is very important to note that the values for Cronbach’s alpha reported by the College analyst are wrong and highly misleading, giving the incorrect impression that this is a highly reliable component of the examination, when this is can not be determined.

Some points raised in relation to the CEQ are also relevant to the other essay-type component of Paper 2, the MEQs, so I shall deal with them in some detail in this section but not repeat this in the MEQ section.

It is my opinion that the CEQ lacks validity, is not adequately reliable, and is potentially unfair to candidates. It must also be very demanding of examiners’ time, raising feasibility issues. It is therefore vulnerable in almost every aspect of the utility formula mentioned in the introduction (van der Vleuten and Shuwirth, 2005).

There is a good deal of literature about essay-type questions that is relevant to the CEQ and also to the MEQs. I have appended a short review of this as Annex 3.

Mapping assessment to the curriculum:

The scoring key identifies five dimensions on which marks are awarded. Only four of the key words used to describe these dimensions can be found in the College curriculum. These are communicate in dimension 3 (although the single appearance of this word in the curriculum refers to verbal communication and not essay writing) and experience, maturity and ethical in dimension 4. It could therefore be argued that the CEQ is assessing very little that is in the curriculum, but a considerable amount that is not. If this is the case, then the CEQ lacks validity.
Fairness to candidates:

Whereas it is absolutely correct not to allow candidates a choice of which essay topics to choose, having only one essay will almost invariably place some candidates at an advantage over others for reasons other than their professional competence, which is presumably what the examination is supposed to be assessing. For example, unless the quotations are taken from prescribed reading for trainees, some candidates might have read the article from which they are taken whereas others might not. Similarly, the quotation might be in an area of particular interest to some candidates but not others.

Appropriateness of using essays in contemporary high-stakes examinations

There are many criticisms of the use of essays and these have been outlined in Annex 3. Essentially, they concern reliability and feasibility.

The CEQ carries a maximum of 40 marks. The CEQ is marked across five domains, each marked on a 9-point scale ranging from zero to 8. Two examiners mark independently. The scoring key reports that “the scores from the two examiners are averaged…”. However this is not always the case.

The reason for this is a third examiner, whose mark was used in each case as the awarded mark, adjudicates on essays where there is a disparity of 15% or more in the marks awarded by the two allocated examiners. This effectively means that the marks awarded by one examiner are ignored and this, in turn, means that candidates whose mark is decided in this way are treated differently to the other candidates. Apart from treating some candidates differently to others, this raises several other questions. For example, what evidence is there that the third examiner’s adjudication is correct? What happens to the examiner whose marks have been over-ruled? What happens in respect of other marks that over-ruled examiners have awarded in the exam, but which perhaps have not reached the 15% difference threshold and will still contribute to the final marks?

Reliability

It has been known for a long while that reliability can be a particular problem with essays. For example, it was identified half a century ago in an Australian study by Dunstan, (1959). It is undoubtedly a problem with this examination, too, but in this instance the problem has been obscured by the marking protocols and incorrect statistical analysis.

Inter-rater reliability has perhaps been most often identified as the major problem in marking essays and it is not solved by double-marking – indeed, few marking problems are solved by double-marking – although its impact can be reduced.

As well as problems with inter-rater reliability, other reliability issues can also come into play. These might include test-retest reliability and intra-rater reliability, which might have implications both for the accuracy of marks awarded to individual candidates and for consistency across diets.
Essays are known to present a problem in respect of internal consistency (the dimension of reliability calculated and reported as the Cronbach \( \alpha \) coefficient). This is because of the small size of the sample size, with usually only a very few essays contributing to the assessment. In this particular instance, there being only one essay in the exam, it is not possible to measure the internal consistency at all, because it has nothing to be consistent with. It is, therefore, impossible to directly calculate \( \alpha \) for a single item. To calculate internal consistency for essay questions there would have to be an exam consisting of several essays, not just a single one, with the same questions being answered by all of the candidates.

A second, related, problem is that of testing time. Even if candidates spent the entire allocated time for Paper 2 (180 minutes) writing essays, it would be nowhere near enough time to achieve an adequate reliability coefficient. Swanson and Case (1992) reported that to achieve a reliability of 0.8 with essays using physician-scorers required 22 essays over 6 hours of testing time (for non-physician scorers this rose to 72 essays over 18 hours).

The scoring key for the CEQ is essentially competency based, giving (albeit very brief) written descriptors of levels of performance in each domain and for every dimension. While it is good practice to use such descriptors, the problem arises here when they have been translated into a numerical mark. Although this gives some numbers that can contribute to the candidates’ final marks, and that have been used for various psychometric calculations, there are two problems with doing this. One is that it is inherently difficult to describe competencies in numeric terms, even using guidelines such as those in the marking key. The second, which is of psychometric importance, is that the intervals between the numbers are not consistent but they are treated in both the calculation of candidates’ marks and in the psychometrics as though they are. For example, is the difference in performance in a dimension between a mark of, say, 1 and 2 the same as the difference between 2 and 3 or 7 and 8?

The way that the numbers are used in reaching a final mark assumes that it intervals between numbers are consistent, but there is no evidence that this is the case.

**Feasibility**

Essays are notoriously time consuming to mark. Moreover, double marking has been found to improve reliability slightly, but nowhere near in proportion to the extra resources required to do this. Therefore, although it might give the outward perception of rigour and fairness, it is an expensive way of contributing relatively little to the quality of the exam.

In an essay-based examination where candidates had to write several essays it would be appropriate to have each single-marked with appropriate sampling for QA purposes because Cronbach’s \( \alpha \) and other statistical measurements could be made to help in identifying potential problems (such as examiner inconsistency) which could then be rectified. However, this exam consists of just a single essay question, so these means of quality assurance are not available because, for example, Cronbach’s \( \alpha \) cannot be calculated.
In view of the poor statistical performance of this component, including poor reliability, its unclear relationship to the curriculum, and the amount of time that it must take to mark the work, I recommend that the CEQ is discontinued at the earliest opportunity.

**Critical Analysis Problems**

In the March and August 2008 examinations the CAPs consisted of two research studies with various questions relating to the methodology, data analysis, findings etc. All candidates attempt the same two questions. Twenty marks are available for answers to questions on each study, making a total of forty marks for the CAP paper, but different questions have different allocations of marks ranging, in the example papers supplied, between one and four.

It they allocated time spent on each component of Paper 2 according to the marks available, as candidates are advised to do, they would spend about 40 minutes on the CAP.

The CAP has one clear distinction that places it above other components of the written examination – it is clearly mapped to the curriculum. Other components should develop along similar lines.

The CAP also has some areas where continued development would be useful.

**Reliability**

The reliability data reported by the College analyst must be incorrect because alpha coefficients in the reported range cannot be correct for a test lasting just 40 minutes. We know from research on several test formats that an hour or more of testing is usually required to achieve a Cronbach alpha of even 0.6 (van der Vleuten et al, 1994, p113). I was able to replicate the calculation made by the College analyst and identified where the error occurred, which is that it had been based on each individual component being treated as separate mini-questions (1.11, 1.12 etc). However, this is incorrect because the data should not have been analysed this way. It should have been calculated on marks for the two main questions and, when done in this way, produces a value in the expected range at 0.57, which is consistent with van der Vleuten’s research.

**Validity**

There are various aspects of validity, but they can be summarised as testing the right things in the right way, with adequate reliability, fairness and a positive impact on student learning.

Let us consider these points in order:
Testing the right things?

The curriculum makes several mentions of the importance of research and the necessity for Psychiatrists to be able to understand and apply research findings (eg K7, S3, S6). Therefore, it is important that this is assessed. Generally, the CAP appears to satisfy this requirement. The questions require more than factual recall, several requiring candidates to demonstrate analysis or application of the material presented. However, there are some aspects of the research components of the curriculum that the CAP does not, and probably cannot, assess, such as clinical application and effectiveness in the ‘Skills’ domain.

Testing in the right way?

The CAP can be justified as a perfectly reasonable way of assessing the ability to critically analyse published articles based on research in Psychiatry. The articles that form the basis of the questions appear (to me as a lay person) relevant to Psychiatry (this is technically referred to as face validity) and the mini-questions seem appropriate (content and construct validity).

Adequate reliability?

This is the main shortcoming of the CAP. However well structured it might be, there is simply not enough testing time, nor are there enough items, to give adequate reliability. This will result in a very large Standard Error of Measurement (SEM – see Annex 1) and, hence, a very large number of borderline candidates.

Fair to candidates?

Any assessment with a very small number of items is fundamentally unfair to candidates, unless they are testing essential material, because they are so heavily penalised if any of them are in an area where they are weak. Allowing compensation between elements of an exam does not remove this problem, it simply conceals it. There are two such elements in the current College examination – the CEQ, with just one question (and, hence, a reliability that cannot be calculated) and the CAP with two questions and poor reliability.

Feasibility

The CAPs must be considerably time consuming to mark. With the paper structured in the way it is, this might be a problem that the College needs to live with for the time being. However, this paper also needs to have considerably more questions and a longer testing time to make it adequately fair and reliable, and this will make the marking problem worse. Alternatively, there might be other ways in which this material could be assessed, such as a Structured Clinical Reasoning (SCR) exam such as that developed in the Faculty of General Dental Practice, Royal College of Surgeons of England.
Modified Essay Questions

This kind of item is known to perform reasonably well and the questions and marking schedules used here seem appropriate. In view of the issues that I have reported with the CAPs and, particularly, the CEQ, the MEQs are probably the only element of Paper 2 worth retaining in the long term. Even so, there is further development work to be done.

Reliability

The Cronbach’s alpha coefficient for the MEQs is 0.70, which is still short of the 0.8 benchmark. Once again, this is probably mainly due to there being insufficient testing time to enable an adequate level of reliability to be achieved.

If Paper 2 consisted of just the MEQs, reliability would very probably pass the 0.8 benchmark (based on current performance and the literature – eg van der Vleuten et al, 1994, p113).

Validity

This component of the written examination appears to have good validity and maps well to the curriculum. Its main failings are in reliability, which can be corrected by increasing the testing time and the number of clinical scenarios, and fairness. The fairness issues are discussed below and can certainly be addressed. That said, this appears to be one of the better components in the examination.

Some other observations

This kind of item is known to perform reasonably well and the questions and marking schedules seem appropriate. As noted above, the testing time indicated is insufficient for the MEQs to achieve adequate reliability. However, there are also two important points about the marking schedules:

1. There seems to have been a deliberate intention that each question carried 25 marks.
2. The maximum marks available according to the marking schedule exceed the total indicated on the question paper.
To elaborate on these points:

1. **25 marks per question**
   There are two issues here – a) combining marks and b) reaching the same total for each question.
   a) Presumably the decision to have each question carrying 25 marks was made on the assumption that they could be added together to give a percentage mark. It is not necessarily as simple as this, as I have discussed elsewhere. Simply adding marks together in this way can result in some questions contributing relatively more than others, whereas the intention is, presumably, that they would all contribute equally.
   b) In trying to ensure that the same maximum mark is available for different components of the same exam, examiners usually decide on a maximum (25 in this case) and then allocate marks so that they add up to 25. However, this often results in one or both of two things: that the marks are disproportionately awarded, so some marks are much quicker or easier to gain than others; and/or that examiners strive to find ways of awarding exactly 25 marks.
   This is a very common, but quite unnecessary problem and is frequently found in MEQs and OSCEs. It is far simpler, and leads to better question design, to note the salient points for which marks will be awarded, allocate marks in proportion to the importance of the points and the time that candidates are likely to take in gaining the marks, and then to recalculate the total for the question to a common standard (here it might be out of 25, or could also reasonably be out of 100).

2. **The marking schedule**
   Following each component of each question, the answer sheet clearly indicates the maximum marks available yet the scoring key for some questions allows additional to be awarded. Although I have been told that the intention is to allow rewards for candidates who perform particularly well, doing it in this way is incorrect. Moreover, since candidates are currently allowed to compensate across exam components, it might be seen as unfair for a candidate not to be awarded marks for something that other candidates do receive marks for because they reached the limit for certain component.

**Feasibility**

Like most other parts of the written examinations, the MEQs must be considerably time consuming to mark. This is likely to be a problem that the College needs to live with for the time being because there are no realistic alternatives at present. However, in terms of value for money, it is far more efficient to use examiner time on marking the MEQs than on other manually marked components in the written examination. The MEQs have the advantage of good validity and, with further development work, can play a valuable part in the College examinations.
Summary of recommendations for Written Paper 2

- Keep marking simple and straightforward. Do not aggregate marks to allow compensation between components – each component should be passed in its own right
- Candidates should re-sit only components they fail
- Withdraw the CEQ immediately
- If retained, CAPs should be revised to include more questions and have a longer testing time. Alternatively (and probably more realistically) explore other ways to assess this material such as the Structured Clinical Reasoning examination.
- Develop the MEQs to include more items and allow them longer testing time.
The Clinical Examination

The clinical examination has two components – an Objective Structured Clinical Examination (OSCE) and an Observed Clinical Interview (OCI). The aggregated scores, reported to be equally weighted, must equal or exceed the “aggregate pass score” for the clinical examination.

There is a problem in the way in which marks in the clinical examination are both awarded and combined. This arises because there are four levels of measurement: nominal (category based, such as male/female); ordinal (first, second, third etc); interval (which uses cardinal rather than ordinal numbers so, for example, the difference between 8 and 10 is the same as that between 18 and 20); and ratio (similar to interval scales, but having a starting point – usually zero – that represents ‘nothing’ of the competency or attribute being measured). Marks can only be combined if they belong to the same level. Moreover, marks from different exam components (eg OCI and OSCE) should not be combined by simply adding them together, without taking account of the impact of the SD of each component.

The marks in both the OCI and the OSCE are converted from competency statements (‘achieved the standard’ etc). The numbers, therefore, do not fit exactly into any of these four groups – they are, in fact, a numerical code for a written statement – letters of the alphabet, colours, geometric shapes etc could all have been used instead. The numbers are not ordinal because the examiners do not rank the candidates; they just decide which of 4 categories for each domain to place them in. They cannot be interval because differences between categories are not equal, nor are the performances of all candidates in any particular category. They are not ratio because the lowest category (‘does not reach the standard’) does not represent ‘nothing’ – it represents a range of performances that are ‘not good enough’. The OCI marks are closest to being nominal (category based) because the numbers represent a category of performance. This would be fine as long as they are not combined but simply retained as a code. For example, if males are coded 1 and females as 2, an analyst might add up all the 1’s and all the 2’s to see how many males and females were involved, but no sensible person would think of adding them together to determine the overall gender of the sample population. By the same token, they could be used in this examination to see, for example, how many candidates surpassed the standard in a particular domain, but numbers from different domains should not be added together to produce some kind of overall mark.

There are ways to overcome this issue if the College is really keen to generate numbers, but those it currently produces are confusing. All that it is really safe to conclude is that good candidates tend to generate higher numbers than weak ones. The data are not robust enough to conclude much more than this, nor for them to be added or compensated across different categories. The various weightings, compensation across categories and so on simply compound the original errors.
Observed Clinical Interview (OCI)

Introduction

The OCI consists of a 50-minute psychiatric interview with a patient, followed by a 20-minute period of thinking/preparation time and a 30-minute viva. The OCI is, therefore, effectively 100 minutes long. It is, essentially, a development of the traditional long case, which was typically not observed but did feature a viva. This is, therefore, a considerable improvement.

In the OCI, two examiners rate the candidate across five domains: data gathering process, data gathering content, data synthesis, action (management) plan and global rating. Poor performance in one or two domains may be compensated for by a superior performance in other domains. This is a debatable practice in the context of patient care and safety, but can be justified in terms of ‘overall performance’.

The documentation says that the:

“OCI examines ability to conduct a psychiatric interview, synthesise the information and formulate a reasonable management plan based on the available information. The OCI is considered to assess a key skill for psychiatry practice. The OCI involves real patients and clinical problems, with the candidate’s performance assessed in an objective and structured manner: examination timing, limited permitted clarification questions and use of criteria marking are tightly prescribed.”

It has also been reported to me that the OCI represents the major hurdle in attaining an overall pass in the examination.

Marks

Examiners independently rate each of the five domains according to four performance criteria:

- Surpasses the standard
- Achieves the standard
- Just below the standard
- Does not achieve the standard.

They then follow a set procedure to reach a consensus mark in each domain.

This examination is, therefore, marked against competencies rather than the number of items right or wrong. This is good practice.
However, the marks are then treated in an usual way. Ratings for competencies are converted into numbers and processed as though they were ‘right/wrong’ data. This is unnecessary and incorrect. It is unnecessary because the standard is already declared - ‘achieves the standard’. There is no need for this to be converted into numbers at all.

It is incorrect because the intervals between points on the competency scale are not equal or regular (ie the difference between ‘achieves’ and ‘just below’ will vary from candidate to candidate – some ‘just below’ candidate will be very close to ‘does not achieve’ for example, yet others might be very close to ‘achieves’.)

Both the process of converting performance standards into numerical marks and combining two different elements (OSCE and OCI) are unnecessary, add more error to that which already exists in the examination, and can produced suboptimal examination performance statistics.

Reliability and validity

The reliability reported for the October 2008 OCI (0.88) was incorrect. It had presumably been calculated from the component parts of the exercise and I was able to obtain the same figure myself when calculating $\alpha$ this way. As I have described above, this is wrong because $\alpha$ should be calculated on marks for whole questions, rather than component parts of questions. It is also at odds with what the literature tells us because the testing time is inadequate to achieve adequate reliability. Kroboth et al (1992), for example, suggest that 6 to 10 cases, each of an hour to an hour and a half duration would be required to achieve a reliability of 0.8.

However, the reliability of the OCI itself cannot be calculated. This is for the same reason that it cannot be calculated for the CEQ – both the CEQ and OCI consist of just one question. In the CEQ it is a single extract from the literature, in the OCI it is a single patient encounter (think of it as one long OSCE station).

The OCI has some poor aspects to its validity. For example, it is not adequate in respect of curriculum coverage or demonstrating competence with the required range of clinical presentations to have an examination component based on just one patient encounter. There is also the consideration that patients will differ in their clinical complexity, behaviour towards the candidate, etc.

Nevertheless, having assessed encounters with real patients in the assessment programme would be highly valid and educationally very important as long as there were an adequate number of them. All of the suggested improvements of which I am aware, such as those summarized by Fitch et al (2007), require several patient encounters, not just one. Also, achieving acceptable reliability is likely to require several hours of testing time. This probably makes it impractical (and extremely expensive) to do in a formal high stakes examination. However, it does lend itself to workplace-based assessment. In pilot trials with workplace-based assessments by the RCPsych in the UK, we found that the Assessment of Clinical Expertise (ACE) instrument was proving very effective and received very positive responses from both trainers and trainees, Brittlebank (2007, p104).
The ACE method was developed to meet the need in psychiatric training for assessing entire patient encounters as well as the components of such encounters. Details of the ACE are covered by Geoff Searle (2007, pp27 et seq) and would be well worth the College’s attention.

**Objective Structured Clinical Examination**

**Introduction**

The College OSCE is not typical of this type of examination, essentially because it has a small number of relatively long stations and involves some atypical marking practices.

The OSCE comprises 6 stations each of 17 minutes duration. There is also some reading/preparation time, for which no marks are allocated. However, this makes the OSCE longer than the OCI (6 x 17 = 102, plus preparation time) yet the two components are reported to be treated equally. Even though they probably are not (because of the ways in which marks are aggregated) and the process itself is incorrect, the OSCE should contribute more to the overall result because it is a longer exam.

One very positive characteristic of the OSCE is that each station is clearly mapped to the College curriculum.

The stations appear to be well designed, but the mathematical procedures used to reach a final mark are excessively complex and this results in a potentially well designed assessment instrument that loses value and credibility through unusual ways of deriving and using numerical data.

Another shortcoming with the OSCE in its current form is that there are not enough stations to enable adequate reliability to be attained. Even though these stations are about twice the duration of normal OSCE stations (which are typically between 5 and 10 minutes), there is not enough testing time to enable the examination to achieve benchmark reliability. The general rule of thumb is that an OSCE should have at least 15 well-performing stations. Practically, this means that there should be a minimum of 18 stations because it is common to find a station or two that needs to be excluded from the examination (for example, because of poor statistical performance, or a problem in running the station).

The relationship between testing time and reliability is not a straight-linear one, but beyond a certain point improvement in reliability diminishes in relation to time (see Annex 1). Therefore, a 20-minute station is not likely to be twice as reliable as a 10-minute one and, by the same token, two 10-minute stations are likely to be more reliable that on 20-minute station. Thus, the College OSCE is likely to be more reliable if it used more stations even if they were of shorter duration.
Marks

Stations are each marked by two examiners and there is a written protocol for deciding on a single mark for each element that is awarded to the candidate.

The examiners rate each candidate’s performance in a number of specified performance domains such as history, proficiency and diagnosis, which are selected according to the nature of the task. Different domains on a station are weighted differently (this is shown in the documents as a proportional value).

For each domain, examiners rate the candidate’s performance according to one of four categories:

- Surpasses standard
- Achieves standard
- Just below the standard
- Standard not achieved

Each of these four categories has a written descriptor, thus making what would technically be referred to as a four-point Likert-type anchored rating scale for each competency being assessed. Therefore, the OSCE is essentially a competency-based assessment, which is exactly what it should be.

Examiners also give a global proficiency rating of definite pass, marginal performance, or definite fail. This, too, is accepted as potentially good practice although it is currently still being researched.

Reliability

The reported reliability of the October 2008 OSCE was 0.63. This is incorrect, I suspect for the same reason that several other reported reliability coefficients are wrong, namely that they have been calculated using the components of each question rather than the actual marks awarded to the candidates for each complete station.

When calculated correctly, the Cronbach alpha value for the October 2008 OSCE is 0.59 but improves to 0.63 if Station 1 is removed.

The OSCE marking should be reviewed because at present it is excessively over-complicated.

The College report on the October 2008 OSCE reports the reliability of 0.63 is “indicating a relatively wide range of tasks and skills being examined over the stations”. This is not an appropriate interpretation. The reliability should not be interpreted to give information about the range of material covered. This misconception might have arisen because very high reliability coefficients (eg ≥0.95) can
indicate that more or less the same things are being assessed in different items. However, it is not correct to conclude that a lower reliability must be due to a wide range of things being tested. In this instance low reliability it is almost certainly due to a combination of two major factors:

1. An insufficient number of stations, giving inadequate testing time;
2. Complex manipulation of marks, adding further error.

Making improvements

OCI

Although there is potentially a very strong case for expert observations of clinical encounters with real patients, the OCI does not currently meet this need adequately. It is not sufficiently reliable, is too short, is based on just one single encounter, and is subject to various mathematical manipulations of marks.

I suggest that the only realistic solution is to move this component into workplace-based assessment, with a requirement for at least 6 full encounters (further research will help us to be more specific – it is likely to be closer to 10, but 6 would be a feasible developmental step at this stage). Mini-ACE assessments might also be useful in supplementing these (see Brown and Malik, 2007, pp 37 et seq).

OCSE

The essence of improving the OSCE, like other aspects of the examination as a whole, rests on two important principles. These concern simplicity and testing time. Many of the numerical aspects of the College examination appear to be unnecessarily complicated, and none of the individual components is given sufficient testing time to reach benchmark reliability.

While the stations themselves seem to be quite well designed and map appropriately to the curriculum, more are needed. If necessary, the stations could be shorter, but there needs to be more of them.

Marking must not only be simplified, but the way in which marks from co-examiners are used should be reviewed. Taking the mean of the two marks awarded sounds logical, but it is not necessarily the best approach.
References


Annex 1

Reliability and Cronbach’s alpha
Gareth Holsgrove April 2009

What do we mean by reliability?

The basic definition of reliability is that it is the ratio between subject variance (which is what we want to measure) and subject + error variance (where what we want to measure is obscured by measurement error). Reliability is expressed as a value between zero and one, being calculated by dividing the subject variance by the subject + error variance. Thus, the smaller the error variance, the higher the reliability coefficient. In high stakes medical examinations, we look to achieve reliability coefficients between 0.85 and 0.9. It is generally agreed that a reliability coefficient of 0.8 is the lowest acceptable value – indeed, in certification examinations the benchmark should probably be higher.

Another way of looking at the reliability coefficient is that it tells us what percentage of all the variance measured is due to genuine differences between candidates (which is what we are trying to measure) and what proportion is due to error (which we need to reduce to acceptable levels – we cannot eliminate it entirely). For example, a coefficient of 0.9 tells us that 90% of the variance is due to genuine differences between candidates and the other 10% is down to error.

Issues of passing and failing

The degree of error in an assessment will need to be taken into consideration when deciding who passes and who fails the exam, particularly since there will be a group of candidates who cannot be confidently placed on one side or the other of the passmark – these are the borderline candidates. In passing, it is worth noting that in assessments that separate candidates into different categories (such as classified honours degrees – 1st, 2i, 2ii etc) there will be borderline candidates around the cutting point between each category. It is also extremely important to note that borderline candidates fall on BOTH sides of the passmark and must all be treated in the same way. Traditionally, in many exams only borderline failures have been treated as borderline, those on the ‘pass’ side have been awarded passes. This is unfair.

Measuring reliability

The expression of reliability most examiners will be familiar with is Cronbach’s alpha coefficient. This takes account of only one (albeit very important) aspect of error – the internal consistency of the test. However, a more comprehensive, though more complex, measure is available through Generalizability Theory. This not only allows different sources of error to be measured, but also allows mathematical predictions to be made about changing the characteristics of the exam – for example, by increasing the number of questions or testing time, or double-marking etc. Although I expect Generalizability Theory to become more widely used, at present there are very few test developers in medical education who are able to use it.
We can see from the description of reliability above (comparing subject variance with subject + error variance) that the only way we can improve reliability is to increase the variance between candidates relative to the error variance. However, this does not simply mean reducing the error, although of course this will help. We can also take steps to increase subject variance.

Improving reliability

In medical education improving reliability has two potential difficulties. The first – common to all assessments - is that they have an element of error, which can be reduced but never removed completely. Moreover, it is usually attributable to more than one element in the exam. The error might be due, for example, to differences between examiners (hawks vs doves), or construction errors in the assessment (such as ambiguous or unclear questions or instructions to candidates – there are many examples of this in the KFCs and SAQs). We can, therefore, reduce error in a number of ways such as improved training for examiners, having explicit marking criteria, and using only well-designed items. We can also improve reliability, to a point, by increasing testing time. However, this is not an exponential graph and there comes a point of diminishing returns in respect of time spent against improvements in reliability (see Figure 1).

Figure 1: Graph for a hypothetical exam component, showing reliability (alpha) in relation to testing time (minutes)

This same characteristic applies when using multiple examiners marking the same work. For example, reliability does improve when items are double marked – and it improves still further if triple or even
quadruple markers are used. However, the improvement is not as good as would be achieved by using single marking and having more items.

Even if the problems of reliability are addressed (through optical mark reading, for example, which eliminates marking and data entry errors) or minimised (through examiner training and careful scrutiny of draft exam papers) there is still an element of random error to contend with. Therefore, we can take steps to minimise error, often very significantly, but there will always be a vestigial element of error that we have to live with. Thus, there is no such thing as an absolutely reliable exam (in medicine or any other subject). The best we can do is minimise the error, calculate the effect of the error that remains, and use this information in the best interests of good patient care and fairness to candidates.

**Measurement error**

In most medical examinations, which are pass/fail, the only candidates who will be affected by error within the exam are those around the passmark, as described above. We can identify these borderline candidates by calculating the *Standard Error of Measurement* (SEM) using the formula:

\[
SEM = \sigma \sqrt{(1 - \alpha)}
\]

(where \(\sigma\) = Standard Deviation)

In most instances, it is sufficient to treat candidates whose marks fall within ±1SEM of the passmark as borderline. This gives a confidence interval (ci) of approximately 68%. In view of other uncertainties within the examination (for example, the fact that using different standard setting methods will produce slightly different passmarks) this is an adequate confidence level. Should greater precision be required, 2 SEMs (ci = 95%) or even 3 SEMs (ci = 99%) might be used, though this would certainly not be the norm and the examination would need to demonstrate quite exceptional statistical performance to justify the use of such a high confidence interval.
Annex 2

A Short Guide to MCQs and EMQs
Dr Gareth Holsgrove, Consultant in Medical and Dental Education
March 2009

Introduction

MCQs and EMQs belong to the same family of test methods (technically known as selected-response item formats) and it is generally accepted that when well-written they are the most reliable of all assessment instruments.

I have developed an approach whereby, if required, MCQs and EMQs can be written together and also several questions testing the same domain can be produced. Both of these qualities are important in building an item bank.

Despite being relatively easy to write, poor MCQs and EMQs abound. There are six main reasons for the prevalence of poor items:

1. Obsolete, non-validated or inappropriate formats are used.
2. Items test simply the recall of facts, rather than application of knowledge.
3. Items test trivial, obscure or irrelevant material.
4. Wording is over-complicated (eg double - or even triple – negatives) or uses imprecise terms such as ‘associated with’ ‘often’ etc.
5. There is no clear ‘best’ answer.
6. The option list is not homologous but a mixture of, for example, diagnoses, medications, clinical signs etc.

MCQs

Although a multitude of MCQ formats have come and gone over the last 50 years or so, it is generally agreed that one is far superior to any of the others. This is the 1 from 5, single best answer (SBA) type. Apart from a variation – the 1 from 4 format, which is popular in North America (but potentially less reliable because of the greater chance of a candidate guessing the correct answer), all other designs are now considered obsolete. The single best answer format comprises a question stem, which is usually just one sentence long, although it can be a little longer. Wherever possible the question stem should be a clinical problem of vignette in order to test the application of relevant knowledge. The question stem is followed by a list of 5 options. These must be homologous (eg all antibiotics) and set out in a logical (alphabetic or numeric) order. Thus, a typical MCQ would look like the example on the next page:
The anatomy of a multiple choice question

1. This is the question stem. If possible it should be a short clinical vignette of one or two sentences.
   
   a) this is option a
   b) this is option b
   c) this is option c
   d) this is option d
   e) this is option e

Options a to e are homologous (eg all antibiotics, lab tests etc) and arranged in a logical order (alphabetic, numeric).

EMQs

EMQs were originally developed as a replacement for short answer questions (SAQs) because they can be machine-marked and they offer the same list of options to all candidates. Both of these factors are important. Mechanical marking is more accurate and very much quicker and cheaper than manual marking. Furthermore, if left to their own devices, candidates often provide answers in SAQs that are partially correct, but might not be included in the answer key. This can lead to various inconsistencies between examiners (for example, some examiners might award some marks to such an answer even though it is not included in the answer key, whereas other examiners might not; or in other instances examiners might differ in their judgements about how to reward one partially correct answer compared with another). This, in turn, impairs the reliability of the exam. On the other hand, not awarding any marks to a partially correct answer because it does not happen to be in the answer key might penalise the candidates, which will impair the validity and overall utility of the assessment.

Reliability and validity are important positive characteristics of EMQs because they tend to be more valid than MCQs and can also be very reliable. They are more valid because they can test a more detailed application of knowledge or a lengthier piece of analysis and clinical reasoning. This is because typically an EMQ question stem is more detailed than that in an MCQ. The stem is usually in the form of a clinical vignette, which might also contain details such as the results of lab investigations or physical findings. It can also be supplemented with diagrams, graphs, pictures (eg radiographs or photographs), lab reports etc. The stem is followed by a list of options (this must be more than 5, is usually 10 to 20, but might be even more). Candidates are asked to select a specified number of responses from the option list. This can be more than one, but the number must be specified – the instructions should not give vague details such as ‘select up to four options’. (NB – EMQs requiring more than 1 answer are usually harder to write that those requiring a single best answer).

EMQs are often written in sets, to be used together in the same exam, where the same theme and option list is used for two or more different vignettes.

Structure of EMQs

EMQs have a specific structure, just as MCQs do. Candidates are orientated by being given the theme for each set of EMQs, followed by a lead-in statement explaining what the candidate is being asked to
do. This is followed by the **option list**, set out in a logical (alphabetic or numeric) order. Finally, the **vignettes** are given. Thus, a typical EMQ would look like this:

---

**Theme:** Infections

**Lead-in statement:** For each patient with an infection, select the single most appropriate antibiotic from the option list. Each option might be used once, more than once, or not at all.

**Option list:**
- a) antibiotic a
- b) antibiotic b
- c) etc……..

1. **(Clinical vignette describing the patient, infection etc – eg “a 50-year old farm worker presented at A&E with an injury to his right foot, which he spiked with a garden fork 3 days ago. He complained of…(describe complaints)...On examination...(describe findings). You take a swab for microbiological investigations and blood for FBC, ESR and blood cultures and the injury is dressed appropriately.**

   The most appropriate antibiotic to use at this stage, while awaiting laboratory results, is....

2. **(Clinical vignette describing the next patient, infection etc)**

3. **(Clinical vignette describing the next patient, infection etc)**

---

Important tips for writing good MCQs and EMQs

MCQs and EMQs are reasonably easy to write for most clinical specialties, but the way in which examiners traditionally set about the task can prove to be very hard work and can result in rather poor items. I have developed the tips below put them into practice with examiners from many medical and dental specialties – and they work! Please try to use them:

- **Testing time is precious - do not waste it on trivia** – concentrate on essential and important topics.
- **Try to write in pairs or (even better) small teams.** These items are much harder to write alone and lone writers are more prone to making mistakes.
- **Don’t write exam items when you are tired** – they are too important.
- **It is a good idea to write MCQs and EMQs together from the same option lists.** Aim to write more than 1 MCQ and, if possible, more than 1 EMQ from each list of options. This then gives ‘matched’ items testing in the same domain for use in different diets of the exam, which is extremely useful in producing an item bank.
• Try to avoid EMQ sets where there is a ‘cascade’ effect, ie where the candidate has to get each item correct in order to get the next one right. It is difficult (but certainly not impossible) to write items like this that are fair and defensible. But it is always better to keep it simple!

Produce MCQs and EMQs using the following steps (which is not the same order that most examiners use – but this works much better!):

- Decide on the theme (eg infections)
- Produce a provisional option list of more than 5 items for an MCQ and at least 8 for an EMQ.
- Select one item from the option list (or the number needed for an EMQ if it is more than one) and write a vignette to which it (or they) would be the best answer.
- Add 4 further items from the provisional option list to make the 5 needed for an MCQ. For EMQs it is usually possible to use all of the remaining options in the final list.
- Arrange options in a logical order (usually alphabetical or ascending numerical).
- Check to make sure that the intended best answer really is clearly the best answer.

Give the item to other people without identifying the intended best answer to ensure that they agree with you. If there is genuine doubt, for an MCQ replace the confusing option(s) with spares from the original option list; for an EMQ remove confusing options from the list.

Two helpful hints:

1. The ‘best’ option(s) must be just that – the best option(s). However, they do have to be the only correct answer, but must be clearly better than the rest. By the same token, other options in the list do not have to be absolutely false (in fact, it is much better if they are not) but they must be clearly less good than the ‘best’ answer. Eg if the ‘best’ answer is ‘b’ the profile might be:

<table>
<thead>
<tr>
<th>absolutely</th>
<th>completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>true</td>
<td>false</td>
</tr>
<tr>
<td>b</td>
<td>a c d e</td>
</tr>
</tbody>
</table>

2. In most cases, it should be possible to correctly answer an MCQ without looking at the option list. In almost every EMQ it should be possible to correctly answer without looking at the options at all. This is one of the acid-tests for a good EMQ.
Annex 3

A brief review of the literature on essay-type questions

In this short annex, I have summarised the main points identified in the literature on essay-type questions and, where appropriate, related these points to the College examination.

The literature on essay-type questions is very large and predominantly critical. I shall not attempt to review it all, but to draw out the points most relevant to the CEQ (although some of them will also be relevant to the MEQ).

Among the positive points made in favour of essays are that they provide an opportunity to assess candidates’ reasoning, ability to identify the pros and cons of a case, and express themselves in writing. This involves the recall and selection of appropriate information, demonstrating relationships and explaining significance (e.g., Miller et al., 1998, Wood, 1991). However, it is open to question whether these particular skills and competencies are clearly set out as requirements in the College curriculum, for if they are not, they should not be in the exam. Moreover, these qualities can be assessed in greater depth (and hence with greater validity) in an extended essay or series of essays rather than in a single item written in about 40 minutes.

The criticism of essay-type examination items is centred mainly on two aspects – reliability and feasibility. The inability to adequately resolve many of the problems arising from them have led to my own conclusion, several years ago, that essays “have so many disadvantages in relation to their advantages that they have an ever-diminishing place in education today” (Holsgrove, 1997). More recently, Wass et al. (2007) confirmed that essays have lost popularity in recent years, partly because of reliability and partly because of feasibility (p20).

As noted above, validity can be improved by good question setting, the use of extended essay formats (which might include theses, dissertations and papers for publication) and by assessing a number of essays rather than a single one written over minutes rather than hours, which will have little validity or reliability, as I shall describe below. Crucially, though, validity can be improved by ensuring congruence with the curriculum – if what is being assessed does not map to the curriculum then it has no validity and, hence, no utility (see van der Vleuten and Shuworth, 2005).

Assigning ways to improve reliability, Hawthorne et al. (2006) conducted research that led them to conclude that “previous experience of marking appears to improve markers’ confidence and is a factor in determining the role which markers adopt. Confidence can be improved by giving clear instructions, along with examples of marking.” However, they also found that new markers are influenced by others early in their marking careers, and they emphasised that course organisers should be mindful of this when arranging double marking. The College appears to have done this in that the two markers are blind to each other’s marks.
This brings us to the issue of double-marking. The same team as cited above, on this occasion led by Rebecca Cannings-John, had previously set out to investigate whether double marking could improve the reliability and, if so, whether it was worth the trouble. They reported that “Generalisability Theory was used to show that, while there was reasonable agreement between markers, the reliability of the mark for the student was still only moderate” (Cannings et al, 2005). Thus, double marking does not greatly improve reliability.

The literature has many similar critiques and reports, all reaching more or less the same findings and conclusions – reliability can be improved somewhat by thorough examiner training and blind double marking, but these measures negatively impact the feasibility of essays as instruments of summative assessment, which are already fundamentally time-consuming and labour-intensive.

In addition to the (often considerable) reliability questions hanging over essays per se (for they are intrinsically unreliable) is the question of the number of essays that should be required in an exam and the time allocated to write them. This is not simply a feasibility issue – for example to do with testing time, invigilation and marking – but also one of adequate curriculum coverage, which is an important component of validity. However, it must be noted that other elements of the curriculum might be tested by other components of the exam as a whole. Nevertheless, the College should consider ‘bangs for its bucks’ and be mindful of cost-effectiveness, among other consideration in the examination.

This brings us to consider the number of essays required to contribute usefully to the overall examination. Swanson and Case (1992) reported that to achieve a reliability of 0.8 (regarded as the lowest acceptable value in a summative assessment, although it is now generally agreed that high-stakes assessments should be between 0.85 and 0.9) with essays using physician-scorers required 22 essays over 6 hours of testing time (for non-physician scorers this rose to 72 essays over 18 hours). Even the most lenient guidance I could find on the subject (Wakeford, 1999, p63) requires long (eg three hours) of testing time and multiple marking to achieve adequate (but unspecified) reliability and also cautions that within these constraints “it may be difficult to permit enough essays to reflect realistically the examination blueprint” (op cit).
ATTACHMENT 2:
Review of Report for RANZCP on the 2008 Examinations
(Hodges Critique)
Scope of Review

The purpose of this review is to examine the report of the consultation on the 2008 examinations submitted in May 2008 to RANZCP by Dr. Gareth Holsgrove. This review is intended not to repeat Dr. Holsgrove’s detailed and comprehensive analysis of the RANZCP examination materials, the data related to examination scores and psychometric analysis, nor to revisit the specific pass/fail standards set for the examination of 2008. Rather, the purpose of this review is to take a high level perspective on the Holsgrove Report and to provide a “second set of eyes” to assist the RANZCP in interpreting the Report and its recommendations. Dr. Holsgrove made many recommendations for changes and thus, the RANZCP has sought my comments about best practices in assessment from a different country (Canada), referencing experience with additional national testing organizations (the Royal College of Physicians and Surgeons of Canada, American Board of Psychiatry and Neurology), and my direct content expertise in the area of the assessment of competence specific to psychiatry.

Qualifications and Perspective of Dr. Holsgrove

Dr. Holsgrove brought to his report the rigorous perspective of an experienced psychometrician. This orientation is particularly helpful in the domain of development and monitoring of scoring systems, examination development and analysis and mathematical models for standard setting. The report contains helpful information about ways to improve the reliability of examinations, some of the common practices of treating and combining scores and widely used standard thresholds that can serve as benchmark marks for quality of examinations overall.
Qualifications and Perspective of Dr. Hodges

My own approach to assessment is broad, and while incorporating psychometric approaches has evolved to include educational, sociological, ethical and other views of what comprises an effective assessment system. Though I have worked extensively with psychometric consultants at several testing organizations, this is not my area of formal expertise. My own doctoral studies in education focused on the sociological, historical and ethical dimensions of assessment systems.

In addition to my doctoral and other research I have formed my views on assessment from working in varied contexts where the theoretical aspects of assessment directly bump up against issues of feasibility, practicality and “ecological validity”. This latter concept is now widely discussed in assessment literature and accords a greater place to the nuances of context than traditional psychometric models.

My perspectives on best practices in assessment have been formed in the following roles:

- Director of Assessment for the Ontario International Medical Graduate Program (1998-2002). Role: Development, monitoring and standard setting for written and performance-based examinations (OSCE) for screening international graduate for further training in various medical specialties in Ontario.
- Member of the OSCE test committee of the Medical Council of Canada (1996-2002). Role: Oversight of the national certification examination for all Canadian Medical graduates.
- Member (2000-2004) and Chair (2004-2008) Royal College of Physicians and Surgeons of Canada Evaluation Committee. Role: Responsible for the development and annual monitoring of the more than 60 examination systems of the various medical specialties in Canada.
- Consultant (1999-2002) to the American Board of Psychiatry and Neurology. Role: Consultation as they considered reform of their national certification examinations.
- Consultant to the RCPSC Examination Board in Psychiatry (1998-2005). Role: Redeveloped of the psychiatry examinations to meet the new standards of the RCPSC.

In addition I have conducted my own research and published peer-reviewed papers over the past 15 years in the areas of OSCEs, performance-based assessment, validity and discourses of competence and incompetence.

Summary of the Holsgrove Report

I was provided a copy of: Confidential report for the RANZCP on the 2008 examinations. Consultant: Dr Gareth Holsgrove, Consultant in Medical and Dental Education, Cambridgeshire, UK. May 2009 (hereafter referred to as “the Holsgrove Report”)

I reviewed this report in detail. As well, I had the opportunity to meet with members of the RANZCP Committee for Examinations in Melbourne in June 2009 and to discuss the examination system in detail. I had additional discussions with the Board of Education Chair and Deputy-Chair as well as the leadership and educational consultants of RANZCP.
Introduction to the Holsgrove report

Dr. Holsgrove examined in detail the RANZCP examinations held in 2008 including examination papers, scoring keys, standard setting approaches and the actual examination data sets. He stated that his task was to "bring an external, international perspective to this work, drawing on best practices from the UK and elsewhere." Overall, he felt that:

As would be expected in an early stage of a major overhaul of an examination, some components of the examination now perform considerably better than others and, although they might have served their purpose adequately in the past, there are components that should be withdrawn from future examinations because it is very likely that they cannot be brought up to the high standards that the College now seeks to achieve.³

He noted that the ways in which marks are calculated and combined could be improved and felt that scores from different examinations components should not be combined. I will discuss this further below, as the experience of the RCPSC is rather different. He also noted the work of van der Vleuten and colleagues who have argued, since 1996, that in addition to the traditional dimensions of reliability and validity of examinations, additional characteristics should be taken into consideration. Dr. Holgrove cited van der Vleuten’s “utility index”, as a means of assessing the adequacy of an examination system, though he did not specify its specific dimensions. This index is very useful and I discuss it in detail below. My impression is that Dr. Holsgrove’s interpretation of the index is somewhat at variance with van der Vleuten’s work. This is discussed below.

Broadly, Dr. Holsgrove presented the following 12 general recommendations (a table of acronyms is presented at the end of this report):

Summary of Recommendations in the Holsgrove report:

1. At present, no component of the examinations, in either the written or clinical parts, has sufficient testing time to generate adequate reliability. Since extending testing time might not be feasible, the number of components must be reduced.
2. Map assessments clearly to the curriculum.
3. Keep marking simple and straightforward. Do not aggregate marks to allow compensation between components – each component should be passed in its own right.
4. Candidates should re-sit ONLY the components they fail.
5. Withdraw the KFCs immediately and examine the same material with EMQs and, if you choose, MCQs and SAQs.
6. EMQs should be redesigned on the standard template and ensure that they test the application of knowledge rather than merely factual recall.
7. If retained, the SAQs should be redesigned – in particular to improve the marking schedule and also to provide more accurate information to candidates.
8. Withdraw the CEQ immediately.
9. If retained, CAPs should be revised to include more questions and have a longer testing time. Alternatively (and probably more realistically) explore other ways to assess this material such as the Structured Clinical Reasoning examination.

³ Hosgrove Report, page 2
10. Develop the MEQs to include more items and allow them longer testing time.
11. Increase the number of OSCE stations, aiming at around 18 stations of up to 10 minutes’
duration — a few double length stations can be used.
12. Consider removing the OCI into the workplace, increased the number of cases observed to at
least 6 full-length encounters, and assess them using the ACE, mini-ACE or similar instruments.

Detailed overview of specific sections of the Holsgrove Report

Following the general comments and recommendations above, Dr. Holsgrove developed in more detail
several themes and examined elements of the examination system in depth. His report focused primarily
on the specific details of each of the examinations components (Written papers 1 and 2, and the Clinical
Examination) and their constituent assessment tools (MEQs, SAQs, KFCs, etc). The report also makes
some mention of the procedures for scoring and standard setting and briefly touches on the relationship
of the testing to the training program (in terms of blueprinting). The Holsgrove report does not address
processes used by the College for quality assurance and monitoring of the examination, the appeal
processes, nor the impact of changes to the examination in terms of educational impact, history/tradition,
legal issues or external communications.

Discussion of written paper 1

Dr. Holsgrove’s recommendations:

- Move from 3 different formats (EMQs, SAQs, KFCs) to one format, preferably EMQ format.
- Increase the uniformity and number of EMQs to boost reliability (currently 0.67).
- Enhance higher order tasks over recall (he is particularly critical of the relevance of the history of
psychiatry)
- Remove the KFCs.
- Increase the number and standardization of marking of SAQs (current reliability 0.78).

Discussion of written paper 2

Dr. Holsgrove’s recommendations:

- Remove the CEQs on the basis of problems of alignment with curriculum, fairness to candidates
and reliability (he notes it is inaccurate to report the reliability of a one question component).
- Consider assessing the Critical Analysis section (CAPs) using another format, adding more
questions/testing time.
- Adjust the MEQs to have more questions/testing time.

Discussion of the Clinical Examination

Dr. Holsgrove’s recommendations:

- OCI: While having high validity as a result of its clinical relevance and ties to competencies, Dr.
Holsgrove points out that the OCI is really one test item and calculation of a reliability is not
appropriate. He recommends either having a lot more scenarios (up to 6) or moving the OCI into
the training program.
- OSCE: Producing a reliability of 0.63, Dr. Holsgrove argues that more, shorter stations should be
used. He uses a concept of a “normal OSCE” and suggested that the best practice is 5-10 minute
stations. He suggested simplifying the marking system and not combining the OSCE marks with
other examination components.
In addition Dr. Holsgrove provided a helpful set of references and 3 Annexes:

Annex 1: Reliability and Cronbach’s alpha; Issues of passing and failing; Measuring reliability; Improving reliability
Annex 2: A short guide to MCQs and MEQs
Annex 3: A brief review of the literature on essay-type questions

**Overall Impressions**

Dr. Holsgrove clearly did a lot of work in preparation for this report. He carefully studied examination materials, scoring rubrics and even reanalyzed some data. Overall, his is a thoughtful and informative report. The report’s focus however, is primarily on psychometric dimensions and primarily reliability. Most of what is recommended is familiar to me from my work with other national testing organizations, and largely conforms to what would be regarded as best practices.

Some of the statements made by Dr. Holsgrove are a bit strong and not all consistent with practices with which I am familiar. For example, there are models that allow compensatory or semi-compensatory scoring (combining of marks from different examination components) such as those used by the RCPSC (discussed below). The decision about retaking all examination components versus only the ones failed is not a subject of universal agreement and is more a practical, ethical and educational consideration. I believe the report tends to overemphasize the psychometric aspects and underemphasize other aspects – particularly “systems” issues.

I wonder if it was quite clear that the RANZCP exams are not exit exams and therefore not as “high stakes” as the final examinations in the last year of other Colleges. Rather they take place in the middle of a training program, and indeed the timing of some components (writtens) is not fixed. With the development of the Curriculum Improvement Project and the desire to create in-training/workplace-based assessments, it seems to me that focusing solely on the summative examinations and their results has left out the context of training and the educational functions of the examination system.

While referencing van der Vleuten’s Utility Index, Dr. Holsgrove does so in a fashion that I believe is somewhat at odds with van der Vleuten’s intentions. Professor van der Vleuten’s Utility Equation does indeed provide a useful framework for reviewing assessment systems. It builds on work by Cronbach (1988) himself, as well as others such as Messick and Birenbaum who have argued for an integrated concept of validity. In these models, reliability is not the most important aspect of assessment quality (Messick 1989, 1994, Birenbaum 2007). The van der Vleuten framework proposes that the utility of an assessment is a product of: validity (V), reliability (R), acceptability (A), educational impact (EI), and cost effectiveness (CE) (Utility = V x R x A x EI x CE).
Dr. Holsgrove wrote in his report,

*Another contemporary development is concerned with the psychometric performance of examinations. Traditionally, this has been reported mainly in terms of reliability (accuracy) and validity (testing the right things in the right way). While both of these issues remain important characteristics, our view has now expanded to include other issues. In 1996 van der Vleuten proposed a conceptual model for defining not just the reliability of validity, but the utility of an assessment. This proposed that the utility could be determined by multiplying a number of factors that included not only reliability and validity, but also educational impact, acceptability to the major stakeholders and investment required in terms of resources. He proposed, and followed up in other papers...that even assessments with poor characteristics in one or more of the components, could still have utility and thus play a useful part in the overall assessment programme.*

This is consistent with van der Vleuten. However, Dr. Holsgrove continued, “since the expression for utility is the multiplication sum, if one of the values falls to zero, then the overall utility itself will be zero.”

However, in his 2005 paper, van der Vleuten’s wrote:

*Some years ago we proposed a conceptual model for defining the utility of an assessment method. The model derived utility by multiplying a number of criteria on which assessment instruments can be judged. Besides such classical criteria as reliability and validity, the model included educational impact, the acceptability of the method to the stakeholders and the investment required in terms of resources. In the model the criteria were weighted according to the importance attached to each of them by a specific user in a specific situation and this defined the utility of the method. This means that the weights of the criteria depended on how the importance of each of the different criteria was perceived by those responsible for assessment in a certain assessment situation or assessment context.*

In other words, van der Vleuten felt that the relative importance of all of the variables that constitute utility must be weighed carefully by those responsible for examinations, and in particular with respect to the context. Further, van der Vleuten specifically stated that the utility index was not a mathematical formula and was at pains to emphasize the complexity of balancing the many needs of an assessment system. He wrote,

*Of course, this utility equation was merely intended as a conceptual model and by no means as an algorithm or new psychometric index. Neither were all possible criteria included in the model, such as transparency, meaningfulness, cognitive complexity, directness and fairness. Regardless of which criteria were included in the equation, the overriding message the model was intended to convey was that choosing an assessment method inevitably entails compromises and that the*

4 Holgrove Report, page 3
5 van der Vleuten and Shuwirth, 2005, page 309
type of compromise varies for each specific assessment context. As an illustration, the weights attached to the criteria in a very high stakes assessment, for instance a certifying examination, will be very different from the distribution of weights among the criteria when the primary purpose of the assessment is to provide feedback to students in an in-training context. A second corollary of the “formula” is that assessment is not merely a measurement problem, as the vast literature on reliability and validity seems to suggest, but that it is also very much an instructional design problem and includes educational, implementation and resources aspects. From this perspective, the utility model is useful, because it helps educators make considered choices in selecting, constructing and applying an assessment instrument.

In his report, Dr. Holsgrove does note that a “perfectly useful assessment system” could be developed with components of differing strengths and weaknesses. However, it is my impression that he gives primacy to reliability, lesser consideration to validity and renders the other elements in van der Vleuten’s index simply as helpful “reminders” of the qualities that an exam must possess. Dr. Holsgrove refers to few of the non-psychometric dimensions of utility in the remainder of the report, thus leaving the reader with the impression that reliability measures are the main, or even the only indicator of quality to consider in changing the examination system.

This discussion of the Utility Index might appear to belabour a small point. However my impression is that this particular interpretation has led Dr. Holsgrove to a tendency to recommend “quick fixes” – using words that convey a sense of urgency such as “withdraw immediately” and “irrational and unnecessary”. Yet, it is my view that undertaking several, simultaneous major redesigns of the examination system, while addressing reliability issues, might risk creating new adverse effects in other domains of the utility equation (cost and other resource utilization, educational impact, effects on stakeholders, etc). Further, while reliability is an important and desirable indicator of quality, too much attention to reliability (in particular over-standardization, over-sampling) can come at the expense of clinical validity (Harlen 2007).

For me, this raises an issue that I feel is not addressed in the report: the issue of an examination quality assurance process. In my many years with the Medical Council of Canada and Royal College of Physicians and Surgeons of Canada, I have seen the value and importance of such a process. My perspective is that development, monitoring and improvement of an examination system is an ongoing process, that spans many years. The field of assessment itself (not unlike clinical medicine) is constantly changing and what constitutes best practices also shifts. Thus I have found that a prudent, incremental process of refinement, innovative and adaptation is preferable. Major new initiatives, such as the introduction of new assessment instruments, should be thoroughly planned, pilot tested and stakeholders given an opportunity to both adjust their practices (this includes students, teachers and administrators) and a careful evaluation of the impact of changes (using all of the variables of the Utility Index) undertaken. A particularly important contextual factor in the selection of assessment tools is the notion that assessment strongly drives learning. Thus the alignment of objectives, instruction, and assessment tools to achieve congruent student behaviour is a priority. At the RCPSC of Canada, the oversight of over 60 different specialty and sub-specialty examinations meant that changes are constant. However we recommended no more than two or three changes in any one year, with a long lead time to notify residents, training directors and teachers, coupled with close evaluation of the impact and effectiveness of changes.

6 Biggs, 1996
The RCPSC Process of Examination System Quality Assurance

The RCPSC is by no means the only testing organization to have created such a process and many of the elements of its examination review and quality assurance are adapted to the Canadian context. However, there are features of this process that might be helpful in thinking about examination review, monitoring and renewal at the RANZCP.

The RCPSC Examination Model

While trying to avoid being too prescriptive, the RCPSC has a global set of standards/guidelines for all specialty examinations. Each is overseen by a separate examination board, all of which are responsible to their respective Specialty Committees, and also to the overall RCPSC Evaluation Committee. Broadly speaking, the RCPSC expects each specialty (including psychiatry) to follow certain standards:

- A final “Comprehensive Objective Examination” (COE), held once per year
- A multi-modality exam assessing knowledge (recommended tools are MCQ and SAQ) and a performance-based exam (OSCE, structured orals, etc)
- Sub-specialties are not to re-examine basic skills and most have a written-only examination
- One final result is generated from all examination components
- All candidates take all parts of the examination
- Each specialty must have a “grid” that establishes a floor (cut off) mark for each examination component below which passing is not possible, and a mark range which is considered “borderline”. Recently a “severe failure” threshold has also been established – below which formal retraining in a RCPSC program is required before the examination can be retaken. For example: 0-45% = severe failure, 45-60% = fail, 60-70% = borderline, 70% + = pass (Each Examination Board and each examination component has a different set of criteria. Generally speaking, the higher the reliability of the component, the narrower the borderline range). Component scores for each part of the examination are combined for a final score, which must be above 70%. Candidates in the borderline range on any examination component, or overall, are subject to discussion by the Examination Board and reading of their Final In-training Evaluation prior to making a pass-fail decision. All discussions are anonymous. Thus, the RCPSC uses a “semi-compensatory” system that allows the combining of scores from different examination components, but establishes thresholds below which passing is not possible. Regardless of scores overall or on any component, the entire examination must be retaken if failed.
- All examinations are subject to annual, rigorous, continuous, quality improvement review (described below)
- There is only one examination for all takers (including international graduates) Confidentiality in terms of origin of candidates, training program, etc. are safeguarded.

RCPSC Evaluation Committee

In additional to ensuring that examination systems conforms to the guideline above, the Evaluation Committee reviews each examination system annually. The philosophy underpinning this review includes:

- Continuous, incremental, cautious, defensible improvement
- The involvement of Fellows, College staff (operations, psychometrics), residents in review
- A mandatory examination blueprints (CanMEDs) that corresponds to the objectives of training for each specialty
- An annual report submitted to the Evaluation Committee by each Examination Board Chair
- Conduct of exams observed by College staff
- Detailed psychometric and other reports prepared annually for each exam by College staff
• An annual residents post-exam survey
• A culture that supports innovation and intervention to improve quality as needed
• Selected Examination Board Chairs attend each Evaluation Committee meeting
• Compliance with certain key policies are monitored (confidentiality, use of the FITER, egregious errors, severe failure, etc.)

Criteria for Annual Review of Exams

There are many factors used to ascertain the quality of each examination system. All of these are taken into account in the final report that is submitted from the Evaluation Committee to each Examination Board and Specialty Committee. The degree to which recommendations from the previous year were addressed is also considered. Criteria that reflect a high quality examination system include:

• Reliability and validity, psychometric data (here there are no absolute standards, but examination boards are expected to strive toward increasing reliability (for example aiming for a Cronbach’s alpha of 0.8) and to monitor trends in reliability year to year
• Cost overall and per candidate
• Evidence-base methods used
• Length of overall exam (recommend 8-12 hours for all components)
• Item creation, banking and reuse rates (floor and ceilings)
• Policy applied appropriately (borderline cases, egregious errors, confidentiality)
• Pass rates by category (Canadian first time takers, repeat takers, international graduates, etc)
• Number and result of appeals
• Time need for Exam Board members to create and analyze examination materials
• Morale and faculty development of Examination Board Members
• “Ecological validity” - impact of policies and changes on residents, training programs, teachers, health care settings and patients

It will be evident from this information and from my earlier comments that I believe a strictly psychometric approach to quality assurance is insufficient. Particular with the rising importance of in-training/workplace-based assessments that will be necessary for competence-based education models, new models are required. Citing van der Vleuten once again:

The current psychometric model has played a major role in improving the quality of assessment of medical competence. It is becoming increasingly difficult, however, to apply this model to modern assessment methods. The central assumption in the current model is that medical competence can be subdivided into separate measurable stable and generic traits. This assumption has several far-reaching implications. Perhaps the most important is that it requires a numerical and reductionist approach, and that aspects such as fairness, defensibility and credibility are by necessity mainly translated into reliability and construct validity. These approaches are more and more difficult to align with modern assessment approaches such as mini-CEX, 360-degree feedback and portfolios.7

van der Vleuten and Shuwrith, 2006, page 296
**Overall Recommendations**

With these discussions and issues in mind, I have responded to each of the recommendations in the Holsgrove report, adding some nuances that might be helpful in their interpretation. I have also added 3 additional recommendations that I hope will be helpful in further developing the RANZCP’s overall assessment system.

**Holsgrove Report Recommendations and Additional Recommendations**

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<thead>
<tr>
<th>Original Recommendations in Holsgrove report</th>
<th>Recommendations</th>
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<tr>
<td><strong>1.</strong> At present, no component of the examinations, in either the written or clinical parts, has sufficient testing time to generate adequate reliability. Since extending testing time might not be feasible, the number of components must be reduced.</td>
<td>Overall, this is a useful recommendation. Reducing over time the number of different tools and combining them into a smaller number of formats will improve reliability. This is a worthwhile goal. The pacing of these changes, however should be incremental and take into consideration the effects on registrars’ examination preparation and the implementation of assessment tools during training in the workplace. Roughly speaking, 3 hours of testing per question type should generate reasonably reliable test scores.</td>
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<td><strong>2.</strong> Map assessments clearly to the curriculum.</td>
<td>This is a very worthwhile task, and is a key goal of the new Curriculum Improvement Project. The assessment blueprint should not be limited to the high-stakes examinations however, and should include all forms of assessment used during the training program, including workplace-based assessment tools.</td>
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| **3. a)** Keep marking simple and straightforward.  
**b)** Do not aggregate marks to allow compensation between components – each component should be passed in its own right. | This is a useful recommendation. As discussed, it is important for the Committee for Examination to determine the best approach – be it compensatory, non-compensatory (as recommended by Drs. Holsgrove) or partially compensatory (as used by the RCPSC). Should partially or fully compensatory models be used, Dr. Holsgrove’s recommendations (eg. conversion to z-scores, rendering scaling equivalent, etc) are important. |
| **4.** Candidates should re-sit ONLY the components they fail. | Again, the Committee for Examinations and the College as a whole must consider the implications of a stepped series of examinations hurdles, each of which must be passed (as with the American Board of Psychiatry and Neurology, or the United States Licensing Authority) or a Comprehensive Examination (as with the Royal College of Physicians and Surgeons of Canada). The primary determinants here are not psychometric, but related to impact on learning, progression through the training program, resources, etc. |
5. **Withdraw the KFCs immediately and examine the same material with EMQs and, if you choose, MCQs and SAQs.**

   This is a useful recommendation and has already been implemented.

6. **EMQs should be redesigned on the standard template and ensure that they test the application of knowledge rather than merely factual recall.**

   A challenge of all examinations is a tendency to drift from higher order tasks to recall. Recall-based questions are easier to write. This is a danger in all formats. An annual quality assurance process and period reviews of the entire question bank are good approaches to make sure the balance between recall questions and higher order questions is maintained.

7. **If retained, the SAQs should be redesigned – in particular to improve the marking schedule and also to provide more accurate information to candidates.**

   I agree that a very practical and useful approach to SAQs is one mark per question, one line per expected answer. This eliminates confusion and simplifies marking. However, as with all other elements, the Committee for Examinations should consider this in the context of registrars’ expectations, examination preparation, College communications, etc.

8. **Withdraw the CEQ immediately.**

   As Dr. Holsgrove has pointed out, essay questions have largely fallen out of favour for high stakes examinations, based on their impossibility of calculating reliability figures and the perception that they are easily misinterpreted and introduce a great deal of subjectivity in marking. Nevertheless, we should remember that many domains (social sciences and humanities, for example) continue to use essays as their primary or sole assessment of competence. This is because essays can test the ability to write, to make an argument, to marshal information, etc. In the health professions, the legal context must be considered. While the assessment of the latter domains is important, it is also necessary to consider the context in which they are used. A rarely encountered format will favour those who have experience with it. As well, essays necessarily embed strong assessment of linguistic ability. The issue is further complicated by the fact that it has been noted that physicians’ ability to write may be compromised by today’s electronic records. This component, perhaps more than any other shows the value of the Utility Index. Options include: moving an essay-type assessment (review paper, critical analysis, detailed case reports) into the training program, continuing to strengthen the scoring system of the CEQ, removing the CEQ and replacing the content with other formats – MEQ, SAQs, etc. It is also my perspective that essay questions should be used with caution on certification examinations.

9. **If retained, CAPs should be revised to include more questions and have a**

   Although this examination component is problematic seen strictly from a psychometric/reliability lens, the Committee for Examination sees the domain of critical
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<td>10. Develop the MEQs to include more items and allow them longer testing time.</td>
<td>This seems a sensible recommendation. My brief review of the test papers suggested that the SAQs and MEQs are not very different and might be either merged into one format or combined in some way. Longer cases and series of responses can be constructed in the SAQ format.</td>
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<td>11. Increase the number of OSCE stations, aiming at around 18 stations of up to 10 minutes’ duration – a few double length stations can be used.</td>
<td>This is a problematic recommendation. Short OSCE stations do, of course, improve reliability. In the domain of undergraduate education, 10-minute or even 5-minute stations are common. For example, the Medical Council of Canada national certification examination uses 14 5- and 10-minute stations. From my experience with the MCC and other large OSCEs, such as the CSE (USA) it is possible to approach, but rarely possible to achieve a reliability of 0.8 with an OSCE. Further, the research of my own group has demonstrated that there are important validity issues in the use of OSCEs for the assessment of competence at higher levels of training. Ideally station length and tasks should be based on what actually happens in practice. While the current RANZCP OSCE occurs in year 3, it might be useful to consider that the RCPSC psychiatry OSCE (year 5) uses 20-minute stations, no checklists and no standardized patients (role-playing is used) based on an extensive review of the literature on OSCEs in psychiatry. (See Hodges et al 2002, 2003)</td>
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<td>12. Consider removing the OCI into the workplace, increase the number of cases observed to at least 6 full-length encounters, and assess them using the ACE, mini-ACE or similar instruments.</td>
<td>Moving the OCI into the training program is a helpful recommendation. This has occurred in Canada – where the so-called STACER is used, in the final 2 years to determine if residents are ready to proceed to final examinations. 2 of 3 STACERS (long case orals – 50 minute interview, 50 minute discussion with 2 examiners, who are neither the supervisor nor the program director) are required to be signed off and</td>
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sent to the RCPSC as a condition for final eligibility for final examinations. Reinforcing the centrality of the long case in psychiatric training/clinical care is thought to be many to be essential at a time when sampling requires formal examination scenarios to be short.

### Additional recommendations

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<td>13.</td>
<td>Establish a robust process for annual review of all examination components. A good process would emphasize continuous, incremental, cautious, defensible improvement in the examination system. Ideally, the review process would involve both registrars and directors of training with interest and expertise in assessment.</td>
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<td>14.</td>
<td>Examine the appeals process in light of the examination development and review process. Report annually (anonymously) the reasons for appeals to the Committee for Examination.</td>
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<td>15.</td>
<td>Continue to forge links between the Committee for Examinations and the Curriculum Improvement Project, working toward one integrated assessment blueprint that would include both formal examinations and in-training/workplace-based assessments.</td>
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### Summary

I am impressed by the commitment of the RANZCP and its Committee for Examination to sustain a high quality examination system. As with all certification bodies around the world, there are challenges in maintaining high psychometric standards and continuing to aim for benchmark levels of reliability is important. At the same time, it is crucial to make thoughtful compromises that will allow the examination system to appropriately support training programs, to ensure a wide range of competencies among graduates, to provide a fair and transparent set of steps toward licensure, to create in the minds of stakeholders and the public a conviction that graduate have a high standard of practice, to maintain fair costs for candidates and reasonable demands on volunteer College members and to engage in a continuous process of reflection and quality improvement. I am convinced that the RANZCP is doing all of these things, and that proactive invitation to both Dr. Holsgrove and me to provide external review and feedback on the examination system is evidence. Working toward a robust, internal quality assurance process, supplemented by periodic external input, consultation and review is consistent with the current approach of many international certification and testing organizations.

Finally, it strikes me that the issues facing certification and licensure organizations around the world are similar. Though I can only speak from my experience with the Royal College of Physicians and Surgeons of Canada, it makes sense that there would be great utility in sharing expertise and best practices between Colleges. I am certain the current Chair of the RCPSC Psychiatry Examination Board, as well as the RCPSC assessment experts and psychometricians would be pleased to consult further with the RANZCP as both colleges strive to evolve high quality examination systems.
References


Annex: Key to Acronyms

EMQ Extended Match Questions
KFO Key Features Questions
SAQ Short Answer Questions
CEQ Critical Essay Questions
CAP Critical Analysis Questions
MEQ Modified Essay Questions
OCI Observed Clinical Interview
OSCE Objective Structured Clinical Examination
COMPETENCY-BASED EDUCATION FOR PSYCHIATRY TRAINING IN CANADA AND THE UNITED KINGDOM

RANZCP CURRICULUM IMPROVEMENT PROJECT
OCTOBER 27TH –NOVEMBER 9 2008

UNIVERSITY OF ALBERTA
UNIVERSITY OF TORONTO
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
ROYAL COLLEGE OF PSYCHIATRISTS UK

PROFESSOR PHIL BOYCE
DR JOHN CRAWSHAW
DR CHRISTINE SPRATT
24 NOVEMBER 2008
Competency-Based Education for Psychiatry Training in Canada and the United Kingdom

Introduction

The Curriculum Improvement Project (CIP) funded a ten-day visit to the main centres engaged in competency-based education (CBE) in specialist training in Psychiatry in Canada and the UK. The CIP team’s itinerary was driven by a desire to interview key stakeholders in Canada and the UK who have been engaged in designing and implementing CanMEDS or other CBE frameworks.

The key outcomes were to:

1. Identify the role of accreditation in CBE curriculum development.
2. Investigate with the relevant people engaged in developing psychiatry curriculum the processes used in developing curricula based on the ‘2007 Objectives in Psychiatry Training’ (CanMEDS Psychiatry Objectives) published through the Royal College of Physicians and Surgeons of Canada (RCPSC).
3. Identify strategies used to implement a new curriculum across a range of educational settings and its application for RANZCP noting especially service vs. training issues.
4. Determine the key implementation challenges and approaches to assure a satisfactory implementation.
5. Observe how in-training-assessments are performed and discuss the processes adopted in order to conduct reliable and valid in-training-assessments
6. Initiate discussions for potential collaborative research.

Table 1: Interview Schedule

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<thead>
<tr>
<th>Institution</th>
<th>Interviewee</th>
<th>Role</th>
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<tbody>
<tr>
<td>University of Alberta</td>
<td>Dr. Kathy Collinson</td>
<td>Program Director</td>
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<tr>
<td></td>
<td>Dr. Laura Stovel</td>
<td>Coordinator Psychotherapy Training</td>
</tr>
<tr>
<td></td>
<td>Dr Brian Stonehocker</td>
<td>Year 1 Coordinator</td>
</tr>
<tr>
<td></td>
<td>Dr. Graham. Elleker &amp; Dr P. J White</td>
<td>Associate Dean PGME</td>
</tr>
<tr>
<td></td>
<td>Kathy Bush &amp; Brenda Meier</td>
<td>Program Administrators</td>
</tr>
<tr>
<td></td>
<td>Dr Pravesh Vallabh and Dr Nick Mitchell</td>
<td>Residents</td>
</tr>
<tr>
<td></td>
<td>Dr Gary Hnatko</td>
<td>Professor Psychiatry and Chair of the RCPSC Specialist Committee for Psychiatry</td>
</tr>
<tr>
<td>Royal College of Physicians and Surgeons of Canada</td>
<td>Dr Andrew Padmos and Executive Team</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>Dr Jason Frank</td>
<td>CanMEDS Coordinator</td>
</tr>
<tr>
<td>University of Toronto</td>
<td>Dr Brian Hodges</td>
<td>Vice Chair: Education and Director Wilson Centre for Research in Education</td>
</tr>
<tr>
<td></td>
<td>Professor Don Wasylenki</td>
<td>Chair: Department of Psychiatry</td>
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<td></td>
<td>Dr Ari Zaretsky</td>
<td>Postgraduate Director</td>
</tr>
<tr>
<td></td>
<td>Professor Allan Kaplan</td>
<td>Vice Chair: Research</td>
</tr>
<tr>
<td>Royal College of Psychiatrists UK</td>
<td>Ms Vanessa Cameron and Executive Team</td>
<td>CEO</td>
</tr>
<tr>
<td></td>
<td>Dr Andy Brittlebank</td>
<td>Associate Dean Education</td>
</tr>
<tr>
<td></td>
<td>Dr Amit Malik</td>
<td>Training Policy Advisor</td>
</tr>
<tr>
<td></td>
<td>Mr. Robert Jackson</td>
<td>Head, Professional Services (CPD)</td>
</tr>
<tr>
<td>UK Department of Health</td>
<td>Dr Hugh Griffiths</td>
<td>Office of the National Clinical Director for Mental Health Department of Health</td>
</tr>
</tbody>
</table>
1. Universities manage specialty medical training programmes. Universities take responsibility for all postgraduate training programmes across all medical disciplines (other than family medicine) and subspecialties. It is seen as being of high status and desirable for the universities. While funding is drawn from the health budget, it goes directly to fund the resident positions. Residents have a contract with the University, not the health service university. The University allocates residents to a particular rotation based on a national ranking system (CARMS: http://www.carms.ca).

2. The number of residents in a training programme is determined by faculty and allocation of resident numbers is done by Deans through relevant committees. It is important to emphasise that not all junior doctors are able to obtain a particular residency programme but applicants will generally be successful in entering their discipline of interest. Successful programs are commonly known among the profession and national ranking leads to competitive and rigorous interviewing by programs.

3. The educational outcomes for each rotation are clearly defined according to the CanMEDS framework. The RCPSC ‘2007 Objectives for Training in Psychiatry’ (CanMEDS Psychiatry Objectives) were formally introduced in July 2008 and all programs are required to modify their curricula accordingly. (This document was presented as part of the CIP Recommendations to General Council in August 08).

4. It is important to emphasise that not all psychiatrists will have a resident assigned to them. Many psychiatrists will work without any junior staff. The allocation and training of a resident is a professionally valuable experience, so faculty work hard to ensure that they provide a good training experience for their resident who will be able to assist them in their work.

5. All training programmes allow for one day per week (some half day in PGY1) quarantined for training activities, learning and competence development. Teaching and learning activities include didactic input in the form of lectures or seminars, the use of multimedia for practice, feedback and training in psychotherapy for example. (See detail in the Appendices).

6. IMGs are essentially supernumerary; residency programmes will allocate a number of places for IMGs to enter the programme after appropriate RPL assessment and according to the requirements laid down by provincial governments. Additional funding comes with IMGs usually from strategies in place through provincial governments.

7. There is widespread interest in the potential of e-learning but it is not widely used for teaching and learning. However there are extensive IT administrative systems that monitor the program and support online assessment. At U Alberta the system is C145 (based on University of British Columbia software), at UT POWER (https://pgme.med.utoronto.ca/power/index.cfm). T-RES is another widely used system across North America (http://www.t- res.net/PublicWeb/Presentation/Products.aspx).

8. Evaluation (of supervisors and teaching and learning) is regular and systematic although residents have a feeling of being asked to evaluate teaching and learning experiences and teachers ‘too often’. This may be modified in line with the broader curriculum work related to the new guidelines. (At U Toronto for example see: http://www.utpsychiatry.ca/Education/PostGraduate/evaluation.asp)

9. Each programme reviews and assesses residents on a regular basis (see Appendices). This may vary across programs and may include:
a. A mid-term formative assessment of the resident by their supervisor using the CanMEDS framework. A repeat assessment at the end of the rotation using the CanMEDS framework that is then recorded for residents’ In Training Evaluation Report (ITER).

b. An annual written assessment includes the US Board Examinations (programs can purchase this examination) and an examination developed by the national collegial group of Program Directors (Coordinators of Postgraduate Education: COPE).

c. An annual clinical examination that is essentially the same as our OCI (STACER)\(^\text{1}\).

d. Progress through the programme depends on success in all assessments – remediation is provided for unsuccessful residents.

10. Assessment is seen as rationale and helpful although residents think the online submission of in-training assessment needs to be complemented by related timely face-to-face feedback. Residents did not believe they were ‘over assessed’.

11. The RCPSC takes responsibility for the final certification of resident. This is based on a clinical examination, a written assessment and a PMDA (this is essentially a nine station OSCE).

12. At U Toronto, there is a specific ‘Clinician Scientist’ or research stream in the program. (See: http://www.utpsychiatry.ca/Research/ClinicianScientistProgram.asp)

There are five places reserved for this stream and it has become increasingly competitive. Aiming to develop the next generation of researchers in psychiatry. The program has also has other opportunities for residents to meet the competencies associated with the Scholar role.

13. The STACER (or clinical exam) is now the responsibility of the residency programme. Each resident is required to pass two out of three STACERS in order to progress. Residents sit for these in their fourth year of residency. They will be required to have passed their STACERS and have satisfactory In Training Evaluations documented before they will be eligible to sit the exit examination.

14. The programme directors see the exam and ITER\(^\text{3}\) processes as labour-intensive but their overall view was this was an appropriate way for this assessment to be conducted. There are well-defined marking criteria and a two-person team assures quality.

15. The STACER is very similar to our OCI with one examiner with the resident examining the patient and another examiner observing the process. The resident interviews the patient 50 minutes, has 10 minutes thinking time prior to a 45 minute viva examination. The viva examination is not led by a structured interview schedule. One residency programme also videotapes the interview to allow for validation of the outcome and for review and feedback purposes. As the CanMEDS Psychiatry Objectives are integrated in psychiatry curricula across Canada both groups indicated expanding their repertoire of assessment to include multi-source feedback and other workplace-based assessment strategies.

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1 The Appendices detail summary material from the key sites


16. Accreditation processes are rigorous. The RCPSC system is well accepted transparent and often ‘unforgiving’. Accreditation is on a six-yearly schedule. However each University will have its own internal review systems, e.g. U Alberta is every three years. Within the training programme a resident is assigned to a member of faculty for a rotation. If a particular rotation is deemed unsatisfactory, accreditation review processes are enacted and if there is evidence, the resident will be removed from that particular rotation and the faculty member will not have a resident assigned to them. All participants indicated that programs take this accreditation programme process seriously as losing accreditation has serious implications for the programme the University and the delivery of services. It provides a powerful lever for directors of programmes to insist upon changes being made to the structure and governance of rotations. (See: http://rcpsc.medical.org/residency/accreditation/index.php)

17. Residents at both sites spoke highly of the well structured, well organised programs. Communication between residents and academic staff is satisfactory and residents believed each institution has transparent and appropriate educational and pastoral services and strategies in place to meet their needs. While we accept that interested residents volunteered to meet us the high standing of both programmes on other measures is indicative that the programs are well structured, that residents enjoy them and succeed. Pass rates are high, withdrawal incidental and remediation processes transparent and well established.

The UK Competency-Based Training Program in Psychiatry

1. The 2005-2007 competency-based curriculum development and implementation has been evaluated by the RCPsych as cumbersome. Consequently in November 2008, the RCPsych submitted a modified curriculum based on CanMEDS (and also mapped to the GMC standards) to the PMETB for approval. The RCPsych was awaiting final approval at time of this report.

2. The College believes training and standard development in relation to CanMEDS and the related assessment are the key challenges facing the training program.

3. Curriculum content will be largely unchanged and in-training assessment (which is generally recognised as workplace-based assessment-WPBA) will be extended.

4. The politics of postgraduate training in the UK has been fraught in recent years with substantial changes based on the Modernising Medical Careers initiative. The College’s trainees have considerable experience already with CBE and WBPA based on the MMC Foundation Years program. There are other NHS and political imperatives which makes the RCPsych program approach to WPBA assessment relatively advanced to the RANZCP. Most obvious is the multidisciplinary approach to WPBA where senior paramedical staff routinely participates in the clinical assessment of psychiatry trainees through multi-source feedback approaches. MSF seems relatively well known based on the MMC experience and the fact that the Foundation Years program has been in place for several years.

5. Recent research into various pilot projects of assessment has given the Education Dean and Training Policy academic group confidence in their tentative approaches, in particular in relation to MSF.

6. The team managing the assessment strategy were equivocal in their view that CBE and WPBA are not possible without robust IT infrastructure to support it. (https://training.rcpsych.ac.uk/)

7. The biggest challenges will be in supporting a cultural shift to WPBA and the Colleges’ capacity to train supervisors and other assessors to recognise competency standards and assess against them.
8. There is a considerable shift in the RCPsych’s thinking with increasing interest in more qualitative approaches in WPBA and an increasing interest in ecological validity. They are heavily influenced by Cees van der Vleuten and his colleagues at U Maastrict (We have reviewed their work in the context of the CIP proposal development and assessment.)

9. Considerably more work needs to be undertaken in relation to the development of competence over time and its assessment. The multidisciplinary approach to learning and assessment in the NHS seems the biggest challenge to this. Minimal training is undertaken for assessors. The College’s Training Department (Dr Andy Brittlebank and a small team) has developed a series of ‘fee for service’ full day workshops on WPBA which they conduct for health regions. It is a requirement of the PMETB that assessors are ‘trained’. (See http://www.rcpsych.ac.uk/clinicalservicestandards/educationandtrainingcentre.aspx)

10. A College funded online web-interface database-driven assessment tool manages the complexities of ITA (original outlay at least £120 000 over two years). There is interest in developing an e-portfolio to manage this and to be integrated with the CPD program. The system designed by the RCPsych draws on strategies implemented by the University of Sheffield as part of the NHS Foundation Year program (see http://www.hcat.nhs.uk/). See also the NHS e-portfolio. There are clear synergies in the work we are doing and collaborative opportunities seem glaring and ought to be acted on.

11. The CPD program is free to members. Major expansion in the recent past has been the development of online CPD modules (managed through the Publications Department). Five percent annually audited. Ten of required 50 hours can be through some agreed form of online CPD.

12. The CPD program is currently undergoing major review of policy and standards in light of government requirements for mandatory re-validation and the internationally recognised view that CPD ought to be more about learning and allowing participants to demonstrate what they have learnt and how they reflect on their learning, i.e. outcomes. The Bologna agreement and a relatively ‘borderless’ Europe has influenced approaches to CPD.

13. Peer review groups are about collaborative learning, development and review of learning goals and achievements rather than any form of clinical review.

14. There is no interest in the support of CPD by pharmaceutical companies and no system for accreditation of external providers: what counts as valid CPD is moderated largely by the peer review group.

DH UK

1. A new Mental Health Service Framework is leading workforce initiatives in the UK. They are experiencing similar issues to those faced internationally. NHS policy is in process of ‘devolving’ delivery responsibilities ‘locally’ through eight new Strategic Health Authorities across the country. There are currently various trials throughout UK of different models of service delivery (‘Improving Access to Psychological Services Project’). Policy direction is increasingly aware of need for a more ‘flexible’ mental health workforce. However the Consultant Psychiatrist is still seen as the ‘clinical leader’.

2. Service/Training conflicts in NHS for specialist medical training similar to that experience in Australia. However claims there is growing interest in the important of dedicated time for training and interest in crating non-training junior posts to meet service needs.
3. Much activity in the sector exploring ‘role definitions’ and different forms that mental health provision may take. Largely concerned with extending scope of practice for existing relevant health workers but also interested in creating new ‘health workers’.

General Considerations for RANZCP Fellowship Program

1. An impressive aspect of the Canadian system is the educational rigour that underpins the training process. Training is high status. Specialists feel valued if they have a resident assigned to them (It also benefits their work practice in that they have junior medical staff.) Considerable effort will continue to be put into faculty development to ensure consistency of approaches by supervisors particularly in the area of in-training assessment and competency development in light of the new CanMEDS Psychiatry Objectives guidelines.

2. In-training assessment is supported appropriately with the ongoing development of well defined criteria to assess residents against the CanMEDS framework. Program Directors see this as a major challenge into the future. The RCPSC under Professor Hnatko’s speciality group which designed the 2007CanMEDS Psychiatry Objectives anticipates programs will develop some specific local strategies to address the requirements.

3. The Programs are supported by well structured, well resourced Information and Communication Technologies and Knowledge Management Systems to support processes. In Canada and the UK it was self-evident and strongly emphasised that CBE cannot succeed without robust IT systems to support all aspects of the training, assessment and evaluation of the program.

4. In Canada much of the recording of information about resident progress was done by administrative staff and not by the programme director. The programme director’s role was to ensure educational standards were being met. None of the programme directors spent time recruiting residents – the central matching process meant that residents were recruited only on an annual basis through a rigorous process.

5. As we move towards a competency-based curriculum we need to take both a top-down and bottom-up approach. The top-down approach would involve us in modifying the Canadian model to suit the Australian & New Zealand environment. This will require thorough review of the Canadian objectives of training and adapting them to our needs.

6. We should requiring our training programmes (state or zone level) to take responsibility for defining the educational outcomes expected from each rotation prior to that being approved and ensuring they are mapped against CanMEDS as we may define the details for our context.

7. We need to be much more rigorous about accreditation. CanMEDS offers a framework for accreditation and the Canadian model already exists for us to draw on. (See: http://rcpsc.medical.org/residency/accreditation/index.php).

8. It was the strongly held view that accreditation needs to be objective and at arms length to the training program. The RCPSC accreditation complemented by the University review processes in Canada and the PMETB in the UK indicate that a review of the RANZCP accreditation processes may be warranted. Given this international experience it seems incongruous to best practice standards that the Committee for Training is responsible for accreditation. A newly designed and more rigorous accreditation process may conceivably be more appropriately managed by Committee for External Liaison and Reporting.

9. Assessment will be a major area of ongoing improvement for the RANZCP program.
a. There seems to be considerable merit in moving the OCI to a more ecologically valid assessment in the training environment. The model described by our Canadian colleagues of requiring a trainee to be successful in 2 out of 3 OCIs may an appropriate way to move forward.

b. There will be a requirement for us to put considerable effort into training our supervisors and directors of training to ensure the educational needs can be met by trainees.

c. There is a rapidly growing literature in WPBA for us to draw on to model rational assessment strategies that measure capability, competence and performance outcomes which a continuously improving curriculum demands. Pilot opportunities present themselves currently in the SIMG program and in rationalising the current over assessment of ‘tasks’ and ‘experiences’ reflected in what many see as merely ‘form filling’ in the current program. Formative assessment needs to be aligned to the curriculum and outcomes and be purposeful to support timely feedback and learning development.

10. The design and development of appropriate ICT tools and infrastructure to meet our needs is crucial to the success of the curriculum renewal and the subsequent expansion of WPBA methods.
Summary of Consultation
Royal Australia and New Zealand College of Psychiatrists (RANZCP)
June 29, 2009 – July 3, 2009

Consultant:

Brian David Hodges, MD, PhD, FRCPC
Professor, Scientist and Director
Wilson Centre for Research in Education
Richard and Elizabeth Currie Chair in Health Professions Education Research
Vice-Chair, Education and International Affairs, Department of Psychiatry
University of Toronto, Faculty of Medicine
200 Elizabeth Street, Eaton South 1-565
Toronto, Ontario M5G 2C4
Tel: 416-340-3079 Fax: 416-340-3792

Summary of Activities
The following is a brief summary of activities and observations made during my visit to the RANZCP in June/July 2009.

Monday/Tuesday, June 29/30, 2009
Meeting with Curriculum Improvement Project Members (CIP)

Activities
- Overview of RCPSC CanMEDs framework and consideration of Canadian and Australia/New Zealand contexts
- Development of CanMEDS-style objectives of training for year 1 Psychiatry
- Development of draft inventory of curriculum methods by CanMEDs role/objectives
- Development of blueprint of options for in-training/workplace-based assessment tools to align with objectives of training and curriculum methods

Outcomes and Observation
The CIP team is a highly motivated group and seemed to find the 2 days helpful in consolidating an understanding of competence-based assessment. Spending a good deal of time developing practical tools, objectives, curriculum and assessment blueprints seemed to be a useful way to engage the committee and also to render the rather abstract idea of competence-based assessment practical. The active participation of registrars was beneficial and throughout the 2 days several members of the committee acted as enthusiastic and skilled leaders and facilitators. Continuing to engage both registrars and these enthusiastic psychiatrist leaders will be helpful as the project advances.

Next Steps
Assuming that the CIP committee is happy with the directions undertaken during the workshops, I might suggest the following next steps:
- Create an overall integrated set of objectives for the whole training program (ideally fairly short)
- Replicate the development process for specific objectives of training for each rotation/component of the training program
- Replicate the process of developing curriculum and assessment tool blueprints for all rotations
- Work towards an integrated assessment blueprint by identifying recommended in-training/workplace-based tools at each step along the competency trajectory (perhaps tying them to “entrustable professional activities” (EPAs) as developed for year 1).
- Develop a curriculum implementation and evaluation plan, to roll out and evaluate the effectiveness and satisfaction with the new curriculum
- Engage the Chair and Vice Chair of the Committee for Examinations in the process to ensure an alignment of the new curriculum, its embedded in-training/workplace-based assessment methods and the more formal examination/certification process

Wednesday July 1, 2009
Meeting with the RANZCP Committee for Examinations

Activities
- Overview of RCPSC examination process for all specialties and for psychiatry, with emphasis on links to the CanMEDs framework
- Overview of in-training/workplace-based assessment and the relationship to formal exams
- Discussions of the RCPSC examination quality assurance process and criteria for examination quality
- Discussion of various aspects and challenges of the RANZCP examinations and the recent external review

Outcomes and Observations
The RANZCP Committee for Examinations is a dedicated group with a skilled and knowledgeable Chair and Vice Chair. Significant efforts are ongoing to develop, monitor and enhance the quality of the RANZCP exams. The College has recently received an external review of the exams that highlighted some foci for change. Some of the recommendations already have been implemented. It was useful to discuss with the Committee for Examinations the assessment practices and markers of quality used by the RCPSC and other testing organizations around the world to mediate somewhat the perception created by the external consultant’s report that there is universal agreement in terms of best practices in assessment. Further, it was helpful to put into context the report’s strong emphasis on the psychometric aspects of exam quality and to focus on utility, feasibility, ecological validity, the impact of changes on the context in which the examination system operates.

Next Steps
On the basis of this discussion, the RANZCP has asked me to prepare a more formal commentary on the report of the external consultant. I will submit this by the end of July 2009. Given the very similar challenges faced by the RANZCP Examination Committee and the RCPSC Psychiatry Exam Board, I will also endeavour to make contact between the RANZCP Committee for Examinations Chair (Dr. Kym Jenkins) and RCPSC
Psychiatry Examination Board Chair (Dr. Katherine Gilles). The sharing of ideas and best practices between boards might be very helpful.

**Thursday July 2, 2009**

**Meeting with Directors of Training and Teachers of Training Programs in Psychiatry from Australia and New Zealand**

**Activities**
- Overview of the CanMEDs framework, competency-based programs and the context of Canada and Australia/New Zealand.
- Overview of in-training/workplace-based assessment models
- Review, refinement and validation of the objectives of training, curriculum and assessment blueprints created by the CIP Committee on June 29/30

**Outcomes and Observations**

This appears to have been a very useful day. The development and implementation of new curricula combined with changes in assessment processes would create uncertainty in any training program. My observation is that engaging the Directors of Training early in the process helps to foster a shared sense of ownership of the process. This group also brings into focus the perception “on the ground” that will aid the “ecological validity” of the new curriculum and assessment tools as they are developed and implemented. It was useful to have members of the CIP Committee, who had developed materials on Monday/Tuesday, participate as facilitators of the day’s activities. This might continue to be a helpful approach as the project moves forward.

**Dinner with Registrars**

I very much enjoyed meeting a group of registrars. Similar to trainees around the world, they are passionate about psychiatry and keen to get the best education possible. Fairness and good communications between registrars and the College are uppermost in their minds. There is a wealth of talent and enthusiasm among this group and continuing to enhance their participation in all College committees (examinations, accreditation, curriculum etc.) seems a good strategy. My experience at the RCPSC is that whenever residents can be engaged as “full partners” on accreditation teams, exam review committees, curriculum planning, etc. their direct engagement bring benefits both in terms of the quality and validity of College processes and also enhances communication (and by proxy) the sentiment about the College among the residents who are the future College Fellows.

**Friday July 3, 2009**

**Special Seminar**

*Medical Education and the Maintenance of Incompetence, and Globalization in Medical Education: Cracks and Crevices*

This special session, hosted by RANZCP, was attended by invitees from several Colleges and partner organizations in Australia and New Zealand. The talks seemed to be well received and there was a rich, engaged discussion. It was a pleasure to have this opportunity to present my work to colleagues from Australia and New Zealand.
Acknowledgements
My visit to RANZCP was extremely well organized and productive. I am very grateful to Dr Christine Spratt, Suzanne Dick and Mark Davies for taking such good care of me and for providing excellent support during a full week of seminars, workshops and talks. I am also grateful to Christine, Suzanne and Mark and in addition Drs. Phil Boyce, John Crawshaw, College CEO Dr Sharon Brownie and College President Dr Richard Prytula for providing such a gracious welcome and several wonderful dinners.
Professor Brian Hodges Consultation
Workshop Participants: Evaluation Survey
CIP Secretariat July 30 2009

Introduction
A series of workshops with Professor Brian Hodges, Vice-Chair Education, Department of Psychiatry, University of Toronto, were held at the RANZCP headquarters in Melbourne, from the 29th June to the 3rd July, 2009. During this week, Professor Hodges met separately with members of the CIP, the Committee for Examinations (CFE), the Committee for Training (CFT), along with a number of DOTs and DoATs. The week was formally concluded with an open seminar, attended by various representatives from other medical colleges, the AMC, university medical programs, RANZCP Fellows and interested others.

As a means of assessing participants’ perceptions of the utility and efficacy of these workshops an electronic survey was sent out to all those who attended (this did not include open seminar participants).

Overview
Three separate surveys were devised and disseminated: one each for the CIP, the CFE and CFT/DOT/DoAT participants; each was comprised of the same seven questions, with only the first question adjusted to incorporate the varying objectives of the different workshops. A total of 43 surveys were distributed, with 19 participants completing the survey (a completion rate of 44.2%). The survey was sent out on 14th July and closed on 4th August.

The survey consisted of three rating questions and four open questions requesting qualitative comment. The rating questions inquired whether participants thought that the aims of the workshops were met, and asked them about the balance of activities, the length, the structure and the utility of the workshops. The open questions asked for comment on what were most and least useful about the workshops, as well as what could have been improved; there was space for general comment at the end of the survey. Due to the small numbers of respondents, the responses to the four open questions were categorised into broad themes.

Outcomes
The responses to the rating questions indicated that participants considered the objectives of the workshops to have been either fully or partially realised, with a smaller number feeling that certain objectives had not been fully attained, particularly within the CIP and the CFT/DOT/DoAT workshops. There was general consensus across each of surveys that the workshops were well structured and that the presenters were of a high standard. Both the CIP and the CFT/DOT/DoAT surveys indicated that there could have been more discussion during the workshops, whilst the CFT/DOT/DoAT and CFE surveys showed that the workshops could have been longer.

Responses to the open questions showed that participants most appreciated hearing about the development of the Canadian model, and having this related by an expert presenter who has been intimately engaged in the CanMEDS development in Canada and internationally. The comments regarding the least useful aspects of the workshops were
split between either that there was not enough time available to complete all of the objectives of the workshop, or that no fault was found with the workshops. Replies to prompting for suggestions to improve the workshops, echoed these sentiments, with calls for more time or praise for the running of the workshops. Open comments at the end of the survey consisted mainly of praise for the calibre of the workshops.
Appendix: Annotated Comments

What did you find MOST useful about the workshop?

<table>
<thead>
<tr>
<th>Theme</th>
<th>n</th>
<th>%</th>
<th>e.g.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian experience developing CanMEDS</td>
<td>6</td>
<td>33.3</td>
<td>Very helpful to hear directly from someone who has had such a great depth of experience with this system. Helped to allay fears about the implementation about this.</td>
</tr>
<tr>
<td>Quality presentations/presenters</td>
<td>6</td>
<td>33.3</td>
<td>Brian Hodges was great!</td>
</tr>
<tr>
<td>Different perspective on our training/exams</td>
<td>4</td>
<td>22.2</td>
<td>Refreshing perspective on assessment of trainees, seems more appropriate for it to be competency based.</td>
</tr>
<tr>
<td>DOT input</td>
<td>1</td>
<td>5.6</td>
<td>Opportunity for DOT input</td>
</tr>
<tr>
<td>Understanding progress of CIP</td>
<td>1</td>
<td>5.6</td>
<td>I found the 'overviews' about the CIP, the stage that contemplations and deliberations had reached, and the issues facing the College, 'sank in' more than they had done previously. I am now much more aware of the process that is being undertaken.</td>
</tr>
</tbody>
</table>

What did you find LEAST useful about the workshop?

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<thead>
<tr>
<th>Theme</th>
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<th>%</th>
<th>e.g.</th>
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</thead>
<tbody>
<tr>
<td>Not enough time</td>
<td>4</td>
<td>30.8</td>
<td>Probably not enough time at the end to achieve workshop objectives fully</td>
</tr>
<tr>
<td>Nothing specifically</td>
<td>4</td>
<td>30.8</td>
<td>I really didn't have any problems with the workshop; it ran smoothly was well catered for, college staff were on top form. Overall it was a worthwhile and stimulating session.</td>
</tr>
<tr>
<td>Workshop structure</td>
<td>1</td>
<td>7.7</td>
<td>Some lack of clarity around tasks and timing of breaks</td>
</tr>
<tr>
<td>Over catered</td>
<td>1</td>
<td>7.7</td>
<td>I didn't need quite so much food.</td>
</tr>
<tr>
<td>Too much on specific details</td>
<td>1</td>
<td>7.7</td>
<td>Exhaustive focus on semantics- e.g. which word to use to describe learning goals, vague general statements as opposed to exactly what a trainee should be able to do. Surely this could be done by email discussion. Lack of discussion as below. Sense that this</td>
</tr>
<tr>
<td>Discussion round tables</td>
<td>1</td>
<td>7.7</td>
<td>The discussion around tables</td>
</tr>
<tr>
<td>Lack of info on CIP progress</td>
<td>1</td>
<td>7.7</td>
<td>Relative lack of information about where CIP and new curriculum are headed apart from some broad concepts</td>
</tr>
</tbody>
</table>

How could we have improved the workshop for you?

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<thead>
<tr>
<th>Theme</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Workshop structure</td>
<td>1</td>
<td>6.7</td>
<td>By having morning and afternoon tea better circumscribed</td>
</tr>
<tr>
<td>Well run</td>
<td>4</td>
<td>26.7</td>
<td>I think that if you continue to run such high caliber meetings we could hardly complain! Well done to the organizers.</td>
</tr>
<tr>
<td>Theme</td>
<td>n</td>
<td>%</td>
<td>e.g.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----</td>
<td>-----</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>More time</td>
<td>7</td>
<td>46.7</td>
<td>Make it a 2 day event with greater emphasis on defined outcomes</td>
</tr>
<tr>
<td>Service Vs Training</td>
<td>1</td>
<td>6.7</td>
<td>Profound lack of discussion about whether having a competency based program can work in Australia if the TRAINING is so influenced by SERVICE demands. This is not the case in Canada, Prof Hodges argues that everything the trainees do is protected by the university.</td>
</tr>
<tr>
<td>Attend more sessions</td>
<td>1</td>
<td>6.7</td>
<td>Looking back I would have liked to attend more sessions though it's not important that I did.</td>
</tr>
<tr>
<td>Progress of CIP</td>
<td>1</td>
<td>6.7</td>
<td>See 2 (Relative lack of information about where CIP and new curriculum are headed apart from some broad concepts)</td>
</tr>
</tbody>
</table>

Any other comments?

<table>
<thead>
<tr>
<th>Theme</th>
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<th>%</th>
<th>e.g.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop praise</td>
<td>4</td>
<td>50</td>
<td>Wow! This is what the College should be doing with its resources: bringing a world expert in training to educate culture carriers within the College.</td>
</tr>
<tr>
<td>Learning experience</td>
<td>1</td>
<td>12.5</td>
<td>I attended the first day of the workshop only. I am there to represent family carers of people with a mental illness, so the whole training process of psychiatrists is a new ‘understanding’ for me. The workshop was a new ‘learning curve’ for me.</td>
</tr>
<tr>
<td>Service Vs Training</td>
<td>1</td>
<td>12.5</td>
<td>Important to discuss how other countries that have a service model similar to ours, which have adapted CANMEDS, have managed the service/education issue, and how they manage the access to sub acute cases issue. Can we have a workplace based training if the</td>
</tr>
<tr>
<td>Held with CFT meeting</td>
<td>1</td>
<td>12.5</td>
<td>Should have been held together with CFT meeting meaning 1 trip to Melbourne for everyone and less expenses for College - could have been combined 1 week meeting CFT + Prof Hodges</td>
</tr>
<tr>
<td>Copies of resources</td>
<td>1</td>
<td>12.5</td>
<td>May be beneficial to have a copy of the presentation given by Prof Hodges so we can present this to supervisors etc.</td>
</tr>
</tbody>
</table>
• Background to CBFP
• Outline of the CBFP Training Program
  – Comparing current & new training program
• Introduction to new components
• Impacts and implementation
  – CBFP project activities and timelines
• Question & Answer
BACKGROUND TO CBFP
Why Change the Curriculum?

- Workforce demands
- Time spent in training
- Exam pass rate
- Lateral entry
- Increase flexibility – not one size fits all;
  - Trainee difference in prior knowledge; rate of competence attainment for different tasks; clinical opportunities
Focus Group Outcomes

- Focus groups held in 2007 identified the following:

<table>
<thead>
<tr>
<th>Key area of competence:</th>
<th>Wanted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical knowledge (general medical and psychiatric)</td>
<td>Clearly defined requirements</td>
</tr>
<tr>
<td>Management and leadership skills (team/colleague &amp; patient/community)</td>
<td>Less paperwork</td>
</tr>
<tr>
<td>Language and communication</td>
<td>Exam preparation program</td>
</tr>
<tr>
<td>Ethical issues and knowledge</td>
<td>Flexibility</td>
</tr>
<tr>
<td></td>
<td>• Complete components more flexibly</td>
</tr>
<tr>
<td></td>
<td>• Sit exams earlier, if criteria are met</td>
</tr>
<tr>
<td></td>
<td>• Opportunity to pursue personal interests with the program</td>
</tr>
</tbody>
</table>
CBFP Aims

• Develop competency based curriculum
• Increase flexibility in training
• Allow for more timely progression
• Provide for lateral entry
  – Recognition of Prior Learning (RPL)
• Maintain high standards of training
• Commenced in 2007 as the Curriculum Improvement Project
• Much development undertaken since 2007
• Moved to Competency Based Fellowship Program (2009) as implementation commenced
Process for CBFP Development

- Review of current curriculum
  - Focus groups with Trainees and DOTs; online survey
- Literature review of international best practice
- Ongoing discussion with RCPsych (UK) & RCPSC (Canada)
- Development of key curriculum components & some associated resources
- Extensive consultation with relevant stakeholders in the development & review of work
- Key General Council Decisions:
  - Approved the *Curriculum Framework* (2008)
  - Endorsed a project-based methodology (2009)
  - Ratified the core Fellowship Competencies (2010)
  - Ratified Minimum Training Requirements (2010)
  - Ratified Summative Assessment Program (2010)
## Recent Curriculum Development Work

### Curriculum development work focus:

<table>
<thead>
<tr>
<th>Goals</th>
<th>Project Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirming component parts</td>
<td>Framework (CanMEDS roles) Fellowship Competencies</td>
</tr>
<tr>
<td></td>
<td>Learning Outcomes Workplace-based assessment Entrustable professional activities</td>
</tr>
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<td>Confirming broad structure</td>
<td>Minimum Training Requirements Summative Assessment Program</td>
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<td>Determining Training Program Pathways</td>
<td>Training Program Model</td>
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<tr>
<td>Aligning existing development &amp; targeting</td>
<td>Learning Outcomes WG EPA WG WBA WG &amp; feasibility studies Work with SATs</td>
</tr>
<tr>
<td>new development at gaps</td>
<td>Publish...</td>
</tr>
<tr>
<td></td>
<td>CBFP Curriculum Document</td>
</tr>
</tbody>
</table>
Current Training

- Time based
  - Structural divide between basic & advanced training
- Apprenticeship model
- Complex ‘required’ activities
- Tension between service and training
- Lengthy time to complete
- Variable Formal Education Course (FEC)
- Trainee dissatisfaction
CBFP Training Program

☑ Time based
☑ Apprenticeship model
☒ Complex ‘required’ activities
😊 Tension between service and training
☒ Lengthy time to complete
☒ Variable Formal Education Course (FEC)
☒ Trainee dissatisfaction
OUTLINE of the CBFP TRAINING PROGRAM
CBFP

- More explicit outcomes – competencies
- Development of competency as Trainees progress through stages of training - developmental trajectory

**Developmental Trajectory**

- **Stage 1**: Low Independence - High Levels Supervision
- **Stage 2**: Developmental Trajectory
- **Stage 3**: High Independence - Low Levels Supervision

**Proficiency Levels**

- **Novice**
- **Basic**
- **Proficient**
- **Advanced**

- **PGY 1/2**
- **Junior Consultant**
Training – Current v CBFP

5 YEAR PROGRAM

BASIC TRAINING

3 YEARS

ADVANCED TRAINING

2 YEARS

CURREN T

Mandatory Rotations

Adult/ acute/ CL/ Child Adolescent

FEC

Mandatory Experiences

Highly variable

5 YEAR PROGRAM

STAGE 1

1 YEAR

STAGE 2

2 YEARS

STAGE 3

2 YEARS

CBFP

Mandatory Rotations

General/ acute/ CL/ Child Adolescent

FEC

Competencies / EPAs / WBAs

Specified outcomes
Assessments – Current v CBFP

**CURRENT**
- Case History 1st Presentation
- Psychotherapy long case
- Written Exam
- OCI
- OSCE
- End of Rotation Forms
- S1 Assessment of knowledge
- Written Exam
- Workplace OCI
- OSCE
- In Training Record

**CBFP**
- Psychotherapy Case
- Scholarly Project
Supervision – Current v cbfp

**Current**
- 2 trainees per supervisor (max)
- Supervision: 4 hrs p/w incl. 1 hr individual clinical
- Rotation assessments

**CBFP**
- 2 trainees per supervisor (max)
- Supervision: 4 hrs p/w incl. 1 hr individual clinical
- Rotation assessments
- WBA
- Occurs here
- Informs these
ST1AK = Stage 1 Assessment of Knowledge; WE = Written Examination; OCI = Observed Clinical Interview; OSCE = Observed Structure Clinical Examination
Building Blocks

- Framework consists of:
  - Fellowship Competencies
  - Learning Outcomes
  - EPAs
  - Developmental Trajectory
  - Developmental Descriptors
  - WBAs
  - Summative Assessment

How do these fit together?
Competencies, Outcomes & EPAs

- Competencies
  - Capabilities achieved through training
  - Professional level
  - On gaining Fellowship trainees will be able to… provide clear, accurate, contextually appropriate written communication about the patient’s condition

- Outcomes
  - More specific
  - Practice level
  - On successful completion of this rotation trainees should be able to… demonstrate comprehensive and legible case record documentation, including discharge summaries and written liaison with referrers, primary care and community organisations
Competencies, Outcomes & EPAs

• EPAs
  – Clinical tasks
  – Core business or high risk
  – Tomorrow you will be allowed to… complete a discharge summary
Simplified Program

Supervisor Assessment

WBA (non-mandatory)

WBA (mandatory)

EPAs

Learning Outcomes

Fellowship Competencies
BRIEF INTRODUCTION TO NEW COMPONENTS
CanMEDS Framework
Fellowship Roles

• Medical Expert
• Communicator
• Collaborator
• Manager
• Health Advocate
• Scholar
• Professional
• Conduct a comprehensive, culturally appropriate psychiatric assessment with patients of all ages
• Demonstrate the ability to perform and report a comprehensive mental state examination, which includes cognitive assessment
• Demonstrate the ability to integrate available information in order to formulate the patient’s condition and make a diagnosis according to ICD or DSM
• Develop, negotiate, implement and evaluate outcomes of a comprehensive evidence based biopsychosociocultural management plan (appropriately revise)
• Demonstrate skills in psychotherapeutic, pharmacological, biological and sociocultural interventions to treat patients with complex mental health problems
• Demonstrate the ability to integrate and appropriately manage the patient’s physical health with the assessment and management of their mental health problems
• Demonstrate the ability to critically appraise and apply contemporary research, psychiatric knowledge and treatment guidelines to enhance patient outcomes
• Demonstrate the ability to appropriately apply mental health and related legislation in patient care
Communicator

- Demonstrate the ability to communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals.
- Demonstrate the ability to provide clear, accurate, contextually appropriate written communication about the patient’s condition.
• Demonstrate the ability to work respectfully with patients, families, carers, carer groups and non-government organisations
• Demonstrate the ability to use interpersonal skills to improve patient outcomes
• Demonstrate the ability to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals
• Demonstrate the ability to work within relevant health systems and with government agencies
• Demonstrate the ability to work within clinical governance structures in health care settings
• Demonstrate the ability to provide clinical leadership within management structures within the health care system
• Demonstrate awareness of the importance of review of and critical appraisal of different health systems and governance/management structures
• Demonstrate the ability to prioritise and allocate resources efficiently and appropriately
• Demonstrate the ability to perform appropriate management and administrative tasks within the health care system
Health Advocate

- Demonstrate the ability to use expertise and influence to advocate on behalf of patients, their families and carers
- Demonstrate the ability to understand and apply the principles of prevention, promotion and early intervention to reduce the impact of mental illness
Scholar

- Demonstrate commitment to lifelong learning
- Demonstrate the ability to educate and encourage learning in colleagues, other health professionals, students, patients, families and carers
- Contribute to the development of knowledge in the area of mental health
Professional

- Demonstrate ethical conduct and practice in relation to patients, the profession and society
- Demonstrate integrity, honesty, compassion and respect for diversity
- Demonstrate reflective practice and the ability to use and provide feedback constructively
- Demonstrate the ability to balance personal and professional priorities to ensure sustainable practice and well being
- Demonstrate compliance with relevant professional regulatory bodies
Implementation of Competencies

- Institutional process
  - Shift from academic conception (teacher focused)
  - Move to needs of society/profession (varying/complex contexts)

Competencies

Linked to workforce needs
Defined by profession

Clear educational outcomes
Implementation of Competencies

- Particularly appropriate for programs leading to professions
  - Aligns:
    - Training Program
    - Learner performance
    - Entry into role

- Demonstrate acquired abilities NOT accrual of program requirements

- Competency-based education is a process NOT a product
Competencies v Outcomes

• Fellowship Competencies
  – Core competencies
  – Common to all areas of practice in psychiatry

• Learning outcomes
  – Specific to area of practice
  – Knowledge & skill expected by completion of area of practice/rotation
  – Discernibly relate back to competencies
    • More than 1 learning outcome likely required to meet competency

Need to complete both
Fellowship Competency:
- High level
- Remain constant throughout training

Learning Outcome:
- Specific to AOP
- Specific to stage of training
Formalising Supervision – Workplace-Based Assessment (WBAs)

WORKPLACE-BASED ASSESSMENT

- Observation of trainee
- Planned meeting
- Trainee self-reflection
- Trainee self-assessment
- Supervisor feedback
- Agreed action/goals
- Activities for learning
- Personal learning plan
Workplace-Based Assessments – the 5A’S Model (5)
Workplace-Based Assessment Tools

- Case-based Discussion
- Observed Clinical Activity (OCA)
- Professional Presentation
- Mini-Clinical Evaluation Exercise (mini-CEX)
WBAs are structured to fit current supervision time

Formalising current activities

Training workshops and professional development

Training resources

Highlights issues early

Timely support from DOT/local training coordinator
Valuing Learning – Feedback...

...aids learning
...is formative
...reinforces good practice
...should be immediate
...corrects performance
...should be specific
...helps to close the gap
...should be frequent
...can be casual
...can be planned
Defining Entrustable Professional Activities (EPAs)

A core unit of work, reflecting a responsibility that should only be entrusted upon someone with adequate competencies

- Is part of essential work in a given context
- Must require adequate knowledge, skill and attitude
- Must lead to recognized output of professional labour
- Should be confined to qualified personnel
- Should be independently executable
- Should be executable within a time frame
- Should be observable and measurable in their process and their outcome (‘well done’ or ‘not well done’)
- Should reflect one or more competencies

(ten Cate 2005)
What Are EPAS?

- Quantify professional disciplinary knowledge and performances
- Identify when trainees can be ‘entrusted’ to progress to more sophisticated levels of partially/unsupervised practice
- Capitalise on professional judgment of competence by clinicians
- Are mapped to Fellowship Competencies in the curriculum
- Are aligned against broad and specific rotational learning objectives and assessment strategies.
Results: Draft EPAs for Stage 1

1. Completing a discharge summary
   - **Description:** Succinct and concise summary of the clinical admission and course with clear follow-up plans.
   - **Assessment:** The supervisor samples randomly the trainees' discharge summaries at least on a monthly basis until competency is demonstrated.
   - **Expected timeframe:** 0-6 months

2. Initiating antipsychotic medication in a patient with schizophrenia
   - **Description:** Discussion of the clinical presentation of the patient, requirement for medication, choice of medication (risks/benefits/costs/availability), informed consent, documentation, communication to patient, carers and families, communication to MDT, review plan
   - **Assessment:** Assessed via a case-based discussion
   - **Expected timeframe:** 3-6 months

3. Active participation in the regular ward round
   - **Description:** Clear and concise communication to other members of the team, keeping to time frames, understand and apply lines of responsibility, managing divergent views and possible conflict, clarify management goals for each patient discussed and allocate tasks to appropriate team members.
   - **Assessment:** Direct observation by supervisor.
   - **Expected timeframe:** 6-12 months

4. Diagnostic explanation to a family about a young adult's illness
   - **Description:** Transfer knowledge of the young adult's illness in everyday terms. Ability to form a therapeutic relationship with the young adults and their family, responding empathically to concerns. Appraise any additional information raised. Awareness of confidentiality issues and any legislation that may impact on the management plan.
   - **Assessment:** Direct observation by supervisor.
   - **Expected timeframe:** Within 12 months
EPA Against CanMEDS Roles

Communicator
- Risk/benefit
- Describe rationale

Medical Expert
- Diagnostic assessment
- Management plan

Collaborator
- Working with team

Manager
- Clear & accurate documentation

Health Advocate
- Cost/benefit analysis
- Access to medication

Professional
- Consent
- Ethics (pharma influence)

Scholar
- Basis pharmacology
- CPGs
- Drug interactions

Initiating Medication
“Passing” EPAs

- Summative decision
  - Trainee *is* or *is not* able to complete activity X independently

- Supervisor decision
  - Supervisor expert judgement, informed by
    - Observation
    - Workplace-based assessment

- Standard of activities
  - Stage of training appropriate
    - E.g. completing a discharge summary Vs. chairing a critical incident review
Level of Supervision is Adapted

- Level 1: not allowed to practice the EPA
- Level 2: practice with full supervision
- Level 3: practice with supervision on demand
- Level 4: “unsupervised” practice allowed
- Level 5: supervision task may be given

*Competence threshold reached; formal entrustment decision, “STAR” (Statement of Awarded Responsibility) is documented in portfolio and in institutional registers, after confirmation by three staff members*
IMPACTS & IMPLEMENTATION
Impacts to Supervision

- Retaining 3 + 1 hours per week model of Supervision
  - Initial modelling of anticipated maximum time costs for Supervisors & Trainees indicates a slight increase.

<table>
<thead>
<tr>
<th>Year</th>
<th>Individual Supervision</th>
<th>EPAs</th>
<th>Admin</th>
<th>Exam prep</th>
<th>Exam co-ord</th>
<th>Other training</th>
<th>TOTAL (hrs)</th>
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<tbody>
<tr>
<td>Stage 1</td>
<td>1</td>
<td>160</td>
<td>10</td>
<td>40</td>
<td>8</td>
<td>16</td>
<td>234</td>
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<td>Stage 2</td>
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<td>5</td>
<td>160</td>
<td>10</td>
<td>40</td>
<td></td>
<td>16</td>
<td>226</td>
</tr>
</tbody>
</table>

- Feasibility studies will inform impacts.
Impacts on Health Services

- Time required for DOTs and Supervisors to complete training in the new CBFP
- Supervision for CBFP will be delivered within the current regulation expectations:
  - Supervisors will continue to be released for training
- Formative assessments can be completed in the 1 hour of one-on-one supervision time.
- Cultural change required to Supervisors approach to supervision.
- The College will provide resources (training resources, professional staff) to run training but will not cover costs to attend training.
- Current supervisor training resource will be modified and used as a resource for the CBFP training.
Key Project Deliverables 2011-2012

• Finalising key new Curriculum elements
  – Workplace based Assessments
  – Entrustable Professional Activities

• Ongoing Quality Assurance of all program changes

• Developing & implementing Supervisor Training model with DOTs

• Communication and engagement with all stakeholders:
  – Ongoing consultations
  – Communiqués to Fellowship and further
  – Website updates (ongoing)

• Feasibility studies

• Aligning assessment with training

• Recognition of Prior Learning
<table>
<thead>
<tr>
<th>Start Dates</th>
<th>Stage of Training</th>
<th>Type of Training</th>
<th>Training Resource</th>
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<tbody>
<tr>
<td><strong>Stage 1</strong></td>
<td>CBFP Preparation</td>
<td>Early Education</td>
<td>CBFP Info PowerPoint's</td>
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<tr>
<td>Feb 2011</td>
<td>Aim: to introduce some of the new initiatives in advance of the roll-out of CBFP to ‘normalise’ processes, get buy-in from DOTS and Supervisors and reduce any ‘fear’.</td>
<td>Within training setting Congress 2011</td>
<td>WBA and feedback Resource Pack</td>
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<tr>
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<td></td>
<td></td>
<td>CBFP Resource Pack (Supervisors)</td>
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<tr>
<td><strong>Stage 2</strong></td>
<td>Core CBFP Training Part I</td>
<td>Pre-workshop preparation</td>
<td>Online tutorials Complete before part II</td>
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<tr>
<td>Nov 2011</td>
<td>Aim: To familiarise Supervisors with the CBFP and new initiatives within the program in preparation for the face-to-face session(s).</td>
<td></td>
<td>CBFP Resource Pack</td>
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<tr>
<td><strong>Stage 3</strong></td>
<td>Core CBFP Training Part II</td>
<td>Workshops</td>
<td>Workshop Module 1</td>
</tr>
<tr>
<td>Nov 2011</td>
<td>Aim: to provide practical training in new CBFP initiatives. Training to a standard so that DOTS and Supervisors are competent to apply initiatives in practice.</td>
<td>Set CBFP Workshops Existing meetings eg Journal Club Congress 2012 Webinars</td>
<td>Workshop Module 2</td>
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<tr>
<td>Train the trainer</td>
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<td></td>
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<tr>
<td>Jan 2012</td>
<td>Supervisor</td>
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<td>Workshop Module 3</td>
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<td><strong>Stage 4</strong></td>
<td>Continuous Professional Training</td>
<td>Professional Development</td>
<td>Training Module 1</td>
</tr>
<tr>
<td>Jan 2013</td>
<td>Aim: to provide a range of modules to support Supervisors in their supervisory role and to provide DOTS with additional training materials to develop supervision skills.</td>
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<td>Training Module 2</td>
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<td></td>
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<td></td>
<td></td>
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<td>Training Module 4</td>
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</table>
Question and Answer Session
Contact Details

- Email: cbfp@ranzcp.org
- Website: http://cbfp.ranzcp.org
STRUCTURAL REFORM OF PSYCHIATRY TRAINING
The RANZCP Competency Based Fellowship Program

Progress Report 9: 1st December, 2011

working with the community
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STRUCTURAL REFORM OF PSYCHIATRY TRAINING .......................................................................................... 1

CBFP Progress Report 9
December 1 2011

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1. Introduction

This report discusses Year 4 of the RANZCP Competency Based Fellowship Program (CBFP), for the period 1st June, 2010 to 30th November, 2011. The report details progress against key deliverables, financial activity and submission of deliverables. Impending challenges to the project are identified with provisional action plans included, as appropriate. The report is identified as the ‘RANZCP Competency Based Fellowship Program, Progress Report 9’.

The Project Management Group responsible for the oversight of the project determined that the program of work associated with the CBFP has evolved from the initial project activities. At the Project Management Groups inaugural meeting in April 2010 it was agreed that it would be more appropriate for the initiative to be known as the Competency-based Fellowship Program (CBFP), in place of Curriculum Improvement Project (CIP), as this more accurately reflects the nature of the changes being implemented, namely a competency-based approach to psychiatry training and education.

2. Key Outcomes Achieved

Key outcomes achieved in the second half of Year 4 of the contract include:

2.1 Communication Strategy and Plan

The CBFP Communication Strategy and Plan has been implemented, ensuring that the perspectives of key stakeholder groups such as the Training Directors and Health Services regarding the likely impact of the new training program are appropriately considered.

2.1.1 The Competency Based Fellowship Program (CBFP) Project Management Group approved a consultation round for engagement of the health services, health departments and those involved in training such as Directors of Training (DOTs) and Hospital/Site Training Coordinators in each of the states/territories in Australia and in New Zealand.

Over the period: 29th November 2010 – 9th August 2011, the Chair of the Board of Education and the Director of Education have visited all Australian states/territories and New Zealand.

Table 1

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Venue</th>
<th>Training Reps</th>
<th>Health Jurisdiction</th>
<th>Number of sessions</th>
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<td>Sydney, NSW</td>
<td>30th Nov 2010</td>
<td>30th Nov 2010</td>
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<tr>
<td>Queensland</td>
<td>Brisbane, Qld</td>
<td>1st Dec 2010</td>
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<td>Victoria</td>
<td>Melbourne, Vic</td>
<td>2nd Dec 2010</td>
<td>9th Aug 2011</td>
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<td>South Australia</td>
<td>Adelaide, SA</td>
<td>10th March 2011</td>
<td>10th March 2011</td>
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<td>Tasmania</td>
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<tr>
<td>Australian Capital Territory</td>
<td>Canberra, ACT</td>
<td>23rd June 2011</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
The sessions included a 30 minute presentation about the CBFP changes followed by a 60 - 90 minute question and answer session which allowed representatives from Health Jurisdictions along with Directors of Training and training representatives to discuss their major concerns and issues.

The presentation itself included:

- Purpose, outline and process of the CBFP
- Comparing current and new training/assessment program
- Workplace-based Assessments – rationale and advantages / disadvantages
- Entrustable Professional Activities (EPAs) – introduction and examples
- Impacts to supervision
- Impacts to Health Services
- Assumptions of impacts on Health Services & Training

A question and answer session followed the presentation based on the current status and future intentions of the College’s implementation of the CBFP. The questions have been collated for all jurisdictions and a final draft report is pending approval of the Chair of the Board of Education, prior to its wider distribution. The first phase of the consultation process has provided invaluable content to inform the change management processes of the project. The second phase of the consultation strategy is currently being planned and will be implemented from January 2012.

The Board of Education and the CBFP Project Management Group recognised the necessity for a Fellow of standing in the College to work closely with the Chair of the Board of Education in the second phase. Dr Stephen Jurd (Chair of the Committee for Training; member of the Board of Education and member of the CBFP Project Management Group) has offered significant pro-bono time in 2012 and will be strongly supported by Project Team members to ensure a continued pro-active communication strategy and presence at key meetings of internal and external stakeholders.

2.1.2 The CBFP website (http://cbfp.ranzcp.org/) has continued to be a key communication forum for the project. Recommendations from development working parties and the Project Management Group overseeing the development work are posted on the website for comment by relevant stakeholder groups. From November 2010 to November 2011, the website has been visited by 4258 individuals.

2.1.3 Monthly communiqués sent to training stakeholders providing updates on project progress (Appendix 1)
2.2 Key curriculum development

Key curriculum and development and implementation strategies supported by dedicated working groups of Fellows, including:

- Board of Education approval of the CBFP Program Pathway to inform new Regulations, Policies and Procedures. Note: The CBFP Regulations and Policies are expected to be ratified by General Council in February 2012
- Learning Outcomes for Stages 1, 2 and 3 completed and approved by the Board of Education
- Draft workplace-based assessment tools (forms) and protocols completed and approved by the Board of Education to progress to Feasibility Studies
- Feasibility Studies methodology approved by the Board of Education. A summary of the two studies is attached (Appendix 2)
- Development Descriptors completed and approved by the Board of Education
- First draft mandatory EPAs completed for Stage 1 and 2
- First draft EPAs for most Areas of Practice for Stage 2 and 3. (Further work scheduled.)
- Supervisor Training Model – Train-the-Trainer Workshops
  - Within the last Progress Report the Train-the-Trainer model was included. The external provider TELLCentre (University of Western Australia) have now concluded five of the workshops in:
    - Perth (17th/18th August 2011);
    - Auckland (25th/26th August 2011);
    - Adelaide (31st August/1st September 2011);
    - Brisbane 8th/9th September 2011)
    - Melbourne (20th/21st September 2011)
    - Sydney (23rd/24th November 2011)
  - A total of 122 participants have been trained as trainers to date.
  - The workshops have been well-received and a final evaluation will be made available in the next progress report to DoHA.
- Workshops held in order to progress:
  - Development of a Stage 2 syllabus
    - Workshop held to determine content and structure
    - Workshop outcomes circulated to training stakeholders for feedback
- Second draft of Stage 2 syllabus to be confirmed and distributed for further review (available on CBFP website http://cbfp.ranzcp.org/)
- The first approval stage will be the sign-off by the Education Content and Quality Group by the 20th January 2012
- Board of Education approval – February 2012

- Development of the Scholarly Project
  - Workshop held to determine content and structure
  - Workshop outcomes circulated to training stakeholders for feedback
  - Second draft of Scholarly Project to be confirmed and distributed for further review (available on CBFP website http://cbfp.ranzcp.org/)
  - The first approval stage will be with the Board of Education in December 2012
  - Board of Education approval is expected February 2012

- Development of the Psychotherapy Long Case
  - Workshop held to determine content and structure
  - Workshop outcomes and proposal distributed to Board of Education for feedback
  - Second draft of Scholarly Project to be confirmed and distributed for further review (available on CBFP website http://cbfp.ranzcp.org/)
  - Board of Education approval is expected February 2012

- Workshops held with members of Sub-committee for Advanced Training (SAT) in Psychiatry of Old Age (POA); Forensic Psychiatry; Consultation-Liaison; Adult Psychiatry; Addiction Psychiatry and the Section of Psychotherapy, in order to progress the development of Stage 3 training and assessment programs in these areas

- Engagement with indigenous mental health representative committees to progress ‘cultural competencies’ work

2. Project quality processes formalised
   - Education Content and Quality Group providing quality review for project deliverables completed, reporting to the Project Management Group

3. The Committee for Specialist International Medical Graduate Education, with funding from the Specialist Training Program (STP), will review the 2011 pilot program using work place based assessments to assess specialist international medical graduates categorised as ‘substantially comparable’ wishing to practice in Australia. It is expected that full implementation of the ‘substantially comparable’ pathway will start in 2012.
Challenges for the Project

The project is currently progressing in accordance with contract deliverables and within budget for 2011. The key challenges for the project include:

- Timely development and implementation of the Competency Based Fellowship Program. In the period July to September the project met with project staff turnover; however, all project officer staff requirements have now been filled.
- Appropriate resourcing of information and communication technologies (ICT) and investment within the RANZCP ICT infrastructure to support the needs of the project

CBFP Year 4 Objectives

Deliverables completed in the second half of Year 4 are detailed in this section.

Project Activity Year 4: 1st June 2011 to 1st December, 2011

1. Curriculum

1.1. Analyse and develop links between curriculum and continuing professional development

The project has continued to progress the work commenced in Year 1, including:

- In November 2011, the Board of Education approved a significant set of resolutions to inform the new regulations, policies and procedures. These resolutions were based on development and analysis work to date for the new program. The resolutions have confirmed the design of the CBFP (program pathway) and brought finality to how the various components of the CBFP come together. The resolutions were presented to General Council for noting November 2011 (Appendix 3)

- A feasibility study to test the work-place based assessments has been developed and approved by the Board of Education The feasibility studies are to begin on a small scale in the second rotation of 2011 for Advanced Training in Child and Adolescent Psychiatry, and on a larger scale for the first rotation in 2012 with first year trainees and their supervisors.

- A Stage 2 syllabus is under development; the syllabus defines the knowledge areas required for trainees during the second stage of training. This knowledge is largely to be acquired in the mandatory Formal Education Courses; the syllabus will be made available to Formal Education Course providers to support alignment in training expectations.

- Workshops continue to be held with all Sub-committee’s of Advanced Training (SAT) groups, to progress the development of specific learning outcomes and assessment programs in these areas of practice. SAT groups are actively considering how their programs, or parts of their programs, might be made available to the broader Fellowship as CPD modules, utilising EPAs to structure this.

- The General Manager, Education and Training, is leading a working party to undertake the mapping/blueprinting of the CBFP. This working party is to
convene 7th December 2011 to inform the scope of work and process required.

1.2. Develop national training network for better support and development of supervisors

As advised in the previous progress report, A working group, Training in the Competency Based Fellowship Program (TiCBFP) was established to assist with the development of a training strategy for the training of Training Directors, supervisors and trainees in the new Fellowship training program. A training model was proposed and accepted, and a Request for Tender sent out to a number of potential external providers to be engaged to facilitate the delivery of the training model. The (appointed) external provider (TELLCentre, University of Western Australia) have facilitated these workshops and the development of teaching/learning resources (these have been provided in hardcopy only and accompany this report) The participants have included Directors of Training and others responsible for training in their states. The schedule for these workshop has been outlined in 2.2 above.

Future work to support supervisors for the next reporting period includes:

- Webinars to be conducted in early December to inform the use of the workplace based assessments.
- Training in the Entrustable Professional Activities session at the Directors of Training Workshop in February 2012
- The development of a comprehensive on-line (web-based) CBFP resource to provide information, support and training modules in all components of the new program
- Congress (May 2012) workshops on the components of CBFP

2. Examination and Assessment

2.1. Third trainee workshop to support sitting examinations

2.2. As part of the implementation of the CBFP, a training model is under development to support trainees in the new program. Under the training strategy, described in section 1.2 of this report, initiatives will be in place to ensure that trainees entering the College’s training program under the CBFP regulations have the opportunity to access support materials describing the training program in detail, including description of the structure and function of the assessment program and examples of workplace-based assessments (the comprehensive CBFP resource as described above in (1.2)Develop national training network for better support and development of supervisors

As agreed with the Department in June, 2008, the delivery of workshops for trainees with respect to assessment will be delayed until the feasibility studies of WBA are concluded. However, workshops to assist trainees to prepare for other College assessments have been developed as pre-Congress events. At the 2011 Congress workshops were held for trainees to cover critical analysis problems and the clinical examinations. Workshops focussing on examination and assessment will remain key events at the 2012 pre-Congress sessions for trainees.
3. Site Accreditation

3.1. Recruitment of an Accreditation Officer

3.2. Implement revised site accreditation review

3.1 Recruitment of an Accreditation Officer

The College has recruited a new ‘Manager, Training and CME’ in June 2011 who has accreditation experience and has taken on the College role of supporting and implementing the new Accreditation process with the relevant training Committees. The College plans to recruit a relevant Admin Officer in 2012 to continue to support the training team in the transition to the new program accreditation standards in 2013.

3.2 Implement revised site accreditation review

The CBFP has been engaged in collaboration with the Accreditation Working Party of the BOE. The working party developed draft policies and procedures to support the implementation of the accreditation processes (Appendix 4). The working party has now officially dissolved and a new Accreditation Sub-Committee of the Committee for Training will commence in 2012 with elections planned for Q1 2012; in order to implement the new ratified policies and procedures in 2012 ahead of the new CBFP program accreditation standards in 2013. The accreditation standards cover educational, clinical and governance areas and will be transitioned across. Existing accredited rotations will be grand-parented into the new process (Appendices 5 and 6). The accreditation process involves oversight by College General Council, the Committee for Training, the Committee for Education Quality Reporting, and the Board of Education.

Contract Alignment

All deliverables for Year 4 of the contract have been significantly progressed towards the implementation of the CBFP from January 2013 for Australian trainees. The workplan outlines the activities of the Project Management Group and associated working groups, highlighting the progression from conceptual thinking to the development of a tangible curriculum, professional development for stakeholders and a detailed communication and organisational change plan to support the implementation.

The work ahead of the CBFP in the forthcoming reporting period between December 2011 and May 2012 will consist of the following activity (A project work plan is attached in Appendix 7)

1. Feasibility testing of WBA tools, including focus, protocols and acceptability
2. The development of a comprehensive on-line (web-based) CBFP resource to provide information, support and training modules in all components of the new program to support all stakeholders (but mainly targeted at Supervisors, Trainees and Directors of Training)
3. Continued consultation, aligned with the stakeholder groups identified in the communication strategy and plan; ongoing and regular communication and consultation with key groups including Training Directors, and health services. The second round of consultation visits is planned to be undertaken in March 2012 by the Chair of the Board
of Education and a senior Fellow in the College who has volunteered to be the 'CBFP Champion' throughout 2012.

4. Further collaboration with the Sub-committees for Advanced Training reviewing their draft specific learning outcomes and assessment requirements for final approval

5. The development and approval of the training regulations and policies for the new training program. Significant regulation/policies include:
   - Recognition of Prior Learning policy;
   - Failure to Progress policy;
   - Remediation policy; and
   - Transitional arrangements into the new training program for current trainees

6. The approval of a Stage 2 syllabus to guide knowledge requirements in Formal Education Courses

7. Consultation with Formal Education Course providers to ensure alignment between course content and the RANZCP syllabus

8. Blueprinting/Mapping of the CBFP learning and assessment components

9. ICT requirements prescribed by the CBFP are currently being considered in a College-wide context by a dedicated ICT working group. An ICT project manager has been recruited to progress this important component of CBFP.

**Budget**

The project is progressing within guidelines with a budget deficit of $138,623.35 (excl GST) at October 31st, 2011 (see appendix 8). Recognising the importance of ensuring the effective implementation of the new curriculum, the Resource Management Committee (RMC) and the General Council (GC) continue to contribute College funding to the project as and when required.

**Conclusion**

The CBFP continues to progress in accordance with the requirements of the contract. Significant progress has been made towards the completion of the Competency Based Fellowship Program curriculum material, with work underway to facilitate the completion and approval of the associated policies and procedures for the program.

The CBFP website continues to provide regular updates and engagement with stakeholders, as increasingly those involved in the training program become invited to comment and review project outcomes. As noted earlier the College is aware of the challenges that may impact on the project, including budget and ICT issues, and continues to plan to mitigate these factors.
The Competency-Based Fellowship Program (CBFP) initiative is developing a competency-based curriculum framework for the RANZCP training program in line with international best practice in specialist medical education. The CBFP will provide an aligned curriculum with integration between outcomes, learning opportunities and assessment and promote key adult learning principles including lifelong learning, self-reflection and workplace-based assessment. The competency-based framework aims to better prepare psychiatrists to be creative problem solvers and critical thinkers who are capable of innovative practice and are committed to accepted professional and societal standards of patient-centred care.

**CBFP Program Pathway**
The Program Pathway Working Party met on 23–24 September to confirm the training pathway of the CBFP. Recommendations from this Working Party will be presented to the Board of Education as resolutions to be approved in November. These resolutions will inform the development of the regulations, policy and procedures that govern the CBFP.

**Scholarly Project and Stage 2 Syllabus**
Draft guidelines and marking criteria for the Scholarly Project and the draft Stage 2 Syllabus were recently sent to key stakeholders and posted on the CBFP website for comment. Valuable feedback has been received and will be carefully considered by the respective Working Parties in November. Thank you to all who provided feedback on these documents, your comments are most appreciated.

**Train-the-trainer workshop evaluation**
Train-the-trainer workshop participants are reminded to complete the online evaluation form on the TELL Centre website. The evaluation form responses provide valuable feedback which is critical to the continuing success of the program. After completing the form, workshop participants are able to download the RANZCP Facilitator Training Program certificate. Thank you to those participants who have already completed their evaluation.

The last train-the-trainer workshop is to be held on 23–24 November in Sydney (registration closed).

**Project activities**
The following CBFP activities were held during October:
- Consultation with key stakeholders on the Scholarly Project and Stage 2 Syllabus.
- SATCAP feasibility pilot study.
- Preparation for the bi-national feasibility study.
- CBFP IT Systems & Support Steering Committee.
- SAT engagement.

**Feasibility Study**
RANZCP will undertake a bi-national feasibility study in January–June 2012 of the four workplace-based assessment tools developed for the CBFP. The purpose of the study is to test the feasibility of the tools in terms of practicality, acceptability and professional utility within the RANZCP training program. The outcomes of the feasibility study will guide further refinement of the tools prior to their implementation.

Webinars for DOTs and supervisors involved in the feasibility study are planned for early December and will provide information and training in the use of the workplace-based assessment tools.

**New staff**
The CBFP welcomes three new Project Officers: Bronwen Evans, Cathy Schapper and Pania Whibley.
Frequently Asked Questions

What is the rationale for the Scholarly Project?

The rationale for the Scholarly Project is in response to a recommendation from the Australian Medical Council to provide training opportunities to encourage academic psychiatry.

The Scholarly Project is premised on the following principles:

- Specialists need to take a leadership role in research and evaluation of their practice.
- The practical experience of scholarship is a fundamental part of postgraduate training and this entails a critique and assimilation of scientific evidence applied to their practice.
- Psychiatrists need to demonstrate a minimal level of skill in scholarship prior to entering independent practice anticipating that these skills will grow and develop throughout their professional lives.

The Scholarly Project has been designed to help trainees meet the Fellowship competencies and will contribute to the trainee’s ability to achieve the following learning outcomes:

- critically evaluate academic material
- demonstrate knowledge of research methodologies
- generate research of peer-review quality.

Why develop a syllabus?

Consistent with the CBFP primary objective of an effective and efficient outcome-oriented framework for the training program, syllabi for Stages 1 and 2 of the CBFP have been developed.

The syllabi intend to define, for trainees and educators, the knowledge base that underpins the acquisition of competencies in Stages 1 and 2 and that are required for progression.

The syllabi content is intended to inform knowledge acquisition across clinical, informal and formal education settings as well as self-directed learning in accordance with the CBFP framework.

Further information:

Information and the latest news can be found on the CBFP website: http://cbfp.ranzcp.org

For further information regarding the CBFP, please email: cbfp@ranzcp.org

Acknowledgement

The Board of Education would like to thank the Fellowship for their continued significant and ongoing contribution to the development of the CBFP.
Introduction
CBFP will undertake a bi-national feasibility studies during 2011/2012 of the Workplace based Assessment tools developed for the RANZCP training program.
The purpose of the feasibility study is to test the feasibility of the WBA tools within the RANZP training program; feasibility in terms of practicality, acceptability and professional utility.
An additional purpose of this study is to inform WBA tools & implementation policy.

SATCAP trial WBA pilot 2011
A pre-feasibility testing of the WBA tools will be undertaken running within SATCAP’s trial of advanced training during rotation two 2011.
2-3 sites will include the Mini-CEX & CbD with a small number of basic trainees, to be used throughout the entire rotation. Tested using a questionnaire, and final interviews.

Feasibility study Rotation 1 2012
Participants will include all first year trainees in rotation one 2012 and their supervisors.
Training zones will be designated one WBA tool, which the supervisor and trainee will undertake.
Trainees/Supervisors to undertake a mandatory WBA within the initial 10 weeks of training.

Pre-implementation plan:
EXECUTIVE SUMMARY

The Competency Based Fellowship Program (CBFP) will be implemented under new education regulations, policies and procedures from December 2012 (New Zealand) and January 2013 (Australia). The project has been managed by the CBFP Project Management Group (CBFP PMG) since April 2010. The framework and educational components of the CBFP were approved by the Board of Education and the CBFP PMG in the form of a project management plan which outlined the scope of work and schedules. Significant development work has been undertaken by the Fellowship by being members of specific working parties since April 2010.

The developed work to date has been through consultation and feedback processes, sign-off by relevant committees, the CBFP Education Content and Quality Group, and subsequent approval by the Board of Education Executive and the Board of Education at the appropriate times.

General Council has previously ratified Board of Education recommended Resolutions to progress the development of CBFP regulations, policies and procedures. Further resolutions have now been considered and developed based on the approved scope of work and the developed work to date by the Program Pathway Working Party members and the Board of Education at their September 2011 and November 2011 meetings respectively.

The Chair of the Board of Education now brings to General Council for noting, an outline of the Board of Education ratified regulations, policies and procedures. Further work is required to develop fully the new CBFP regulations, policies and procedures. This work will be guided by the approval of GC to restructure the education regulations and will be presented to General Council 2012/1 for their ratification.
RESOLUTION Previously Ratified by General Council (out-of-session September 2010)

1. New trainees entering the RANZCP training program from 1 December, 2012 (New Zealand) and 1 January, 2013 (Australia) will be enrolled under the new CBFP regulations.

RESOLUTIONS Previously Ratified by General Council (GC 2010/4)

2. For Fellowship of the RANZCP, trainees are generally required to complete a minimum 60 months (FTE) of accredited training in approved training programs.

3. Training will be divided into the following three stages:
   - Stage 1 (Basic level – one year);
   - Stage 2 (Proficient level – two years)
   - Stage 3 (Advanced level – two years)

4. Progression between the stages of training is dependent on the attainment of competent performance across all the roles (medical expert, communicator, collaborator, manager, health advocate, scholar, professional).

5. Stage 1 of training requires the mandatory completion of a minimum of 12 months (FTE) of accredited training in an approved general psychiatry training post, 6 months of which must be in an acute setting.

6. Stage 2 of training requires the mandatory completion of a minimum of 24 months (FTE) accredited training in an approved training program.

7. Trainees are required to complete rotations in the following mandatory areas of practice:
   - 6 months (FTE) approved training in Consultation–Liaison Psychiatry
   - 6 months (FTE) approved training in Child and Adolescent Psychiatry

8. Trainees will also undertake rotations in the following areas of practice, achieving competent performance to a proficient standard:
   - Addiction
   - Psychiatry of Old Age
   - Forensic
   - Adult
   - Rural
   - Indigenous
   - And other areas of practice as approved by the Board of Education

9. Stage 3 of training requires the mandatory completion of a minimum of 24 months (FTE) accredited training in an approved training program.
10. The following areas of practice have been identified:
   - Addiction
   - Adult
   - Child and Adolescent
   - Consultation–Liaison
   - Forensic
   - Indigenous
   - Psychiatry of Old Age
   - Psychotherapies
   - Research/Academic
   - Rural
   - And other areas of practice as approved by the Board of Education

11. The trainee will demonstrate competence to a proficient level in psychotherapies by the end of their training. The development of psychotherapeutic skills will develop throughout training.

12. Trainees will be required to complete one long psychotherapy intervention (approximately 1 year or 40 sessions) and a minimum of four briefer interventions.

13. In order to obtain Fellowship trainees must have successfully completed a College approved scholarly project.

14. The Observed Clinical Interview (OCI) Examination is a clinical examination required for Fellowship of The RANZCP.

15. The OCIs can be attempted in Stage 3 once the Written Examination is successfully completed. The OCI standard is set at the level of junior consultant.

16. From 2012 the OCI Examination is no longer coupled to the Objective Structured Clinical Examination (OSCE) in terms of time, geography or the calculation of results. They are separate examinations. From 2012 if a candidate passes either the OCI Examination or OSCE they are not required to complete these again unless currency expires.

17. The Objective Structured Clinical Examination (OSCE) is a clinical examination required for Fellowship of The RANZCP.

18. The OSCEs can be attempted in Stage 3 once the Written Examination is successfully completed. The OSCE standard is set at the level of junior consultant.

19. From 2012 the OSCE Examination is no longer coupled to the OCI in terms of time, geography or the calculation of results. They are separate examinations. From 2012 if a candidate passes either the OCI Examination or OSCE they are not required to complete these again unless currency expires (refer to Link 19).
1. There will be staggered implementation of the CBFP regulations
   - Stage 1 to start December 2012
   - Stage 2 to start December 2013
   - Stage 3 to start December 2015

2. Transitional arrangements will apply for current trainees.

3. An application for Recognition of Prior Learning (RPL) must be completed at the time of application to the approved training program.

4. College approved training must occur in a College-approved training post

5. In order to supervise trainees in the College Fellowship program, supervisors will be required to be accredited College supervisors.

6. Transitional arrangements will apply for current supervisors

7. (Accreditation) Criteria for approval of training posts will include the ability of the post to fulfill the supervision level required and to ensure that all supervisors are trained in the assessment of competencies of the CBFP.

8. (Accreditation) A policy should be considered to stipulate the accreditation of supervisors within the different areas of practice.

9. During Stage 2, the trainee will achieve competent performance to a proficient level in the following areas of practice:
   - Addiction Psychiatry
   - Psychiatry of Old Age

10. This can be achieved through a specific Addiction or Psychiatry of Old Age rotation (Stage 2) or as an experience within Stage 1 or 2 of training.

11. Competence will need to demonstrate that trainees have been entrusted in the prescribed activities by the successful completion of the Addiction and Psychiatry of Old Age EPAs.

12. During Stage 3, trainees will achieve competent performance to an advanced level in either a single area or multiple areas of practice.

13. Trainees in Stage 3 can complete 24 months (FTE) in a single area of practice.

14. Trainees undertaking 12 months of research/academic or specialised administrative/managerial training during Stage 3 must continue to maintain clinical currency in an area of clinical psychiatry.

15. Each (current) mandatory experience would need to be demonstrated in the supervisor’s In Training Assessment and should be clearly linked to a professional CanMEDS role. Policies
would be developed on how to ensure that supervisors were competent to assess the competence of trainees in these areas.

16. Workplace-based assessment (WBA) tools will be used for the formative assessment of competencies.

17. The WBA tools will be determined by the Board of Education.

18. A policy will be developed to specify the nature of and how those WBA tools will be used with the introduction of the CBFP.

19. Progression through training requires the trainee to be entrusted to perform specific EPAs.

20. The mandatory EPAs for each stage of training and area of practice are determined by the Board of Education.

The following professional activities must be entrusted by the end of Stage 1 [details still to be finalised]:

- Active participation in the multidisciplinary ward round.
- Providing an explanation to a family about a (young) adult’s major mental illness.
- Initiating an antipsychotic medication in a patient known to have schizophrenia who is suffering from positive symptoms.
- Producing succinct, organized and informative discharge summaries in a timely manner.

21. The following EPAs must be assessed and achieved at a proficient level by the end of Stage 2. [details still to be finalised]

- Demonstrating proficiencies in all the expected tasks associated with prescription, administration and monitoring of ECT.
- The application and use of the Mental Health Act.
- The safe and effective use of clozapine in psychiatry.
- Comprehensive risk assessment.

The following EPAs are specific to the areas of practice (as named) and must be assessed and achieved at a proficient level by the end of Stage 2. [details still to be finalised]

22. Addiction psychiatry

- Stabilisation of drug dependence.
- Integrated assessment and management of a person’s substance use and mental health problems.

Psychiatry of Old Age

- Comprehensive care planning – management of old age dementia.
- Pharmacology – demonstrating use of antipsychotics and/or antidepressants in patients over 75 years of age.
The following EPAs are specific to

**Consultation–Liaison psychiatry**

- Care for a patient with delirium.
- Manage clinically significant psychological distress in the context of a patient’s medical illness in the general hospital.

**Child & Adolescent psychiatry**

- Reporting assessment of an adolescent to the multidisciplinary team.
- Clinical interview of a pre-pubertal child.

23. EPAs will be required for the following areas of practice:

   - Indigenous
   - Rural

24. For each of the remaining rotations in Stage 2, a minimum of two EPAs must be assessed and achieved at a proficient level. Branch Training Committees will advise which EPAs must be completed during the rotation.

25. For all Stage 3 rotations, a minimum of two EPAs must be assessed and achieved at an advanced level.

26. There may be an opportunity to use RPL on a case-by-case basis to accredit Certificate EPAs undertaken during Stage 2 of training.

27. Completion of an In-Training Assessment form, as part of the formative assessment process, at the mid-rotation point.

28. Completion of an In-Training Assessment report, as part of the summative assessment process (in order to progress), at the end of the rotation.

29. That an appropriate subcommittee (the Scholarly Project Subcommittee) be established to govern the conduct and assessment of the scholarly project.

30. That the written examination is set at the knowledge level and application of knowledge of a junior consultant.

31. The written examination can be attempted after acquiring the Fellowship competencies to a proficient level.

Note: GC has ratified 30. and 31. above. “*The Written Examination is placed on the threshold of Stage 2 and Stage 3 training (current years 3-4)*” is recommended to be removed from the regulations.

Following a vote by the Board of Education, eight out of thirteen members voted in favour of having no restrictions as to when trainees could attempt the examination and agreed that they should be permitted to attempt the examination at any time after Stage 1 training.

32. The first written examination set at the junior consultant level will be available to be sat in March 2015.

33. Current trainees’ last opportunity to sit the Written Examination under current regulations will be August 2016.
Contents

1. Title
   The RANZCP Training Accreditations Policy

2. Policy Statement
   Accreditation of RANZCP Training rotations and programs is a core quality assurance activity of the College.

3. Purpose
   The Training Accreditations Policy ensures that RANZCP rotation and program accreditations are performed in a transparent, standardised and rigorous manner that is robustly monitored and reviewed.

4. Scope Objectives
   The Training Accreditations Policy applies to RANZCP accreditation of all Training programs and rotations throughout Australia and New Zealand. This includes the sites of Training within the programs, i.e. the settings of the rotations.
   This Policy supports robust governance and reporting processes associated with Training Accreditations.

5. Policy Details
   This Policy is supplemented by the Training Accreditations Standard Operating Procedures (SOPs) which outline the procedure and processes whereby the Accreditation Subcommittee of the Committee for Training (ASC) coordinate program accreditation visits to each RANZCP Training program bi-nationally on a five-yearly basis.

6. Roles and Responsibilities – for all parties
   • Accreditation Subcommittee
     As per the SOPs and ASC Regulation: To train and appoint accreditors from the Accreditor Panel to each visit; to maintain and review Accreditation Standards; to review Accreditation Reports and:
     i. Address any process variances
     ii. Evaluate the visit from a procedural perspective, including effective management of conflicts of interest
     iii. Compile and annual report to the Board of Education (BOE) and Committee for Education Quality Reporting (CEQR) regarding the operation of the year’s visits.
   • Accreditor Panel
     To conduct program accreditation visits as per the SOPs. Each visit receives a:
- Lead Fellow, experienced in accreditations, to lead the visit.
- Additional Fellow, to contribute to the professional review of the program.
- Trainee observer, to participate in the visit.
- Secretariat member, who is dedicated to Training Accreditations and who is responsible for completing the Accreditation Report as per the SOPs.

- **Local Director of Training**
  - To prepare, with assistance from the Secretariat member, and pre-visit paperwork and to host the visit and to respond to Accreditation Report recommendations.

- **Local Directors of Advanced Training**
  - To contribute to pre-visit paperwork and the visit as required and to respond to Accreditation Report recommendations.

- **Local Trainees**
  - To complete Annual Accreditation Surveys and to participate in Accreditation Visits as per the SOPs.

- **Local Supervisors**
  - To complete Annual Accreditation Surveys and to participate in Accreditation Visits as per the SOPs.

- **Committee for Training**
  - To receive the final Accreditation Report as per the SOPs and:
    i. Endorse the report
    ii. Monitor progress on any recommendations (via the Secretariat support staff member)
    iii. Disseminate the report as per the SOPs, including to BOE and College General Council as required in the event of major concerns and/or disaccreditation.

- **Committee for Education Quality Reporting**
  - To receive an annual report from the ASC regarding the operation of the year’s visits for review.

- **Fellowship Attainment Committee**
  - To be advised of matters referred from ASC/CFT to BOE.

- **Branch Training Committee**
  - To contribute to pre-visit paperwork and the visit as required, and to disseminate the final Accreditation Report as per the SOPs and to respond to Accreditation Report recommendations.

- **Board of Education**
  - To consider any concerns or disaccreditations reported to it by the ASC/CFT.

- **College General Council**
  - To be aware of any disaccreditations or other major concerns.

- **Health Services**
  - To contribute to pre-visit paperwork and the visit as required and to respond to Accreditation Report recommendations.

7. Monitoring, Evaluation and Review
   The Training Accreditations Policy is to be monitored by the BOE. Its operation is to be monitored by the CEQR. It will be reviewed as required by the ASC and CFT and updates require General Council approval.

8. Definitions and Abbreviations – to include the term and its meaning
   - **Accreditor**: Member of Accreditor Panel visiting the Training program
   - **ASC**: Accreditation Subcommittee of the Committee for Training
   - **BOE**: Board of Education
   - **BTC**: Branch Training Committee
   - **CFT**: Committee for Training
   - **DOAT**: Director of Advanced Training
   - **DOT**: Director of Training
FAC  Fellowship Attainment Committee  
GC  College General Council  
Program  Training zone  
Rotation  Training Post  
SAT  Subcommittee for Advanced Training  
Site  Location of Training within a program, eg hospital  
SOP  Standard Operating Procedure  
TRC  Registrar Representative Committee  

9. Associated Documents  
   Accreditation Schedule  
   Accreditor Panel Position Descriptions  
   Annual Accreditation Surveys  
   ASC Position Descriptions  
   ASC Regulation  
   FAQ documents: Supervisors and Trainees  
   Standards Report pro forma  
   Training Accreditation SOPs  
   Training Accreditation Standards  
   Training Accreditation Standards Reports  
   Training AccrEDITor Handbook  

10. References  
    As per Associated Documents  

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### Rotation Accreditation Standards
**Royal Australian & New Zealand College of Psychiatrists (RANZCP)**

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**Rotation Accreditors:**

- Director of Training:  
- Clinical Director / nominated delegate: 
- Trainee representative: 

**Interviewee names:**

1. 
2. 
3. 
4. 
5. 
6. 

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**APPENDIX 5**
ROTATION ACCREDITATION STANDARDS

Instructions for the completion of accreditations or reaccreditation of training rotations:

1. The rotation must be part of an established vocational training program approved by the Royal Australian & New Zealand College of Psychiatrists (RANZCP) Committee for Training.

2. Training requirements, as outlined in the rotation standards, must be met. Two excellence standards are outlined in Standard 4.2 and are voluntary standards indicating service excellence.

3. Standards 1, 2, 4 and part of 5 are directly related to the rotation being accredited. Standards 3, & part of 5 include overarching service or organisational training standards that support the educational experience of a trainee in that rotation; these sections should be completed by the DoT (Director of Training) of the training zone.

4. Accreditors will be guided by the rotation accreditation standards in this document.

5. Accreditors must use the appropriate standards for basic or advanced training for both initial and reaccreditation of rotations.

6. Please attach any requested documents e.g. Position Description, Orientation Information etc.

7. All newly established positions require accreditation as a College approved rotation.

8. All existing rotations require 5-yearly reaccreditations.

9. Evidence of each rotations accreditation against the standards must be provided at the formal 5-yearly training program accreditation visits. Copies of accreditation documents should be submitted to Secretariat member prior to an accreditation visit.

10. It is the responsibility of each branch training committee or individual training program to arrange rotation accreditation and reaccreditation processes. These groups should prioritise visits to those rotations requiring foremost attention.

11. Accreditors should be two members of the branch or local training committee (or delegates of these committees,) and should include a trainee representative.

12. Trainees, supervisors, the team leader and the manager responsible for the rotation should receive a copy of the Standard Operating Procedures and Accreditation Standards before the visit.

13. Accreditors should meet with trainees currently in the rotation and may request to speak with former trainees who have completed the rotation. Accreditors should meet with the trainees separately from the supervisors.

14. The accreditors must also meet with the supervisor(s) and the team leader/operations manager.
15. Other staff may be included at the accreditors’ discretion or guided by previous site report recommendations.

16. After the accreditation visit is completed, all participating staff will receive a succinct report. The Branch Training Committee (BTC) is responsible for distributing the report.

17. The report must include commendations, recommendations, and timelines for the implementation of any recommendations.

18. The BTC retains ultimate responsibility for the accreditation, monitoring and review of all training rotations.

**ROTATION ACCREDITATION STANDARDS**

**STANDARD 1: Service requirements and rotation position description**

**CRITERIA**

1.1 Every rotation must have a position/job description

All trainees must be provided with a written job description for the rotation that outlines:

- the place, nature, quantity of clinical work (FTEs), times at work and rotation category
- communication policies and expectations for the rotation (clinical notes, referrals, discharge summaries)
- expected clinical responsibilities including multi-disciplinary team review meetings
- participation in handover
- on-call/on-duty responsibilities
- teaching responsibilities to house officers and medical students.

**EVIDENCE**

- A copy of the position description

1.2 A process is in place to continuously monitor and review the trainee’s work and case load

Services must have processes to:

- monitor trainee workloads
- address concerns when they are raised by trainees or supervisors
- manage trainee workloads to ensure they are not excessive.

**EVIDENCE**

- A statement that indicates the expected case load during the rotation
1.3 Trainees must have access to appropriate orientation for the rotation
Trainees should receive a written or verbal orientation to the rotation by their supervisor, team leader or from another nominated staff member.

Trainees should be introduced to the multi-disciplinary team by their supervisor or team leader.

EVIDENCE
- A copy of the orientation handbook or information provided to the trainee

1.4 Trainees must have access to generic and required service training
Trainees must be free to attend service training as required during the rotation.

EVIDENCE
- An outline of service training sessions to be attended by the trainee

1.5 Trainees have the ability to take study and annual leave during the rotation
Trainee may take a maximum of 6 weeks of all types of leave during a 26 week rotation. During sub-specialty rotations, a maximum of 4 weeks leave may be taken.
Service has adequate staffing and systems in place to ensure trainees are able to take leave.

EVIDENCE
- Trainee is able to confirm they have been able to take leave

STANDARD 2: Provision of required training experiences

CRITERIA

2.1 An accredited Formal Education Course (FEC) is available to trainees in the rotation
Services are required, as per Regulation 12.1 of the RANZCP Training and Assessment Regulations, to provide assured access to a recognised (and committee approved) formal education course. Trainee attendance at a FEC is compulsory for a minimum of 3 years.

Services must ensure that:
- Trainees have protected time to attend the FEC and are not required to respond to pagers or phone calls during learning sessions
- Advanced trainees can attend training requirements, such as psychotherapy group supervision and peer review groups.
2.2 The rotation has an adequate capacity to train and offers a range of experiences

The rotation must provide a range of experiences to allow a trainee to develop the knowledge and skills required to satisfy the learning objectives of the rotation.

Basic trainees should:
- Be able to achieve continuity of care during the rotation, if required by the trainee
- Be able to achieve the required range of psychotherapy experiences and psychotherapy supervision, if required by the trainee
- Have access to a range of training experiences needed to satisfy basic training requirements as stipulated in the RANZCP Training and Assessment Regulations.

Advanced trainees should:
- Be provided with support to achieve learning goals for psychological aspects of management in psychiatry
- Be provided with support to achieve learning goals for biological aspects of management in psychiatry
- Be provided with support to achieve learning goals for social aspects of management in psychiatry
- Be provided with support to achieve the application of consultative skills in psychiatry
- Be able to participate in required CPD activities
- Be provided with support to develop leadership and management skills in psychiatry.

EVIDENCE
- The learning objectives for the rotation
- A statement outlining what additional training requirements may be met in the rotation (e.g. ECT, old age, addiction, child and adolescent, consultation liaison)
- A copy of the training program to be attended by the advanced trainee.
- Have the ability to attend examination preparation programs
- Have supervisor assistance available to help prepare for trainee clinical examinations, either during supervision or as additional assistance.

- Institutional bullying and harassment of trainees is unacceptable and services must ensure that there are mechanisms to promptly address bullying and trainee grievances.

- Services must have adequate processes to support any trainee involved in a critical incident or subjected to threats or an assault during their clinical work and have a process to review such incidents.

**EVIDENCE**
- A copy of the services bullying and harassment policy
- An outline of critical incident policies and processes

### 3.2 Adequate processes to monitor and encourage the progress and training experience of trainees within the program

There are adequate processes to monitor the performance of trainees and to provide formal and informal feedback.

Timely feedback and remediation processes are in place for any poorly performing trainees. These processes occur both within rotations and across changes between rotations, and specific progress reviews are organised as required.

Supervisors should receive:
- Feedback about the performance of a trainee in previous rotations
- Progress reviews prepared by the DOT.

**EVIDENCE**
- Supervisor and trainee are able to confirm standard is being met

### STANDARD 4: Institutions/services and training rotations

**CRITERIA**

#### 4.1 An adequate level of resourcing and day-to-day support is provided to trainees

The rotation offers trainees the opportunity to work in a safe and supportive environment that has processes in place to ensure they have adequate access to resources and supports for learning, including:

- Access to library services, institutional or library internet access and office desktop access to intranet. Minimum requirements are basic psychiatry texts and a representative range of journals, access to the RANZCP website and to other important online resources such as the
• During the rotation, the supervisor and clinical director monitor the service-training tension and ensure the trainee has sufficient time for learning and training experiences. Should this be in 1.2?
• Pathways exist to maximize supervisor and trainee safety, including after-hours policies, safe assessment areas, optional duress alarms, access to support and security staff, and training in the management of challenging behaviour.
• During the rotation, the trainee has access to acute psychiatry experience on after-hours rosters, with the provision of adequate consultant supervision, crisis team staff support (or similar) and systems for accessing inpatient beds.

Services should aspire to meet the following non-mandatory, excellence standards:
• During the rotation, the trainee has the opportunity to participate in audit or other quality assurance programs
• Trainee is able to work with allied, non-medical professional staff, in particular psychologists, psychiatric nurses, social workers and occupational therapists, all of whom make significant contributions to the training experience of trainees.

EVIDENCE
• Visit to library during accreditation visit
• A copy of current safety guidelines and policies

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**4.2 Adequate office or workspace facilities are available to trainees**

Services must provide adequate facilities for trainees to conduct their clinical work, including access to office facilities for confidential interviews and psychotherapy with patients, and adequate facilities to conduct physical examinations or provide appropriate medical care.

Ideally, services should provide an office, to be used by at most 2 trainees, for necessary clerical work and internet access as specified in 4.1. Where the team has no personal offices, at least a desk, computer workstation and lockable storage area for the trainee’s texts and equipment must be provided. The trainee must also have access to a room for study or dictation, sufficient IT access and office space so that clinical work is not impeded.

EVIDENCE
• Inspection of office or workspace facilities during accreditation visit

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**4.3 Processes to ensure that specific training requirements, as defined in the training objectives, are met in mandatory rotations**

Supervisors and service directors should be aware of specific training experiences that must be provided in mandatory rotations and ensure that these are provided. The provision of required training experiences is to be monitored by the DOT at the 6-monthly meetings with trainees.

Processes are in place to address any shortfalls in mandatory rotations, regarding their ability to meet the required training objectives.
All adult psychiatry rotations must:
- Provide a good grounding in core clinical skills as per the training objectives for first year trainees
- Provide the opportunity for trainees to complete the 10 observed interviews as per Link 33, and to receive formative feedback.

All consultation-liaison rotations must:
- Provide a liaison component as well as the consultation experience, as per Regulation 5.8
- Ensure that trainees spend no more than 30% of their time in the Emergency Department.

Child and Adolescent psychiatry rotations must:
- Provide trainees with the opportunity to comprehensively assess the minimum of 5 pre-pubertal children and 5 adolescents during the term as per Regulation 8.6, Link 34.

EVIDENCE
- Training record indicates that trainee was able to meet all specific training requirements and training objectives in the rotation.

STANDARD 5: Supervision
CRITERIA
5.1 Adequate provision of supervision within the program
Supervision should be provided in accordance with Regulation 7.1 with wherever possible, supervision being provided by suitable College Fellows following the apprenticeship model of training. It is expected that:
- Trainees are able to achieve the requirement for mutually observed interviews and assessments (trainee observing supervisor and supervisor observing trainee)
- Trainees receive a minimum of 20 hours 1:1 supervision in each 26 week rotation (or 40 hours for a 1st-yr trainee) and undertake 4 hours of conjoint work with their supervisor weekly, of which at least 2 hours must be outside ward meetings. Closer supervision should be provided for first year trainees.
- Supervisors work alongside trainees in the workplace for a minimum of 3 sessions weekly (i.e. three half days)
- Supervision sessions are regularly scheduled and free of interruptions
- Supervisors are aware of the people under the trainee’s care to facilitate a clear line of clinical responsibility from the trainee to the clinical supervisor.
- Content of supervision should involve an integrated and comprehensive approach to assessment and treatment. Supervision should enhance the trainee’s skills, knowledge, skills and attitudes in line with the RANZCP curriculum learning objectives.
• Supervisors will provide 3-monthly and 6-monthly written feedback for the registrar and the local training committee. This must be discussed with the registrar at the time and the registrar should be given a copy by the supervisor. The principal supervisor should consult with other supervisors, on-call psychiatrists and senior members of the clinical team before providing this feedback.
• The recommended ratio of trainee to supervisors is not more than two trainees per fulltime (1.0 FTE) consultant.

EVIDENCE
• Rosters indicate that regular, protected supervision time is scheduled
• Thorough written feedback reports are completed on time

5.2 Adequate standards of training and accreditation for supervisors within the program

Rotation supervisors must:
• Complete approved supervisor training and maintain accreditation as a College supervisor by undergoing refresher training every 5 years
• Have access to and be able to demonstrate familiarity with the RANZCP Training and Assessment Regulations, the Curriculum and the RANZCP Code of Ethics
• Attend a supervisors peer review session, or a meeting of psychiatrists where supervision is the focus, a minimum of 3 times per year
• Follow College approval processes for non-RANZCP supervisors if they are not currently a Fellow.

EVIDENCE
• Supervisor is able to produce evidence of current accreditation
### Standard 1 – Service requirements and rotation (position) description

<table>
<thead>
<tr>
<th>Accreditation Standard</th>
<th>Details of this Standard</th>
<th>Specific Requirements Linked to this Standard</th>
<th>Detail how this Standard is Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Every rotation must have a position / job description</td>
<td>Trainees must be aware of and preferably given a written job description for the rotation.</td>
<td>The trainee must receive a written job description outlining:&lt;br&gt;- The place, nature, quantity of clinical work (FTEs), times at work and rotation category&lt;br&gt;- Outline communication policies and expectations for the rotation (clinical notes, referrals, discharge summaries)&lt;br&gt;- Expected clinical responsibilities including multidisciplinary team (MDT) review meetings&lt;br&gt;- Expectations of participation in Hand Over.&lt;br&gt;- On-call / on duty responsibilities during the rotation&lt;br&gt;- Time to attend required training e.g. Formal Education Course (FEC)&lt;br&gt;- Access to regularly, scheduled clinical supervision sessions&lt;br&gt;- Teaching responsibilities to house officers and medical students&lt;br&gt;- Please attach copy of position description.</td>
</tr>
<tr>
<td>1.2</td>
<td>A process is in place for monitoring and reviewing the trainee’s work and case load</td>
<td>The trainee must be aware of policies and guidelines to request a workload review</td>
<td>Services must have:&lt;br&gt;- Processes to monitor trainee’s workload in place and a policy on how concerns about excessive workloads are raised and addressed&lt;br&gt;- Processes and policies to address the trainee’s concerns about workload and / to help trainees manage clinical workloads.&lt;br&gt;- Please indicate trainee’s expected case load</td>
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</tr>
<tr>
<td><strong>1.3</strong></td>
<td>Trainees receive appropriate orientation for the rotation.</td>
<td>Adequate orientation and introduction to the multi-disciplinary team should be provided by the supervisor and /team leader.</td>
<td>The trainee receives verbal or written orientation to the rotation by the supervisor, team leader or by another nominated staff member.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Please attach a copy of the orientation handbook (if available)</td>
</tr>
<tr>
<td><strong>1.4</strong></td>
<td>Trainees have access to generic and any required in-service training</td>
<td>Trainees must be able to attend service training requirements during the rotation</td>
<td>Indicate service training requirements for the trainee:</td>
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<tr>
<td><strong>1.5</strong></td>
<td>Trainees have the ability to take study and annual leave during the rotation</td>
<td>Trainees can take study and annual leave - but all types of leave may not exceed 6 weeks in total of the 26-week rotation.</td>
<td>A trainee may take the maximum of 6 weeks of all types of leave during a rotation. During sub-sPECIALITY rotations, a maximum of 4 weeks leave may be taken. The service has sufficient staff numbers and systems in place to enable trainees to take leave.</td>
</tr>
</tbody>
</table>
## Standard 2 – Provision of Required Training Experiences

### 2.1
An accredited **Formal Educational Course** (FEC) is available to trainees in the rotation

**Regulation 12.1 of the RANZCP Training and Assessment Regulation**

Assured access to a recognised (and committee approved) formal education course

<table>
<thead>
<tr>
<th>All trainees must be able to attend a Formal Education Course or Advanced Training Programme.</th>
<th>The trainee can <strong>attend a FEC</strong> if required. (A trainee must attend three years of a FEC during basic training).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainees have <strong>protected time</strong> to attend the FEC and are not required to respond to pagers and phone calls during learning sessions.</td>
<td>Advanced trainees can attend required generic and specific training requirements during the rotation.</td>
</tr>
</tbody>
</table>

### 2.2
The rotation has a reasonable capacity to meet **expected learning objectives** for the rotation and provide the appropriate **range of experiences**

**RANZCP Training and Assessment Regulations 2.5-2.7 and 4.4 (Links 22-29)**

<table>
<thead>
<tr>
<th>The rotation reasonably meets the learning objectives or competences expected of the rotation.</th>
<th>Basic training:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainees have access to training experiences during the rotation e.g. psychotherapy, NGO and carer experiences, addiction and old age psychiatry experiences etc.</td>
<td>Trainees can achieve learning objectives of the rotation</td>
</tr>
<tr>
<td>Trainees can achieve continuity of care during the attachment if this is needed by the trainee.</td>
<td>Trainees are able to achieve the required range of psychotherapy experiences and psychotherapy supervision if this is needed by the trainee.</td>
</tr>
</tbody>
</table>

**RANZCP Training and Assessment Regulations 9.4 Links (62-28)**

<table>
<thead>
<tr>
<th>Advanced Training:</th>
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</thead>
<tbody>
<tr>
<td>Advanced trainees are provided with the support to achieve learning goals for psychological aspects of management in psychiatry.</td>
</tr>
</tbody>
</table>

✈️ Please include the learning objectives that will be achieved during this rotation:

- ECT
- Old Age
- Addiction
- Child and Adolescent
- Consultation Liaison
<table>
<thead>
<tr>
<th><strong>Advanced trainees are provided with the support to achieve learning goals for biological aspects of management in psychiatry.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced trainees are provided with the support to achieve learning goals for psychological aspects of management in psychiatry.</strong></td>
</tr>
<tr>
<td><strong>Advanced trainees are provided with the support to achieve learning goals for social aspects of management in psychiatry.</strong></td>
</tr>
<tr>
<td><strong>Advanced trainees are provided with the support to achieve the “application of consultative skills” in psychiatry.</strong></td>
</tr>
<tr>
<td><strong>Advanced trainees are able to participate in required CPD activities (e.g. peer review)</strong></td>
</tr>
<tr>
<td><strong>Advanced trainees are provided with the support to develop leadership and management skills in psychiatry.</strong></td>
</tr>
</tbody>
</table>

*Please include a copy of the generic advanced training programme that an advanced trainee in the rotation can attend.*
### Standard 3 – Organisation, Monitoring and Support of Trainees

| 3.3 Adequate processes to support Trainees to complete their training | There are processes to support trainees in achieving their assessments and examinations during the rotation | Trainees have the ability to attend examination preparation programmes during the attachment: 

Supervisor assistance is available to help prepare for trainee clinical examinations (during supervision or as additional assistance) |
<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>The Training Committee and DOT recognise that institutional bullying of trainees is unacceptable and ensure that there are processes to address this promptly, should it occur</td>
<td>There are mechanisms to deal promptly with trainee grievances or with any institutional bullying within the rotation, should this occur</td>
<td></td>
</tr>
</tbody>
</table>
| The program ensures that local Services and Institutions have adequate processes to support any trainee involved in a Critical Incident or subjected to threats or an assault during their clinical work, and to review any such incident | There are pathways in place to support a trainee involved in a Critical Incident; subject to threats or an assault, so as to ensure that the trainee is appropriately supported. | A copy of the services bullying and harassment policy 
An outline of critical incident policies and processes |

<table>
<thead>
<tr>
<th>3.4 Adequate processes are in place to monitor and promote the progress and training experience of Trainees within the program</th>
<th>There are adequate processes to monitor the performance of trainees and to provide formal and informal feedback</th>
<th>Supervisors receive feedback about a trainee from a previous rotation or has received progress reviews prepared by the DoT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely feedback and remediation processes are in place for any poorly performing trainees. These processes occur both within rotations and across changes between rotations, and specific progress reviews are organised as required</td>
<td>Supervisors are made aware by the DoT of a remediation or performance management plan for a trainee working in the service.</td>
<td></td>
</tr>
</tbody>
</table>
## Standard 4 – Institutions/Services and Training Rotations

<table>
<thead>
<tr>
<th>4.1</th>
<th>An adequate standard of training is provided at any <strong>Institutions or Services</strong> within the program</th>
<th>Trainees have access to a variety of training options in the organisation and have supports in place to facilitate learning.</th>
<th>Trainees can regularly attend local seminars, journal clubs, and grand rounds during the rotation.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Trainees have ready access to library services. They have access to institutional or library internet and office desktop access to an intranet service. Minimum requirements include access to basic psychiatry texts and a representative range of journals, access to the RANZCP website and to other important on-line resources.</td>
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<td></td>
<td>Trainees have the ability to participate in acute psychiatry experience through after-hours rosters, with clearly outlined consultant supervision, Crisis Team staff support (or similar) and clearly outlined pathways for accessing inpatient beds.</td>
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<td></td>
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<td>During the period of the rotation, the Supervisor and Clinical Director monitor the service-training tension and ensure that the trainee has sufficient time for learning and training experiences.</td>
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<td>Whilst on the rotation, pathways exists to maximise supervisors’ and trainees’ safety, including after-hours policies, safe assessment areas, option of duress alarms, access to support and security staff, and training in the management of challenging behaviour.</td>
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<tr>
<td><strong>Excellence standard</strong></td>
<td></td>
<td>Whilst on the rotation the trainee has the ability to participate in audit or other quality assurance programs</td>
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<tr>
<td>Excellence standard</td>
<td>The trainee has access to and the ability to work with allied, non-medical professional staff who make significant contributions to the training experience of trainees, in particular psychologists, psychiatric nurses, social workers and occupational therapists</td>
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<tr>
<td>4.2 Adequate processes exist to <strong>accredit Training rotations</strong> within the educational program</td>
<td>All rotations must meet standards for accreditation: To be accredited, the rotation must:</td>
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<td></td>
<td>Have adequate clinical supervision and ability to access help or advice from a consultant in the workplace.</td>
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<td></td>
<td>Have clear lines of clinical responsibility from the trainee to the responsible consultant, at all times during the rotation</td>
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<td></td>
<td>Provide adequate facilities for trainees to conduct their clinical work, including work stations, office facilities for confidential interviews, telephone discussions, or psychotherapy. They require facilities to conduct physical examinations or to provide other required medical care.</td>
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<tr>
<td></td>
<td>Preferably to provide an office for the trainee to study and conduct clinical work. The maximum of 2 trainees sharing an office is recommended.</td>
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<tr>
<td></td>
<td>Where the team has no personal offices, the trainee should have access to a desk, computer workstation and lockable storage area for personal gear, texts and equipment. Trainees must have close access to rooms for study, confidential telephone calls and to dictate correspondence.</td>
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<tr>
<td></td>
<td>Trainees must have sufficient access to computer so that clinical work is not impeded.</td>
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</table>

⇒ Visit to library during accreditation

A copy of current safety guidelines and policies
| 4.4 Adequate processes to ensure that specific training requirements are met within mandatory rotations (as in the Regulations or as recommended by Faculties or Sections) | Supervisors and Service Directors are aware of the specific training experiences required for mandatory rotations and ensures that the rotation provides these. Each mandatory rotation’s ability to provide required training experiences as set out in the Training Objectives for the rotation and is monitored via the DOT/Deputy at the 6-monthly meetings with trainees. Processes are in place to address any shortfalls in mandatory rotations and their inability to meet the required training objectives. | Provide sufficient opportunities to promote trainee development, e.g. make formal presentations of their work during clinical meetings and supervision, and for mutual observation of interviews by the trainee and supervisor. | Adult Psychiatry rotations must provide adequate training in core clinical skills as per the training objectives and competences identified for the first year trainees. Adult Psychiatry rotations provide the opportunity for trainees to complete the 10 Observed Interviews as in Link 33, and to receive formative feedback about their performances. Consultation-Liaison rotations provide a liaison component as well as the consultation experience. Regulation 5.8 During the Consultation-Liaison rotation, in accordance with the recommendations of the Section of Consultation-Liaison Psychiatry, not more than 30% of a trainee’s time is spent in the Emergency Department. During the Child & Adolescent rotation the trainee must be able to comprehensively assess the minimum of five pre-pubertal children and five adolescents during the term Regulation 8.6 Link 34 |
### Standard 5 – Supervisors

| 5.1 Adequate provision of **Supervision** within the program  
*Regulation 7.1 (Link 38)* | The ratio of approved supervisors to trainees is satisfactory.  
The apprenticeship model of training is preserved.  
Wherever possible, supervision is provided by suitable College Fellows | Trainees are able to achieve the requirement for mutually observed interviews and assessments (trainee observing supervisor and supervisor observing trainee) |  |

- Trainees receive a minimum of 20 hours of individual supervision in each 26-week rotation, and 4 hours of weekly joint work with their supervisor, with closer supervision for the first year (a minimum of 2 hours/week excluding ward meetings).
- Supervisors work alongside trainees in the workplace for a minimum of 3 sessions weekly (i.e. three half-days).
- Supervision sessions must be regularly scheduled and free of interruptions.
- Supervisors know about the people under the trainee’s care. This will facilitate a clear line of clinical responsibility for the trainee to the clinical supervisor.
- The content of supervision includes an integrated and comprehensive approach to assessment and treatment. Supervision should enhance the trainee’s skills, knowledge & attitudes in line with the RANZCP curriculum and rotation’s learning objectives.
- Supervisors provide 3-monthly and 6-monthly written feedback for the registrar and the local training committee. This must be discussed with the registrar at the time, and the registrar should be given a copy by the supervisor. The principal supervisor should consult with other supervisors, on-call psychiatrists and senior members of the clinical team, before providing this feedback.
- The recommended ratio of trainee to supervisors |
<table>
<thead>
<tr>
<th>5.2 Adequate standards of <strong>Training and accreditation for Supervisors</strong> within the program</th>
<th>College processes for the approval and training of supervisors as in Link 38 are followed</th>
<th>is not more than two trainees per fulltime (1.0FTE) consultant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>College processes for the approval of non-RANZCP supervisors have been followed</td>
<td>The supervisor has completed approved supervisor training (e.g. a workshop) initially and thereafter a supervisor update training program every 5 years.</td>
<td></td>
</tr>
<tr>
<td>The supervisor has access to and demonstrates familiarity with the <strong>RANZCP Training and Assessment Regulations</strong>, the <strong>Curriculum</strong> and the <strong>RANZCP Code of Ethics</strong></td>
<td>The supervisor attends a supervisors' peer review session (or a peer meeting of psychiatrists where supervision is a substantial focus) for the minimum required 3 sessions per year.</td>
<td></td>
</tr>
</tbody>
</table>
STANDARD OPERATING PROCEDURES

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1. GENERAL INFORMATION

1.1 Introduction
The bi-national RANZCP Committee for Training (CFT) is responsible for the accreditation of all training programs in Australia and New Zealand. Accreditation visitors, the “accreditors”, ensure that training programs provide quality educative experiences which facilitate the training of safe and competent psychiatrists.

Training programs must meet the CFT Standards for Accreditation of Training Programs. Accordingly, the visitors assess:

- the degree to which the apprenticeship model of training is applied
- the adequacy of lines of clinical responsibility
- that the provision of supervision meets College requirements
- that the range of individual rotations throughout the training program provides satisfactory training and gives a sufficiently broad clinical experience
- working conditions and workload of trainees, and the resources / facilities provided
- the overall organisation of the program
- the atmosphere and morale within the program.

1.2 Frequency
1.2.1 Routine accreditation visits of training programs are conducted every five years.
1.2.2 Inter-cycle visits will be conducted in the case of a recommendation for a follow-up visit, by the accreditors, or to address other identified issues or requests.
1.2.3 Visits will usually occur over two days.

1.3 Accreditation Visitors
1.3.1 A team of four accreditors will attend the visit, comprising:
   - A lead Fellow (from another Training program)
   - An additional Fellow (from another Training program)
   - A Trainee observer (from another Training program)
   - A Secretariat staff member with specific responsibility for Training accreditations.
1.3.2 Fellows and Trainees participate as accreditors on a pro bono basis.
1.3.3 The Chair of the Branch Training Committee (BTC) and one local Trainee is invited to attend the accreditation as an "observer".
1.3.4 In special circumstances, psychiatrists or other relevant College personnel, other than members of the CFT and Directors of Training (DOTs), may be invited to participate in accreditation visits.
1.3.5 The Secretariat member will be a full member of the accreditor team with primary responsibility for recording and documentation.
1.3.6 All accreditors will be members of the “Accreditor Panel” and will have been trained in RANZCP Training accreditations.

1.4 Accrèditor Panel
1.4.1 The accreditor panel, from which accreditors are selected for each accreditation, will include DOTs, Service Directors (who are Fellows), experienced Supervisors (who are Fellows), Trainees and the Secretariat member.
1.4.2 Members are selected on to the accreditor panel by (1) providing expressions of interest (when called for), (2) meeting the requirements of the relevant Accrèditor Position Description, and (3) being appointed by the Accreditation Subcommittee of the CFT (ASC).
1.4.3 A minimum of eight accreditors comprise the panel.
1.5 Funding of Visits
1.5.1 The CFT budget funds program accreditations.
1.5.2 Accreditors do not receive a salary, however economy class airfares and travel expenses are reimbursed in accordance with College guidelines.
1.5.3 Costs incurred in addition to those allowed for within College guidelines cannot be met by the College.
1.5.4 Every effort should be made to reduce costs, such as arranging visits backed on to existing meetings.

1.6 Reporting
1.6.1 The accreditation report should ensure clarity of expression and the recommendations should correlate with the content in the body of the report. The report must outline recommendations and provide a timeframe within which required change is expected. Recommendations may be classified according to matters which:
- Must be rectified for continuing accreditation of aspects of the training program
- Should be addressed
- Fall outside the brief of the Board of Education (BOE) but on which observations are made for consideration by the institutions and training programs concerned.

The report will nominate when the next visit is to be undertaken (either by the CFT or local BTC). If the next visit is to occur sooner than would be routinely expected, details will be given about which aspects of the training program are to be scrutinised.

1.6.2 Should any appeal result in amendment to a final Accreditation Report, these are to be approved by the CFT and to be identified via an addendum page and/or “tracked-changes” with appropriate explanation. Recirculation of the report should be accompanied by a formal communiqué from the CFT and this communicated to the BOE.

1.7 Appeals
1.7.1 The procedure for reconsideration of a decision of a BOE Committee is outlined on the College website via “Pre-Fellowship – Complaints Resolution”.

1.7.2 Procedures for appeals, to be followed upon exhaustion of the procedures for reconsideration, are detailed in the document ‘RANZCP Appeals Process’.

1.8 Timeline

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Accreditation Process</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Year prior to</td>
<td>Identify sites to be accredited in the coming visit.</td>
<td>DOT</td>
</tr>
<tr>
<td>accreditation visit</td>
<td>Inform the CEO of the Health Service.</td>
<td>Secretariat</td>
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<tr>
<td></td>
<td>Allocate site visitors.</td>
<td>ASC</td>
</tr>
<tr>
<td>12 weeks prior to</td>
<td>Confirm the date of the accreditation visit.</td>
<td>Secretariat</td>
</tr>
<tr>
<td>accreditation visit</td>
<td>Send the Director of Training all draft documentation for the visit.</td>
<td>Secretariat</td>
</tr>
<tr>
<td>8 weeks prior to</td>
<td>Send accreditation information to supervisors and trainees and other stakeholders.</td>
<td>Secretariat</td>
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<tr>
<td>accreditation visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks prior to</td>
<td>Complete the timetable for the accreditation visit and schedule meetings.</td>
<td>DOT</td>
</tr>
<tr>
<td>accreditation visit</td>
<td>Circulate the timetable to accreditors.</td>
<td>Secretariat</td>
</tr>
<tr>
<td></td>
<td>Make travel and accommodation bookings.</td>
<td>Visitors</td>
</tr>
<tr>
<td>4 weeks prior to</td>
<td>Complete pre-visit documents.</td>
<td>DOT</td>
</tr>
<tr>
<td>accreditation visit</td>
<td>Circulate all documents to the accreditors</td>
<td>Secretariat</td>
</tr>
<tr>
<td></td>
<td>Make any local travel / catering arrangements required.</td>
<td>DOT / Secretariat</td>
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<tr>
<td>2 weeks prior to</td>
<td>Accreditors teleconference</td>
<td>Secretariat</td>
</tr>
<tr>
<td>accreditation visit</td>
<td></td>
<td>and accreditors</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Activity</td>
<td></td>
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<td>---------------------------</td>
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<tr>
<td><strong>The accreditation visit</strong></td>
<td>- Complete an initial draft report on the day of the visit.</td>
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<td></td>
<td>- Provide informal, verbal feedback to the Director of Training.</td>
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<td></td>
<td>- Circulate the first draft of the Accreditation Report to the accreditors.</td>
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<td>- Finalise Accreditation Report.</td>
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<td></td>
<td>- Forward the final draft of the Accreditation Report to the DOT for factual confirmation.</td>
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<td></td>
<td>- Send the final report to the ASC and the CFT (Executive).</td>
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<td>- Advise the BOE of any concerns.</td>
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<td>- Advise BOE and GC (General Council) of any recommendation for disaccreditation of a training program.</td>
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<td></td>
<td>- Submit the final report to the BTC and DOT.</td>
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<td>- Disseminate the final report to local Training Committees, service management, Trainees, local Training institutions, and other stakeholders as appropriate.</td>
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<td></td>
<td>- Undertake to monitor progress with recommendations.</td>
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<tr>
<td><strong>1 week post accreditation visit</strong></td>
<td>- Evaluate the visit from a procedural perspective, including management of conflicts of interest.</td>
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<td><strong>2 weeks post accreditation visit</strong></td>
<td>- Address any process variances</td>
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<td><strong>4 weeks post accreditation visit</strong></td>
<td>- Final day for formal reconsideration of the report, 28 days after its publication.</td>
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<td></td>
<td>- Compile an annual report to the BOE and the Committee for Education Reporting (CEQR) regarding the operation of the year’s visits.</td>
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<td></td>
<td>- Accreditation surveys conducted and results monitored and disseminated to relevant DOTs, the CFT and accredits.</td>
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<tr>
<td><strong>12 weeks post accreditation visit</strong></td>
<td>- Undertake to monitor progress with recommendations.</td>
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<tr>
<td><strong>28 days post accreditation visit</strong></td>
<td>- Final day for formal reconsideration of the report, 28 days after its publication.</td>
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<tr>
<td><strong>Annually</strong></td>
<td>- Compile an annual report to the BOE and the Committee for Education Reporting (CEQR) regarding the operation of the year’s visits.</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>- Address any process variances</td>
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</table>
2. PRE-VISIT PREPARATION

2.1 Responsibilities of the Committee for Training (CFT)
The CFT delegates to the ASC to:

2.1.1 Schedule accreditation visits and allocate accreditors to visits twelve months in advance.

2.2 Responsibilities of the Secretariat

2.2.1 A formal letter is sent to the CEO of the Health Service (as identified by the DOT) as notification of the intended accreditation visit, approximately one year in advance.

2.2.2 A date for the visit is confirmed with the DOT and the accreditors, twelve weeks prior to the visit.

2.2.3 All relevant documents are circulated to the Director of Training for completion eight weeks prior to the visit. The documents include:

- CFT Standards for Accreditation of Training Programs
- Pre-Visit Information for Training Programs (including checklist of all mandatory training requirements for accreditation)
- Visit Timetable Template
- Sample Visit Timetable
- Copy of previous Accreditation Report
- Standard letter formats to be sent to service providers

2.2.4 Accreditation information, including the visit dates and accreditor details, is sent to supervisors and trainees, and any other stakeholders as identified by the DOT, eight weeks prior to the visit.

2.2.5 The Accreditation timetable is obtained from DOT and provided to accreditors six weeks prior to the visit.

2.2.6 All accreditation information and documentation is collated and sent to the visitors, four weeks prior to accreditation.

2.2.7 Assistance to be provided to the DOT as required for local travel / catering requirements, four weeks prior to the visit.

2.2.8 A brief, preparatory teleconference is held with the DOT and the accreditors, two weeks prior to the visit.

2.3 Responsibilities of the Program Director of Training (DOT)

2.3.1 Upon confirmation of the visit date (12 months prior to the visit), the sites to be including in the accreditation are to be identified.

2.3.2 The date for the accreditation visit is confirmed in conjunction with the Secretariat and the accreditation visitors, twelve weeks prior to the visit.

2.3.3 Confirm with the Secretariat the details of all stakeholders (e.g. trainees, supervisors, relevant hospital administrators) who should be advised regarding the upcoming visit, eight weeks prior to the visit.

2.3.4 Meetings are scheduled and the timetable for the visit is completed and provided to the accreditors via the Secretariat six weeks prior to the visit.

2.3.5 Pre-visit documentation is completed and provided to the accreditors via the Secretariat four weeks prior to the visit.

2.3.6 Any arrangements for local travel / catering should be confirmed four weeks prior to the visit and the Secretariat can assist this.

2.4 Responsibilities of the Accreditors

2.4.1 The accreditors will make their own travel arrangements, with assistance from the College approved Travel Agent, around six weeks prior to the visit. Sufficient time should be allowed prior to and following the visit to discuss pertinent issues.

2.4.2 Visitors will receive the pre-visit documentation approximately four weeks prior to the accreditation visit. Visitors should familiarise themselves with the content. Documents will include:
- A copy of the current rotation Trainee Placement Report (Secretariat can provide)
- A copy of the Annual Supervisor Summary (Secretariat can provide)
- Institutions involved and specific aspects of training offered
- Mechanisms for allocation to training rotations
- After-hour rosters
- Assessment procedures for trainees and feedback to supervisors
- Terms of reference and structure of the local training committee
- Minutes of the most recent meeting(s) of the local training committee
- Details of the Formal Educational Course in basic training and any advanced training courses
- Any facilities requiring particular attention
- The relevant standard pro-forma report(s) for completion at the end of the visit.

2.4.3 Accreditors and the DOT need to attend a preparatory teleconference two weeks prior to the accreditation visit.

2.5 Responsibilities of the Branch Training Committee (BTC)

2.5.1 The BTC should provide assistance to the DOT in the preparing paperwork and scheduling meetings as necessary.
3. ON THE DAY ACTIVITIES

3.1 The Accreditors
3.1.1 The visit is transcribed as it occurs, by the Secretariat member, in order to produce the initial draft report.
3.1.2 Accreditors should collaborate with the DOT during the visit and may provide informal, verbal feedback at the time.

3.2 The Visit Timetable
3.2.1 In general it is more efficient to hold all meetings at a central venue, and only to travel to specific locality visits.
3.2.2 Required meetings:
   3.2.2.1 Director(s) of Training (initial meeting)
   This is a brief, familiarisation meeting about the training program and current issues of concern.
   3.2.2.2 Trainee only meetings
   All available trainees in the training program should be included. Meetings are confidential and trainees can be de-identified to maintain anonymity. This should allow trainees to speak openly and to be honest about all aspects of training, particularly regarding supervision. This meeting should always take place prior to supervisor and administrator meetings.
   3.2.2.3 Local Trainee Representative Committee (TRC) / Association of Psychiatrists in Training (APT) meeting
   This meeting is strongly recommended. It could be scheduled at the trainee meeting time.
   3.2.2.4 Supervisor meeting
   Supervisors will be asked to:
   - describe the supervision processes within the training program
   - discuss any problems with the supervision process
   - discuss the training and roles of supervisors
   - review the trainee assessment procedures (i.e. mid cycle and end of rotation assessments).
   3.2.2.5 Branch / Local Training Committee meeting
   Areas of discussion can include:
   - how training programs are developing
   - comparisons with developments in other areas of Australia and New Zealand
   - information on liaison between local training committees and the BCT and CFT.
   3.2.2.6 Accreditation visitor meeting time
   For reflection; to consider findings, initial report, and feedback to be offered to the DOT.
   3.2.2.7 Feedback meeting
   This meeting includes the DOT, potentially the Chair of the BTC, and the accreditors. Feedback will be general and tentative. Formal recommendations are given after due consideration and preparation of a formal written report.
3.2.3 Recommended meetings:
   3.2.3.1 CEO and/or senior administrator (of the training institutions) meeting
   3.2.3.2 Meeting with other appropriate academic personnel
   3.2.3.3 Training facilities
   Different institutions will be visited on successive visits. Training facilities to be seen include:
   - clinical areas
   - trainee office accommodation
   - seminar areas
   - library facilities.
   3.2.3.4 Meetings with individual psychiatrists or trainees (on request)
Arranged through the local Training Committee where particular problems exist and involve those individuals who require specific attention.
4. POST VISIT REQUIREMENTS

4.1 Responsibilities of the Committee for Training (CFT)
4.1.1 Advise the BOE of any significant concerns, what recommendations have been made, and how they will be monitored, four weeks following the visit.
4.1.2 Advise the BOE and GC of any visits resulting in any disaccreditation, four weeks following the visit.
4.1.3 Provide the final Accreditation Report to the BTC (and DOT) for dissemination four weeks following the visit.
4.1.4 Progress with the Accreditation Report is monitored in collaboration with the Secretariat.
4.1.5 The final Accreditation Reports should be tabled at each face-to-face meeting of the CFT and BTC Chairs should speak to the recommendations.
4.1.6 A summary of Accreditation Report recommendations, and their status, is to be tabled at CEQR, FAC (Fellowship Attainment Committee) and BOE face-to-face meetings.

The CFT delegates to the ASC to:
4.1.7 Evaluate accreditation visits from a procedural perspective, including management of conflicts of interest, within twelve weeks of a visit.
4.1.8 Address any process variances identified in accreditation visits within twelve weeks of them being identified,
4.1.9 Compile an annual report to the BOE and the CEQR regarding the operation of the year’s visits.

4.2 Responsibilities of the Secretariat
4.2.1 The first draft of the Accreditation Report is provided to the accreditors 1 week following the visit.
4.2.2 The final draft of the Accreditation Report is provided to the DOT, for factual check, two weeks following the visit.
4.2.3 The final Accreditation Report is proof-read and provided to the ASC and the CFT four weeks following the visit.
4.2.4 Progress with the Accreditation Report is monitored in collaboration with the CFT.
4.2.5 Accreditation surveys are conducted annually and results are monitored and appropriately disseminated to relevant DOTs, the CFT and accreditor panels.

4.3 Responsibilities of the Program Director of Training (DOT)
4.3.1 The draft Accreditation Report is factually checked with tracked-changes returned to the Secretariat within two weeks of the visit.

4.4 Responsibilities of the Accreditors
4.4.1 The first draft of the Accreditation Report should be finalised two weeks following the visits.
4.4.2 The final Accreditation Report will be submitted to the ASC and CFT four weeks following the visit and so any comments from the DOT, regarding the first draft, should be considered before then.

4.5 Responsibilities of the Branch Training Committee (BTC)
4.5.1 The final report should be disseminated to local Training Committees, service management, Trainees, local Training institutions, and other stakeholders as appropriate, four weeks following the visit.
4.5.2 Any appeal to the final report must be submitted to CFT within 28 days of the visit.
5. REFERENCE

5.1 ASSOCIATED DOCUMENTS

- Training Accreditations Policy
- Accreditation Schedule
- Accreditor Panel Position Descriptions
- Annual Accreditation Surveys
- ASC Position Descriptions
- ASC Regulation
- FAQ documents: Supervisors and Trainees
- Pre-Visit Information for Training Programs
- Sample Accreditation Visit Timetable
- Sample Report
- Standards Report pro forma
- Training Accreditation SOPs
- Training Accreditation Standards
- Training Accreditation Standards Reports
- Training Accreditor Handbook

5.2 INTERPRETATION

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Accreditor</td>
<td>Member of Accreditor Panel visiting the Training program</td>
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<tr>
<td>ASC</td>
<td>Accreditation Subcommittee of the Committee for Training</td>
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<tr>
<td>BOE</td>
<td>Board of Education</td>
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<tr>
<td>BTC</td>
<td>Branch Training Committee</td>
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<tr>
<td>CFT</td>
<td>Committee for Training</td>
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<td>DOAT</td>
<td>Director of Advanced Training</td>
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<tr>
<td>DOT</td>
<td>Director of Training</td>
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<tr>
<td>FAC</td>
<td>Fellowship Attainment Committee</td>
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<td>GC</td>
<td>College General Council</td>
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<tr>
<td>Program</td>
<td>Training zone</td>
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<td>Rotation</td>
<td>Training Post</td>
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<tr>
<td>SAT</td>
<td>Subcommittee for Advanced Training</td>
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<tr>
<td>Site</td>
<td>Location of Training within a program, eg hospital</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>TRC</td>
<td>Registrar Representative Committee</td>
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### CBFP KEY MILESTONES (as at November 2011)

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Baseline Planned COMPLETION date</th>
<th>REVIEWED DUE DATE</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase I Competency Based Fellowship Program</strong></td>
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</tr>
<tr>
<td><strong>CBFP Minimum Training Requirements Approval</strong></td>
<td>Completed</td>
<td>Completed</td>
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<tr>
<td><strong>CBFP Assessment Summative Program Approval</strong></td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Program structure (curriculum framework)</strong></td>
<td>20 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Fellowship Competencies</strong></td>
<td>Mar 2011</td>
<td>Completed</td>
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<tr>
<td><strong>Competence Developmental Trajectory</strong></td>
<td>20 Dec 2010</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Developmental Descriptors</strong></td>
<td>Apr 2011</td>
<td>June 2012</td>
</tr>
<tr>
<td>Developmental Descriptors sign-off by ECQG</td>
<td>6 Apr 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Developmental Descriptors (in principle) sign-off by BOE</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; Aug 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Review of Developmental Descriptors by CFE Exec and other stakeholders (via website)</td>
<td>10 October 2011</td>
<td>29 November 2011</td>
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<tr>
<td>Final Review and Amendments following Feasibility Study</td>
<td>31 March 2012</td>
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</tr>
<tr>
<td>Approval by BoE</td>
<td>June 2012</td>
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<tr>
<td><strong>Learning Outcomes</strong></td>
<td>Apr 2011</td>
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<tr>
<td>Working Group established</td>
<td>3 Feb 2011</td>
<td>Completed</td>
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<tr>
<td>Learning Outcomes review/signoff by ECQG</td>
<td>Aug 2011</td>
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<td>Learning Outcomes review/sign off BOE</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; July 2011</td>
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<td>Readiness for Mapping Process</td>
<td>Nov 2011</td>
<td>Completed</td>
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<tr>
<td>Specific Learning Outcomes for Stages II and III by SATs</td>
<td>March 2012</td>
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<tr>
<td><strong>CBFP Generalist Training Pathway (Program Pathway Working Party)</strong></td>
<td>Apr 2011</td>
<td>Completed</td>
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<td>Stage I / II</td>
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<tr>
<td>Stage III Generalist Requirements (Program Pathway working party review)</td>
<td>Apr 2011</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; Oct 2011</td>
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<td>BOE Approval</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; November 2011</td>
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<td><strong>Entrustable Professional Activities</strong></td>
<td>May 2011</td>
<td>June 2011</td>
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<tr>
<td>EPAs Stage 1, 2</td>
<td>7 Mar 2011</td>
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<td>EPAs Stage 3 Generalist</td>
<td>11 Mar 2011</td>
<td>August 2011</td>
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<tr>
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<tr>
<td><strong>Phase I  Competency Based Fellowship Program</strong></td>
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<tr>
<td>EPAs SAT first iteration/development</td>
<td>November 2011</td>
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<tr>
<td>Stage 1 EPAs; Stage 2 EPAs approval by BOE</td>
<td>12 November 2011</td>
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<tr>
<td>Stage 3 EPA development, approval by BOE</td>
<td>12 November 2011</td>
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<tr>
<td>Final review and amendments by reconvened EPA Working Party</td>
<td>January 2012</td>
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<tr>
<td>Further iteration, development work by SATs on respective EPAs</td>
<td>February 2012</td>
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<tr>
<td>Final Approval (ECQG)</td>
<td>March 2012</td>
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<tr>
<td>Final Approval (BoE)</td>
<td>May 2012</td>
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<tr>
<td><strong>Workplace Based Assessment Tools</strong></td>
<td>13 May 2011</td>
<td>Completed</td>
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<tr>
<td>WBA Tools sign-off (ECQG)</td>
<td>13 May 2011</td>
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</tr>
<tr>
<td>WBA Tools sign-off BOE to proceed to Feasibility Studies</td>
<td>16 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Feasibility Studies:  Workplace Based Assessment</strong></td>
<td>29 June 2012</td>
<td></td>
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<tr>
<td>Working Party established</td>
<td>1 April 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Working Party convened</td>
<td>13 May 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Feedback from DOTs</td>
<td>3 June 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>WBA Feasibility Study methodology &amp; evaluation recommendations</td>
<td>8 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Research tools finalised</td>
<td>29 July 2011</td>
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<tr>
<td>BOE face-to-face introduction to feasibility study &amp; consultation</td>
<td>28 July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Methodology &amp; evaluation approval (BOE)</td>
<td>12 Aug 2011</td>
<td>Completed</td>
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<tr>
<td>DOT Survey complete – Survey Monkey</td>
<td>9 Sept 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Support resources determined and produced</td>
<td>31 Oct 2011</td>
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<tr>
<td>- Webinars</td>
<td></td>
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<tr>
<td>- Other materials</td>
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<tr>
<td>Webinars</td>
<td>30 Nov 2011</td>
<td>12 Dec 2011</td>
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<tr>
<td>WBA Feasibility Studies</td>
<td>First part rotation 1 2012*</td>
<td>First part rotation 1 2012</td>
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<tr>
<td>Data collection deadline</td>
<td>End week 16 Rotation 1 2012*</td>
<td>End week 16 rotation 1 2012</td>
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<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
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<tr>
<td><strong>Phase I  Competency Based Fellowship Program</strong></td>
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<tr>
<td>Data input &amp; analysis</td>
<td>9 June 2012</td>
<td>9 June 2012</td>
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<tr>
<td>Final Feasibility Studies Report</td>
<td>29 June 2012</td>
<td>29 June 2012</td>
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<tr>
<td><strong>CAP pilot – WBA Feasibility Study</strong></td>
<td>28th Feb 2012</td>
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<tr>
<td>CAP WBA pilot design &amp; consent form finalised</td>
<td>27 June 2011</td>
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<td>CAP WBA pilot Study takes place</td>
<td>Rotation 2 2011 (from July/Aug 2011)</td>
<td>Oct/Nov 2011</td>
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<tr>
<td>Research tools finalised (Questionnaire, WBA monitoring form &amp; Focus Group questions)</td>
<td>31 Oct 2011</td>
<td>31 Oct 2011</td>
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<tr>
<td>Data collected (Questionnaire, WBA monitoring form &amp; Focus Group questions)</td>
<td>31 Jan 2012</td>
<td>31 Jan 2012</td>
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<tr>
<td>Data analysis</td>
<td>28 Feb 2012</td>
<td>28 Feb 2012</td>
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<td>Report complete</td>
<td>28 Feb 2012</td>
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<tr>
<td><strong>Stage 1 Assessment of Knowledge</strong></td>
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<td>Stage 1 Syllabus</td>
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<td>Stage 2 Syllabus</td>
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<tr>
<td>Consideration of requirements by BOE</td>
<td>10th May 2011</td>
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<td>Establishment of Stage 2 Syllabus Working Party</td>
<td>June 2011</td>
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<tr>
<td>Stage 2 syllabus working party convened</td>
<td>July/August 2011</td>
<td>Completed</td>
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<tr>
<td>Stage 2 syllabus scoping</td>
<td>July/August 2011</td>
<td>Completed</td>
</tr>
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<td>Stage 2 syllabus development (1st Draft)</td>
<td>September 2011</td>
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<td>Stage 2 syllabus stakeholder review</td>
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<td>Additional development requirements (as identified in review)</td>
<td>October 2011</td>
<td>November 2011</td>
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<td>Stage 2 syllabus review and sign off by ECQG</td>
<td>20 January 2012</td>
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<tr>
<td>Stage 2 syllabus sign off by BOE Exec</td>
<td>30 January 2012 (out-of-session)</td>
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<td><strong>Stage 1 Assessment removed from CBFP Project Management Plan</strong></td>
<td>August 2011 (GC meeting)</td>
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<td><strong>Accreditation of Formal Education Course providers</strong></td>
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<td>Consultation with Formal Education Course providers on Stage 1 and 2 Syllabus</td>
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<td>Scoping, Planning and Development</td>
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<td>Further consultation with FEC providers</td>
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<td>Implementation by FEC Accreditation Committee</td>
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<tr>
<td><strong>Summative OCA (OCI) CFE Ownership – removed from CBFP Project Management Plan</strong></td>
<td>BOE August 2011 meeting</td>
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<td><strong>Psychotherapies Long Case Assessment</strong></td>
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<td>28 September 2011</td>
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</tr>
<tr>
<td>Psych. Long Case working party convened</td>
<td>2 November 2011</td>
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<tr>
<td>Psychotherapies assessment scoping complete</td>
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<td>Psychotherapies assessment draft forms and protocols</td>
<td>15 November 2011</td>
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<tr>
<td>Psychotherapies assessment draft forms and protocols review</td>
<td>22 November 2011</td>
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<tr>
<td>Additional development requirements (as identified in review)</td>
<td>12 December 2011</td>
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<tr>
<td>Key stakeholders review of Psychotherapies assessment</td>
<td>11 January 2012</td>
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<tr>
<td>Psychotherapies assessment requirements approval (ECQG)</td>
<td>10 February 2012</td>
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<tr>
<td><strong>Scholarly Project</strong></td>
<td>Sept 2011</td>
<td>1st December 2011</td>
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<td>Sch Project working party convened</td>
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<td>Finalise draft Scholarly Project requirements</td>
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<td>Consultation cycle of Scholarly Project draft</td>
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<td>Additional development requirements (as identified in review) for final draft</td>
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<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
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<tr>
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<tr>
<td><strong>Phase I Competency Based Fellowship Program</strong></td>
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<tr>
<td>Scholarly Project Approval (ECQG)</td>
<td>20 January 2012</td>
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<tr>
<td><strong>In Training Records – Tracking Trainee Progress</strong></td>
<td>Aug 2011</td>
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<tr>
<td>Develop future processes</td>
<td>November 2011</td>
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<tr>
<td>Review and develop Supervisor Forms (mid and end of year rotations) (first draft)</td>
<td>24&lt;sup&gt;th&lt;/sup&gt; September 2011</td>
<td>December 2011</td>
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<tr>
<td>Wider review/consultation of proposed Supervisor Assessment Forms</td>
<td>November 2011</td>
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<tr>
<td><strong>CBFP Assessment Blueprinting (Mapping)</strong></td>
<td>February 2012</td>
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<tr>
<td>Identify appropriate expertise (external) to undertake Blueprinting work (including contract negotiation)</td>
<td>30 November 2011</td>
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<tr>
<td>Mapping learning objectives/competencies against formative and summative assessments (Stages 1 – 3)</td>
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<tr>
<td>Mapping Competencies against formative and summative assessments approval</td>
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<tr>
<td><strong>Regulations</strong></td>
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<tr>
<td>Training and Assessment Regulations Scoping working party established</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; April 2011</td>
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<tr>
<td>Training and Assessment Regulations Scoping working party convened</td>
<td>1 Mar 2011</td>
<td>Completed</td>
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<tr>
<td>Restructure current regulations</td>
<td>June/July 2011</td>
<td>Oct 2011</td>
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<tr>
<td>Gain endorsement of restructured current regulations by appropriate governance (GRC and GC)</td>
<td>Aug 2011</td>
<td>Nov 2011</td>
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<tr>
<td>Review current Regulations against change requirements of the CBFP (high level)</td>
<td>Sept 2011</td>
<td>December 2011</td>
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<tr>
<td>Development Working Groups nominated/established (if required)</td>
<td>Sept 2011</td>
<td></td>
</tr>
<tr>
<td>Develop draft new Regulations</td>
<td>TBC</td>
<td>January 2012</td>
</tr>
<tr>
<td>New Regulations Approval</td>
<td>2012 (TBC)</td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>Transition / Sunset clauses (proposal)</strong></td>
<td>September 2011</td>
<td></td>
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<tr>
<td>Key Milestones</td>
<td>Baseline Planned COMPLETION date</td>
<td>REVIEWED DUE DATE</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Phase I   Competency Based Fellowship Program</strong></td>
<td></td>
<td></td>
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<tr>
<td>Convene Working Party to develop Transition policy, guidelines and processes</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Approval Transition policy, guidelines and processes</td>
<td>November 2011</td>
<td>January 2012</td>
</tr>
<tr>
<td><strong>Recognition of Prior Learning Policy</strong></td>
<td>Sept 2011</td>
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<tr>
<td>RPL Working Party convened</td>
<td>July 2011</td>
<td>Completed</td>
</tr>
<tr>
<td>Review of first draft by key stakeholders and feedback received</td>
<td>January 2012</td>
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<tr>
<td>Approval RPL policy, guidelines and processes</td>
<td>November 2011</td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>Training and Assessment Policies</strong></td>
<td>Sept 2011</td>
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<tr>
<td>Review current Training and Assessment Policies, Guidelines and Links</td>
<td>September 2011</td>
<td>Completed</td>
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<tr>
<td>Develop change requirements to Training and Assessment Policies/guidelines/links</td>
<td>March 2012</td>
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<tr>
<td>(Draft)</td>
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<tr>
<td><strong>Remediation Processes</strong></td>
<td>February 2012</td>
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<tr>
<td>Review current Remediation processes</td>
<td>TBC</td>
<td>February 2012</td>
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<tr>
<td>Develop changes to Remediation processes against outcomes of the CBFP</td>
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<tr>
<td><strong>Training Program</strong></td>
<td>Jun 2012</td>
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<tr>
<td>Training Model/Program Working Party convened</td>
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<tr>
<td>Training Model/Program Scoped, Planned and Developed for Supervisors</td>
<td>7 Dec 2010</td>
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<tr>
<td>Training Model/Program Scoped, Planned and Developed for Trainees</td>
<td>24 Jan 2011</td>
<td>November 2011</td>
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<tr>
<td>Planning for Train the trainers</td>
<td>3 Mar 2011</td>
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<tr>
<td>Planning for Supervisor training</td>
<td>24 Mar 2011</td>
<td>November 2011</td>
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<tr>
<td>Planning for Trainee training</td>
<td>22 June 2011</td>
<td>November 2011</td>
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<tr>
<td>Tender Selection Process for external provider to develop and deliver Train the Trainer Model</td>
<td>April 2011</td>
<td>Completed</td>
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<tr>
<td>Key Milestones</td>
<td>Baseline Planned completion date</td>
<td>REVIEWED DUE DATE</td>
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<tr>
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<tr>
<td><strong>Phase I  Competency Based Fellowship Program</strong></td>
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<tr>
<td>Successful tenderer Agreement signed</td>
<td>May 2011</td>
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</tr>
<tr>
<td>Information Resource Pack (Workplace-based assessment and feedback) developed and published</td>
<td>15 May 2011</td>
<td>Completed</td>
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<tr>
<td>Training Package developed by provider</td>
<td>30 June 2011</td>
<td>Completed</td>
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<tr>
<td>Support Resources developed</td>
<td>7 July 2011</td>
<td>Completed</td>
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<tr>
<td>Deliver 5 Facilitator Programs</td>
<td>30 Nov 2011</td>
<td>Completed</td>
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<tr>
<td>Set up of TELL Centre Facility (online support)</td>
<td>7 July 2011</td>
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<tr>
<td>Roll-out Supervisor workshops by trained Trainers</td>
<td>July 2012</td>
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<tr>
<td>Roll-out Trainee workshops</td>
<td>Aug 2012 (TBC)</td>
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<tr>
<td><strong>Implementation (Stages I and II)</strong></td>
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<tr>
<td><strong>Stage I</strong></td>
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<tr>
<td>CBFP Resource Package</td>
<td>TBC (2012)</td>
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<tr>
<td>Draft publishing of CBFP resource package complete</td>
<td>March 2012</td>
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<tr>
<td>CBFP resource package documentation review complete</td>
<td>April 2012</td>
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<tr>
<td>CBFP resource package approval (ECQG/PMG - BOE)</td>
<td>May 2012</td>
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<tr>
<td><strong>Stage II</strong></td>
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<tr>
<td>New Zealand Implementation</td>
<td>Dec 2012</td>
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<tr>
<td>Australia Implementation</td>
<td>Jan 2013</td>
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<tr>
<td><strong>Post Go Live (Completion Dates)</strong></td>
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<td><strong>Post Implementation Review</strong></td>
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<td><strong>Key Milestones</strong></td>
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<tr>
<td><strong>Phase II  ICT Systems and Support Development</strong></td>
<td>Baseline Planned completion date</td>
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<tr>
<td>Establish ICT Steering Committee for CBFP</td>
<td>10 May 2011</td>
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<tr>
<td>Convene ICT Steering Committee</td>
<td>June 2011</td>
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<tr>
<td>Engagement of Project Manager</td>
<td>March 2011</td>
<td>Completed (part-time)</td>
</tr>
<tr>
<td>Project Management (Scope) Plan</td>
<td>May 2011</td>
<td>Aug/Sept 2011</td>
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<tr>
<td>Detailed Plan</td>
<td>Sept 2011</td>
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## Project Financial Report for the Period 02/03/2007 - 31/10/2011

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<thead>
<tr>
<th>Description</th>
<th>GST Exclusive</th>
<th>GST</th>
<th>Total Incl GST</th>
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<td>Project Revenue</td>
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<td>Interest - Bank</td>
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<td>$4,597.85</td>
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<td><strong>Total Revenue</strong></td>
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<td>$(13,646.01)</td>
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<td>Equipment Hire</td>
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<td><strong>$(51,556.78)</strong></td>
<td><strong>$(2,084,557.98)</strong></td>
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<td><strong>$137,421.22</strong></td>
<td><strong>$(1,202.13)</strong></td>
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quality psychiatric care and mental health
**President’s Message**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to leading the achievement of quality psychiatric care and mental health for our community. To support our vision we have built on the previous 2009-2011 Strategic Plan to outline the future direction of the College.

A survey of all College members was undertaken to gauge views regarding the College’s Strategic Plan and to seek input into the direction of an updated Plan for 2012-2014. The feedback was discussed by General Council and the Plan updated to reflect the responses from members.

Advocating for the leading role that psychiatrists have in delivering mental health care was identified as a key priority by members, as was increasing the community’s awareness and understanding of mental illness.

Preparation of medical specialists in the field of psychiatry, and support and enhancement of clinical practice continue to be key objectives of the College.

The membership is the College and as such a new objective has been included in this Strategic Plan specifically about enhancing the value of College membership.

This new Strategic Plan will continue to adapt to the evolving mental health landscape. All priorities and objectives will be supported by an operational plan including key performance indicators that will be reported to General Council on a regular basis.

Dr Maria Tomsic
President

**Our Values**

- Collaboration with the community to achieve improved health outcomes for those most at risk.
- Improved access to mental health treatment for all members of the community.
- Clinical excellence and evidence-informed practice.
- Organisational integrity, excellence and transparency.
- Compassionate and ethical care, behaviour and standards of practice.
- Forward thinking and innovative.
- Committed to being a more environmentally responsible organisation.
- Committed to early intervention and recovery.
- Improved health outcomes and access to mental health services for Indigenous populations.

**Our Strategic Priorities**

Our strategic priorities over the next three year period 2012-2014 are:

1. **Preparation of medical specialists in the field of psychiatry**
   - Attract an increased number of medical graduates to the specialty of psychiatry.
   - Increase the number of graduates and Indigenous graduates successfully completing psychiatry training and entering practice.
   - Strengthen the Trainee Representative Committee and trainee input into RANZCP decision-making.
   - Effectively progress all aspects of the Competency Based Fellowship Program.
   - Maintain full Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) accreditation.
   - Enhance the College’s role in training provision.
   - Support the training and integration of overseas trained psychiatrists with targeted training.

2. **Support and enhancement of clinical practice**
   - Ongoing enhancement of the CPD program, development of continuing medical education opportunities and the expansion of specialised CPD materials, including online library facilities.
   - Support for workforce planning, recruitment growth, retention and the changing role of psychiatrists both in the public and private sectors and rural and disadvantaged areas.
   - Promote and encourage research in psychiatry.
   - Continue to develop and enhance in-house conference support services.
   - Strengthen and enhance outcomes related to functions of the current Board of Practice and Partnerships.

3. **Enhancing the value of College membership**
   - Support for workforce planning, recruitment growth, retention and the changing role of psychiatrists both in the public and private sectors and rural and disadvantaged areas.
   - Promote growth and provide increased professional support to RANZCP affiliates and overseas trained psychiatrists and enhance pathways to fellowship.

4. **Influence and leadership across the mental health sector**
   - Informing demand and supply for psychiatry workforce.
   - Promote the role of psychiatrists in mental health care and policy.
   - Advocate for mental health outlays commensurate with the burden of disease due to mental illness.
   - Promote activities to improve the physical health of people with mental illness.
   - Advocate for improvement of mental health care through innovation within existing and new services.

**Our Vision**

A fellowship of psychiatrists leading the achievement of quality psychiatric care and mental health for our community.

**Our Objectives**

The RANZCP is a collegial community of medical specialists and trainees committed to:

1. **Preparation of medical specialists in the field of psychiatry**
   - Provides the leading role in the training, support and examination of specialist psychiatrists.
   - Actively involved in the assessment, orientation and support of overseas trained psychiatrists.

2. **Support and enhancement of clinical practice**
   - Sets and supports standards of psychiatric practice.
   - Supports and provides lifelong learning via formal continuing professional development (CPD) and conference activities.

3. **Enhancing the value of College membership**
   - Provides a broad range of relevant services, support and resources to all College members.
   - Responds to members’ needs through new initiatives, advocacy and representation.

4. **Influence and leadership across the mental health sector**
   - Takes a leading role in the mental health sector and the ongoing development/progression of mental health policy, practice and administration.
   - Provides informed input in workforce development, distribution, role evolution, regulation and accreditation.
   - Publishes leading psychiatric journals.

5. **Partnerships and collaboration**
   - Collaborates with people with mental illness, their families and carers to maximise opportunities for recovery.
   - Actively forms partnerships and alliances to improve the mental health of our community.

6. **Organisational effectiveness and performance**
   - Strives to achieve excellence in respect to organisational governance, culture, systems, employment and calibre of staff.

- Committed to being a more environmentally responsible organisation.
- Committed to early intervention and recovery.
- Improved health outcomes and access to mental health services for Indigenous populations.

- Informing demand and supply for psychiatry workforce.
- Promote the role of psychiatrists in mental health care and policy.
- Advocate for mental health outlays commensurate with the burden of disease due to mental illness.
- Promote activities to improve the physical health of people with mental illness.
- Advocate for improvement of mental health care through innovation within existing and new services.
5.3 Continue engagement with the Australian Federal and New Zealand Governments and increase engagement with Australian State Governments.

6. Organisational effectiveness and performance
6.1 Review and strengthen governance systems and processes.
6.2 Strengthen the relationship with branches, faculties and sections with appropriate resource support.
6.3 Maintain a strong program of continued internal workforce (secretariat) development and support.
6.4 Maintain the financial security of the College with appropriate fiscal management and planning, to ensure the long term viability and standing of the membership services of the College.
6.5 Continually improve communication within the College about College processes.
6.6 Continually improve transparency and accountability.

5. Partnerships and collaboration
5.1 Take an active role in collaborating and working with:
- People with mental illness, their families and carers.
- Aboriginal people.
- Torres Strait Islanders.
- Māori.
- Mental health professionals.
- Mental health organisations – bi-national and international.

5.2 Continue to develop links and leadership with international organisations and colleagues in South East Asia and the Asia Pacific region and advance formal alliances and projects in partnership with the UK and Canadian Royal Colleges and in the USA.

REPORTING AND IMPLEMENTATION

The priorities in this Strategic Plan will be supported by an operational plan including key performance indicators that will be reported to General Council on a regular basis.

Delivery is further enhanced through a regular monitoring and reporting system which is embedded as part of the organisation’s normal business function. College Boards and Committees will ensure that their work plans align with the objectives and priorities of the Strategic Plan.

Reports flow through formal mechanisms including the Committee structures, General Council and the College’s Annual Report thus providing a level of accountability, transparency and reassurance for College members and all associated stakeholders.
Fellowship Competency Statements

The core competencies, as outlined in the Fellowship Competencies Table 1 below, broadly define the capabilities expected of all trainees on attaining Fellowship of the College. The concept of competency-based education, as it relates to the development of objectives for training, is that these objectives, or competencies, should articulate the desired outcome of training i.e. the knowledge, skills and attitudes expected of learners upon completion of their training. The competencies listed in the table are end point competencies for all trainees engaged in attaining Fellowship of the College, defined across the major roles expected of a doctor in the 21st century, recognising that contemporary expectations of the range of abilities of the doctor extends beyond that of being medical experts. These Fellowship Competencies have been refined into definitive statements iterating the College’s understanding of psychiatry in Australia and New Zealand, described through the CanMEDS roles.

Medical Expert
As Medical Experts, psychiatrists perform comprehensive, culturally appropriate psychiatric assessments with patients of all ages. Fundamental to the practice of psychiatry is the ability to perform and report thorough mental state examinations, integrating all available information to accurately formulate and diagnose patient conditions, subsequently providing an evidence-based biopsychosociocultural management plan, mindful of the impacts of patients’ physical health. Demonstrable skills in psychotherapeutic, pharmacological, biological and sociocultural interventions are requisite. Psychiatrists define and review patient outcomes, revising management as appropriate based on this review. Medical expertise is supported by the application of contemporary research, psychiatric research and treatment guidelines, as well as the application of mental health and related legislation in patient care.

Communicator
As Communicators, psychiatrists communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals, using their interpersonal skills for the improvement of patient outcomes. Communication skills range from the ability to provide clear, accurate, contextually appropriate written communication about patients’ conditions, to being able to enter into dialogue about psychiatric issues with the wider community.

Collaborator
As Collaborators, psychiatrists are able to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals, whilst working within relevant health systems and with government agencies. Psychiatrists are also able to work respectfully with patients, families, carers, carer groups and non-government organisations.

Manager
As Managers, psychiatrists are able to work within clinical governance structures in healthcare settings, providing clinical leadership, and able to work within management structures within the health care system; the ability to critically review and appraise different health systems and management structures is also requisite. Psychiatrists prioritise and allocate resources efficiently and appropriately, with the facility to perform appropriate management and administrative tasks within the healthcare system, applying health and other relevant legislation where appropriate. Psychiatrists also incorporate an awareness and application of information and communication technology (ICT) into their practice.

Health Advocate
As Health Advocates, psychiatrists use their expertise and influence to advocate on behalf of individual patients, their families and carers, as well as more broadly, on an epidemiological level.
Psychiatrists lessen the impact of mental illness through their understanding of and application of the principles of prevention, promotion and early intervention.

**Scholar**
As Scholars, psychiatrists are committed to lifelong learning, having the ability to critically appraise and apply psychiatric and other health information for the benefit of patients. Psychiatrists are able to transfer information to colleagues, other health professionals, students, patients, families and carers and are able to facilitate the learning of colleagues, trainees and other health professionals, contributing to the development of mental health knowledge.

**Professional**
As Professionals, psychiatrists’ commitment to their patients, profession and society is demonstrated through their adherence to ethical conduct and practice, complying with all relevant regulatory requirements, at all times comporting themselves with integrity, honesty, compassion and respect for diversity. Psychiatrists actively engage in reflective practice, giving due consideration to feedback received from others. Psychiatrists are expected to contribute to the profession beyond their commitment to patient care, whilst mindful of the necessity of maintaining a responsible equilibrium between personal and professional priorities in the pursuit of sustainable practice and well-being.

**Table 1 Fellowship competencies**

<table>
<thead>
<tr>
<th>CanMEDS Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Expert</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Conduct a comprehensive, culturally appropriate psychiatric assessment with patients of all ages</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to perform and report a comprehensive mental state examination, which includes cognitive assessment</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate the ability to integrate available information in order to formulate the patient’s condition and make a diagnosis according to ICD or DSM</td>
</tr>
<tr>
<td>4.</td>
<td>Develop, negotiate, implement and evaluate outcomes of a comprehensive evidence based biopsychosociocultural management plan (appropriately revise)</td>
</tr>
<tr>
<td>5.</td>
<td>Demonstrate skills in psychotherapeutic, pharmacological, biological and sociocultural interventions to treat patients with complex mental health problems</td>
</tr>
<tr>
<td>6.</td>
<td>Demonstrate the ability to integrate and appropriately manage the patient’s physical health with the assessment and management of their mental health problems</td>
</tr>
<tr>
<td>7.</td>
<td>Demonstrate the ability to critically appraise and apply contemporary research, psychiatric knowledge and treatment guidelines to enhance patient outcomes</td>
</tr>
<tr>
<td>8.</td>
<td>Demonstrate the ability to appropriately apply mental health and related legislation in patient care</td>
</tr>
<tr>
<td><strong>Communicator</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate the ability to communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to provide clear, accurate, contextually appropriate written communication about the patient’s condition</td>
</tr>
</tbody>
</table>
**Table 1 continued:**

<table>
<thead>
<tr>
<th>CanMEDS Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collaborator</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate the ability to work respectfully with patients, families, carers, carer groups and non-government organisations</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to use interpersonal skills to improve patient outcomes</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate the ability to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals</td>
</tr>
<tr>
<td>4.</td>
<td>Demonstrate the ability to work within relevant health systems and with government agencies</td>
</tr>
<tr>
<td><strong>Manager</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate the ability to work within clinical governance structures in health care settings</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to provide clinical leadership within management structures within the health care system</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate awareness of the importance of review of and critical appraisal of different health systems and governance/management structures</td>
</tr>
<tr>
<td>4.</td>
<td>Demonstrate the ability to prioritise and allocate resources efficiently and appropriately</td>
</tr>
<tr>
<td>5.</td>
<td>Demonstrate the ability to perform appropriate management and administrative tasks within the health care system</td>
</tr>
<tr>
<td><strong>Health Advocate</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate the ability to use expertise and influence to advocate on behalf of patients, their families and carers</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to understand and apply the principles of prevention, promotion and early intervention to reduce the impact of mental illness</td>
</tr>
<tr>
<td><strong>Scholar</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate commitment to life long learning</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the ability to educate and encourage learning in colleagues, other health professionals, students, patients, families and carers</td>
</tr>
<tr>
<td>3.</td>
<td>Contribute to the development of knowledge in the area of mental health</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Demonstrate ethical conduct and practice in relation to patients, the profession and society</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate integrity, honesty, compassion and respect for diversity</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate reflective practice and the ability to use and provide feedback constructively</td>
</tr>
<tr>
<td>4.</td>
<td>Demonstrate the ability to balance personal and professional priorities to ensure sustainable practice and well being</td>
</tr>
<tr>
<td>5.</td>
<td>Demonstrate compliance with relevant professional regulatory bodies</td>
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</tbody>
</table>
### Competency-Based Fellowship Program (CBFP) Outline

#### CBFP overview
- The RANZCP has adopted the seven CanMEDS roles, expressed in the CBFP as the Fellowship Competencies. The Fellowship Competencies are end point competencies for all trainees engaged in attaining Fellowship of the College.
- Typically 60 months full time equivalent (FTE) to complete.
- Implementation begins:
  - Stage 1 (1st year): 1 December 2012 (NZ); 1 January 2013 (Australia)
  - Stage 2 (2nd and 3rd years): December 2013
  - Stage 3 (4th and 5th years): December 2015
- Current trainees – transitional arrangements will apply.
- Transition of existing trainees will not occur before 2014.
- Progression between stages depends on attainment of Fellowship Competencies as demonstrated through successful completion of all mandatory assessments AND time spent in rotations.

#### Formal Education Course
- All trainees must be enrolled in a Formal Education Course.
- Syllabus developed to inform Formal Education Courses. Stage 1 Syllabus approved by the Board of Education (BOE). Stage 2 Syllabus in process to be sent to BOE for approval 2012/2013.

#### Incorporation of existing training experiences into the CBFP
- The following experiences are embedded in the Fellowship Competencies and demonstrated through successful achievement of the Learning Outcomes (assessed by sign-off on the summative End of Rotation In-Training Assessment Report):
  - Ethical Conduct and Practice
  - Working with people with mental illness, their families and carers
  - Working with non-Government and other community organisations
  - Longitudinal management of patients with enduring psychiatric illness
  - Working with patients from culturally and linguistically diverse backgrounds.
- Branch Training Committees (BTCs) continue to provide learning opportunities to help trainees achieve Learning Outcomes set out in Policy and Procedures.
- Requirement to undertake a specified number of activities per year to meet working with Consumers and Carers, non-Government and other community organisations training objectives has been removed.

#### Psychotherapies
- Competence to a proficient level in psychotherapies demonstrated by end of training.
- Psychotherapeutic skills will develop throughout training.
- Trainees are required to complete the Psychotherapies Long Case consisting of one long psychotherapy intervention (~1 year or 40 sessions) and a minimum of 4 briefer interventions, each from different domains, of 5–10 sessions each. Trainees will be encouraged to complete these by the end of Stage 2.
- Trainees will be required to write up the Psychotherapies Long Case for summative assessment. The requirements of this assessment are still being finalised.
- The domains for the four briefer interventions are still being reviewed. Current suggestions are:
  - Structured therapy (CBT, IPT, DBT); Family therapy; Group therapy; Supportive therapy; Psychological intervention in crisis.
  - Competence to a proficient level in psychotherapies demonstrated by end of training.

#### Scholarly Project
- College-approved project must be successfully completed to attain Fellowship.
- Trainees will be encouraged to undertake the Scholarly Project earlier in training, rather than later.
- Scholarly Project Subcommittee will be established to govern the conduct and assessment of the scholarly project.
- Examples of appropriate Scholarly Projects include: a quality assurance project or clinical audit; a systematic and critical literature review; original and empirical research (qualitative or quantitative); a case series.
- Other Scholarly Projects may be approved on a case-by-case basis.

#### Formative assessment: Workplace-based Assessments (WBAs)
- WBAs will be used for formative assessment of competencies. NEVER used as a mechanism to ‘mark’ or ‘pass/fail’ – they are an indicator as to how the trainee is going.
- Supervisors are required to be competent in conducting WBAs and able to provide the trainee with meaningful and effective feedback.
- Supervisors will use a minimum of 3 WBAs to inform assessment of each EPA.
- WBAs tools have been selected by the BOE and include: Observed Clinical Activity (OCA), Mini Clinical Evaluation Exercise (Mini-CEX), Professional Presentation, and Case-based Discussion (CbD).

#### Summative assessment: Extracted Professional Activities (EPAs)
- Progression through training requires trainees to be entrusted to perform specific EPAs to an appropriate standard for the stage of training.
- A minimum of 2 EPAs should be assessed and achieved for every 6 month FTE rotation.
- A minimum of 3 WBAs will be used by Supervisors to inform assessment of each EPA.
- Mandatory EPAs are set by BOE.
- Fellowship EPAs across all Stages DO NOT have to be signed off by a supervisor who has a Certificate in the respective area of practice (unless the trainee is enrolled in an Advanced Certificate); however, Supervisors must be accredited and current.
- Summative In-Training Assessment Reports MUST be submitted to the College.

#### Supervisor In-Training Assessment reports – ITAs
- Formative In-Training Assessment Forms MUST be held in the trainee’s record within the College.
- Summative In-Training Assessment Reports MUST be submitted to the College.

#### Summative assessment: Examinations
- Written examination:
  - Knowledge level and application of knowledge set at the junior consultant standard.
  - Threshold of Stage 2 and 3 (years 3 & 4) – although trainees are allowed to sit the written exam from early Stage 2, is not recommended.
  - Attempted after acquiring specified competencies to proficient level and demonstrated by satisfactory in-training assessments including EPAs.
  - No longer a barrier to entering Stage 3 of training: trainees may complete the first 6 month FTE rotation including the 2 required Stage 3 EPAs
- Clinical examinations, held in Stage 3 and set at the junior consultant standard:
  - Observed Clinical Interview (OCI): Attempted after passing written exam; trainees must pass 2 out of 3 OCIs.
  - Objective Structured Clinical Examination (OSCE): Attempted after passing written exam; 12 stations.
Stage 1
12 months FTE – first intake December 2012
Minimum 12 months FTE accredited training in approved General Psych training post; 6 months in an acute setting.

**Supervision**
- Minimum 4 hours/week for 40 weeks of this:
  - 2 hours/week outside ward rounds and case review.
  - Minimum 1 hour individual supervision of clinical work.
- WBAs will typically occur in supervision time.
- EPAs may or may not be formally signed off in supervision time.

**Mandatory EPAs**
1. Producing succinct, organised and informative discharge summaries in a timely manner.
2. Initiating an antipsychotic in a patient known to have schizophrenia.
3. Active participation in the multidisciplinary ward round.
4. Providing an explanation to a family about a young adult’s major mental illness.

Stage 2
24 months FTE – first intake December 2013
Minimum 24 months FTE accredited training in an approved program.

**Supervision**
- Minimum 4 hours/week for 40 weeks annually.
- 1 hour/week individual supervision of clinical work.

For every rotation in Stage 2, a minimum of two EPAs should be assessed and achieved at a proficient level.

**Mandatory Areas of Practice**
Mandatory area of practice rotations and Stage 2 EPAs (must be entrusted by end of Stage 2):
- **Consultation-Liaison Psychiatry (6 months FTE)**
  a) Care for a patient with delirium.
  b) Manage clinically significant psychological distress in the context of a patient’s medical illness in the general hospital.
- **Child & Adolescent Psychiatry (6 months FTE)**
  c) Develop a management plan for an adolescent where school attendance is at risk.
  d) Clinical assessment of a pre-pubertal child.

Trainees will achieve competent performance to a proficient level in the following areas of practice, which are achieved through entrustment of specific EPAs to a proficient standard:
- **Addiction Psychiatry**
  a) Management of intoxication and withdrawal.
  f) Co-morbid mental health and substance use problems.
- **Psychiatry of Old Age**
  e) Management of continence and care of elderly patients.
  h) The appropriate initiation of antipsychotics and antidepressants in patients aged 75 years and over (or under 75 with excessive frailty).

Stage 3
24 months FTE – first intake December 2015
Minimum 24 months FTE accredited training in an approved program.

**Supervision**
- 4 hours per week for 40 weeks annually.
- 1 hour/week individual supervision of clinical work.

**Advanced Certificates**
Trainees may apply and, if successful, enrol in an Advanced Certificate in a College-established Area of Practice.

**College-established Areas of Practice**
Trainees can complete 24 months FTE in a single area of practice.

Trainees will achieve competent performance to an advanced level in either a single or multiple areas of practice:
- Addiction
- Adult
- Child & Adolescent
- Consultation-Liaison
- Forensic
- Indigenous
- Psychiatry of Old Age
- Psychotherapies
- Research/Academic
- Rural
- Other areas of practice as approved by the BOE.

**EPAs**
A minimum of two EPAs should be entrusted at an advanced level in Stage 3 for each rotation.

**Clinical currency**
Trainees who undertake 12 months of research/academic or specialised administrative/managerial training during Stage 3 must continue to maintain currency in an area of clinical psychiatry.

**Written Exam (Junior Consultant Level)**

**Elective rotations**
Trainees will also undertake 2 elective 6-month (FTE) rotations in the following areas of practice, achieving competence to a proficient standard demonstrated by EPAs:
- Addiction
- Adult
- Forensic
- Indigenous
- Psychiatry of Old Age
- Rural
- Other areas of practice as approved by the BOE.

**Mandatory EPAs**
To be attained by the end of Stage 2:
1. Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
2. The application and use of the Mental Health Act.
3. Assessment and management of risk of harm to self and others.
4. The safe and effective use of clozapine in psychiatry.
5. Cultural Competence.

**Observed Clinical Interview (OCI) – attempted after written exam**

**Objective Structured Clinical Examination (OSCE) – attempted after written exam**
REGULATIONS

BASIC TRAINING
AND
ADVANCED TRAINING FOR FELLOWSHIP

Regulations to be read in conjunction with the Curriculum and Logbook for Basic Training and Advanced Training for Fellowship
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1 INTRODUCTION

1.1 The College
The Royal Australian and New Zealand College of Psychiatrists (RANZCP) works with and for the general community to achieve the best attainable quality of psychiatric care and mental health\(^1\). The RANZCP is the principal body that represents the medical specialty of psychiatry in Australia and New Zealand. The Board of Education (BOE) is responsible for accreditation and assessment of training and recommendations to the College General Council for the award of Fellowship of the College (FRANZCP) and of certificates of advanced training. The Board carries out these responsibilities with the assistance of the Fellowship Attainment Committee (FAC), Committee for Training (CFT), the Subcommittees for Advanced Training (SAT), the Committee for Examinations (CFE) and the Committee for Specialist International Medical Graduates Education (CSIMGE). Administrative staff at College headquarters in Melbourne support these committees.

At a state level, and in New Zealand, Branch/Psychiatry Training Committees (BTC) coordinate training. At an individual service or hospital level, training is under the direction of a Director of Training and a local training committee, assisted by supervising Fellows and accredited non-College supervisors.

The Trainee Representative Committee (TRC) is a subcommittee of General Council which represents and advocates for psychiatric trainees. BOE recognises TRC as the principal representative organisation for trainees.

The Australian and New Zealand Association of Psychiatrists in Training (ANZAPT) is a separate organisation, which also represents and advocates for psychiatric trainees.

1.2 Training and Assessment Overview
The RANZCP Fellowship training program includes a minimum of 3 years basic training, followed by a minimum of 2 years advanced training. The process of training is described in this document and in the relevant advanced training regulations, and the goals of training are described in the relevant curricula. Throughout training, you are required to adhere to the College Code of Ethics. All components of basic training and assessment must be completed before commencing advanced training and no components of basic training can be accredited towards advanced training. Assessment is ongoing and includes summative assessments by your supervisors, case histories, written examinations and clinical vivas.

During the training process you will develop skills to treat mental illness and mental health problems and to decrease the level of distress experienced by people with mental health problems and mental illness, carers and communities, utilising a broad biopsychosociocultural model which acknowledges the diversity of each person's experience. The College places particular emphasis on you developing a sensitive awareness of the impact of mental health problems and mental illness on a person’s quality of life and the meaning of recovery for that person, including the specific needs of Aboriginal and Torres Strait Island and Maori people with mental health problems and mental illness.

The BOE recognises that it is not possible to mandate training in all areas of psychiatry before completion of basic training. You are encouraged to develop skills in such other areas, such as psychiatry of intellectual disability and forensic psychiatry, when appropriate opportunities are available.

The College is committed to the development of effective training programs for specialists in psychiatry and is an active participant in the Australian Medical Council accreditation process for specialist medical colleges. As such, it supports the broad aims of all specialist training programs in developing the future specialist's expertise as a medical expert, communicator, collaborator, manager, health advocate, scholar and professional. These aims are discussed further in Appendix 1.

\(^1\) The College acknowledges that language is contestable and contextual, and changes over time. It recognises the differences in language used between Australia and New Zealand and that mental health problems affect a wide range of people at different times in their lives. In an attempt to be as inclusive as possible, the College has chosen to use the term "people with mental health problems and mental illness" when referring to consumers, and those affected by mental health problems and mental illness at some stage in their lives, and "carers" to include family, significant others and whanau. It is acknowledged that this terminology will need to be periodically reviewed.
2 REQUIREMENTS WHICH APPLY TO BOTH BASIC AND ADVANCED TRAINING

2.1 Registration
To register as a trainee you must:

- Satisfy the entry criteria as outlined in 4.2 and 9.2 below
- Complete an application form and submit requisite documentation to College headquarters via BTCs
- Pay the prescribed fees

Upon payment of the prescribed fees, you will receive a start-up log book with directions for accessing documentation from the College website for completion as you progress through training.

2.2 Accreditation
In order to have the various training experiences outlined below accredited you must:

- Liaise with your Director of Training
- Register as a College trainee (see 4.2 and 9.3 below)
- Have each of your training rotations/experiences approved by your Director of Training
- Submit relevant log book documentation confirming satisfactory completion of each requirement. Non submission of appropriate Training Forms within 3 months of completing the relevant requirement may result in non accreditation of that requirement.
- Satisfy all other training requirements
- Pay the prescribed fees by the published annual closing date.

After registration as a trainee you may apply to the CFT/SAT for retrospective accreditation of training completed in an approved training post in an approved training program outside Australia or New Zealand. You may also seek retrospective accreditation for such training within Australia and New Zealand, if undertaken concurrently with the AMC examinations or NZREX examination and qualifying process. Generally no more than 12 months of such Australasian training will be accredited. However for candidates who have undertaken substantially equivalent to RANZCP basic training programs, up to 36 months of retrospective accreditation may be granted on a case-by-case basis.

Accreditation shall not be granted for experience gained in non-approved or short term locum posts.

To undertake part of your training overseas in an approved training program, you must apply prospectively to the CFT/SAT for consideration.

2.3 Interrupted Training
While you may interrupt your training at any stage, you are required to notify the College of this and continue to pay a ‘break in training’ fee to maintain your training record. Such breaks in training may have implications for maintaining the currency of your progress in the training and assessment process, as detailed in 4.3 and 9.3 below.

2.4 Part-time Training
In Basic Training and Advanced Training pre-Fellowship: If you train part-time, this must be at least a half-time FTE basis in order to be accredited. Part-time training may be undertaken on a 0.5, 0.6, 0.7, 0.75, 0.8 or 0.9 FTE basis, and must satisfy all of the requirements outlined in these regulations, over a proportionately longer period (see Regulation 4.3 below).

In Advanced Training post-Fellowship: In rare instances, part-time training at less than 0.5 FTE but no less than 0.30 FTE may be approved by the Committee for Training, or for Fellows, the relevant Sub-Committee. Currency issues must be carefully considered and applications must be supported by the DOT/DOAT.

2.5 Ethical Standards
You are required to adhere to the College Code of Ethics at all times and must participate in an approved activity on ethical practice for each pro rata year of training. These activities should include the importance of professional boundaries and relationships with pharmaceutical companies.
2.6 **Rural Mental Health**
You must complete significant experience in rural mental health service delivery. This may be completed in basic or advanced training. Wherever possible, this experience shall be completed as part of a residential rotation in a rural/regional service which is at least 3 month FTE, although a minimum of 15 days working directly with a supervisor in a rural/regional clinical service may be accepted locally (by BTC/DOT).

You may spend all of your training in rural areas, provided these experiences satisfy the requirements as set out in these Regulations.

See objectives for this training experience (Regulation 3.1 below).

2.7 **Continuity of Care**
You must treat, under supervision, at least 6 people with mental health problems and mental illness over at least 9 months each, in addition to the individual(s) chosen to satisfy the psychotherapy case history requirement. These 6 people should be discussed with your principal supervisor and also with the consultant with primary clinical responsibility (if that person is not your principal supervisor).

See objectives for this training experience (Regulation 3.2 below).

3 **TRAINING OBJECTIVES FOR BOTH BASIC AND ADVANCED TRAINING**

3.1 **Rural Mental Health**
By the completion of training you shall have developed an understanding of the challenges of rural mental health service delivery and of rural mental health issues and be able to:

(i) Appropriately utilise the available mental health service resources when making decisions about the assessment and treatment of people with mental health problems and mental illness presenting in rural/regional areas

(ii) Liaise with appropriate local mental health and primary health workers to manage people with mental health problems and mental illness under your care in a rural/regional area within their own community

(iii) Liaise with health professionals outside the rural/regional area to arrange appropriate care and safe transfer of rural/regional people with severe mental illness and mental health problems, when necessary

(iv) Demonstrate familiarity with video-conferencing, as available

(v) Demonstrate an awareness of the sociocultural influence of rural life on the common psychiatric disorders, in terms of the epidemiology, aetiology, presentation, management and prognosis

(vi) Demonstrate an understanding of the special needs of members of minority groups who live in rural/regional areas

(vii) Demonstrate an understanding of mental health issues which are unique to or especially prevalent in rural communities

(viii) Demonstrate an understanding of the need to use different models of service delivery in different settings, appropriate to the specific community.

3.2 **Continuity of Care**
By the completion of training you shall be able to:

(i) Assess and manage people with a broad range of psychiatric conditions encountered in various clinical settings

(ii) Work with general practitioners, other primary health care providers and other mental health professionals in the care of people with a broad range of psychiatric illness

(iii) Demonstrate a knowledge and understanding of the longitudinal nature of psychiatric disorder

(iv) Demonstrate an awareness of and skills in dealing with issues arising in doctor-patient relationships over a period of time

(v) Demonstrate skills in the enhancement of treatment compliance.
4 BASIC TRAINING

4.1 Overview of Basic Training

Basic training involves completion of 3 years FTE clinical training in specified areas, as detailed below. It is based on a broad biopsychosociocultural model.

The focus in the first year is on the acquisition of knowledge and skills in phenomenology, interviewing, clinical assessment and the principles of management planning.

The focus in the second and third years of training is on the development of knowledge and skills in clinical management and teamwork.

4.2 Entry to Basic Training

To enter basic training in psychiatry you must:

- Have satisfactorily completed at least 1 year full time equivalent (FTE) general medical training
- Have current general registration as a medical practitioner in Australia, New Zealand or other approved country, state, territory or dependency and be in good standing with the relevant Medical Registration Board or equivalent approved body
- Be selected to enter an approved basic training program
- Be appointed to an approved training post.

4.3 Currency of Basic Training and Assessment

Each component of your basic training and assessment remains valid for eight years. Trainees who exceed this period will need to repeat and complete the training experienced lapsed. A number of flexible options are available to assist the trainee to achieve this. The Trainee must complete a minimum of either three months experience in a compulsory rotation or complete 10 Cases under appropriate supervision. Trainees must discuss Currency needs with their Training Directors well in advance to determine which of the options their services/employers can accommodate. It may be necessary for a number of trainees in some services to complete the entire 6 month rotation.

4.4 Required Training Experiences during Basic Training

During basic training, you must be provided with opportunities to be involved in the assessment and management of people with a broad range of psychiatric conditions in a variety of settings. You must provide evidence of satisfactory completion of the following:

- Approved training in involvement with people with mental health problems and mental illness
- Approved training in carer involvement
- Approved training in non-government and other community organisations
- Approved training in the mental health of Aboriginal and Torres Straits Island people or Maori
- 12 months FTE approved training in adult psychiatry. During this time you must complete a minimum of 10 observed interviews that are documented as satisfactory by your supervisor.
- 6 months FTE approved training in child and adolescent psychiatry
- 6 months FTE approved training in consultation-liaison psychiatry
- Approved training in the practice of psychiatry of old age
- Approved training in addiction psychiatry
- Approved training in psychotherapy
- Approved training in Electroconvulsive Therapy (ECT)

See below for the designated objectives for all of these training experiences.

5 MANDATORY TRAINING EXPERIENCES DURING BASIC TRAINING

5.1 Formal Education

During the first 3 years of training you must demonstrate satisfactory progress in a recognised formal education course.
5.2 **Experience with People with Mental Health Problems and Mental Illness**

Your BTC shall, in consultation with local groups representing people with mental health problems and mental illness, ensure that each training program has significant input by people with mental health problems and mental illness during basic training. Also, during each year of basic training (on a pro rata basis) you must participate in at least 1 approved activity where the involvement of people with mental health problems and mental illness is central to the training experience.

See objectives for this training experience (Regulation 8.1 below).

5.3 **Carer Experience**

Your BTC shall, in consultation with local carer groups, ensure that each training program has systematic and ongoing input by carers during basic training. Also, during each year of basic training (on a pro rata basis) you must participate in at least 1 approved activity, which is carer led and increases your understanding of the day to day living experience of carers.

See objectives for this training experience (Regulation 8.2 below).

5.4 **Experience with Non-Government (NGO) and Other Community Organisations**

During each year of basic training (on a pro rata basis) you must participate in at least 1 approved activity that assists you to demonstrate an understanding of the role of, non-government sector and other community organisations in mental health service provision.

See objectives for this training experience (Regulation 8.3 below).

5.5 **Mental Health of Aboriginal and Torres Strait Island People & Maori**

Where available, you should undertake during basic training approved training in the mental health of Aboriginal and Torres Strait Island people or Maori. The minimum requirement will be that you complete an approved training module on either Aboriginal and Torres Strait Island mental health or Maori mental health in basic training.

See objectives for this training experience (Regulation 8.4 below).

5.6 **Adult Psychiatry**

You must complete two 6 month FTE rotations in adult psychiatry with at least 6 months FTE in an acute adult psychiatry service. These two 6 month FTE rotations should occur within the first year of training however may be completed within 18 months FTE of commencement of training, at the discretion of your Director of Training.

See objectives for this training experience (Regulation 8.5 below).

5.7 **Child and Adolescent Psychiatry**

During basic training you must undertake your training in child and/or adolescent psychiatry in a service specialising in the treatment of children, adolescents and their families.

See objectives for this training experience (Regulation 8.6 below).

5.8 **Consultation-Liaison Psychiatry**

During basic training you must undertake your training in this area in a consultation-liaison psychiatry service of a general hospital and its associated services.

See objectives for this training experience (Regulation 8.7 below).

5.9 **Psychiatry of Old Age**

During basic training you must complete approved training in psychiatry of old age (POA). The minimum requirement is evidence of the assessment and/or management of at least 10 people with mental health problems and mental illness over the age of 65 years, formally discussed with an appropriate RANZCP and Faculty of Psychiatry of Old Age approved supervisor. Wherever possible this experience shall be completed as part of a training rotation in a POA service.

See objectives for this training experience (Regulation 8.8 below).
5.10 **Addiction Psychiatry**
During basic training you must complete approved training in addiction psychiatry. When this is not possible, you must have evidence of the management of:

(i) at least 9 people with substance abuse or dependence, meeting the following criteria:
   - the management of the substance use disorder is a major focus of your treatment
   - supervision of the management of these people is by an appropriately qualified supervisor
   Of these 9 people, there must be at least 1 with opiate dependence and a further 5 with problems of substance dependence.

(ii) at least 1 person with pathological gambling.

See objectives for this training experience (Regulation 8.9 below).

5.11 **Psychotherapy Experience**
During basic training you must complete supervised experience with a range of psychological therapies, including each of the following:

(i) Therapy informed by psychodynamic principles of a person for at least 40 hours for a minimum of 6 months with at least 1 session weekly

(ii) Brief psychologically-based therapy of 2 people, each requiring at least 10 sessions of such therapy

(iii) Cognitive and/or behavioural psychotherapy of at least 2 people for at least 5 sessions each

(iv) A minimum of 5 sessions of marital or family or group therapy.

See objectives for this training experience (Regulation 8.10 below).

5.12 **ECT Experience**
During basic training you must attend and participate in the delivery of a minimum of 10 ECT treatments under the direct supervision of an appropriately trained psychiatrist. At least one of these treatments must be the first received by a person who has not previously been treated with ECT. At least three of the 10 people treated should be directly managed by you under appropriate supervision throughout their course of ECT.

See objectives for this training experience (Regulation 8.11 below).

5.13 **Experience in Other Medical Specialities**
Training in other medical specialties may be approved by the Committee for Training on a case by case basis, provided a psychiatric supervisor is available throughout the experience.

6 **ASSESSMENT OF BASIC TRAINING**

6.1 **Overview of Assessment of Basic Training**
Assessment of your basic training shall occur as you progress through the first 3 years of the College training program. You shall be regularly assessed by your supervisors, you shall submit 2 case histories, and you shall complete a written examination and two clinical examinations.

6.2 **Assessment of Basic Training**
Your basic training is assessed as follows:

(i) **Summative Assessments** by your supervisor

(ii) 2 **Case Histories** of people managed under supervision as outlined below:
   a) A person presenting for the first time to the mental health service, whom you have personally managed.
   b) A person(s) in whom the predominant mode of intervention has been psychological

(iii) **A Written Examination**, which may be attempted at any point in basic training. This examination assesses your knowledge of the theoretical and scientific underpinnings of psychiatry, and clinical and ethical issues in psychiatry. A critical appraisal question will be included

(iv) **A Clinical Examination** with assessment based on:
   a) Observed Clinical Interviews (OCI) and presentations
   b) Objective Structured Clinical Examination (OSCE).
   These examinations assess your clinical skills across a range of psychiatric disorders including components where integration of general medical skills and knowledge are central to the case

(v) **Eligibility to sit** the Clinical Examination
You are eligible to apply to sit this examination if at the time of application you have:
- Completed a minimum of 30 months FTE accredited basic training
- Completed all mandatory basic training experiences (see Regulation 2.5 and 4.4); the Psychotherapy experience informed by psychodynamic principles of a person for at least 40 hours for a minimum of 6 months with at least 1 session weekly (see Regulation 5.11 i) is exempt from this eligibility requirement.
- Passed the first presentation case history (see Regulation 6.2 ii a)
- Passed the written examination

(vi) Remediation for Multiple Failures of Assessment
    Before applying to sit the written or clinical examination or to submit a case history for the third and every second subsequent attempt thereafter, you must complete a remediation program of duration as outlined in the remediation policy (see link 83), to the satisfaction of the CFT.

7 SUPERVISION DURING BASIC TRAINING

7.1 Supervision of your clinical work

Supervision of your clinical work during basic training will be a vital part of the assessment of your professional competence. Your training is based on an apprenticeship model. The level and form of supervision provided shall vary as you progress through the training program, but the following must apply:

(i) Clinical supervision shall be for not less than 4 hours per week for not less than 40 weeks in each year of training. At least 1 of these 4 hours per week shall include individual supervision of your current clinical work; this applies whether you are part-time or full-time. The other 3 hours of supervision must be at least on a pro-rata basis if you are part-time.

(ii) During the first year of training you shall receive closer supervision, with at least 2 of the 4 hours per week supervision provided outside ward rounds/case review meetings. Your supervisor should focus on interviewing skills and mental state examination. Supervision shall also address diagnosis, formulation and principles of management.

(iii) Supervision of the biological, social, psychological and cultural aspects of assessment and treatment shall be provided throughout basic training as a component of the 4 hours basic supervision. 1 of the 4 hours required supervision (apart from the individual hour of supervision of current clinical work) should be devoted specifically to this type of supervision.

(iv) Supervision sessions shall be scheduled.

(v) You shall observe your supervisors conducting diagnostic and therapeutic interviews. Your supervisors shall observe you conducting interviews in each year of basic training.

(vi) Supervision must cover all aspects of your work, including after-hours work.

(vii) Whenever you are on duty, there must be a clear line of responsibility from the person with mental health problems and mental illness through you to a particular psychiatrist. This will most appropriately occur when the psychiatrist responsible for the care of your patients is also your primary clinical supervisor. This psychiatrist is the most appropriate supervisor to provide the one hour of individual supervision.

(viii) In general, your principal supervisor will be working in the same clinical setting as you for at least three half days per week.

Responsibilities of Supervisors

Clinical supervision of your basic training shall be by supervisors approved by your BTC. Clinical supervisors shall generally have no more than 2 trainees under their supervision at one time. The responsibilities of your clinical supervisors are to:

(ix) Review with you at the beginning of each rotation the training objectives for that rotation

(x) Provide formative feedback on your progress, half-way through each rotation, which shall be used to identify your strengths and weaknesses as well as your progress towards the training objectives for the rotation

(xi) Complete a summative assessment at the end of your rotation based on the relevant training objectives. This assessment shall take into account your progress in those areas identified in the formative appraisal and further development of your areas of competence.

(xii) Create a suitable learning environment for you while under supervision

(xiii) Ensure a wide range of opportunities is available for you to develop your clinical skills.
## 8 TRAINING OBJECTIVES FOR BASIC TRAINING

### 8.1 Experience with People with Mental Health Problems and Mental Illness

By the completion of basic training you shall be able to:

(i) Demonstrate an understanding of the need for information about all aspects of mental health care to be available in a usable form to all people with mental health problems and mental illness

(ii) Demonstrate an understanding of the need for people with mental health problems and mental illness to be appropriately involved in decision-making about all aspects of mental health care

(iii) Demonstrate an understanding of the principles of the participation of people with mental health problems and mental illness in planning, delivery, monitoring and evaluating mental health services. In particular, that the participation of people with mental health problems and mental illness must be appropriate, must be adequately resourced, must be supported at senior management level and must be a continuous, working partnership

(iv) Demonstrate an understanding of the challenges which may adversely affect the involvement of people with mental health problems and mental illness in mental health services, such as time, money, cultural issues, language, gender, housing and occupational status

(v) Demonstrate skills in working with groups representing people with mental health problems and mental illness, specifically the facilitation of open and constructive communication between people with mental health problems and mental illness, carers and service providers

(vi) Demonstrate an understanding of the involvement of people with mental health problems and mental illness in mental health services within an ethical framework which stresses the need for service providers to respect individual autonomy and self-determination

(vii) Recognise the continuum of the participation of people with mental health problems and mental illness in mental health services, which ranges from receiving information, to being consulted, giving advice, jointly planning, having a role in decision-making, being part of mental health services and having complete control

(viii) Demonstrate a familiarity with the most recent government and non-government policy in relation to the participation of people with mental health problems and mental illness in mental health services

(ix) Demonstrate an understanding of the varying relationships between people with mental health problems and mental illness, carers and providers in mental health services and the processes of the promotion of mental health

(x) Demonstrate an understanding of the importance of the prevention of mental illness and mental health problems, early and timely intervention, and the achievement of recovery (the ability to live well in the presence or absence of mental illness and mental health problems)

(xi) Demonstrate an understanding of the specific issues faced by people with mental health problems and mental illness who are Aboriginal and Torres Strait Island or Maori, as well as other minority marginalised groups.

### 8.2 Carer Experience

By the completion of basic training you shall be able to:

(i) Demonstrate an understanding of the impact of mental illness and mental health problems on carers, and the need for emotional support

(ii) Demonstrate an ability to understand the need for, and how to impart information about mental illness, treatment and care, and mental health systems to carers

(iii) Demonstrate an ability to combine the "lived experiences" of carers with the professional knowledge of the clinician in decision-making about relevant aspects of mental health care

(iv) Recognise the value of involving carers in planning, delivery, monitoring and evaluation of mental health services

(v) Demonstrate an understanding of barriers to carer participation, including time, money, emotional distress, cultural issues, language, gender and socio-economic status.

### 8.3 Experience with Non-Government and Other Community Organisations

By the completion of basic training you shall be able to:

(i) Understand the role of non-government and other community organisations in providing care and support for people with mental illness and mental health problems and their carers

(ii) Understand the relationships of these organisations within the health and social welfare sectors and mechanisms to achieve integrated care

(iii) Understand some of the range of philosophies of care provided by these organisations and how these may differ from publicly funded secondary mental health services.
8.4 **Mental Health of Aboriginal and Torres Strait Island People and Maori**

By the completion of basic training you shall have an understanding of the mental health issues facing Aboriginal and Torres Strait Island People or Maori and the problems in providing indigenous mental health care, and shall be able to:

(i) Demonstrate a knowledge and understanding of the epidemiology of mental health problems facing indigenous people in Australia or New Zealand
(ii) Conduct an assessment and provide treatment of an indigenous person and their family
(iii) Utilise and adapt the available mental health resources for the assessment and treatment of indigenous peoples
(iv) Liaise with appropriate local indigenous mental health and health workers to facilitate treatment for indigenous people with mental health problems as close to their families as possible
(v) Demonstrate an awareness of and sensitivity to the mental health issues relating to persons of Aboriginal and Torres Strait Island origin or persons of Maori origin, as appropriate.

8.5 **Adult Psychiatry**

By the end of your first year of training you shall be able to:

(i) Conduct a competent clinical interview (both initial and follow-up) with a wide range of people with mental health problems and mental illness
(ii) Perform a mental status examination and acquire a thorough understanding of the phenomenology of psychiatric illness
(iii) Perform a risk assessment of self-harm/suicide and dangerousness to others
(iv) Demonstrate an understanding of the importance of the maintenance of professional boundaries in the practice of psychiatry
(v) Demonstrate an understanding of the locally relevant mental health act and its application
(vi) Present a diagnostic formulation of a range of disorders taking into account biomedical, psychosocial and cultural factors in the person’s presentation and illness
(vii) Propose a management plan that demonstrates an awareness of the place of biomedical and psychosocial interventions in the investigation and treatment of the person’s illness
(viii) Implement a management plan under the supervision of a consultant psychiatrist
(ix) Understand clinical practice guidelines for the more common psychiatric disorders and apply them where appropriate
(x) Work as a member of a multidisciplinary mental health team, showing an awareness of the contribution of various members of that team
(xi) Demonstrate an ability to involve and inform people with mental health problems and mental illness and their carers in the assessment, diagnosis and management process
(xii) Demonstrate a basic understanding of critical appraisal in the evaluation of published psychiatric research
(xiii) Demonstrate basic competence in psychopharmacology.

8.6 **Child and Adolescent Psychiatry**

By the end of the child and adolescent psychiatry rotation you shall be able to:

(i) Demonstrate knowledge of developmental trajectories and their importance in the assessment of children and adolescents.
(ii) Demonstrate a knowledge and understanding of the impact of psychiatric disorders and behavioural and emotional problems on the development of children and adolescents
(iii) Demonstrate an awareness of the impact of family, school and cultural factors on children and adolescents
(iv) Conduct a clinical interview with children and adolescents of different ages and their families. This requires comprehensive assessment of a minimum of five pre-pubertal children and five adolescents during the term.
(v) Demonstrate an understanding of the nature and specific manifestations of mental health problems in the young
(vi) Demonstrate (a) an understanding of the role of psychological, cognitive, behavioural and academic skills assessment in the evaluation of children and adolescents, (b) an ability to perform an appropriate physical examination, organise investigations and (c) an ability to interpret the results of such assessments and investigations
(vii) Present a diagnostic formulation taking into account developmental, psychological, educational, socio-cultural and biological factors
(viii) Formulate a management plan based on the above formulation
(ix) Implement treatment using psychosocial and biomedical approaches as appropriate, under supervision
(x) Identify and work with a range of other services involved in a young person’s life, such as schools, general practitioners, protective services, foster care agencies etc
(xi) Demonstrate an understanding of the role of psychiatrists in the prevention of mental health problems.
8.7 **Consultation-Liaison Psychiatry**

By the end of the consultation-liaison psychiatry rotation you shall be able to:

(i) Demonstrate an understanding of the impact of medical illness and the system in which it is treated and how this affects the presentation, experience, and impact of psychiatric and psychosocial morbidity

(ii) Demonstrate the skills needed to conduct a biopsychosociocultural assessment, create a formulation, and implement appropriate treatment in the context of the general hospital including effective communication with the rest of the treatment team

(iii) Demonstrate the ability to assess reactions to illness, and to differentiate the presentation of depression and anxiety in the medical setting

(iv) Demonstrate an understanding of the combined trajectories of illness and the developmental issues of the person with mental health problems and mental illness

(v) Demonstrate an understanding of and ability to assess and treat somatisation and somatoform disorders

(vi) Demonstrate an understanding of and ability to assess and manage common neuropsychiatric disorders, with a particular emphasis on delirium

(vii) Demonstrate an understanding of the particular needs of special populations with psychiatric and psychosocial morbidity in the medical settings, including the young, the old, the indigenous and those with intellectual disability

(viii) Demonstrate an ability to assess and manage acute and emergency presentations of psychiatric morbidity in the general medical setting

(ix) Demonstrate an ability to formulate the key ethical dimensions that arise in providing psychiatric care in a medical setting.

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8.8 **Psychiatry of Old Age**

By the completion of basic training you shall be able to:

(i) Demonstrate a knowledge and understanding of the importance of developmental issues in the assessment and management of older people

(ii) Perform an assessment of the mental state of older persons, in hospital, community and long term residential care settings. This should include an appreciation of the differences between young and old

(iii) Demonstrate a knowledge and understanding of the significance of underlying medical conditions and pharmacological treatment in the presentation of older people

(iv) Assess the competence of an older person to care for themselves and manage their own affairs and evaluate their testamentary capacity

(v) Participate in the assessment and management of older persons by a multidisciplinary team

(vi) Demonstrate knowledge of community resources including government programs, voluntary agencies, self-help groups and private facilities that are available to meet the needs of older people

(vii) Demonstrate an understanding of the key role of family members and other carers in the care of older people

(viii) Demonstrate knowledge and skills in assessment and management of issues facing some older people, including elder abuse, suicide, euthanasia and ageist attitudes.

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8.9 **Addiction Psychiatry**

By the completion of basic training you shall be able to:

(i) Conduct a detailed assessment for problems and disorders related to the area of addictions such as substance use, abuse and dependence and gambling.

(ii) Demonstrate knowledge and skills in the assessment and management of people with combined substance use disorders and other mental illnesses.

(iii) Display knowledge of the theory of addictions, actions of psychoactive substances of abuse, as well as their psychiatric and their medical complications

(iv) Demonstrate knowledge of harm minimisation strategies, prevention strategies and other public health approaches to substance use disorders

(v) Formulate and carry out an appropriately tailored management plan for people with a substance use disorder and individuals with pathological gambling

(vi) Explain the mechanisms of action of the psychological and biological treatments available for addictions

(vii) Participate in interdisciplinary management of people with disorders of addiction.
8.10 **Psychotherapy**

By the completion of basic training you shall be able to:

(i) Formulate an individual's psychological issues in terms of basic developmental principles
(ii) Assess and describe an individual's personality functioning, relationship style, adaptive and maladaptive or defensive behaviours
(iii) Recognise the transgenerational transmission of relationship difficulties and psychological problems
(iv) Select an appropriate psychological therapy
(v) Integrate appropriately the psychological therapies with biological and social therapies
(vi) Demonstrate an understanding of the psychotherapies in terms of their historical development, theoretical underpinnings, research base and outcomes, including
   - Normal human development across the lifespan
   - The infant-carer relationship
   - Developmental psychopathology
   - Attachment and other psychoanalytic theories
   - Families and couples therapies
   - Group psychotherapies
   - Individual dynamic psychotherapies
   - Structured therapies, including cognitive behavioural therapies.

8.11 **ECT**

By the completion of basic training you shall be able to:

(i) Demonstrate an awareness of prevailing societal attitudes to ECT, and how these might require particular sensitivity in preparing people and their families for this treatment
(ii) Demonstrate an understanding of the process of obtaining informed consent for ECT and the relevant sections of your local Mental Health Legislation
(iii) Demonstrate an understanding of the accepted indications and relative/absolute contraindications for ECT
(iv) Demonstrate an understanding of medical/anaesthetic aspects of ECT including pre-ECT assessment, post-ECT complications (and their management) and potential effects of medication
(v) Demonstrate competence in the following aspects of administration of ECT: electrode placement; stimulus dosing; seizure monitoring using EEG or "isolated limb" technique; recognition and management of missed, inadequate or prolonged seizures
(vi) Demonstrate an understanding of the criteria for reaching a decision to terminate a course of ECT
(vii) Demonstrate an understanding of management following a course of ECT, including relapse prevention using psychological or pharmacological strategies as well as maintenance ECT
(viii) Demonstrate an adequate knowledge base in relation to ECT, including evidence of efficacy, hypothesised mechanisms of action, physiological responses and the significance of the electrical parameters utilised in ECT.

9 **ADVANCED TRAINING**

9.1 **Overview of Advanced Training**

Advanced training involves 2 years FTE supervised experience in: general clinical psychiatry - Generalist Stream Advanced Training (GSAT) OR an Approved Program Advanced Training (APAT) OR a combination of these two.

Advanced training also requires completion of seven core advanced training experiences. Whilst an apprenticeship style of training continues, the emphasis during these 2 years FTE training is on adult learning, self-directed learning and the processes used in continuing medical education. It is expected that all advanced training will be informed by an eclectic approach, which takes account of the biological, psychological, social and cultural aspects of the individual and his or her mental illness or mental health problems.

Fellows of the College may do further advanced training. Post Fellowship advanced trainees are not required to complete the core advanced training experiences although you may choose to do so.
9.2 Entry to Advanced Training

9.2.1 Entry to Generalist Stream Advanced Training (GSAT)

To enter Generalist Stream Advanced Training you must have completed:

- 36 months FTE of basic training with satisfactory supervisor reports
- The 2 required case histories
- All basic training required experiences listed (see Regulation 2.5, 4.4 and 5)
- Passed the Written Examination
- Have current general registration as a medical practitioner in Australia, New Zealand or other approved country, state, territory or dependency and be in good standing with the relevant Medical Registration Board or equivalent approved body
- Be selected to enter Generalist Stream Advanced Training, with selection ratified by your Director of Advanced Training (or, where there is conflict of interest, to the assigned Selection Panel)
- Be appointed to an appropriate approved GSAT training post.

9.2.2 Entry to Approved Program Advanced Training (APAT)

To enter Approved Program Advanced Training you must have completed:

- 36 months FTE of basic training with satisfactory supervisor reports
- The 2 required case histories
- All basic training required experiences listed (see Regulation 2.5, 4.4 and 5)
- Passed the Written Examination
- Passed the Clinical Examination
- Have current registration as a medical practitioner in Australia, New Zealand or other approved country, state, territory or dependency and be in good standing with the relevant Medical Registration Board or equivalent approved body
- Be selected to enter Approved Program Advanced Training with selection ratified by your Director of Advanced Training (or, where there is conflict of interest, to the assigned Selection Panel)
- Be appointed to an appropriate approved APAT training post.

Note: Confidential information may be received about the applicants as part of the entry process. The applicant however has the opportunity to respond to any adverse comments before the formal interview.

9.3 Currency of Advanced Training and Assessment

Advanced training and assessment must be completed within 6 years of completion of basic training and assessment. If not, the CFT/FAC will review your overall training and assessment.

9.4 Duration and Content of Advanced Training

Advanced training can be undertaken in one of three ways, as follows:

9.4.1 Generalist Stream Advanced Training

2 years FTE in general clinical psychiatry. This training shall comprise 12 months FTE in clinical psychiatry and a further 12 months FTE in one or more areas of psychiatry or clinically relevant research, which is approved prospectively by your Branch Training Committee. At least 12 months FTE must be undertaken following successful completion of the clinical examination.

9.4.2 Approved Program Advanced Training

2 years FTE in an approved advanced training program.

9.4.3 Combined GSAT/ APAT

A period of time in GSAT combined with a period of time in APAT (the latter after successful completion of the clinical examination) to a total of 24 months FTE. At least 12 months FTE must be undertaken following successful completion of the clinical examination.

For advanced training to be accredited in any of the above 3 options, you must satisfactorily complete and document the following seven core experiences:

(i) Experience in psychological aspects of management in psychiatry
(ii) Experience in biological aspects of management in psychiatry
(iii) Experience in aspects of social management in psychiatry
(iv) Experience in cultural aspects of management in psychiatry
(v) Experience in the application of consultative skills in psychiatry
(vi) CME activities
(vii) Skills development in leadership and management in psychiatry

In any of the 3 options, up to 12 months FTE may be spent in clinical research.

9.4.4 Awarding of Fellowship and Advanced Training Certificate

On completion of two years FTE advanced training in any of the above three options you will be eligible for nomination to the CFT/FAC for admission to Fellowship of the College.

On completion of two years FTE of an Approved Program Advanced Training, you will be eligible for nomination by the Subcommittee of that approved program CFT and FAC for the award of a Certificate of Advanced Training in that discipline. Completion of all requirements for the award of Fellowship is necessary for eligibility to receive the Certificate.

10 MANDATORY TRAINING EXPERIENCES DURING ADVANCED TRAINING

10.1 Experience in Psychological Aspects of Management in Psychiatry
During advanced training you are required to further develop and integrate psychological aspects of management into your clinical practice. Therefore you must spend at least 1 hour per week throughout the 2 years, for at least 40 weeks of each year of advanced training, devoted to the provision of formal psychotherapy (of any modality) to a number of different people. At least 1 hour per month must be spent in individual or group supervision of these psychotherapeutic experiences.

10.2 Experience in Biological Aspects of Management in Psychiatry
Early in your advanced training, you must identify 3 specific learning goals in biological psychiatry to increase your knowledge of biological treatments relevant to your chosen subspecialty, and propose an approach to achieving each of these goals.

10.3 Experience in Social Aspects of Management in Psychiatry
Early in your advanced training, you must identify 3 specific learning goals in social psychiatry to increase your knowledge of social aspects of management as relevant to your chosen subspecialty, and propose an approach to achieving each of these goals.

10.4 Experience in Cultural Aspects of Management in Psychiatry
Early in your advanced training, you must identify 3 specific learning goals in cultural psychiatry to enhance your awareness of the part cultural beliefs play in mental illness, and propose an approach to achieving each of these goals.

10.5 Experience in the Application of Consultative Skills in Psychiatry
During advanced training you must learn how to clearly communicate your assessment and management plans and how to provide expert consultation to other health professionals, including general practitioners. You must also learn how to provide leadership in a multidisciplinary mental health team setting. To achieve this you must demonstrate significant interaction with general practitioners and other non-psychiatric health professionals. You must also attend (as part of the 4 hours required supervision) individual or group supervision to reflect on interactions with general practitioners and other non-psychiatric health professionals on at least 8 occasions each year.

10.6 CME Activities
To introduce you to a CPD style approach to CME, you must undertake and document during advanced training at least 50 hours of CME activities over 2 years. These activities will involve a mix of educational experiences, quality assurance tasks, self-directed learning, teaching and supervision. 15 hours can be gained from the experiences defined in Regulations 10.2 to 10.4 above.
10.7 **Skills Development in Leadership and Management in Psychiatry**
During advanced training, you must complete appropriate formal leadership and management training approved by your BTC, to prepare you for your role as a consultant psychiatrist.

See objectives for this training experience (Regulation 11.2 below).

10.8 **Assessment of Advanced Training**
Assessment of advanced training shall include:

(i) **Summative assessments** by your supervisor
(ii) Review of your training documentation and reports by the relevant SAT
(iii) **Research project** (depending on advanced training program)
(iv) **Final report**.

10.9 **Supervision during Advanced Training**
Supervision of advanced training shall occur as follows:

(i) Training experiences shall include at least four hours of clinical supervision per week, of which one hour shall be individual supervision, for at least 40 weeks of the year.
(ii) Supervision shall be specifically related to the chosen program/stream of training and clinical work. Supervision shall include a focus on aspects of the assessment and treatment of people under your care and under the care of your supervisor, and other supervision related to psychotherapy (Regulation 10.1), biological skills (Regulation 10.2), social skills (Regulation 10.3), cultural skills (Regulation 10.4), and consultative skills (Regulation 10.5). It shall include regular direct supervision of your clinical work by the responsible psychiatrist.
(iii) Discussion of other relevant aspects of work in the chosen program/stream shall be included as appropriate. Clinical and staff meetings must be specifically organised for the purpose of advanced training in order to count as part of the four hours clinical supervision
(iv) Supervision shall be undertaken by supervisors approved by your SAT.

11 **TRAINING OBJECTIVES FOR ADVANCED TRAINING**

11.1 **Clinical**
By the completion of advanced training within your chosen subspecialty, you shall be able to:

(i) Perform a comprehensive assessment of people with a range of psychiatric disorders. The assessment should demonstrate a consultant standard sophistication in integrating biological, psychological and socio-cultural aspects.
(ii) Develop a comprehensive, practical management plan on the basis of (i) above, and demonstrate the capacity to anticipate potential difficulties that may arise during implementation
(iii) Competently utilise a range of psychotherapeutic interventions, and select the most appropriate one for an individual's circumstances.

11.2 **Leadership and Management in Psychiatry**
By the completion of advanced training within your chosen subspecialty, you shall be able to:

(i) Understand the basic competencies required in management roles
(ii) Understand the national health policy framework within which psychiatry and mental health services are delivered
(iii) Articulate the opportunities and challenges within management roles for clinicians which differ from clinical roles
(iv) Demonstrate the capacity to engage in discussion around funding models for mental health and be able to debate more than one frame of reference
(v) Demonstrate understanding of organisational change theory and how it can be applied to mental health services
(vi) Understand how a Quality Improvement activity might work in a service setting
(vii) Understand how to increase the engagement of people with mental health problems and mental illness in mental health services
(viii) Understand how to apply adult learning concepts to the management of career transitions and the stresses inherent in undertaking management and leadership roles for psychiatrists.
12 ADMINISTRATIVE STRUCTURE

12.1 Approval of Training Programs

Approval of an existing training program, a new training program or a new component of an existing program is undertaken by the CFT/SAT, following receipt of a completed application form. The committee may hold a site visit to the program before granting approval.

The CFT/SAT conducts a site visit to each approved training program at intervals of approximately three years for the purpose of assessing conformity with the training regulations. Following such visits, the committee determines continuing approval of the program. Official reports of the site visits and the recommendations of the committee are provided to the relevant training program after consideration by the committee. In addition, the committee may authorise a site visit and review ongoing approval of any program at any time it deems necessary.

Training Programs

Each training program must have the following:

- A comprehensive rotational training program providing all the necessary experiences to enable training for all trainees
- A Director of Training formally designated by the CFT/SAT
- An appropriate administrative structure with appropriate committees overseeing the administration of the training program
- A register of approved institutions, services and posts used for training within the training program
- Assured access to a recognised formal education course
- Adequate procedures for the monitoring of standards of formal educational courses/learning modules

Supervisors

The following must be in place:

- Appropriate selection, training and appointment procedures
- Adequate procedures for monitoring the performance of supervisors, and providing formal and informal feedback
- Appropriate procedures for dealing with unsatisfactory supervisors

Trainees

The following must be in place:

- Appropriate selection and appointment procedures
- Adequate procedures for monitoring the training and performance of trainees, and providing formal and informal feedback
- Appropriate procedures for dealing with unsatisfactory trainees.

Role of Director of Training

There shall be an agreement (preferably in writing) between the Director of Training and the heads of the relevant clinical services regarding the aims and goals of training.

The Director of Training shall:

- Be aware of the functioning of the clinical facilities involved in the program and maintain a relationship with them such that modifications can be made if these are deemed necessary for a trainee's training experience
- Ensure that training centres take responsibility for the trainees' development, including the provision of appropriate clinical experience and supervision of the quality of the trainees' work, and opportunities to make formal presentations of their work in clinical meetings
- Approve each of the trainee's rotations/training experiences
- Ensure that consultant responsibility is taken for each trainee (that is, that there are clear lines of clinical responsibility from the trainee to the consultant at all times) and that the required level of supervision is provided
- Be responsible for a process of evaluation of the training program.

Each program should be clear about the goals, objectives, form and content of the program, and the system of evaluation and ongoing review of the trainees, the supervisors and the program.

Approved Institutions and Services

A psychiatric service shall meet the following requirements in order to be eligible for approval for training purposes:

- Adequate clinical facilities to provide the relevant approved training and a suitable range of clinical experiences
- Adequate numbers of consultant staff to provide clinical support to trainees at all times, as well as the required supervision from approved supervisors
- Clear lines of clinical responsibility extending from the trainee to the responsible consultant
- Ready access to suitable library facilities. Minimum requirements are basic psychiatry texts and a representative range of journals
- Adequate teaching sessions encompassing a variety of topics. These sessions may include seminars, journal clubs and tutorials.
- Ready access to information systems, for example the Internet
- Adequate facilities for trainees to conduct their clinical work. These shall include office facilities for confidential interviews and necessary clerical work, and adequate facilities for conducting physical examinations and for the appropriate medical care of people with mental health problems and mental illness
- Appropriate medical audit procedures and quality assurance programs.

**Approved Training Posts**
A psychiatric training post shall meet the following requirements in order to be eligible for approval for training purposes:
- Provide appropriate clinical experience
- Fulfil the requirements of consultant availability and supervision
- Be part of an approved training program.

## 13 ASSESSMENT OF SPECIALIST INTERNATIONAL MEDICAL GRADUATES

### 13.1 Assessment of Specialist International Medical Graduates

Specialist International Medical Graduates (SIMGs) who **HAVE** been determined as partially comparable by the Committee for Specialist International Medical Graduate Education and are exempt up to 12 months Advanced Training, will be assessed as follows:

(i) **Summative Assessments by your supervisor**

(ii) **Two Case Histories**, unless granted exemptions by the Committee for Specialist International Medical Graduate Education. The **Case Histories** are of people managed under supervision as outlined below:
   a) A person presenting for the first time to the mental health service, whom you have personally managed
   b) A person(s) in whom the predominant mode of intervention has been psychological.

(iii) **A Written Examination**, unless granted exemptions by the Committee for Specialist International Medical Graduates Education. This examination assesses your knowledge of the theoretical and scientific underpinnings of psychiatry, and clinical and ethical issues in psychiatry. A critical analysis question will be included.

(iv) **Eligibility to sit** the Clinical Examination. You are eligible to apply to sit this examination if at the time of application you have:
   - Current Exemptions status
   - Completed all mandatory training experiences (from which you have not been granted exemptions)
   - Passed the required case histories, unless you have been granted exemption
   - Passed the written examination, unless you have been granted exemption
   - Attended a Clinical Examination Preparation Workshop or approved equivalent.

(v) **Remediation** for Multiple Failures of Assessments
   Before applying to sit the written or clinical examination or to submit a case history for the third and every second subsequent attempt thereafter, you must complete a remediation program of duration as outlined in the remediation policy (see Link 83a), to the satisfaction of the CSIMGE.

Specialist International Medical Graduates who **HAVE** been determined as substantially comparable by the Committee for Specialist International Medical Graduates will be assessed as follows:

Satisfactory completion of a supervised work placement for a period of at least 12 months full time equivalent (FTE), and satisfactorily completion of regular Workplace based Assessments, involving regular supervisor reports, Case based Discussions and 360° Feedback.
## 14 GENERAL

### 14.1 Exemption
The FAC/BOE may exempt you from any or all aspects of the training and assessment requirements as outlined above.

### 14.2 Exclusion
The FAC/BOE, on advice from its committees, may exclude you from the training and/or assessment program at any stage.

### 14.3 Review and Appeals
You may request a review of a decision affecting you in relation to training and assessment. The relevant committee and/or the BOE will consider such requests. If you are adversely affected by a decision in relation to training or assessment you may appeal to the Appeals Committee of the College in accordance with the relevant College By-laws.

### 14.4 Admission to Fellowship
On completion of all training and assessment requirements, you will be eligible for nomination to the FAC for admission to Fellowship of the College.

### 14.5 Re-entry to Training
Applicants wishing to re-join the training program are required to satisfy current entry criteria. Non-specialist International Medical Graduates require appropriate registration, as detailed in [Link 5](#).
### Goals of RANZCP Training and Assessment

<table>
<thead>
<tr>
<th>Medical expert/Clinical decision-maker</th>
<th>To be knowledgeable about:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>- normal biological, psychological and social development from infancy to old age</td>
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<tr>
<td></td>
<td>- aspects of those biomedical, social and psychological sciences which underpin the practice of clinical psychiatry</td>
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<tr>
<td></td>
<td>- the epidemiology, aetiology, psychopathology, clinical features, and natural history of psychiatric disorders and psychological reactions in people with mental health problems and mental illness and carers, including concepts of impairment, disability and handicap</td>
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<tr>
<td></td>
<td>- general medical and surgical conditions, particularly in those areas of general medicine which relate to psychiatric practice</td>
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<tr>
<td></td>
<td>- the impact of psychiatric disorders and their treatment on people with mental health problems and mental illness and carers.</td>
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</table>

To be able to:
- perform a comprehensive psychiatric assessment in people with mental health problems and mental illness of all ages
- care for mental health problems in people with mental health problems and mental illness from infancy to old age
- competently assessing people with mental health problems and mental illness for the presence of medical illnesses.

| Communicator | To be able to clearly, considerately and sensitively communicate with people with mental health problems and mental illness, carers, other health professionals and members of the general public in a variety of settings. |
| Collaborator | To be able to collaborate effectively with people with mental health problems and mental illness, carers, other health professionals and members of the general public in a variety of settings. |
| Manager      | To be knowledgeable about the organisation and delivery of mental health care including the ethical, economic, geographical and political constraints within which it is delivered. |
|              | To be able to "manage" effectively in a health setting and the community. |
| Health Advocate | To be knowledgeable about and be able to apply the principles and processes of (mental) health promotion and (psychiatric disorder) illness prevention. |
| Scholar      | To be involved in constant critical review of scientific principles and clinical precedent. |
|              | To be knowledgeable about the principles of scientific method in practice and the use of this knowledge to evaluate developments in psychiatric research. |
|              | To be able to undertake a research or evaluation study and critically appraise published research relevant to psychiatry. |
| Professional | To uphold the integrity of the medical profession and recognise the privileges accorded them. |
|              | To be knowledgeable about the principles of medical ethics, the development of professional attitudes and mechanisms for the development and maintenance of clinical competence, acknowledging the need for professional and public accountability |
## APPENDIX 2

### Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
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<tr>
<td>ANZAPT</td>
<td>Australian and New Zealand Association of Psychiatrists in Training</td>
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<tr>
<td>APAT</td>
<td>Approved Program Advanced Training</td>
</tr>
<tr>
<td>BOE</td>
<td>Board of Education</td>
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<tr>
<td>BTC</td>
<td>Branch/Psychiatry Training Committee</td>
</tr>
<tr>
<td>CEX</td>
<td>Committee for Exemptions</td>
</tr>
<tr>
<td>CFE</td>
<td>Committee for Examinations</td>
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<tr>
<td>CFT</td>
<td>Committee For Training</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>DOT</td>
<td>Director of Training</td>
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<tr>
<td>ECE</td>
<td>Exemptions Candidate Examination</td>
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<tr>
<td>ECT</td>
<td>Electroconvulsive Therapy</td>
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<tr>
<td>FAC</td>
<td>Fellowship Attainment Committee</td>
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<tr>
<td>FRANZCP</td>
<td>Fellowship of the Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
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<tr>
<td>GC</td>
<td>General Council</td>
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<tr>
<td>GSAT</td>
<td>Generalist Stream Advanced Training</td>
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<tr>
<td>IMG</td>
<td>International Medical Graduate</td>
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<tr>
<td>M-OCI</td>
<td>Modified - Observed Clinical Interview</td>
</tr>
<tr>
<td>M-OSCE</td>
<td>Modified - Observed Structured Clinical Examination</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<tr>
<td>NZREX</td>
<td>New Zealand Medical Registration Examination</td>
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<tr>
<td>OCI</td>
<td>Observed Clinical Interview</td>
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<tr>
<td>OSCE</td>
<td>Observed Structured Clinical Examination</td>
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<tr>
<td>POA</td>
<td>Psychiatry of Old Age</td>
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<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>SAT</td>
<td>Subcommittee Advanced Training</td>
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</table>
CURRICULUM ADVANCED TRAINING FELLOWSHIP

Curriculum to be read in conjunction with the Regulations and Logbook for Basic Training and Advanced Training for Fellowship
PREFACE

One of the key purposes of The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is to ensure high quality training in psychiatry in Australia and New Zealand. This Advanced Training Curriculum follows on from the Curriculum for Basic Training, enhancing and refining the attitudes, knowledge and skills developed during basic training. It relates to the final two years of psychiatric training prior to the achievement of Fellowship, so focuses more on the attitudes, knowledge and skills required at a consultant level of practice.

This general Fellowship Curriculum for Advanced Training should be read alongside the specific Curriculum relevant to an advanced training approved program, if trainees are undertaking a specific approved program. The RANZCP is grateful for the contribution of people with mental health problems and mental illness, and their carers, to the development of the educational objectives delineated in the Regulations and Curricula.

The College places particular emphasis on ethical practice and appropriate professional attitudes throughout training. Any curriculum can only represent the state of educational expectations at a given time and will require periodic revision. All professionals are responsible for identifying relevant additional issues for study, reflection and skill development throughout their career.

John Condon
Chair
Fellowships Board
ADVANCED TRAINING ATTITUDES OBJECTIVES

The following attitudes objectives should be read in conjunction with the RANZCP Code of Ethics and any other ethical guidelines published by the RANZCP. Advanced trainees are expected to be familiar with and adhere to the ethical codes and guidelines of the RANZCP.

ATA 1 ATTITUDES TO PEOPLE WITH MENTAL HEALTH PROBLEMS AND MENTAL ILLNESS, CARERS AND THE COMMUNITY

Advanced trainees should maintain and deepen attitudes of respect for the humanity and dignity of the individual, which they have developed during basic training. Advanced trainees will demonstrate this attitude by:

ATA 1.1 Continuing to work collaboratively with people with mental health problems and mental illness, their carers and appropriate cultural advisers, so as to facilitate empowerment and to balance the needs of all involved, and those of the wider community.

ATA 1.2 Continuing to avoid discrimination against or exploitation of people with mental health problems and mental illness, whether current or past patients, on any grounds. Never unjustifiably refusing to assess and when necessary treat, any person with mental health problems or mental illness.

ATA 1.3 Maintaining and further developing attitudes of respect for the dignity and privacy of the individual in complex clinical situations where confidentiality must be weighed against risk, and balancing this against the needs of all involved.

ATA 1.4 Working to minimise stigma and to promote community education, and fostering this attitude in junior colleagues, the multidisciplinary team, and in the community in general.

ATA 1.5 Developing a sophisticated understanding of the differential power relationship between psychiatrists and people with mental health problems and mental illness, and continuing to provide advocacy for individuals and maintenance of appropriate professional boundaries.

ATA 2 ATTITUDES TO CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS AND MENTAL ILLNESS

Advanced trainees should maintain and further develop attitudes towards the care of people with mental health problems and mental illness, which they have developed during basic training. Advanced trainees will demonstrate this attitude by:

ATA 2.1 Aiming to continue to serve the best interests of people with mental health problems and mental illness by striving to deliver the best possible assessment and treatment and by avoiding intentional or foreseeable harm.

ATA 2.2 Striving to improve the well being of people with mental health problems and mental illness and their carers, by advocating for the just allocation of services. Developing a preparedness to take action if services, by reason of fiscal restriction or other factors, fall below minimal standards.

ATA 2.3 Acknowledging the limitations of their expertise (despite their more senior status) and seeking and utilising appropriate supervision, both individual, clinical, and for psychotherapy.
ATA 2.4 Continuing to develop positive attitudes towards consultation and communication with primary care health professionals, advisors, referrers and agencies as appropriate, so as to provide people with mental health problems and mental illness with the best possible assessment and treatment. Demonstrating appropriate leadership within multidisciplinary teams and with junior colleagues in this regard.

ATA 2.6 Continuing to develop positive attitudes towards partnership and collaboration with people with mental health problems and mental illness and their carers, to manage informed consent processes in complex clinical situations, and to encourage empowerment and a recovery-centred approach.

ATA 3 ATTITUDES TO THE SCIENTIFIC BASIS OF PSYCHIATRY

Advanced trainees should maintain and further develop attitudes towards the need to inform clinical experience with an evidence base, and for critical appraisal within psychiatry. Advanced trainees should demonstrate their understanding of this need for constant critical review by:

ATA 3.1 Continuing to develop an attitude of awareness of the relative benefits, outcomes, risks and costs of different procedures and treatments.

ATA 3.2 Maintaining an openness to change and development of their own practice in the light of demonstrated advances in knowledge.

ATA 3.3 Striving to add to their own knowledge base and to that of their colleagues and of psychiatry, by methodologically sound research or critical review projects, conducted according to established ethical and scientific principles.

ATA 4 ATTITUDES TO THE PROFESSIONAL ROLE OF PSYCHIATRISTS

Advanced trainees are on the threshold of greater professional responsibility thus they need to maintain an attitude of recognising the privileges accorded to them and of sharing the responsibility of upholding the integrity of the medical profession. Advanced trainees will demonstrate these attitudes by:

ATA 4.1 Continuing to develop self-knowledge and to recognise that their own physical and mental health is necessary to enable them to undertake their professional responsibilities competently. This attitude is demonstrated by seeking appropriate assistance in the event of poor health which interferes with professional duty, ceasing to treat patients until such time as their health is satisfactorily restored, and informing the appropriate clinical authorities to allow for alternative care for patients.

ATA 4.2 Recognising the obligation to maintain appropriate personal moral standards and boundaries in their professional practice, and in those aspects of their personal life, which may reflect upon the integrity of the medical profession.

ATA 4.3 Continuing to show respect for the knowledge and skills of their psychiatric colleagues, other medical colleagues and other health professionals. Expressing viewpoints with candour yet respect in the event of differences of opinion, and seeking to develop constructive and cooperative working relationships.

ATA 4.4 Recognising their greater responsibility and leadership role compared to basic trainees should they become aware of unprofessional conduct or ill health in a colleague or other health professional, so as to ensure that appropriate action is taken.
ATA 4.5 Developing a positive attitude towards the provision of teaching, in-service training and supervision to the multidisciplinary team, junior colleagues, basic trainees and students.

ADVANCED TRAINING KNOWLEDGE OBJECTIVES

ATK 1 DEVELOPMENT AND MAINTENANCE OF PSYCHIATRIC KNOWLEDGE

Advanced trainees are expected to build on the knowledge, which they have developed during basic training, to maintain and extend this, and to integrate this knowledge more fully into their clinical practice. Advanced trainees should further their knowledge of:

ATK 1.1 The principles and processes of mental health promotion and of the prevention of mental health problems and mental illness. The use of preventative strategies and interventions, and the influences of lifestyle, social, cultural and environmental factors in promoting health and preventing mental illness.

ATK 1.2 Roles for a psychiatrist in illness prevention and health promotion, in mental health, general health and community settings.

ATK 1.3 Normal biological, psychological and social development from infancy to old age and how this may affect the development of mental health problems and mental illness or be indicative of illness.

ATK 1.4 Factors that may be associated with vulnerability to mental health problems and mental illness and protective factors associated with resilience.

ATK 1.5 Factors specific to indigenous peoples, including relevant environmental, historical, social and political issues.

ATK 1.6 The biomedical, social and psychological sciences, which underpin the practice of clinical psychiatry, including ethical theory and the history of psychiatry.

ATK 1.7 The epidemiology, aetiology, psychopathology, clinical features and natural history of mental health problems and mental illnesses, including concepts of impairment and disability.

ATK 1.8 The range of possible treatments for mental health problems and mental illnesses including biological, psychotherapeutic and social interventions. This should include their theoretical underpinnings and the principles underlying the choice and integration of such interventions, including relative cost effectiveness and specific patient and environmental factors.

ATK 1.9 Medico-legal issues relating to the practice of psychiatry, with particular emphasis on privacy legislation, competence, guardianship and mental health act legislation.

ATK 1.10 The impact of psychiatric disorders and their treatment on people with mental health problems and mental illness and their carers, and on society as a whole.
ATK 1.11 General medical and surgical conditions, particularly in those areas, which relate to psychiatric practice. Includes knowledge about the presentation, investigation, diagnosis and treatment of such conditions, either as differentials to be excluded or as complicating factors in mental health problems and mental illnesses.

ATK 1.12 The psychosocial and cultural aspects and the meaning of medical illness for individuals and their carers, and of the interaction of this with mental health problems and mental illness.

ATK 2 THE SCIENTIFIC BASIS OF PSYCHIATRY

Advanced trainees should continue to develop their understanding of scientific method and research methodology, and the use of this to evaluate developments in psychiatric knowledge. Advanced trainees should further their knowledge of:

ATK 2.1 The history and philosophy of scientific thought.

ATK 2.2 Scientific analysis and the interpretation of psychiatric literature and the results of research, via critical appraisal.

ATK 2.3 Research methods, including quantitative and qualitative methodologies and principles, clinical trial design, statistical techniques and outcome assessment.

ATK 3 SERVICE ISSUES, LEADERSHIP AND MANAGEMENT

Advanced trainees should further develop their knowledge about the organisation and delivery of mental health care including the ethical, economic, geographical and political constraints within which it is delivered. Advanced trainees should further their knowledge of:

ATK 3.1 Philosophical and ethical principles underlying mental health service delivery.

ATK 3.2 Cultural, economic, practical and political factors, which influence the health care and social welfare systems when providing services for the individual.

ATK 3.3 The national health policy framework within which psychiatry and mental health services are delivered and RANZCP strategies and policies regarding mental health services.

ATK 3.4 The basic principles of health services management as they relate to the provision and management of psychiatric services, with specific knowledge of quality improvement programs and outcome measures in local mental health services.

ATK 3.5 An understanding of organisational change theory and how it can be applied to mental health services.

ATK 3.6 Different funding mechanisms for psychiatric services and the implications of these for the delivery of services.

ATK 3.7 The role of groups representing people with mental health problems and mental illness and other major mental health groups or organisations in relation to the delivery of mental health services.
ATK 3.8  The principles of clinical leadership, the opportunities challenges and competencies required for clinicians in management roles, and the possible stresses for psychiatrists in undertaking leadership and management roles.

ATK 4 PROFESSIONAL RESPONSIBILITY

By the completion of advanced training, trainees should be knowledgeable about the principles of medical ethics, the development of professional attitudes and mechanisms for the development and maintenance of clinical competence, acknowledging the need for professional and public accountability. Advanced trainees should further their knowledge of:

ATK 4.1  The principles of medical ethics as applied to psychiatric practice, in particular the RANZCP Code of Ethics as a guide to professional conduct.
ATK 4.2  The critical role of peer review in the maintenance of professional standards.
ATK 4.3  The principles governing the maintenance of practice standards and quality improvement, including knowledge of relevant RANZCP position statements and other guidelines for clinical practice.
ATK 4.4  Effective mechanisms for ensuring continuing medical education and the components of the RANZCP Continuing Professional Development (CPD) program.
ATK 4.5  The management of career transitions utilising the principles of life long and adult learning.

ADVANCED TRAINING SKILLS OBJECTIVES

ATS 1 HEALTH PROMOTION AND ILLNESS PREVENTION SKILLS

By the completion of advanced training, trainees should be able to apply specific knowledge of the principles and processes of health promotion and illness prevention. In particular, advanced trainees should be able to:

ATS 1.1  Utilise appropriate opportunities for a psychiatrist to become involved in health promotion and illness prevention activities in a range of settings. Advanced trainees should, wherever possible, use preventative approaches in clinical practice, incorporating the influences of lifestyle, social, cultural and environmental factors so as to promote health and recovery.

ATS 1.2  Recognise protective factors, which contribute to psychological resilience in individuals or groups, and assist people with mental health problems and mental illness in the development of such factors.

ATS 1.3  Recognise the relevance of the experience of illness by carers, and use this information effectively in health promotion activities with these individuals and with carer groups.
ATS 2 ADVANCED CLINICAL SKILLS

By the completion of advanced training, trainees should have further developed their clinical skills to a consultant standard of sophistication, in their assessment and treatment of people with mental health problems and mental illness. In particular, advanced trainees should be able to:

ATS 2.1 Perform a comprehensive assessment of people with a range of psychiatric disorders. The assessment should demonstrate a consultant standard of sophistication in integrating biological, psychological and socio-cultural aspects into a diagnostic formulation.

ATS 2.2 Refine skills in the development of a therapeutic alliance and in communicating clearly, considerately and sensitively with people with mental health problems and mental illness and their carers, where necessary involving professional interpreters and cultural advisers.

ATS 2.3 Maintain and develop skills to competently assess individuals for the presence of medical illnesses, and to integrate the interrelation between physical illness and psychiatric disorder in both assessment and management.

ATS 2.4 Develop a comprehensive, practical management plan on the basis of a full assessment, and demonstrate the capacity to anticipate potential difficulties that may arise during implementation.

ATS 2.5 Competently utilise a range of biological, social, cultural and psychotherapeutic interventions, and select the most appropriate interventions for an individual's circumstances.

ATS 2.6 Further develop the skills to work in partnership and collaboration with people with mental health problems and mental illness and their carers, managing informed consent processes in complex clinical situations and encouraging empowerment and a recovery-centred approach.

ATS 2.7 Further develop skills in appropriate methods of assessment and in the development of holistic management planning with indigenous peoples, using the expertise of cultural advisors.

ATS 2.8 Continue to develop skills in choosing the most appropriate setting for an individual's treatment, ideally selecting the least restrictive option for that person, but where necessary using provisions for involuntary treatment humanely. Advanced trainees should refine skills in the implementation and interpretation of privacy legislation, competence assessments, guardianship and mental health act legislation.

ATS 2.9 Further develop the ability to implement a quality cycle in clinical management by routinely re-evaluating diagnostic and management decisions to monitor their appropriateness and thus ensure optimal care.
ATS 3  SCIENTIFIC AND RESEARCH SKILLS IN PSYCHIATRY

By the completion of advanced training, trainees should have the skills necessary to design a research or evaluation study and to critically appraise published research relevant to psychiatry. In particular, advanced trainees should be able to:

ATS 3.1 Continue developing their skills in applying evidence-based principles to critically appraise and interpret new knowledge and critically analyse research reports relevant to psychiatry.

ATS 3.2 Continue developing their skills in the methodology of research design and implementation in psychiatry, with the ability to address problems in study design, measurement and statistical analysis.

ATS 3.3 Refine skills in managing information technology so as to effectively and efficiently locate and utilise quality information from relevant sources.

ATS 3.4 Interpret and disseminate relevant scientific information within mental health services and in relation to public debate, on issues relevant to the field of psychiatry. In doing so, advanced trainees should differentiate their role as educators based on professional knowledge from their personal views.

ATS 4  WIDER ROLES OF A PSYCHIATRIST AND LEADERSHIP AND MANAGEMENT SKILLS

By the completion of advanced training, trainees should have developed consultant level skills related to the wider roles of a psychiatrist in a health setting and in the community. In particular, advanced trainees should be able to:

ATS 4.1 Continue to develop the ability to work in a multidisciplinary environment, including skills in supervision, teaching and mentoring of team members and junior colleagues.

ATS 4.2 Continue to develop skills in consultation and communication with primary care health professionals, advisors, referrers and agencies as appropriate, so as to provide people with mental health problems and mental illness with the best possible assessment and treatment.

ATS 4.3 Refine skills in maintaining good clinical records to facilitate communication with other health professionals and meet medico-legal requirements, mindful of confidentiality issues and the requirements of privacy legislation. Utilise electronic systems as appropriate for this purpose. Further develop skills in report writing, documentation and letters to referrers and others.

ATS 4.4 Continue to develop skills necessary to work in partnership with individuals and groups representing the interests of people with mental health problems and mental illness and their carers, working towards the best possible outcomes.

ATS 4.5 Further develop leadership and management skills within clinical teams, mental health services, and in interactions with the wider community, so as to contribute effectively to the planning and organisation of mental health services.

ATS 4.6 Continue to develop skills in the evaluation of services and the use of outcome and quality improvement measures in improving outcomes for people with mental health problems and mental illness and for their carers.
ATS 4.7  Develop skills so as to advise those responsible for the provision of health services, including acting as an advocate and working with advisory, statutory and voluntary bodies that have a role in the provision of psychiatric services.

ATS 4.8  Continue to develop skills necessary for effective team performance including conflict resolution, problem solving, the ability to delineate and work within role boundaries, team goal setting and development, and change management.

ATS 4.9  Further develop administrative, organisational and time-management skills and the ability to use electronic mail and modern communications systems for organisational communication.

ATS 4.10 Develop skills in utilising peer review and continuing medical education activities, to maintain personal growth and adult learning.
Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program

RANZCP General Council
23rd August 2008

Prepared by the Curriculum Improvement Project Reference Committee

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Executive Summary

Introduction

In 2007 the Department of Health and Ageing (DoHA) funded The Royal Australian and New Zealand College of Psychiatrists (the College) to undertake an extensive five-year Curriculum Improvement Project (CIP) as part of the federally-funded Structural Reform of Psychiatry Training Project. The CIP is principally concerned with curriculum renewal and redevelopment of the existing RANZCP five-year Fellowship training program. The Board of Education (BOE) was established by the College General Council in 2007 to lead strategic education policy development and to operationalise the management of the College’s educational activities; the renewal of the College’s educational governance sits alongside related national and international movements to redefine and modernize undergraduate and postgraduate medical education.\(^{(1-5)}\) In a recent paper the BOE\(^{(6)}\) indicated that:

Confidence in the quality of the RANZCP graduate is significantly influenced by their requirement to obtain experience in a variety of settings and with a variety of service users…this means the ability to make appropriate assessments, to draw reliable and valid conclusions from that information (diagnosis and formulation), and above all to produce a management plan, driven by the assessment conclusions and being able to implement it. The goal [is] the gaining or restoration of mental health. Such a management/recovery plan is expected to utilise whatever empirical or state-of-the-art therapeutic programs, knowledge, skills and other competencies [that] are appropriate and necessary for that particular service user's improvement.

If one accepts this view then it necessarily follows, as the BOE suggests, that certification must graduate candidates who demonstrate that they have the capability to meet the ‘specified standard, to develop and implement an appropriate specialist level of patient management’.\(^{(6)}\)

Historically, curricula models in undergraduate and postgraduate medical education have ranged from case-based and problem based-learning models\(^{(7-11)}\) to experiential learning and apprenticeship models\(^{(12, 13)}\) and, increasingly, simulation-based learning models\(^{(14)}\) and those informed by inter-professional learning.\(^{(15-17)}\) The College’s existing curriculum\(^{1}\) is based on the principles of apprenticeship, a well accepted traditional model of specialist training predicated on experiential learning and time-in-training where learning is supported by expert supervision. The model maintains that by ‘observing’, ‘participating’ and, later, ‘doing’, a trainee will develop sufficient skills to practise competently within the specialist role. Like other apprenticeship models the College’s current program has been subject to criticism. Specifically in the recent past there has been evidence of:

- poor curriculum alignment between stated learning objectives, teaching and learning strategies and assessment requirements;
- perceived variability in the quality of the formal education course which currently ranges from a Master’s qualification to locally coordinated programs in particular state and territory jurisdictions;
- competing demands for service provision and training requirements for trainees; and
- extended time taken for trainees to complete the program; on available data the average time to completion is seven years.

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\(^{1}\) Available [www.ranzcp.org/training/trainingresources/basictraining](http://www.ranzcp.org/training/trainingresources/basictraining)
[www.ranzcp.org/training/trainingresources/ advancedtraining](http://www.ranzcp.org/training/trainingresources/advancedtraining)
A new program ought to be informed by a more **effective** and **efficient** outcome-oriented framework than is currently the case and which better reflects the College’s commitment to **continuous improvement** as ‘fit-for-purpose’ in its educational undertakings.

In the last two decades the health care environment has come under considerable pressure in Australia and internationally, not least from a growing shortage of qualified practitioners in all medical specialties\(^\text{18-21}\), reflecting the urgent need for sustainable workforce planning. Concomitantly there has been an expanding interest in extending opportunities for the more timely preparation of specialist medical practitioners to meet the exponential rise in service needs and to assure that such specialists are prepared to be capable and competent experts. \(^\text{18-21}\) This is especially so in the case of mental health where the recent Lancet Series on Global Mental Health\(^5\) highlights the parlous state of education for mental health professionals, including psychiatrists, in particular for those in low and middle income countries. Moreover, in the developed world, there is increasing acceptance that the current preparation of psychiatrists is inadequate to meet society’s needs.\(^5\)

These trends internationally and within the domestic context reflect a shift in curriculum theorising and curriculum development in specialist medical education and training – from more traditional apprenticeship models to those it is anticipated may better reflect contemporary models of competency or outcomes-based educational frameworks. \(^21, 25-30\) In some medical education jurisdictions this is evidenced by dramatic changes in the governance of postgraduate medical education, for example, in the United States\(^22\), Denmark\(^23\), Canada\(^24-31\) and most recently in the United Kingdom\(^32\) as related governing bodies respond to the pressures for educational change. Given these matters it is timely for the College to be reviewing its broad educational values and framework that underpin its practices.

Training of medical specialists does not occur in a vacuum and, this being so; some reference to the clinical **contexts** of training is required in the development of the curriculum framework, not least because a number of related factors are contributing to the reform process. These factors include but are not limited to:

- a chronic shortage of medical specialists;
- a shifting political climate which demands evidence-based practice in the training of medical specialists in that competence is demonstrated;
- a growing emphasis on cultural competence in specialist medical education;
- shifting demographic demands – significantly, an aging population which in coming years will require greater resource allocation and focus on the disorders of aging (dementia, life-span);
- workforce planning issues which anticipate an influx of medical graduates in 2012 which may mean that for the first time there will be a mismatch between the positions available and the numbers of graduates in Australia;
- the need for the development of comprehensive and well defined quality assurance processes to ensure that standards are met throughout training and that they are maintained throughout one’s professional life;
- consideration of the learning environment, noting the variability in the quality and accountability of training environments and the well recognised tension between training requirements and service demands;
- the role of supervision and its central role in all aspects of specialist education including curriculum development and the learning environment;
- the requirement for infrastructure support to effectively implement best practice standards in the area of outcomes-based education frameworks;
- a shift in educational thinking and generational change within the profession of psychiatry itself.
These issues are referenced here not for resolution but to illustrate the range of factors that require consideration as the CIP progresses. They also highlight the need for successful change management strategies to be developed to support effective implementation of the proposed changes. Consideration of the contextual and political factors in the design and implementation phase allows for maximum engagement of stakeholders thus creating the necessary 'buy in' to facilitate change. To ignore them would potentially limit the utility and application of the framework to the training environment. Further it potentially creates competing goals with funding agencies, thereby creating an educationally sound framework which is unable to be implemented.

The Proposal

This proposal argues that that the College’s Fellowship and continuing professional development programs be informed by a concept of adult learning that emphasises:

1. a recognition of the existing expertise which medical graduates bring to their vocational training programs;
2. a commitment to the active engagement of learners in the interprofessional learning environment of clinical practice;
3. the development of self-regulation and critical reflection on one’s practice and learning habits (meta-cognition);
4. a learning environment that promotes the demonstration of the social responsibilities and accountabilities of specialist psychiatrists;
5. an appreciation that self-directed, independent learning occurs in collaborative environments; and
6. a commitment to continuous professional development that emphasises both personal development and the priority of patient rights and participation.

This proposal is underpinned by international best practice benchmarks in specialist medical education and training where there is growing evidence that postgraduate medical education is less reliant on the assumption that exposure within the clinical setting will, of itself, equip trainees to successfully navigate the role of a specialist psychiatrist.

Competent Performance

The College accepts that postgraduate medical education must prepare specialist psychiatrists who are creative problem-solvers – critical thinkers capable of innovative practice and who are committed to accepted professional and societal standards of patient-centred care. The Fellowship curriculum must be informed by defensible educational approaches that promote self-regulation and responsibility for one’s own professional development across the lifetime of professional practice.

In order to define ‘competence’ to accommodate these principles, the proposal rejects a behavioural approach which is largely concerned with the aggregation of objectifiable skills, as technicist, simplistic and narrow, and supports a more holistic or qualitative approach to competence which better reflects the complexity of the contemporary professional practice of specialist psychiatrists.

It is proposed therefore that the College draws on Goveart’s\(^{33}\) and McAllister’s\(^{34}\) conceptions of competence and competent performance where the concept of ‘competent performance’ is the underpinning educational philosophy to guide the curriculum framework. ‘Competent performance’ is defined as the capability to perform skilfully and thoughtfully in diverse practice settings. It refers to the capable exercise of professional judgment in practice settings of change and impermanence; competent performance implies the integration of knowledge, skills, judgment and attitudes. Competent performance is linked to professional roles and domains of practice and demands self-
regulation and critical reflection. Implicit and integral to this view, is the idea that professional practice behaviours are situational and reflect the individual's capacity for innovation, creativity and problem-solving.

The Royal College of Physicians and Surgeons of Canada and CanMEDS

It is proposed that the 2005 Royal College of Physicians and Surgeons of Canada ‘CanMEDS Physician Competency Framework’ model in conjunction with the associated Royal College of Physicians and Surgeons of Canada ‘2007 Objectives of Training in Psychiatry’ be adapted for the Royal Australian and New Zealand College of Psychiatrists thereby providing the basis for the College’s Fellowship curriculum (see Appendix 1). By harnessing the existing evidence there is an opportunity to be innovative, and to link with undergraduate and postgraduate training to promote notions of lifelong learning and continuous professional development.

The CanMEDS framework comprises seven roles which are defined and described in terms of competency standard statements:

1. Professional;
2. Communicator;
3. Collaborator;
4. Manager;
5. Health Advocate;
6. Scholar; and
7. Medical Expert.

The framework:
- aims to provide an educational construct which informs curriculum planning in medical education;
- has a focus on articulating a comprehensive definition of the competencies needed for medical education and practice with the goal of improving patient care and health outcomes;
- it has the construct of ‘medical expert’ central, as it is integral to the role of the physician, and therefore informs other roles within the framework; and
- sees all roles being equally valued to integrate with the medical expert role.

Structuring an adapted framework retains the RCPSC CanMEDS roles but serves a number of purposes:

1. It offers the opportunity to incorporate the available RCPSC CanMEDS empirical and implementation data to the Australian and New Zealand context. This is of value given the dominant role that the framework has in the training of medical specialists across jurisdictions globally.
2. The availability of outcome data from jurisdictions (most notably Canada and Denmark) where the framework has been in use for a significant period, allows collaboration in framework evaluation that reduces the requisite timeframe between implementation and impact evaluation.
3. It enables the College to build on existing collaborative relationships with an experienced and ‘expert’ partner, i.e. the RCPSC, in the area of specialist medical education.

While this approach would reflect a different curriculum framework to that being adopted in pre-vocational training, there is potential for sufficient linkages with the Australian Junior Doctor Framework” for trainees to see the curriculum coherence into specialist training. To facilitate this, curriculum design must remain cognizant of the principles of ‘competent performance’ across the lifespan of the medical professional, ensuring that statements to this effect are prominent within

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the curriculum. Where possible, these statements should include explicit reference to the competencies or standards with which pre-vocational trainees enter specialist training and how these relate to specialist curricula. It is recommended that the College’s proposed competency-based curriculum framework will form the foundation of Fellowship training and inform the continuing professional development program.

Proposal Summary

The proposed Curriculum Framework will:

1. Define an innovative learning environment for the training of specialist psychiatrists to meet the demands of their profession and the community’s needs to improve overall mental health.

2. Be evidence-based against benchmarked best practice in specialist medical education so that:
   - the fundamental place of experiential learning in specialist psychiatry training is explicit;
   - trainees are engaged in meaningful inter-professional learning opportunities;
   - flexibility in learning opportunities are available;
   - adult learning, lifelong learning and self regulation within a competency-based model of learning, assessment and remediation are explicitly supported.

3. Adopt the concept of ‘competent performance’ as a premise for a competency-based curriculum framework.


5. As part of the planning process the proposed curriculum framework has been mapped to the existing Australian Medical Council (AMC) Accreditation Standards for Specialist Medical Education in the following section. It addresses Standard 1–Standard 6 in detail as the framework justification. Standard 7–Standard 13 are more relevant to curriculum implementation; where the current status of the project allows it implications for implementation are addressed.

The proposal seeks in principle approval from General Council for the implementation of a competency-based curriculum model, drawing on the strengths and broad international acceptance of the RCPSC CanMEDS with the CanMEDS ‘2007 Objectives of Training in Psychiatry’ as the best-evidence framework for the College. This proposal illustrates subsequently that the proposed framework has the potential to meet the requirements of the AMC Standards for Specialist Medical Education. The College’s unique context will be the leading concern, without compromising the underlying CanMEDS roles—adaptation will accommodate emerging views of the psychiatrist as clinical leader, teacher and educator, and an increased emphasis on inter-professional collaboration and cultural competence for the Australian and New Zealand contexts.

Implementation Issues

Frank and Danoff argue that CanMEDS is now integral to the fabric of medical education in Canada. However given the time taken to implement a major innovation such as this and the length of specialist training, limited direct evidence regarding the impact of CanMEDS on curriculum design or health outcomes broadly is available. Still, there is ample evidence of the influence of CanMEDS internationally in the public discourses surrounding competency or outcomes-based medical education, with many specialist colleges and undergraduate medical programs using CanMEDS or modifications of it for curriculum design, outcomes assessment
purposes (13, 33, 34, 36, 38, 43-52), to inform applicant interviews into undergraduate medical schools (53, 54) and a residency program (28).

Implementation Domains

Frank and Danoff (26) provided a descriptive report of the implementation of CanMEDS across medical education jurisdictions in Canada in the two decades since the project began: four implementation domains were proposed and these are used to preface the implementation issues the College faces:

1. standards for curriculum teaching and assessment;
2. faculty development initiatives for CanMEDS;
3. research and development resources;
4. outreach and communication approaches.

Standards for Curriculum, Teaching and Assessment

1. The curriculum will be designed by dedicated workgroups of College Fellows and overseen by the CIP Reference Committee.
   a. Workgroups will be chaired by members of the CIP Reference Committee.
   b. Workgroups will be structured according to the CanMEDS roles.
   c. Workgroups will be supported administratively and educationally by the Secretariat.
2. Additional Secretariat support in the form of educational development expertise is available within the existing budget and will be employed.
3. It is anticipated that a Formal Education Course (FEC) will be designed and developed centrally for flexible online delivery. The CIP Reference Committee will oversee the curriculum of the FEC.
4. The project will support the development of curriculum materials electronically through a curriculum mapping database.
5. In–training and work-place based assessment design will be integrated across the curriculum in a meaningful way to accommodate a balance of formative and summative assessment and to enable the development of indentified competencies. A collaborative project with SATCAP and Dr Sue McAllister (University of Adelaide) in Semester 2 2008 will inform the broader development of assessment processes along with other appropriate international experts and the Office of Postgraduate Medical Education at the University of Sydney, who will continue to be consulted as required.

Faculty (Fellowship) Development Initiatives for CanMEDS

1. A four-year implementation work-plan has been recently negotiated with the Department of Health and Aging.
2. A series of bi-national consultation meetings are currently being conducted with key internal stakeholders by Professor Boyce, Dr Crawshaw and Dr Spratt and Ms Dick.
3. Subsequent curricula development will be planned and established through appropriate business planning and project specifications. Associated workgroups will be supported by a range of staff development strategies exploring competency-based curriculum models, supervision and related teaching and learning issues.

Research and Development Resources

1. Curriculum development will be supported by dedicated design and development workgroups noted above.
2. External educational support and consultation will be accommodated in the current budget and will include collaboration with the Office of Postgraduate Medical Education at the University of Sydney and an appropriate external expert on workplace-based assessment in specialist medical education, building existing relationships with the Australian and New...
Zealand College of Anaesthetists and the Royal Australasian College of Physicians in particular in relation to workplace-based assessment models.

3. Information and communication technologies (ICT) will be central to the delivery of the new curriculum and processes are in place for addressing ICT issues as a strategic priority for the College.

4. A quality improvement and evaluation framework will be designed concurrently to develop Accreditation Standards in line with CanMEDS that reference the AMC standards.
   a. This framework will also accommodate a process evaluation and establish an educational research and development program.

**Outreach and communication approaches**

1. The Registrar Representative Committee is a key stakeholder and members of the CIP Reference Committee presented to the most recent face-to-face meeting.

2. A broad Communication and Change Management Strategy for the RRC and all College stakeholders has been developed and implementation is underway.

**Summary Key Implementation Issues**

Subject to gaining in principle approval by the College General Council and the outcomes of the upcoming stakeholder consultation, a detailed Implementation Plan will be presented to General Council in November 2008.

1. The evaluation of the implications of changes to time-based training and the associated workforce issues in particular those service implications related to ‘registrar rotations’ might be foreseen as a significant obstacle to implementation. However, a competency approach may offer potential for increased flexibility in the current rotation system.

2. Changes to the overall assessment and examination strategy to a new approach in keeping with competency-based curriculum models, including for example:
   a. The introduction of new models of workplace-based formative assessment including multi-source feedback.
   b. Redesigning the OCI as a series of formative in-training assessments rather than as a single summative assessment.
   c. Retention of some form of written examinations and OSCE, with review of the timing of such examinations in relation to competence development.

3. The broad professional development and training issues for supervisors and others who provide training experiences:
   a. New models of teaching and learning, supervision and supervisor training, mentoring, and peer learning opportunities will be required.

4. Extensive internal discussion regarding the Information and Communication Technologies (ICT) required to support the development of the curriculum and its implementation (e.g. the development of a curriculum mapping database to capture all aspects of the curriculum framework and materials development) and the requirements for an e-portfolio and other e-learning approaches. This includes additional resource allocation which cannot be solely provided by the CIP.

**Conclusion**

This proposal recommends a competency-based curriculum model, drawing on the strengths and broad international acceptance of the Royal College of Physicians and Surgeons of Canada (RCPSC) CanMEDS[35] as the best-evidence framework for the training of medical specialists. This provides us with an opportunity also to address a number of the identified curriculum shortcomings in the current program. It also provides an opportunity to link undergraduate and postgraduate training to promote notions of lifelong learning and continuous professional development.
A Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program that meets the AMC Accreditation Standards for Specialist Medical Education

Reading this section

Standard 1-Standard 6 are addressed in detail as the framework justification. Standard 7–Standard 13 are more relevant to curriculum implementation; where the current status of the project allows it implications for implementation are addressed. Each relevant standard statement is italicised and is followed by a supporting justification and rationale based on the proposed framework.

1. The Context of Education and Training

1.1. Governance

1.1.1. The training organisation’s governance structures and its education and training, assessment and continuing professional development functions are defined.

1.1.2. The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.

1.1.3. The training organisation’s internal structures give priority to its educational role relative to other activities.

1.2. Program Management

1.2.1. The training organisation has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:

- Planning, implementing and reviewing the training program(s) and setting relevant policy and procedures
- Setting and implementing policy and procedures relating to the assessment of overseas trained specialists
- Setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activity

1.2.2. The training organisation’s education and training activities are supported by appropriate resources including sufficient administrative and technical staff.

Justification

The Board of Education (BOE) reports to the RANZCP General Council. The BOE overseas six operational committees (Examinations, Training, Specialist IMG Education, External Liaison and Reporting, Educational Projects and Continuing Medical Education) and holds strategic responsibility for the educational governance of the College’s educational activities as articulated in its bylaws:

- Formulating and developing strategic education policy advice for General Council on all matters relating to Fellowship and the award of certificates of advanced training in those special areas of psychiatric practice as General Council may approve;
Overseeing all activities of the six Board Committees and any other bodies established by the Board in terms of their respective composition, function, and budget;  
Advising General Council regarding decisions taken about suitably qualified persons for admission as Fellows and advising General Council on the award of certificates related to training in special areas of psychiatry;  
Identifying appropriate measures for assessment of specialist international qualified medical graduates and for determining requirements for further training, assessment, examination or exemption which may be appropriate to achieve Fellowship;  
Formulating advisory policy, programs and procedures for continuing medical education for Fellows and fostering on-going participation therein; wider Congress involvement; and standards in continuing professional development activities;  
Providing advice to relevant external authorities and bodies on all matters relating to the regulation of training, assessment and examination required to achieve Fellowship and professional development in Australia and New Zealand, and establishing liaisons and alliances with those entities.

The College’s current educational governance structure is outlined elsewhere and in various internal policy documents. It is anticipated that the existing structure offers a rigorous model on which to manage the proposed curriculum framework and training model. However, the need for some extension of current arrangements in particular in relation to the quality improvement strategies that support accreditation, teaching and learning broadly and the assessment system specifically would be required (See Standards 3, 5 and 12).

1.3. Educational Expertise and Exchange

1.3.1. The training organisation uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.  
1.3.2. The training organisation collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs.

Justification

The Curriculum Improvement Project (CIP) Reference Committee has drawn on external and internal educational expertise and implemented a number of evidence-based strategies to inform the development of the framework. In the first instance the able and experienced CIP Reference Committee, Chaired by Professor Phil Boyce and Deputy Chair Dr John Crawshaw, is supported by Secretariat staff Ms Suzanne Dick and Dr Christine Spratt, with postgraduate and doctoral qualifications and extensive experience in Psychology and Education respectively and who have dedicated roles on the project.

The Committee has drawn on the expertise of the Office of Postgraduate Medical Education (OPME) at the University of Sydney in the development of the proposal through a collaborative workshop (curriculum frameworks, alignment and assessment) with the BOE and the OPME has provided ongoing critical comment as the proposal has developed. The CIP Reference Committee has begun collaborations with the RCPSC Specialist Committee for Psychiatry, through Professor Gary Hnatko at the University of Alberta and Dr Andrew Padmos, CEO of the RCPSC and an educational visit with those groups and the Royal College of Psychiatrists (UK) is planned for October 2008. Deliberations with our international collaborators will include:

• Discussions with the relevant people engaged in implementation strategies for competency-based curriculum models generally;
Discussions with the relevant people regarding the pragmatic challenges of designing the processes they are using to implement their current curriculum based on the ‘2007 Objectives in Psychiatry Training’ published through RCPSC;

Investigation of strategies used to implement such new curricula across a range of training settings in hospital, community settings and private practice settings;

Investigating the feasibility of using CanMEDS in a determined manner to reduce time-in-training and ensure graduation is based on the achievement of the identified competencies;

The opportunity to observe in clinical settings how in-training-assessments are performed and discuss the processes adopted in order to conduct reliable and valid in-training assessments;

Initiate discussions for potential collaborative research.

The CIP Reference Committee is also collaborating with the Sub-Committee for Advanced Training in Child and Adolescent Psychiatry (SATCAP) (through Professor Phil Hazell and Dr Prue McEvoy), and Dr Sue McAllister (University of Adelaide) to develop a workplace-based assessment and competency framework for the Certificate in Advanced Training in Child and Adolescent Psychiatry which will inform the broader development of the CIP particularly in relation to assessment. The CIP has partially funded and is currently collaborating with SATCAP on this project. In addition the Secretariat on behalf of the Committee researched and wrote a systematic literature review and has consulted with the Royal Australian College of Anaesthetists and the Royal Australasian College of Physicians in particular on related matters of workplace-based assessment—forthcoming collaboration with these groups involves the engagement of international assessment expertise to consult to the project.

2. The Outcomes of the Training Program

2.1. Graduate Outcomes

2.1.1. The training organisation has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners’ role in the delivery of health care. The outcomes are related to community need.

2.1.2. The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.

2.1.3. The training organisation makes information on graduate outcomes publicly available.

Justification

Graduate outcomes will be explicitly informed by the concept of ‘competent performance’ described herein and articulated in the RCPSC CanMEDS roles which will be contextualised and redeveloped for the RANZCP Fellowship program. The proposed curriculum framework, the associated curriculum and anticipated graduate outcomes draws on Govearts’s[33] and McAllister’s[34] conceptions of competence and competent performance:

Competent performance refers to the capable exercise of professional judgment in practice settings of change and impermanence; it is always developmental and context dependent.

Competent performance implies the integration of knowledge, skills, judgment and attitudes.

Competent performance is linked to professional roles and domains of practice and demands self-regulation and critical reflection.

With an explicit focus on the roles of carers, the patient or consumer and multidisciplinary colleagues, any curriculum must prepare specialist clinicians to practice in accordance with the expectations of stakeholders and the edicts of their profession. Competent performance is therefore particularly relevant to the important and complex roles and responsibilities held by psychiatrists within mental health systems and the community more generally.
The activities, relevant documents and proposals of the CIP including the CanMEDS statements will be publicly available through the website: http://cip.ranzcp.org/

3. The Education and Training Program – Curriculum Content

3.1. Curriculum Framework

3.1.1. For each of its education and training programs, the training organisation has a framework for the curriculum organised according to the overall graduate outcomes and which is publicly available.

3.2. Curriculum Structure, Composition and Duration

3.2.1. For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.

3.2.2. Successful completion of the training program must be certified by a diploma or other formal award.

Justification

A curriculum framework is an overarching conceptual representation of the intended teaching aims, learning objectives and learning and teaching experiences of an educational program. Curricula frameworks provide the scaffolding on which curriculum designers build the specific structures that enable learning and competence development.

In the health sciences, a curriculum framework is usually based on disciplinary bodies of knowledge, the requirements of accrediting organisations, the social and political demands of health services and society, as well as related theories of learning, professional education and professional practice. The design of a curriculum framework precedes the more detailed development of the specifics of the curriculum; the latter is generally recognised as a ‘syllabus’ or domains of content knowledge that inform teaching and learning strategies.

In exploring various notions of competence, this proposal rejects a behavioural approach to competence which is largely concerned with the aggregation of objectifiable skills, as technicist, simplistic and narrow. Conversely it supports a more holistic or qualitative approach to competence which better reflects the complexity of the contemporary professional practice of specialist psychiatrists.

While the RCPSC CanMEDS has defined the nature of competency frameworks internationally, there is less compelling evidence regarding the precise structure of curriculum processes to achieve desired competency outcomes or convincing evidence regarding definitive approaches to meet defined outcome standards or to suggest that competency-based curricula may affect time-in-training. Similarly there is anecdotal evidence that commitment to competency-based models and to improve the clinical practice of professionals may have some positive influence on health outcomes.

The available evidence suggests that educationally defensible curricula typified by the qualitative concept of competence outlined earlier, ought to include:

- a specific educational philosophy;
- collaborative engagement with key stakeholders to devise a competency framework in keeping with regulatory requirements and the identified educational philosophy, as well as the expectations of the specific discipline;
• performance outcomes or competencies that are transparent, performance oriented, clearly communicated and aligned to appropriate assessment;
• the design and development of appropriate pedagogical strategies including:
  o learner-centred approaches that offer flexibility but include structured learning programs and appropriate dedicated supervision;
  o due attention to the importance of feedback;
  o a learning environment and climate for learning that is motivating and engaging;
  o opportunities for online and blended learning;
  o opportunities for both mentoring and peer support;
  o opportunities for interprofessional learning;
  o appropriate faculty development and the establishment of transparent program wide continuous improvement and evaluation processes;
  o in-training and workplace-based assessments that are criterion referenced against stated competencies and which provide timely formative feedback;
  o rational remediation processes.

CanMEDS preceded by a decade other developing frameworks, in particular ‘The Outcome Project’ of the American Graduate Council for Medical Education and the ‘Modernizing Medical Careers’ initiative in the United Kingdom (UK) and more recently that of the Royal College of Psychiatrists (UK). This accounts for the highly influential role CanMEDS has played in informing global movements in postgraduate medical education. More recently, the RCPSC has collaborated with specific medical speciality groups across Canada and the Specialist Committee in Psychiatry developed the document, the ‘2007 Objectives for Training in Psychiatry’ that extends the more generic CanMEDS roles to Psychiatry and attempts to establish training specifics, that is precise competency standards for psychiatry that would guide the design of the training ‘path’ or learning program and concurrently establish rigorous accreditation processes.³

The evidence related to the educational efficacy of competency-based medical education is largely related to CanMEDS⁴⁶ however is limited to surveys of the perception of participants of developing competence ⁴⁶⁻⁴⁹, qualitative and case reports of curricula innovations ¹³, ⁴⁶, ₅⁰⁻⁵₃ and several empirically based studies, the latter particularly related to assessment strategies. ⁴⁴, ₅₄⁻₅₇ Essentially these yield a snapshot of the current environment in a specific context. This is to a significant extent due to the duration of specialty training, whereby trainees are currently engaged in the program; therefore any outcome results are largely unknown at this time. That said inferences can be drawn based on available data.

Despite the limitations of the existing research, the curriculum approaches based on CanMEDS exemplify aspects of what is generally considered ‘good’ curriculum practice; that is, it is fit-for purpose, efficient and effective and includes:

• the development and dissemination to stakeholders of a specific educational philosophy that meets the expectations of the specific discipline;
• collaboration with key stakeholders to devise a competency framework in keeping with regulatory requirements and the identified educational philosophy;
• the design and implementation of appropriate teaching and learning strategies;
• the design, implementation and evaluation of a robust assessment approach that leads learning and measures performance outcomes of learners;
• the implementation of change management strategies for stakeholders; and
• the establishment of a defensible continuous quality improvement and evaluation process.

After consideration and review of various other models including the recently released Royal College of Psychiatrists (UK) (RCPsych) curriculum, the proposal argues that RCPSC CanMEDS

³ Personnel communication: Professor Gary Hnatko, Chair, RCPSC Specialist Committee in Psychiatry July 2008.

Curriculum Improvement Project Reference Committee: Curriculum Framework Proposal against AMC Standards (GC_v5_140808)
framework offers a more comprehensive framework than the RCPsych because the RCPsych framework is a relatively new implementation therefore there is little supporting empirical evidence for its efficacy and this is unlikely to emerge until the current cohort attain registration and commence practice in 2012. While some may argue one of its strengths lies in the level of detail of the year by year statements of the expectations of trainees, this can create a complicated framework which is difficult to navigate and appears to lack coherence across domains. Moreover its basis in the four competency domains of the UK’s ‘Good Medical Practice’ strategy are so broad that it is difficult for stakeholders to immediately or intuitively access content, relative to the CanMEDS framework.

This Proposal presents the RCPSC CanMEDS model as the preferred curriculum framework for the College’s fellowship and continuing professional development programs.

Once endorsed by General Council, the CIP Reference Committee will oversee the pragmatic curriculum development processes in accordance with the curriculum framework. The curriculum development and implementation approach will be informed by Harden’s implementation inventory for outcomes based education. This model was selected given its application specifically to outcomes based education, the philosophy which underpins the proposed RANZCP framework, and its comprehensive structure to guide effective curriculum development and implementation. Harden’s model has been used to inform the development of a flexible work plan which of course will be modified dependent on the outcomes of this proposal. (See Appendix 2).

### 3.3. Research in the Training Program

3.3.1. The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.

3.3.2. The training program allows appropriate candidates to enter research training during Specialist education and to receive appropriate credit towards completion of specialist Training.

**Justification**

The RCPSC CanMEDS framework and the ‘2007 Objectives of Training in Psychiatry’, specifically addresses the requirements for research and research training through the development of the ‘Scholar’ role. Specifically and for example, the ‘Scholar’ role competency standard statement requires graduates to:

Demonstrate a lifelong commitment to reflective learning as well as the creation, dissemination, application and translation of medical knowledge.

In the context of building research capability, the curriculum will enable a developmental approach to the growth of research skills for Trainees. Research competencies may be attained through a variety of supervised projects such as a quality assurance project or clinical audit; a systematic literature review; original and empirical research or a theoretical discussion on a topic of relevance to the scientific basis of psychiatry or clinical practice.
3.4. Flexible Training

3.4.1. The program structure and training requirements recognise part-time, interrupted and other Flexible forms of training.

3.4.2. There are opportunities for trainees to pursue studies of choice, consistent with training Program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training Programs both here and overseas, and give trainees appropriate credit towards the Requirements of the training program.

Justification

This proposal recommends that consideration be given to eliminating the basic training/advanced training division in a new training program. A competency-based curriculum has the potential to enable the College, through its faculties and sections, to better prepare trainees to advanced competence thereby creating improved opportunities for flexibility across sub-specialties in a better integrated curriculum. Such an approach will also appeal to the increasing demands for credentialing from employers who expect employees to provide evidence to demonstrate they are competent in specific areas. The proposed adoption of ‘competent performance’ as the underpinning concept of the anticipated CanMEDS based framework, offers a sound rationale for designing a more flexible curriculum. It is problematic that there are no mandated summative assessments currently in the existing advanced training program that compel trainees to provide evidence of their capabilities on its completion.

Part-time and Interrupted Training

The Fellowship program ought to provide more flexibility in the type and extent of training opportunities directed by trainees developing interests as well as workplace demands and rigorous assessment of competence which emerging workplace-based assessment models can potentially provide. Importantly it suggests that ‘training-for-competence’ will more easily serve the needs of candidates experiencing interrupted training thereby assuring that trainees complete the program once competence is assured rather than according to time limited rotations determining satisfactory completion.

Pursue Studies of Choice

A competency-based curriculum, unrestricted by adherence to ‘time-in-training’, can accommodate the attainment of particular competency standards in certain core (or ‘basic’) areas and subsequently provide trainees with the opportunity to develop advanced competencies to expert or master level. Such a ‘spiral’ curriculum has the potential to develop core capabilities that allow trainees to demonstrate competence to identified proficient standards prior to undertaking the kinds of experiential learning and workplace based assessments that would then enable them to demonstrate advanced competence in more specific disciplinary specialties. Moreover, it allows more choice for individuals to pursue particular areas of interest.

This has the additional benefits of allowing those who have achieved fellowship to complement or extend their knowledge and competence in a number of areas. This may also assist where fellows have an identified need for remediation to access appropriate resources to facilitate competence.

Recognition of Prior Learning (RPL)

The proposed curriculum will also provide a consistent organisational approach to the principles of RPL as there are a range of current and emerging requirements to assess existing competencies of prospective trainees, for example international medical graduates. The focus of RPL principles is that skills, knowledge and understanding from previous formal or non-formal learning experiences can be recognised. The establishment of appropriate competency assessment strategies should be structured to recognise current competence through the acknowledgement of alternative pathways for learning gained from courses or study already
undertaken or experiences from paid or unpaid work. More contemporary approaches to RPL better suited to the proposed competency program will be developed.

3.5. The Continuum of Learning

3.5.1. The training organisation contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum.

Justification

Rapid advances in medical knowledge and biotechnology, globalisation and information technologies serve to reinforce the need to maintain one’s knowledge and competent performance over time. Lifelong learning presumes the capacity to critically reflect on one’s practice and performance and this capability is developed from undergraduate medical education. More transparent integration of curriculum approaches across the lifespan from undergraduate, pre-vocational and vocational training to continuing professional development is increasingly evident. Such approaches assist practitioners to develop and apply expected professional standards to their own performance and practices, recognize and address learning needs as they arise and continue learning over their professional life. Consequently, the proposed curriculum framework will support a more determined and explicit relationship between the fellowship program and the College’s Continuing Medical Education (CME) and Continuing Professional Development (CPD) programs.

Moreover, CanMEDS seems well suited to progressing the competency-based model recently established for the early post graduate years though the Australian Junior Doctor Curriculum Framework which:

• provides an outline of the knowledge, skills and behaviours required for prevocational doctors;
• aims to provide a bridge between undergraduate curricula and that of college training programs, with the framework for Junior Doctors governing trainees in PGY1, PGY2;
• is built around three key learning areas: Clinical Management, Communication and Professionalism, with these learning areas being divided into eleven categories, which are then separated into learning topics, and ultimately competencies;
• emphasises significant skill development within the framework;
• comprises defining statements differentiating between beginning and more advanced trainees, anticipating that the trainees will develop greater proficiency and mastery as they progress through training;
• provides supporting documentation illustrating the ways in which learning topics are to be taught and the standards to be achieved;
• provides an example of what competencies trainees can be expected to have attained at the entry into specialist training.

The junior doctor framework demonstrates a significant emphasis on skill development which limits the ability to which it can be extended to encompass specialty training in the area of psychiatry. It is anticipated that a modified CanMEDS framework will allow more transparent and demonstrable links between the junior doctor framework (despite its limitations) and that developed for psychiatry, ensuring promotion of the value of life long learning in the evolution of the specialist.
4. The Education and Training Program - Teaching and Learning

4.1.1. The training is practice-based involving the trainees’ personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.

4.1.2. The training program includes appropriately integrated practical and theoretical instruction.

4.1.3. The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

Justification

The psychiatric trainee commences post-graduate training having previously developed significant knowledge and skills in medicine. Learning and teaching in psychiatry training therefore values the existing knowledge and achievements of trainees, engaging them in meaningful interactions and activities, which extends and applies skills and insights to the contexts in which they perform their role. The specialist psychiatrist must have not only a sufficient educational basis to respond to the presenting patient but also the skills to develop and maintain knowledge, including the ability to respond to innovations throughout their professional life. Curriculum design therefore must enable competent performance over time, and promote professionalism and lifelong learning.

The designed curriculum will therefore be innovative, flexible and outcome-oriented so that the role of the psychiatrist is not reduced to a simple range of skills or attributes, but rather reflects the interplay of all these factors to achieve proactive and positive health outcomes for patients, carers and other stakeholders. The nature of competency development as outlined in the new ‘2007 Objective for Training in Psychiatry’ documents provides for the ‘learning continuum’ and the ‘developmental trajectory’ to agreed standards. They describe that trajectory in the following terms:

- **Introductory knowledge:** recognise, identify or describe principles;
- **Working knowledge:** demonstrate core aspects of psychiatry, such as basic interviewing, problem formulation and treatment. Understand scientific literature;
- **Proficient:** demonstrate working knowledge enhanced by developmental, cultural, lifespan perspective allowing detailed interviewing, and biopsychosocial problem formulation with capacity to teach, consult, access and manage referrals. Can review scientific literature;
- **Advanced:** beyond minimum training includes capability for detailed and sophisticated understanding which is interdisciplinary leading to advanced teaching and consultation on complex referrals. Readily able to demonstrate familiarity and apply scientific literature; and
- **Expert/Master:** advanced training beyond core competency and demonstrates enhanced capability to manage patient with complex co morbidities, treatment resistance or rare conditions. Capacity to critically review the literature with enhanced expertise and generate new questions of study.\(^{[59]}\)

Teaching and learning approaches will need to be extended to include more determined opportunities for trainees to meet such developmental competencies and proposed strategies have been outlined in Standard 3.3. The proposal also raises complex implications for supervisory models and assessment in a new competency-based program (See Standards 5 and 11).
Integrated Practical and Theoretical Instruction

This proposal allows interesting and innovative flexible delivery and flexible learning approaches including e-learning experiences, presenting a range of ‘electives’ based in particular experiential learning opportunities which potentially provides more self-direction/flexibility for trainees so they are able to direct their own interests within the demands of attaining desired competencies. This also provides increased opportunities for interprofessional learning than currently exists. A Formal Education Course (FEC) may be designed and developed centrally for flexible e-learning delivery—in which case it is proposed that the CIP Reference Committee will oversee the curriculum of the FEC. Close collaboration with the CME and the CFT is anticipated with the aim of ensuring more coherent integration with the post-fellowship learning and development strategies inherent in the lifelong learning/reflective practitioner model currently evolving with the CPD program; thereby creating an outcomes-based curriculum model that is potentially highly inclusive for trainees and Fellows. Further, it would be supported by carefully aligned evidence-based workplace and in-training assessment strategies enabling trainees to demonstrate the desired outcomes and learning experiences; all aspects of the trainees’ competence attainment to become a specialist might be captured and demonstrated for evidence in an e-portfolio. This proposal in no way diminishes the skills or competencies required to perform specific specialist roles, but rather provides an alternative framework through which they are developed and assessed.

5. The Education and Training Program - Assessment of Learning

5.1. Assessment Approach

5.1.1. The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.

5.1.2. The training organisation uses a range of assessment formats that are appropriately aligned to the components of the training program.

5.1.3. The training organisation has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability.

Justification

It is widely accepted across the post-secondary sector that assessment is central to learning – it is neither peripheral nor additional; it should be reflected across the curriculum as multidimensional, integrated and performative; it is most beneficial when it is ongoing (formative) not episodic. Models of assessment should foster learning and measure learning outcomes; assessment strategies should be authentic, valid and reliable. An aligned system of learning is imperative to success and demands learning outcomes (or competencies); teaching strategies and assessment approaches are coherent and integrated thereby offering assurances to stakeholders that graduates meet desired performance outcomes.

In the context of competency-based medical education, assessment is generally designed as in-training or workplace-based assessment. Typically, workplace-based assessment refers to those formative and summative strategies that attempt to measure outcome performances in authentic settings of the workplace; importantly, such assessment should be developed so that it provides the College and its stakeholders with a broader measure of the doctors’ capabilities in practice than the traditional approaches of standard written or clinical examinations have achieved.
Introduction of curricula which emphasises developing competency rather than time-in-training requires a review of assessment practices, to ensure alignment and ultimately that performance standards are met. A more determined investigation of in-training and workplace-based assessment processes implied by the proposed curriculum framework will evolve as the CIP progresses—this may include a review of the assessment literature and other benchmarking activities.

Currently there is a growing literature in workplace-based assessment across the medical education sector and while debates regarding the validity and reliability of various forms of workplace-based assessment, there is substantial preliminary evidence to inform approaches to guide assessment practice. The design and development of appropriate assessment approaches that reflect contemporary approaches in specialist medical education that will be evident in the proposed curriculum include:

1. Work-based assessment methods  
   a. 360 assessment or Multi source feedback  
   b. Direct observation of procedural skills  
   c. Incognito standardised patients  
   d. Mini-CEX (clinical evaluation exercise) or Mini ACE (assessment of clinical expertise)  
   e. Patient surveys  
   f. Portfolios  
   g. Videotaped consultations

2. Other assessment methods  
   a. In-training assessment  
   b. Marking or rating scales and checklists  
   c. Peer assessment  
   d. Self assessment  
   e. Evidence-based medicine: case presentation and journal club  
   f. Patient and case log books

The CIP Reference Committee has partially funded and currently collaborates with SATCAP on a workplace-based assessment project (See Standard 1.3). More extensive curriculum planning for assessment, will address workload issues and the preparation and training of supervisors (See Standard 11).

5.2. Feedback and Performance

5.2.1. The training organisation has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.

5.2.2. The training organisation facilitates regular feedback to trainees on performance to guide learning.

5.2.3. The training organisation provides feedback to supervisors of training on trainee performance, where appropriate.

Justification

Timely and appropriate feedback integrated with authentic assessment is central to successful learning outcomes. The proposed competency framework potentially allows for more rigorous and transparent feedback processes than exist within the current program. The planned workplace-based assessment models will be more explicitly aligned to expected outcomes and have greater potential to allow for the provision of more appropriate feedback and for developing the trainees’ capacity for critical self-reflection and assessing their own stage of learning and competence development.
mentoring or coaching models is known to contribute positively to improving the efficacy of feedback, thereby successful outcomes (See Standard 6).

5.3. Assessment Quality

5.3.1. The training organisation has a policy on the evaluation of the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

Justification

As part of the proposed framework it is anticipated that some form of ‘Quality Assurance for Teaching and Learning Framework’ (QATLF) will be designed. Such a framework might comprise a number of policy documents including a more transparent and explicit ‘Assessment Policy’ to accommodate an assessment program that is more focussed on formative and in-training or workplace-based assessment (See Standard 10).

6. The Education and Training Program - Monitoring and Evaluation

6.1. Ongoing Monitoring

6.1.1. The training organisation regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.
6.1.2. Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.
6.1.3. Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.

6.2. Outcome Evaluation

6.2.1. The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.
6.2.2. Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

Justification

Quality improvement monitoring and evaluation processes concern themselves with making judgements about how curricula meet identified outcomes and contribute to desirable graduate attributes as well as assessing the value and effectiveness of teaching and learning. The vision of the CIP for the ‘Quality Assurance for Teaching and Learning Framework’ (QATLF) will reflect the standards articulated in the AMC Standards as described herein and in the Australian Qualifications Training Framework

1. Standard 1: The provision of quality training and assessment across all of its operations.
2. Standard 2: Adherence to principles of access and equity and maximizes outcomes for its clients.
3. Standard 3: Management systems are responsive to the needs of clients, staff and stakeholders and the operational environment.

7. **Implementing the Curriculum – Trainees**

7.1. **Admission Policy and Selection**

8. **Trainee Participation in Training Organisation Governance**

8.1.1. The training organisation has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

9. **Communication with Trainees**

9.1.1. The training organisation has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.
9.1.2. The training organisation provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.
9.1.3. The training organisation provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

The relationship between the College and trainees has been an area of considerable focus in recent years with various reports and reviews noting communication, transparency and participation of trainees in the educational processes of the College as requiring attention. The key mechanism for achieving consultation on the CIP is the Registrar Representative Committee (RRC), with the RRC being represented in the composition of the CIP Reference Committee, and the project oversight Committees, the Committee for Education Projects and the Board of Education. The links developed with the RRC will be supplemented by a communication strategy (see Appendix 3) and learner centred approaches to accessing materials, using a variety of mechanisms such as information and communication technology and face-to-face forums. The primary method of accessing project information will be via a dedicated website. This will include access to the information about the ongoing progress of the project, copies of relevant papers, interviews with key stakeholders and other relevant materials.

This standard predominantly relates to the working operation of the curriculum however some detail is provided here to illustrate the approach undertaken in the initial planning phase that will ultimately inform the implementation phase. The inclusion of a consultation strategy for trainees reflects their significant role within the Fellowship program and their importance within what constitutes a large scale curriculum initiative for the College. The 2005 AMC Review identified the relationship between the College and Trainees in decision making concerning training and assessment processes as an area requiring further development and this, associated with best-practice educational approaches means that it remains a significant focus for the CIP. The communication strategy developed is premised on inclusion and acknowledges trainees as key stakeholders.
10. Resolution of Training Problems and Disputes

10.1.1. The training organisation has processes to address confidentially problems with training supervision and requirements
10.1.2. The training organisation has clear impartial pathways for timely resolution of training related disputes between trainees and supervisors or trainees and the organisation.
10.1.3. The training organisation has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
10.1.4. The training organisation has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Justification

Across the College there are various processes which purport to provide a transparent, equitable and timely resolution to disputes. However, the 2005 AMC Review stated:

The lack of a robust and accessible complaints handling procedure within the College was highlighted as a major concern, although the College’s steps to improve the process are noted. (80)

The 2005 AMC review also referenced the response to the AMC surveys, where more than 50% of respondents across the basic and advanced training programs stated they would not feel comfortable using the College’s formal processes for requesting reconsideration of decisions made by Committees. Issues about dispute resolution and complaints handling have therefore been areas of concern for the College with a number of changes in recent years being undertaken in an attempt to address them, most notably the amalgamation of several Committees and the creation of the Board of Education and the Registrar Representative Committee. Adopting a competency-based model provides an opportunity to actively develop these processes, by providing explicit learning statements and in-built quality assurance process to support both the development of content, and the resolution of disputes.

11. Implementing the Training program – Delivery of Educational Resources

11.1. Supervisors, Assessors, Trainers and Mentors

11.1.1. The training organisation has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the training organisation to these practitioners.
11.1.2. The training organisation has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training of supervisors and trainers.
11.1.3. The training organisation routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles.
11.1.4. The training organisation has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.
11.1.5. The training organisation has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.
Justification

Competent supervision is recognized by all stakeholders as fundamental to the success of the Fellowship program. While the College has taken proactive steps to implement continuous improvement strategies in relation to supervision, there are indications that such quality improvement approaches should not only remain a key concern of the CIP but that the proposed competency-based framework and curriculum presents major implications for teaching and learning. Clinical teaching and supervision is fundamentally about maintaining standards of patient care and ultimately contributing to health outcomes and evidence suggests that effective supervision has a positive effect in these areas. Current models of supervision may not serve the needs of an innovative program that relies explicitly on in-training assessment and arguably more formal requirements for ‘teaching’.

Teaching and learning approaches to accommodate the demands of the proposed curriculum remain under investigation. New models for teaching, learning and supervision are being widely investigated across medical education and for the College the following are relevant:

1. Supervision
   - Reframing supervision as a teaching and learning activity and redeveloping training, feedback, evaluation and assessment approaches for supervisors.
   - Concurrently a review of remuneration and investigation of alternative models of paid supervision will be investigated.

2. Mentoring: The RANZCP has received additional funding from DoHA to develop and pilot a mentoring model for Year 1 Registrars. The principle outcomes are to:
   - Develop a blended mentoring training material using face to face and online mentoring systems for delivery;
   - Develop resources which add value and direction to continuation of the mentor and mentee relationship inclusive of reflective logs;
   - Identify and develop specific requirements for one on one and group mentoring relationships; and
   - Develop a communication and rollout strategy for the program.

This mentoring project will inform the CIP and will inform developing models of teaching and supervision that are appropriate to competency-based curriculum frameworks.
12. **Clinical and Other Educational Resources**

12.1.1. The training organisation has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the training organisation are publicly available.

12.1.2. The training organisation specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.

12.1.3. The training organisation’s accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.

12.1.4. The training organisation works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

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**Justification**

The learning environment is central to the Fellowship program and the experience of trainees. It is well recognised that the dispersed nature of the training program presumes a degree of variability in the learning environments for trainees. There has been some work undertaken by the Committee for Training to provide greater standardisation throughout site accreditation visits and the 2005 AMC review noted that health departments and health services managers perceived the site accreditation undertaken by the College as rigorous. However, the review also noted that despite a seemingly transparent process around accreditation of programs, services and posts, 30 to 40 percent of trainees did not believe that the College addressed criteria around clinical experience, continuing education activities, rosters, availability of supervision, dedicated time for teaching and training, and opportunities for informal teaching and training in the work environment.

The proposed curriculum framework provides an opportunity to introduce greater accountability for service providers throughout the accreditation process by making explicit the expectations of the College regarding the characteristics of the learning environment. In fact one of the significant advantages of the development of the ‘2007 Objectives of Training in Psychiatry’ by the RCPSC for use in Canada has been the ability to use the standards to define accreditation outcomes thereby increasing rigour in accreditation of sites and transparency in the expectations of the site for all stakeholders.

The ability to modulate the learning environment is recognised by the CIP as critical to the success in implementing the proposed framework. Collaboration and consultation with service representatives will ensure that the proposal developed compliments service needs, and where there is conflict between service and training needs, these are negotiated and resolved at an organisational level, via the accreditation processes. Again this standard has greater application in the implementation phase of the proposal, however the interconnectedness of all aspects of the training program requires that it be given consideration as the project develops, and that a model of inclusion be adopted with service providers to facilitate implementation.

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4 Personnel Communication, Dr Andrew Padmos, CEO, RCPSC, July 10 2008.
13. Continuing Professional Development

13.1. Continuing Professional Development Programs

13.1.1. The training organisation’s professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.

13.2. Retraining

The training organisation has processes to respond to requests for retraining of its fellows who have been absent from practice for a period of time.

13.3. Remediation

The training organisation has processes to respond to requests for remediation of its fellows who have been identified as underperforming in a particular area.

The principles of competent performance have significant implications for continuing medical education and the Continuing Professional Development program (jointly referred to as CPD), where performance may vary over time and across contexts. Changes in best practice, workforce demands and the prevailing clinical or organisational culture can all potentially impact on the maintenance of competent performance for trainees and fellows.

The proposed curriculum framework plays a critical role in informing the standards which can reasonably be expected by a psychiatrist at any given stage of their development, for example, five years post-fellowship ‘working in teams’ may have a significant leadership component as an expected performance standard, as compared with that which may be expected on awarding fellowship. Moreover, the curriculum framework requires consideration of the skills necessary for the psychiatrist to keep pace with innovation and evolution within medicine and the profession itself, therefore equipping trainees to undertake life long learning.

Best practice standards in relation to curricula development note the need for alignment of prevocational, vocational training and CPD in ensuring not only attainment but maintenance of benchmark standards. The imperative therefore in proposing a revised Curriculum Framework is to remain cognizant of the implications for CPD and ensuring ‘fit’ between the two, thereby promoting well established concepts of and commitment to life long learning that already exist in the professional life of fellows. Moreover, a competency-based framework intuitively has the capacity to better serve the needs of remediation and retraining and work in psychiatry is beginning to investigate more formally the way in which competency programs can better recognise and remediate poor performance.  


14. References

32. Postgraduate and Medical Education Training Board. Postgraduate and Medical Education Training Board: Curricula. 2007 [updated 2007; cited]; Available from: http://www.pmetb.org.uk/.
Proposal for a Competency-Based Curriculum Framework for the RANZCP Fellowship Program

General Council: AMC STANDARDS

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42. Swing SR. The ACGME outcome project: retrospective and prospective. Medical Teacher. 2007;29(7):648-54.
Appendix 1 RCPSC 2007 “Objectives for Training in Psychiatry”
OBJECTIVES OF TRAINING IN PSYCHIATRY

2007

(Please see also the “Policies and Procedures” booklet.)

DEFINITION

Psychiatry is the branch of medicine concerned with the biopsychosocial study of the etiology, assessment, diagnosis, treatment and prevention of mental, emotional and behavioral disorders alone or as they coexist with other medical or surgical disorders across the life span.

GOALS

Upon completion of training, the resident is expected to be a competent specialist in Psychiatry, capable of assuming a consultant’s role in the specialty. Residents must demonstrate the requisite knowledge, skills, and attitudes for effective patient-centered care and service to a diverse population across the life span. The resident must acquire a working knowledge of the theoretical basis of Psychiatry, including its foundations in the basic medical sciences and research.

In all aspects of specialist practice, the resident must be able to address issues of gender, age, culture, ethnicity, spirituality and ethics in a professional manner.

PSYCHIATRY COMPETENCIES

Upon completion of residency training, Psychiatrists will have developed a range of specific competencies as Medical Experts defined as follows:

Introductory knowledge: Able to recognize, identify, or, describe principles.

Working knowledge: Able to demonstrate core aspects of Psychiatry, such as basic interviewing, problem formulation and treatment. The resident can understand the scientific literature.
Able to demonstrate working knowledge enhanced by a developmental, cultural, and lifespan perspective, allowing detailed interviewing and bio-psychosocial problem formulation with capacity to teach, consult, assess and manage referrals. The resident can review the scientific literature.

The following defined competencies are intended to be achieved beyond the minimum training requirements and may be pursued as part of a resident’s selectives and electives during their residency:

**Proficient:**

Detailed and sophisticated understanding which is multimodal and interdisciplinary, leading to advanced teaching and consultation on complex referrals. The resident is readily able to apply and demonstrate familiarity and apply the scientific literature.

**Advanced:**

Requires advanced training beyond core residency which leads to enhanced skills that enable management of patients with complex comorbidities, treatment resistance or rare conditions. The expert psychiatrist has the capacity to critically review the literature with enhanced expertise and generate new questions for study.

**Expert/Master:**

Requires advanced training beyond core residency which leads to enhanced skills that enable management of patients with complex comorbidities, treatment resistance or rare conditions. The expert psychiatrist has the capacity to critically review the literature with enhanced expertise and generate new questions for study.

Core competence will be reflected in achievements at the Introductory, Working Knowledge and Proficient levels. This is the minimum training required to achieve successful completion of training in Psychiatry.

At the completion of training, the resident will have acquired the following competencies and will function effectively as a:

**Medical Expert**

**Definition:**

As *Medical Experts*, psychiatrists integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient centered care across the life span – including children, adolescents, adults and the elderly, and in a number of settings – including hospital inpatient, outpatient and community settings. *Medical Expert* is the central physician role in the CanMEDS framework.
Key and Enabling Competencies: Psychiatrists are able to…

1. Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care

   1.1. Effectively perform a consultation, including the presentation of well documented assessments and recommendations in written and/or verbal form in response to a request from another health care professional.

   1.2. Demonstrate effective use of all CanMEDS competencies relevant to Psychiatry.

   1.3. Identify and appropriately respond to relevant clinical issues arising in patient care including:

      1.3.1. Awareness of factors influencing the patients reactions to the physician and others,

      1.3.2. Awareness of ones own reactions when dealing with patients, including the suicidal, depressed, psychotic, demanding, violent, hostile, silent or withdrawn patient,

      1.3.3. Boundary issues,

      1.3.4. Burden of medical, surgical and psychiatric illness to individuals, families and systems

      1.3.5. Capacity / Competence

      1.3.6. Confidentiality

      1.3.7. Co-morbidity – medical, psychiatric, developmental or substance abuse

      1.3.8. Consent

      1.3.9. Culture and spirituality

      1.3.10. End of life issues

      1.3.11. Family issues

      1.3.12. Legal and forensic matters

      1.3.13. Long term illness and rehabilitation

      1.3.14. Psychiatric manifestations of medical and neurological illness

      1.3.15. Stigma

      1.3.16. Suicide, self harm, or harm directed towards others

      1.3.17. Systems issues

      1.3.18. Therapeutic alliance

      1.3.19. Trauma, abuse or neglect

   1.4. Effectively and appropriately prioritize professional duties when faced with multiple patients and problems.

   1.5. Demonstrate compassionate and patient centered care.

   1.6. Recognize and respond to the ethical dimensions in Psychiatric decision making.
1.7. Demonstrate Psychiatric expertise in situations other than patient care, such as providing expert legal testimony or advising governments, as needed.

2. Establish and maintain clinical knowledge, skills and attitudes appropriate to their practice

2.1. Establish, apply and maintain knowledge of the clinical, socio-behavioral, and fundamental biomedical sciences relevant to Psychiatry across the life span. Although the psychiatrist develops competence to interview, assess and treat patients across the life span, the level of psychiatric competence developed for children, adolescents, and the elderly will not be to the level of the subspecialist. The level of competence in each of knowledge, skills and attitudes must be relevant to Psychiatry, include a life span approach, and must be assured at the designated level of Introductory, Working Knowledge, or Proficient for purposes of core competence in each of:

2.1.1. Psychiatrists will be proficient in the following:

2.1.1.1. Etiology, symptoms, course of illness and treatment of:

2.1.1.1.1. Anxiety disorders

2.1.1.1.2. Adjustment disorders and V codes (noncompliance, malingering, antisocial behavior, borderline IQ, bereavement, academic and occupational problems, cognitive decline, phase of life)

2.1.1.1.3. Alcohol and other substance abuse disorders

2.1.1.1.4. Attention Deficit Hyperactivity Disorder

2.1.1.1.5. Delusional disorders and other psychoses

2.1.1.1.6. Dementias

2.1.1.1.7. Organic brain syndromes/delirium

2.1.1.1.8. Personality disorders

2.1.1.1.9. Psychiatric disorders secondary to medical conditions

2.1.1.1.10. Mood disorders

2.1.1.1.11. Schizophrenia

2.1.1.2. Health care and other regulations – mental health act, confidentiality, dependant adults legislation, child welfare act, young offenders

2.1.1.3. Normal and abnormal development

2.1.1.4. Normal aging

2.1.1.5. Normal and abnormal psychology

2.1.1.6. Nosology

2.1.1.7. Psychopharmacology and somatic therapies

2.1.1.8. Psychotherapeutic constructs – individual, family and group

2.1.1.9. Referral patterns, community agencies, systems of mental health care and delivery
2.1.2. Psychiatrists will have a working knowledge of the following:

2.1.2.1. Etiology, symptoms, course of illness and treatment of:

   2.1.2.1.1. Conduct Disorders
   2.1.2.1.2. Developmental disabilities including mental retardation
   2.1.2.1.3. Eating disorders
   2.1.2.1.4. Impulse control disorders
   2.1.2.1.5. Learning Disorders
   2.1.2.1.6. Movement disorders
   2.1.2.1.7. Oppositional Defiant Disorder
   2.1.2.1.8. Other disorders first presenting in childhood
   2.1.2.1.9. Pervasive developmental disorders
   2.1.2.1.10. Sexual dysfunction
   2.1.2.1.11. Sleep disorders
   2.1.2.1.12. Somatoform Disorders

2.1.2.2. Forensic

2.1.2.3. Genetics

2.1.2.4. Medical statistics

2.1.2.5. Neuroanatomy

2.1.2.6. Neurochemistry

2.1.2.7. Pharmacology

2.1.2.8. Physiology

2.1.2.9. Public health principles

2.1.2.10. Research methodology

2.1.3. Psychiatrists will have an introductory knowledge of the following:

2.1.3.1. Etiology, symptoms, course of illness and treatment of:

   2.1.3.1.1. Sexual and gender identity disorders

2.1.3.2. Complementary and alternative care

2.2. Describe the RCPSC framework of competencies relevant to Psychiatry.

2.3. Psychiatrists will be proficient in applying lifelong learning skills of the Scholar Role to implement a personal program to keep up-to-date, and enhance areas of professional competence.

2.4. Psychiatrists will be proficient in contributing to the enhancement of quality care and patient safety in psychiatric practice, integrating the available best evidence and best practices.
3. **Perform a complete and appropriate assessment of a patient**

   3.1. Establish and maintain an effective working relationship.
   
   3.2. Effectively identify and explore issues to be addressed in a patient encounter, including the patient’s context and preferences.
   
   3.3. For the purposes of diagnosis and management, prevention or health promotion perform an appropriate and accurate mental status examination.
   
   3.4. For the purposes of diagnosis and management, prevention or health promotion, perform an appropriate and accurate diagnostic family interview
   
   3.5. For the purposes of prevention and health promotion, diagnosis and/or management, perform a focused physical or neurological examination that is relevant and accurate.
   
   3.6. Demonstrate proficiency in selecting appropriate investigative methods in a resource effective and ethical manner including:
   
       3.6.1. medical investigation or consultation
       
       3.6.2. collateral information gathering
   
   3.7. Demonstrate working knowledge selecting appropriate investigative methods in a resource effective and ethical manner including:
   
       3.7.1. psychological investigations
       
       3.7.2. questionnaires
       
       3.7.3. neuropsychological investigations
       
       3.7.4. neuroimaging
   
   3.8. Demonstrate proficiency in effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnosis and management plans
   
       3.8.1. Integrate and present a biopsychosocial understanding
       
       3.8.2. Develop and implement an integrated biopsychosocial treatment plan

4. **Use preventive and therapeutic interventions effectively**

   4.1. Demonstrate a proficiency in implementing an effective management plan in collaboration with patients and their families, including:
   
       4.1.1. Developing and implementing an integrated biopsychosocial treatment plan
       
       4.1.2. Assessing suitability for, and prescribe appropriate psychopharmacological treatments across the life span
       
       4.1.3. Assessing suitability for, prescribe and deliver appropriate somatic treatments (e.g. ECT) across the life span
       
       4.1.4. Demonstrate proficiency in assessing suitability for, prescribe and deliver appropriate psychological treatments including:
       
           4.1.4.1. Cognitive Behavioral
4.1.4.2. Crisis intervention
4.1.4.3. Family
4.1.4.4. Psychodynamic
4.1.4.5. Supportive

4.1.5. Demonstrate working knowledge in assessing suitability for, prescribe and deliver appropriate psychological treatments including:

4.1.5.1. Behavioral
4.1.5.2. Dialectic Behavior Therapy
4.1.5.3. Group Therapy
4.1.5.4. Interpersonal therapies

4.1.6. Demonstrate introductory knowledge in assessing suitability for prescribing and delivery of appropriate psychological treatments including:

4.1.6.1. Brief psychotherapy
4.1.6.2. Mindfulness training
4.1.6.3. Motivational interviewing
4.1.6.4. Relaxation

4.1.7. Demonstrate a proficiency in assessing and managing treatment of emergent side effects across the life span, in each of psychopharmacological, somatic and the psychological therapies

4.1.8. Demonstrate proficiency in assessing and managing treatment adherence

4.2. Demonstrate effective, appropriate and timely application of preventative and therapeutic interventions relevant to Psychiatry.

4.3. Ensure appropriate informed consent is obtained for therapies

4.4. Ensure patients receive appropriate end-of-life care

5. **Demonstrate proficient and appropriate use of procedural skills, both diagnostic and therapeutic**

5.1. Demonstrate effective, appropriate, and timely performance of diagnostic procedures relevant to Psychiatry (including but not limited to diagnostic interviewing, questionnaire administration, neuroimaging interpretation)

5.2. Demonstrate effective, appropriate and timely performance of therapeutic procedures relevant to Psychiatry (including but not limited to ECT, psychotherapy).

5.3. Ensure appropriate informed consent is obtained for procedures.

5.4. Appropriately document and disseminate information related to procedures performed and their outcomes.

5.5. Ensure adequate follow-up is arranged for procedures performed.
6. Seek appropriate consultation from other health professionals, recognizing the limits of their expertise
   6.1. Demonstrate insight into their own limitations of expertise via self assessment.
   6.2. Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care.
   6.3. Arrange for follow-up care services for a patient and their family.

**Communicator**

*Definition:*

As *Communicators*, psychiatrists effectively facilitate the doctor patient relationship and the dynamic exchanges that occur before, during and after the medical encounter. Psychiatrists enable patient centered therapeutic communication through shared decision making and effective dynamic interactions with patients, families, caregivers, other professionals, and other important individuals. The competencies for this role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. This is a central skill relevant to the practice of Psychiatry, across the life span.

**Key and Enabling Competencies: Psychiatrists are able to…**

1. **Develop rapport, trust, and ethical therapeutic relationships with patients and families**
   1.1. Recognize that being a good communicator is a core clinical skill for psychiatrists, and that effective physician-patient communication can foster patient satisfaction, physician satisfaction, adherence and improved clinical outcomes
      1.1.1. Use expert verbal and non-verbal communication
      1.1.2. Convey an attitude that is non-judgmental
   1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
   1.3. Respect patient confidentiality, privacy and autonomy
   1.4. Listen effectively
   1.5. Be aware and responsive to nonverbal cues
   1.6. Effectively facilitate a structured clinical encounter

2. **Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals**
   2.1. Gather information about a disease, but also about a patients beliefs, concerns, expectations and illness experience
2.2. Seek out and synthesize information from other sources, such as a patients’ family, caregivers and other professionals

3. **Accurately convey relevant information and explanations to patients and families, colleagues and other professionals**

   3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision making

4. **Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care**

   4.1. Effectively identify and explore problems to be addressed from a patient encounter, including the patient’s context, responses, concerns and preferences

   4.2. Respect diversity and difference, including but not limited to the impact of gender, religion, and cultural beliefs on decision making

   4.3. Encourage discussion, questions, and interaction in the encounter

   4.4. Engage patients, families, and relevant health professionals in shared decision making to develop a plan of care

   4.5. Effectively address challenging communication issues such as obtaining informed consent, delivering bad news and addressing anger, confusion and misunderstanding

5. **Convey effective oral and written information about a psychiatric encounter**

   5.1. Maintain clear, accurate, appropriate and timely records, written or electronic, of clinical encounters and plans

   5.2. Effectively present verbal reports of clinical encounters and plans

   5.3. When appropriate, effectively present medical information to the public or media about a medical issue

**Collaborator**

**Definition:**

As **Collaborators**, psychiatrists effectively work within a health care team to achieve optimal patient care. Psychiatrists work in partnership with others who are appropriately involved in the care of individuals or specific groups of patients. This is increasingly important in a modern multi-professional environment, where the goal of patient centered care is widely shared. It is therefore essential that psychiatrists be able to collaborate effectively with patients and a multidisciplinary or interdisciplinary team of expert health professionals for the provision of optimal patient care, education and scholarship.
Key and Enabling Competencies: Psychiatrists are able to…

1. Participate effectively and appropriately in an interprofessional healthcare team
   1.1. Clearly describe their roles and responsibilities to other professionals within the health care team
   1.2. Describe the roles and responsibilities of other professionals within the health care team.
   1.3. Recognize and respect the diversity of roles, responsibilities and competencies of other professionals in relation to their own
   1.4. Work with others to assess, plan, provide and integrate care for individual patients, or groups of patients
      1.4.1. Demonstrate the ability to provide treatment collaboratively with physicians providing primary care and understand the roles and contributions of these physicians
      1.4.2. Describe the roles and contributions of the work place, schools, forensic services and other agencies as part of a continuum of service
   1.5. Where appropriate, work with and learn from others to assess, plan, and review other tasks, such as research problems, educational work, program review or administrative responsibilities
   1.6. Participate effectively in interprofessional team meetings
   1.7. Enter into interdependent relationships with other professionals for the provision of quality care
   1.8. Identify, recognize and describe principles of group / system dynamics
   1.9. Respect team ethics, including confidentiality, resource allocation and professionalism
   1.10. Where appropriate demonstrate leadership in the health care team

2. Effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict
   2.1. Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team
   2.2. Work with other professionals to prevent conflict
   2.3. Employ collaborative negotiation to resolve conflicts
   2.4. Respect differences, misunderstandings and limitations that may contribute to interprofessional tension
   2.5. Reflect on interprofessional team function
Manager

Definition:

As Managers, psychiatrists are integral participants in healthcare organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the health care system.

Key and Enabling Competencies: Psychiatrists are able to…

1. Participate in activities that contribute to the effectiveness of their healthcare organizations and systems
   1.1. Work collaboratively with others in their organizations
   1.2. Participate in systemic quality process evaluation and improvement, such as patient safety initiatives
   1.3. Describe the structure and function of the healthcare system as it relates to Psychiatry, including the roles of physicians
   1.4. Describe principles of healthcare financing, including physician remuneration, budgeting and organizational funding

2. Manage their practice and career effectively
   2.1. Set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
   2.2. Manage a practice including finances and human resources
   2.3. Implement processes to ensure personal practice improvement
   2.4. Employ information technology appropriately for patient care

3. Allocate finite healthcare resources appropriately
   3.1. Recognize the importance of just allocation of healthcare resources, balancing effectiveness, efficiency and access with optimal patient care
   3.2. Apply evidence and management processes for cost-appropriate care

4. Serve in administration and leadership roles, as appropriate
   4.1. Chair or participate effectively in committees and meetings
   4.2. Lead or implement a change in health care
   4.3. Plan relevant elements of health care delivery (e.g., work schedules)
Health Advocate

Definition:

As Health Advocates, psychiatrists responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

Key and Enabling Competencies: Psychiatrists are able to…

1. **Respond to individual patient health needs and issues as part of patient care**
   1.1. Identify the mental health needs of an individual patient
   1.2. Identify opportunities for advocacy, health promotion and disease prevention with individuals to whom they provide care, via:
      1.2.1. Awareness of the major regional, national and international advocacy groups in mental health care
      1.2.2. Awareness of governance structures in mental health care
      1.2.3. Awareness of legal issues in mental health care

2. **Respond to the health needs of the communities that they serve**
   2.1. Describe the practice communities that they serve
   2.2. Identify opportunities for mental health advocacy, health promotion and disease prevention in the communities that they serve, and respond appropriately
   2.3. Appreciate the possibility of competing interests between the communities served and other populations

3. **Identify the determinants of mental health for the populations that they serve**
   3.1. Identify the determinants of mental health of the populations, including barriers to access to care and resources
   3.2. Identify vulnerable or marginalized populations within those served and respond appropriately

4. **Promote the health of individual patients, communities, and populations**
   4.1. Describe an approach to implementing a change in a determinant of health of the populations they serve
   4.2. Describe how public policy impacts on the health of the populations served
   4.3. Identify points of influence in the healthcare system and its structure
   4.4. Describe the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism
4.5. Appreciate the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper

4.6. Describe the role of the medical profession in advocating collectively for health and patient safety

Scholar

Definition:

As Scholars, psychiatrists demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.

Key and Enabling Competencies: Psychiatrists are able to…

1. Maintain and enhance professional activities through ongoing learning.
   1.1. Describe the principles of maintenance of competence
   1.2. Describe the principles and strategies for implementing a personal knowledge management system
   1.3. Recognize and reflect learning issues in practice
   1.4. Conduct a personal practice audit
   1.5. Pose an appropriate learning question
   1.6. Access and interpret the relevant evidence
   1.7. Integrate new learning into practice
   1.8. Evaluate the impact of any change in practice
   1.9. Document the learning process

2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions
   2.1. Describe the principles of critical appraisal
   2.2. Critically appraise retrieved evidence in order to address a clinical question
   2.3. Integrate critical appraisal conclusions into clinical care

3. Facilitate the learning of patients, families, students, residents, other health professionals, the public and others, as appropriate
   3.1. Describe principles of learning relevant to medical education
   3.2. Collaboratively identify the learning needs and desired learning outcomes of others
   3.3. Select effective teaching strategies and content to facilitate others’ learning
   3.4. Demonstrate an effective lecture or presentation
3.5. Assess and reflect on a teaching encounter
3.6. Provide effective feedback
3.7. Describe the principles of ethics with respect to teaching

4. **Contribute to the development, dissemination, and translation of new knowledge and practices**
   4.1. Describe the principles of research and scholarly inquiry
   4.2. Describe the principles of research ethics
   4.3. Pose a scholarly question
   4.4. Conduct a systematic search for evidence
   4.5. Select and apply appropriate methods to address the question
   4.6. Appropriately disseminate the findings of a study

**Professional**

**Definition:**

As *professionals*, psychiatrists are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.

**Key and Enabling Competencies: Psychiatrists are able to…**

1. **Demonstrate a commitment to their patients, profession, and society through ethical practice**
   1.1. Exhibit appropriate professional behaviors in practice, including honesty, integrity, commitment, compassion, respect and altruism
   1.2. Demonstrate a commitment to delivering the highest quality care and maintenance of competence
   1.3. Recognize and appropriately respond to ethical issues encountered in Psychiatry
   1.4. Appropriately manage conflicts of interest
   1.5. Recognize the principles and limits of patient confidentiality as defined by professional practice standards and the law
   1.6. Maintain appropriate relations with patients.

2. **Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation**
   2.1. Appreciate the professional, legal and ethical codes of practice
   2.2. Fulfill the regulatory and legal obligations required of current practice
   2.3. Demonstrate accountability to professional regulatory bodies
2.4. Recognize and respond to others’ unprofessional behaviours in practice
2.5. Participate in peer review

3. **Demonstrate a commitment to physician health and sustainable practice**
   3.1. Balance personal and professional priorities to ensure personal health and a sustainable practice
   3.2. Strive to heighten personal and professional awareness and insight
   3.3. Recognize other professionals in need and respond appropriately
Learning Outcomes Stages 1, 2 & 3

The table below contains the learning outcomes to be completed during each stage of training in the CBFP.

- The learning outcomes for Stage 1 are to be achieved in the two generalist rotations
- The learning outcomes for Stage 2 will be achieved during the area of practice rotations (child & adolescent and consultation liaison, plus two elective rotations of the trainee’s choice). These outcomes will remain the same throughout Stage 2. They will be supplemented by a smaller set of specific outcomes related to each of the areas of practice (for Child & Adolescent, Consultation- Liaison, Addiction, Old Age Psychiatry, Forensic, Psychotherapies, Rural and Indigenous)
- The learning outcomes for Stage 3 will be achieved in either the advanced generalist program rotations or the specialty certificate programs. As with the Stage 2 learning outcomes, there will be supplementary learning outcomes to be achieved, specific to the area of practice within which the trainee is practicing.

The learning outcomes describe a progression in the expected sophistication of trainees’ practice.

- The learning outcomes for Stage 1 are focused on the acquisition of knowledge and skills required to practice within the general adult clinical setting, establishing a solid foundation for trainees’ later practices
- The learning outcomes for Stage 2 enable the trainees to apply their knowledge and skills within a variety of settings and with diverse patient populations
- The learning outcomes for Stage 3 reflect the increased level of responsibility expected of trainees at this stage of training, preparing them for the transition into being consultant psychiatrists and for lifelong learning?

It is recognised that the College cannot fully and comprehensively prescribe the training experiences of trainees throughout Australia and New Zealand as the delivery of training programs is variable, and individual training experiences are unique, to some extent. The learning outcomes do, however, prescribe the minimum expectations of what trainees’ will need to complete in their rotations in order to achieve Fellowship.

NOTE

- Cells with X in them indicate that no predecessor/successor was required/intended for that row (e.g. the trainee can be assumed to have met the outcome earlier, or the outcome might subsumed within a broader, more advanced outcome)

CBFP Learning Outcomes: Approved in Principle BoE 2011/3 (pending SLO final development work)
<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL EXPERT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Conduct an organised psychiatric assessment with a focus on:</td>
<td>Conduct a comprehensive psychiatric assessment with an emphasis on development of advanced interviewing skills</td>
<td>Conduct a comprehensive psychiatric assessment integrating both generalist and sub-specialist assessment skills, collateral history and synthesising the information to produce justifiable formulation/hypothesis</td>
</tr>
<tr>
<td>• History taking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Psychiatric interview skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Phenomenology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MSE with relevant physical and cognitive examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtaining collateral history from other sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Accurately construct a differential diagnosis for common presenting problems, using a diagnostic system (DSM, ICD)</td>
<td>Use a detailed understanding of the diagnostic system to provide a justification for diagnosis and differential diagnosis, and apply these to a variety of clinical settings and patient groups</td>
<td>Identify limitations of diagnostic classification systems to guide treatment</td>
</tr>
<tr>
<td>3. Identify and summarise relevant biological, psychological, cultural and social contributors to the patient illness and recovery</td>
<td>Generate a broad formulation incorporating relevant theoretical constructs to inform a management plan, and apply these to a variety of clinical settings and patient groups</td>
<td>Develop a treatment plan informed by the formulation</td>
</tr>
<tr>
<td>4. Construct and implement safe management plans under supervision using recognised biological (ECT and psychopharmacology) and psychosocial approaches, with reference to relevant treatment guidelines</td>
<td>Construct and implement tailored management plans, with supervision, using evidence based biological and psychosocial approaches, with expertise on the development of skills in psychopharmacology</td>
<td>Construct a comprehensive management plan, incorporating both psychopharmacological and psychological approaches, that is sensitive to prognosis and barriers to implementation</td>
</tr>
<tr>
<td>5. Undertake the assessment and initial management of psychiatric emergencies, with due regard for safety and risk, under</td>
<td>Undertake the assessment and initial management of psychiatric emergencies in specialty patient groups and a variety of</td>
<td>Undertake the assessment and management of a broad range of psychiatric emergencies independently, recognising the need for</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision</th>
<th>Settings</th>
<th>Consultation, referral and supervision where required</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Describe the principles and practical application of the mental health legislation and informed consent, and able to work appropriately with the relevant mental health legislation</td>
<td>Undertake designated tasks under the mental health legislation and other applicable legislation (Guardianship, Advance Directives, Forensic mental health, legislation relevant to other aspects of mental health and health care service provision) under supervision.</td>
<td>Appropriately manage medicolegal issues related to mental health (for example guardianship, advance directives, mental health act, forensic etc)</td>
</tr>
<tr>
<td>7. Identify the principles of reflection, and use supervision to engage in reflection on clinical activities</td>
<td>Engage in critical reflection and self monitoring during clinical practice, integrating and translating new knowledge and skills into changes in clinical practice</td>
<td>Practice in a critically reflective and responsive manner, comfortably dealing with complexity, ambiguity and uncertainty in relation to clinical practice and can identify how and when to seek further assistance/advice (e.g. second opinion assessment, advice from experts, transfer of care)</td>
</tr>
<tr>
<td>8.</td>
<td>Understanding the principles of report writing and legal terms with regards to relevant legislation</td>
<td></td>
</tr>
</tbody>
</table>

**COMMUNICATOR**

<p>| Use effective and empathic verbal and non-verbal communication skills in all clinical encounters with the patient, their families and carers. | Adapt verbal and non-verbal communication to suit a wider range of professional settings, both clinical and non-clinical. | Effectively manage challenging communications, and complex structures communications, including conflict with patients, families and colleagues to promote positive outcomes |
| Recognise challenging communications, including conflict with patients, families and colleagues, and discuss management strategies in supervision to promote positive outcomes | X | X |</p>
<table>
<thead>
<tr>
<th></th>
<th>CBFP Learning Outcomes: Approved in Principle BoE 2011/3 (pending SLO final development work)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Recognise and incorporate the needs of culturally and linguistically diverse populations, including the use of interpreters and culturally appropriate health workers</td>
</tr>
<tr>
<td>4.</td>
<td>Provide accurate and structured verbal reports regarding clinical encounters, using a recognised communication tool</td>
</tr>
<tr>
<td>5.</td>
<td>Demonstrate comprehensive and legible case record documentation including discharge summaries and written liaison with referrers, primary care providers and community organisations (where relevant), under supervision</td>
</tr>
</tbody>
</table>

**COLLABORATOR**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Participate constructively as a member of a multidisciplinary mental health team, demonstrating an awareness of the roles and contribution of various members of the MDT</td>
<td>Recognise and apply theories of group participation in multidisciplinary and multi-agencies settings</td>
<td>Initiate and facilitate collaboration within all group settings (clinical and administrative meetings)</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate an ability to work collaboratively and respectfully with consumer and carer representatives, other health professionals and other agencies to improve patient outcomes</td>
<td>Identify barriers and apply techniques to maintain and enhance therapeutic relationships</td>
<td>Engage in reflective learning of one’s own role within all group settings and therapeutic relationships</td>
</tr>
<tr>
<td>3.</td>
<td>Develop therapeutic relationships with patients, carers and relevant others</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**MANAGER**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Describe one’s own scope of practice, responsibilities and line of reporting</td>
<td>Describe the principles of clinical governance and organisational structures that interact</td>
</tr>
<tr>
<td>CBFP Learning Outcomes: Approved in Principle BoE 2011/3 (pending SLO final development work)</td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>HEALTH ADVOCATE</strong></td>
<td>with mental health service provision</td>
<td><strong>SCHOLAR</strong></td>
</tr>
<tr>
<td>2. Identify the operational structures of the service and one’s role within this structure</td>
<td>Undertake expanded roles within own trainee structure (e.g. committee representation, rostering)</td>
<td>Demonstrate independent, self-directed learning practices through participation in a</td>
</tr>
<tr>
<td>3. Organise, prioritise and delegate tasks within the clinical setting</td>
<td>Demonstrate decision making based on own workload, patient needs, access to services and cost implications</td>
<td>Critically evaluate health policy and their impacts on patients and the wider community</td>
</tr>
<tr>
<td>4. Describe the principles of quality improvement and recognise opportunities for service improvement</td>
<td>Participate in quality improvement processes</td>
<td></td>
</tr>
<tr>
<td>5. Locate and apply legislative/regulatory requirements and service policies (e.g. adverse outcomes reporting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Apply principles of change management to service development</td>
<td></td>
</tr>
<tr>
<td><strong>HEALTH ADVOCATE</strong></td>
<td></td>
<td><strong>SCHOLAR</strong></td>
</tr>
<tr>
<td>1. Describe health inequalities and disparities in relation to clinical setting</td>
<td>Describe health inequalities and disparities in relation to broader health issues to mobilise additional resources when needed</td>
<td></td>
</tr>
<tr>
<td>2. Identify the impact of the cultural beliefs and stigma of mental illness on their patient, families and carers.</td>
<td>Describe the principles of prevention, promotion, early intervention and recovery, and apply these to clinical practice</td>
<td>Constructively address competing attitudes towards mental health</td>
</tr>
<tr>
<td>3. Describe the scope and role of local consumer and carer organisations within mental health care</td>
<td>Advocate for mental health within clinical settings and the broader community</td>
<td></td>
</tr>
<tr>
<td>4. Advocate for the patient within the MDT, with particular emphasis on ensuring patient safety</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Course and academic presentations</td>
<td>Range of learning activities, including peer review</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2. Critically evaluate academic material</td>
<td>Demonstrate knowledge of research methodologies</td>
<td></td>
</tr>
<tr>
<td>Generate research of peer review quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Identify and describe the principles of giving and receiving feedback</td>
<td>Develop the skills to provide effective feedback</td>
<td></td>
</tr>
<tr>
<td>Develop the ability to effectively supervise and appraise performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Describe principles of teaching and learning</td>
<td>Apply principles of teaching and learning during case presentation, journal club and other professional presentations</td>
<td></td>
</tr>
<tr>
<td>Present to an audience, e.g. grand rounds, workshops; adapt presentation according to audience need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Present to colleagues, medical students and members of the public, including patients</td>
<td>Actively participate in teaching</td>
<td></td>
</tr>
</tbody>
</table>

**PROFESSIONAL**

| 1. Adhere to professional and ethical standards of practice, in accordance with the RANZCP Code of Conduct and Code of Ethics, and local regulatory bodies | Identify the influence of industry and resource availability in local services, financing agencies and others, and the impact on professional practice and patient care |
| Integrate ethical practices in a variety of clinical and non-clinical settings |
| 2. Identify and fulfil legislation, regulations and College requirements regarding training, employment and professional registration | X | X |
| 3. Identify strategies to balance personal well-being and professional priorities in adapting to trainee responsibilities | Develop and apply skills to effectively manage the balancing of personal and professional priorities |
| Participate in activities to contribute to and enhance the profession, whilst maintaining sustainable work/life balance |
| 4. Identify pathways and legislation to report unprofessional behaviours or misconduct of colleagues, and act on these as appropriate, using supervision | X |
| Independently apply legislation and be able to self-report |
| 5. Identify learning goals and anticipated milestones in training, in supervision | Independently self evaluate strengths and weaknesses, and identify strategies to address areas for development |
| Participate in continuing professional and career development |
CBFP Developmental Descriptors

The following table contains the Developmental Descriptors for use in the Competency-Based Fellowship Program. The Developmental Descriptors are behavioural descriptors for the Fellowship Competencies.

The descriptors articulate how the overarching Developmental Trajectory applies for each of the Fellowship Competencies at the Basic, Proficient and Advanced level. The descriptors chart the anticipated developmental trajectory of trainees’ performance as they progress towards Fellowship. It is recognised that the behaviours described in the Developmental Descriptors do not represent the exclusive range of behaviours, and are provided only as a guide.

These descriptors are intended to provide supervisors and trainees with a reference point for defining performance standards. It is anticipated that the descriptors will be of use as criteria supporting workplace-based assessments and guiding the provision of formative feedback to trainees.

The Developmental Trajectory illustrates the broad changes expected of trainees’ practice as they progress through training:

<table>
<thead>
<tr>
<th>Aspect of Practice</th>
<th>BASIC</th>
<th>PROFICIENT</th>
<th>ADVANCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment ME 1*</td>
<td>Conducts a standard assessment of a patient with typical psychiatric disorders, but requires supervision to elicit all necessary data and to</td>
<td>With supervision, performs a detailed and comprehensive assessment of a patient presenting with typical and atypical features.</td>
<td>Performs a detailed and comprehensive assessment of a patient presenting with complex or multiple problems, or in special groups.</td>
</tr>
<tr>
<td></td>
<td>End of Stage 1</td>
<td>End of Stage 2</td>
<td>End of Stage 3</td>
</tr>
<tr>
<td><strong>History Taking</strong>&lt;br&gt;ME 1*</td>
<td><strong>Sociocultural</strong>&lt;br&gt;ME 1, 3*</td>
<td><strong>Mental State Examination</strong>&lt;br&gt;ME 2*</td>
<td><strong>Formulation</strong>&lt;br&gt;ME 3*</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Follows recommended framework for history taking. Hypothesis-driven for simple problems. Requires supervision to clarify important positive and negative features from the history and for accuracy and interpretation of mental state examination. Demonstrates adequate assessment of risk.</td>
<td>Identifies key sociocultural issues relevant to the psychiatric assessment. Requires supervision to deepen understanding.</td>
<td>Conducts and presents a thorough MSE, assessing the key aspects of observation of appearance, behaviour, conversation and rapport, affect and mood, thought (stream, form, content, (normal and abnormal), perception, cognition, insight and judgement. Able to perform some targeted cognitive assessments correctly. Succinct presentation of the MSE (and cognitive assessment) with accurate use of phenomenological terms and appropriate positive and negative findings. <em>(OCI marking sheet just below standard)</em></td>
<td>Produces an accurate BPS formulation and requires supervision to link salient factors.</td>
</tr>
<tr>
<td>History taking is targeted according to the patient’s presentation and is hypothesis-driven. Uses supervision to enhance understanding of relevant issues, including in-depth analysis of risks.</td>
<td>Integrates sociocultural issues and patient’s needs into the psychiatric assessment. Uses supervision to enhance understanding.</td>
<td>Conducts and presents a thorough, relevant and succinct MSE, with accurate use of phenomenological terms and appropriate identification of positive and negative findings. Performs an accurate cognitive assessment targeted to the patient’s presentation that provides useful information. Interprets findings of cognitive assessments correctly and can discuss their application. <em>(Surpasses the standard on ECE MARKING SHEET)</em></td>
<td>Able to identify and succinctly summarise important aspects of the history, using a BPS framework, and develop hypotheses as to how these factors interacted such that the patient now</td>
</tr>
<tr>
<td>History taking is appropriate to setting, focused and hypothesis driven. Sophisticated understanding of immediate and long-term risks of the individual case.</td>
<td>Generates a sophisticated sociocultural formulation and applies this formulation to the treatment plan of the patient.</td>
<td>Conducts and accurately presents a tailored MSE in complex patients, in a variety of settings and for a variety of reasons. Approach is organised and efficient. Decides on the importance of a cognitive assessment, chooses the most appropriate tests and performs them in a meaningful manner that provides useful information targeted to the patient’s presentation. <em>(Surpasses the standard on ECE MARKING SHEET)</em></td>
<td>Sophisticated integration of information on complex or unusual cases into a BPS formulation.</td>
</tr>
</tbody>
</table>

---

1 BPS refers to the Biopsychosocial Model described by Engel (Engel G.L. (1977), *The Need for a New Medical Model: A Challenge for Biomedicine*, Science, 196: 129 – 136), which includes cultural and spiritual dimensions within the social domain.
| **Information Gathering**  
ME 3* | Under supervision, describes, gathers and integrates additional information acquired from other sources and places this information into a chronological and developmental perspective. |
|---------------------------------------------|-------------------------------------------------------------------------------------------------|
| **Vulnerability and Resilience**  
ME 3, 4* | Describes vulnerability and resilience factors but requires supervision to incorporate these into the formulation and management plan. |
|---------------------------------------------|-------------------------------------------------------------------------------------------------|
| **Management Plan**  
ME 4* | Designs a comprehensive management plan for complex or unusual cases. The trainee can hypothesise the potential therapeutic alliance difficulties, and the barriers to treatment. The trainee describes the anticipated treatment response for a condition and can speculate about potential problems arising during care. |

V0.7 Developmental Descriptors
To accompany WBA tools Feasibility Study Rotation 1, 2012 materials.
To be updated following study.
<table>
<thead>
<tr>
<th>Development</th>
<th>of management.</th>
<th>can adjust the plan accordingly as required.</th>
<th>elaborates discharge/termination arrangements in advance and these are tailored to the patient’s condition and specific needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow Up</strong></td>
<td>Follows procedures for appropriate follow up and transfer of care to primary or other carers. Some supervision might be required.</td>
<td>Tailors the follow up care arrangements to the patient’s presentation and arranges transfer of care in an accurate, succinct and timely manner.</td>
<td>Designs follow up care arrangements and transfer of care with clear direction of potential problems that can occur in the care plan.</td>
</tr>
<tr>
<td><strong>ME 4</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Investigations</strong></td>
<td>Identifies and can interpret routine / standard range of haematological biochemical tests other investigations (including neuro-imaging) involved in routine psychiatric care. May require support to prioritise interventions and interpret abnormal results.</td>
<td>Justifies the selection of investigations, and demonstrates ability to prioritise these in a hierarchy of essential to least important. Demonstrates cost-benefit reasoning in the selection of investigations. Requires assistance to prioritise interventions in more complex situations.</td>
<td>Initiates consultation and support to manage complex and unfamiliar clinical problems. Reflects on limitations and value of interventions in care of patients.</td>
</tr>
<tr>
<td><strong>ME 5</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Procedures</strong></td>
<td>Identifies and undertakes routine diagnostic procedures including physical examination, laboratory tests, and questionnaires. Requires assistance with interpretation.</td>
<td>Justifies selection of diagnostic procedures and interprets results.</td>
<td>Independently undertakes and interprets relevant investigations and physical examination in a resource effective and ethical manner.</td>
</tr>
<tr>
<td><strong>ME 6</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Critical Appraisal</strong></td>
<td>Identifies principles of evidence-based practice to guide the development a management plan for routine or uncomplicated presentations, with aid of supervisor.</td>
<td>Independently applies evidence-based management principles in routine cases. Uses supervision to identify gaps in theoretical knowledge in more complex cases.</td>
<td>Critically evaluates available scientific evidence to Guide the development of the management plan.</td>
</tr>
<tr>
<td><strong>ME 7</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Integrate Information</strong></td>
<td>Identifies appropriate ways of obtaining relevant basic science and clinical information to augment understanding. Requires support to evaluate source of information. Also requires support to integrate newly acquired knowledge with prior learning and apply to clinical practice.</td>
<td>Incorporates relevant clinical information and evaluates its sources, requiring minimal support to integrate this with prior learning and application to practice.</td>
<td>Critically evaluates and integrates medical, developmental, psychological and sociological information and its sources, and applies this appropriately to practice.</td>
</tr>
<tr>
<td><strong>ME 7</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Legislation</strong></td>
<td>Describes mental health and related legislation but may need assistance in its application to individual cases.</td>
<td>Applies mental health and related legislation accurately and independently in routine and difficult cases.</td>
<td>Trainee is fully aware of responsibilities under mental health and related legislation. Appreciates the strengths and weaknesses of mental health and related legislation and able to use independently.</td>
</tr>
<tr>
<td><strong>ME 8</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtaining Information</td>
<td>Gathers relevant information from other informants with guidance from supervisor, in a professionally sensitive manner.</td>
<td>Gathers relevant information from other professionals and informants to inform assessment, recognising confidentiality, bias and other variables</td>
<td>Reflects on the relevance of information obtained from other professionals to generate a complete and sophisticated understanding of complex cases.</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Communicate Management Plan</td>
<td>Communicates a basic but safe management plan to patient and caregivers but requires supervision to ensure flexibility of approach.</td>
<td>Communicates a comprehensive management plan to patient and caregivers. Adopts a maintenance focus including psychoeducation, early warning signs, access to treatment and patient self-evaluation.</td>
<td>Effectively communicates management plan and discusses its acceptability with the individual and family/carer. Contemplates potential barriers and negotiates flexible alternatives as required.</td>
</tr>
<tr>
<td>Rapport</td>
<td>Interacts effectively with patient and caregivers, with supervision. May at times be somewhat overly technical or elaborate, or be more active or directive or passive than the situation ideally requires, but still maintains adequate rapport. Identifies core components of rapport establishment and common barriers for poor establishment of rapport.</td>
<td>Adapts interactions to the individual patient and caregivers to facilitate establishment of rapport, mindful of the background of the patient and caregivers, with minimal supervision.</td>
<td>Independently tailors interactions according to the developmental stage and background of the patient and caregivers. Can self-evaluate establishment and maintenance of rapport in the therapeutic environment.</td>
</tr>
<tr>
<td>Documentati on</td>
<td>Follows institutional/organisational procedures to produce written information. Written information may be somewhat over-inclusive or lacking detailed information.</td>
<td>Demonstrates the ability to produce more sophisticated documentation, such as complex reports and clinical reviews, under supervision. Shows discernment in selection of content, and tailors documentation to intended audience.</td>
<td>Produces complex clinical documentation (such as medico legal reports, briefs about critical incidents etc) with minimal input from supervisor. For example, produces a sophisticated report that provides salient and integrated information and plan that can also be used by others. Documentation is succinct and professional.</td>
</tr>
<tr>
<td>Interagency</td>
<td>Identifies and communicates effectively with agencies involved in patient care with supervision.</td>
<td>Liaises and negotiates with relevant agencies, justifying shared care, with minimal support.</td>
<td>Recognises complex issues related to liaison and contributes to higher level discussion or interagency working groups.</td>
</tr>
<tr>
<td>Working Alliance</td>
<td>Establishes and maintains rapport and engagement of families/carers in straightforward cases but requires supervision to improve competence in this</td>
<td>Establishes and maintains rapport, and engages each family member in the assessment process but seeks supervision to further enhance this skill. Less</td>
<td>Establishes and maintains an effective working alliance with the patient and relevant others, in complex/difficult situations. For example, selects</td>
</tr>
<tr>
<td>COL 1*</td>
<td>area. For example, requires assistance to select content with reference to possible positive and negative implications for patient and caregivers.</td>
<td>supervision required in complex situations. For example, level of assistance to select content with reference to possible positive and negative implications for patient and caregivers will depend on complexity and prior experience.</td>
<td>content with reference to possible positive and negative implications for patient and caregivers.</td>
</tr>
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</tr>
<tr>
<td>MDT COL 3*</td>
<td>Identifies key roles, values and responsibilities of professionals in the multidisciplinary team. Participates in the multidisciplinary team with assistance of supervisor.</td>
<td>With minimal supervision, promotes good multidisciplinary team function, effectively taking leadership role in routine multidisciplinary team meetings when indicated, and can negotiate complex issues.</td>
<td>Effectively leads complex multidisciplinary team meetings when indicated, for example in critical incidents, and actively encourages contributions from all members of the multidisciplinary team to promote efficient and effective multidisciplinary team function.</td>
</tr>
<tr>
<td>Systems Theory COL 3*</td>
<td>Identifies important dynamic systems-related issues impinging on team functions in supervision.</td>
<td>Explains how systems theory is relevant to multidisciplinary team function and shows awareness of intrapersonal issues that may affect multidisciplinary team functioning.</td>
<td>Works with multidisciplinary team to prevent, negotiate and resolve conflict and other issues within multidisciplinary team independently but seeks support where indicated.</td>
</tr>
<tr>
<td>Psychiatrist Role COL 3*</td>
<td>Distinguishes key roles, and responsibilities of psychiatrists in the health care system from other mental health professionals</td>
<td>Describes the range of roles and responsibilities of psychiatrists in the health care system.</td>
<td>Describes more complex roles and responsibilities of psychiatrists in the system of care, including psychiatrists’ role in conflict of interest situations in the organisation and sponsorship</td>
</tr>
<tr>
<td>Liaise with Psychiatrists COL 3*</td>
<td>Liaises appropriately and effectively with the supervisor, psychiatrists, including the on-call psychiatrist.</td>
<td>Liaises effectively with psychiatrists with minimal supervision in complex clinical situations.</td>
<td>Liaises effectively with psychiatrists in complex clinical situations.</td>
</tr>
<tr>
<td>Recruitment COL 3/4*</td>
<td>With supervision, identifies and recruits additional services appropriately.</td>
<td>Recruits other professionals appropriately to contribute to management.</td>
<td>Demonstrates an ability to prioritise the use of additional resources, according to patient need.</td>
</tr>
<tr>
<td>Role of Key Agencies COL 4*</td>
<td>Identifies key agencies and can describe services provided.</td>
<td>Describes in detail the roles and responsibilities of key agencies and identifies a broad range of additional agencies.</td>
<td>Describes the roles and responsibilities of a wide range of agencies and has a sophisticated approach to utilising their services.</td>
</tr>
<tr>
<td>Service Provision Gaps</td>
<td>Identifies major gaps in service provision and integration and reflects on this within the context of supervision</td>
<td>Identifies gaps in service provision and integration and can minimise the impact in most circumstances with supervision</td>
<td>Identifies gaps in service provision and integration in relation to complex patients and communicates the impact on the family and patient using local relevant clinical governance structures.</td>
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<tr>
<td>COL 3/4 &amp; MAN 2*</td>
<td></td>
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</tr>
<tr>
<td>Consultation COL 4*</td>
<td>Provides effective consultation to other health professionals and agencies around individual patient care or broader systemic issues affecting the well being of populations.</td>
<td>Provides consultation to relevant agencies and can develop both individual comprehensive management plans and systemic interventions with minimal supervisory support</td>
<td>Consults effectively to multiple agencies around complex individual presentations and systemic issues.</td>
</tr>
<tr>
<td>Professional Role MAN 1*</td>
<td>Describes and adheres to the trainee role within the clinical line of responsibility.</td>
<td>Explains the role of the trainee within the system and the learning environment.</td>
<td>Performs a professional role within the system, acknowledging limitations of responsibility, the ability to tolerate and manage uncertainty, and participates in organisational governance processes.</td>
</tr>
<tr>
<td>Systemic Issues MAN 1*</td>
<td>Identifies systemic issues impacting on patient care at a personal and clinical level with supervision.</td>
<td>Identifies issues but needs assistance to identify at what level intervention would be most effective within current the governance structure.</td>
<td>Describes principles of change management and change processes and with supervision can proactively contribute to change in a manner that advances mental health care.</td>
</tr>
<tr>
<td>Clinical Leadership MAN 2*</td>
<td>Identifies the clinical leadership role of a psychiatry trainee, including whilst on-call</td>
<td>Participates effectively as a junior leader at the local hospital level, with guidance and support.</td>
<td>Participates effectively in committees and meetings in all roles. Able to participate in committees concerning service development and planning, capacity enhancement, financial and human resource allocation.</td>
</tr>
<tr>
<td>Quality Improvement MAN 3*</td>
<td>Describes the principles of quality assurance.</td>
<td>Articulates the principles behind design, critical review and development of systemic quality evaluation processes.</td>
<td>Participates in the design, development and critical review of systemic quality improvement.</td>
</tr>
<tr>
<td>Service Development MAN 2, 4*</td>
<td>With assistance, identifies and describes the impact of resource allocation on wider health systems.</td>
<td>With supervision identifies gaps in service provision and critically discusses service development and planning, capacity enhancement and human resource allocation. Shows an understanding of</td>
<td>Takes a leadership role in discussions regarding development and planning, capacity enhancement and human resource allocation. Shows a sophisticated understanding of funding for services.</td>
</tr>
<tr>
<td><strong>Resource Allocation</strong> MAN 4*</td>
<td>Under supervision, describes the costs, benefits and risks of psychiatric care.</td>
<td>Analyses the balance of costs, benefits and risks of psychiatric care.</td>
<td>Management plans take account of cost/risk/benefit analysis to influence resource allocation.</td>
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<tr>
<td><strong>Documenta</strong> <strong>tion</strong> MAN 5*</td>
<td>Accurately documents the case assessment, formulation and management plan, with supervision. Requires supervision to assist with integration of information.</td>
<td>Accurately documents sophisticated case assessments, formulations and management plans.</td>
<td>Autonomously completes documentation requirements, and is able to provide supervision to ensure others fulfill their documentation obligations.</td>
</tr>
<tr>
<td><strong>Clinical Responsibilities</strong> MAN 5*</td>
<td>Reliably attends to required clinical responsibilities.</td>
<td>Reliably attends to required clinical responsibilities and, with assistance, manages complex and unfamiliar situations.</td>
<td>Meets work demands responsibly and in a timely manner in complex and unfamiliar clinical situations.</td>
</tr>
<tr>
<td><strong>Patient and Systems Engagement</strong> HA 1*</td>
<td>Engages with individual patient and the more immediate systems with supervision to provide quality care.</td>
<td>Engages with individual patient and multiple systems with supervision to positively influence outcomes.</td>
<td>Engages with individual patient and multiple systems to positively influence outcomes.</td>
</tr>
<tr>
<td><strong>Advocacy Groups</strong> HA 1*</td>
<td>With support, identifies the relevance of advocacy groups and their role in supporting patient and caregivers. Actively seeks and evaluates local and regional groups and makes recommendations with support.</td>
<td>Actively links patient and caregivers to relevant local and/or regional advocacy groups.</td>
<td>Actively links patient and caregivers to relevant local and/or regional advocacy groups, encourages development of advocacy groups.</td>
</tr>
<tr>
<td><strong>Prevention and Promotion</strong> HA 2*</td>
<td>Integrates principles of prevention and health promotion to planning and service provision in mental health services with supervision.</td>
<td>Integrates principles of prevention and health promotion to planning and service provision in mental health services. With supervision can apply these to wider systems.</td>
<td>Integrates principles of prevention and health promotion to planning and service provision in mental health settings and wider systems.</td>
</tr>
<tr>
<td><strong>Epidemiology</strong> HA 2*</td>
<td>Describes basic epidemiology and identifies sources of epidemiological data relevant to clinical decision making.</td>
<td>Demonstrates the application of epidemiology to clinical practice. With supervision critically reviews epidemiological data to judge how this influences</td>
<td>Critically reviews and applies relevant epidemiological data to inform clinical decision making and service provision for individuals and</td>
</tr>
<tr>
<td>Developmental Descriptors</td>
<td>Description</td>
<td>Description 2</td>
<td>Description 3</td>
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<tr>
<td>Knowledge Gaps SCH 1*</td>
<td>Requires individual supervision to help identify deficiencies in relevant knowledge and skills, and ways to remedy these deficiencies.</td>
<td>Uses supervision to identify areas of knowledge deficiency and review the existing literature to enhance understanding.</td>
<td>Identifies gaps in own knowledge, generate new questions for study and evaluates obtained knowledge.</td>
</tr>
<tr>
<td>Reflection SCH 1 PROF 3*</td>
<td>Actively engages and participates in supervisory relationship to identify learning needs and develop appropriate action plans, and evaluates these periodically.</td>
<td>Collaboratively uses supervision to develop reflective practices to ensure ongoing learning and professional development.</td>
<td>Establishes and participates reflectively in peer and mentoring relationships to ensure ongoing learning and professional development.</td>
</tr>
<tr>
<td>Teaching SCH 2, COM 1*</td>
<td>Communicates at a level and in a manner that can be comprehended by familiar audiences.</td>
<td>Communicates at a level and in a manner that can be comprehended by most audiences.</td>
<td>Communicates at a level and in a manner that can be comprehended by the audience being addressed.</td>
</tr>
<tr>
<td>Learning Needs Assessment SCH 2*</td>
<td>Identifies the learning needs of others but may require support to prioritise these. With supervision, selects content and, guided by best teaching practices, develops an effective educational strategy.</td>
<td>Reflects on and prioritises the learning needs of others. Develops effective educational strategies with support.</td>
<td>Reflects on and prioritises the learning needs of others and develops tailored educational strategies.</td>
</tr>
<tr>
<td>Supervision SCH 1, 3*</td>
<td>Describes the essential components and value of clinical supervision.</td>
<td>Critically appraises the components of the supervisory relationship, and limitations to the supervisory process.</td>
<td>Develops supervisory skills through formal training.</td>
</tr>
<tr>
<td>Scholarly Activity SCH 3*</td>
<td>Describes research approaches, such as study design, methodology, and conducting literature reviews.</td>
<td>Identifies an area of practice appropriate for scholarly investigation and refine plans with supervision.</td>
<td>Creates a scholarly project through planning, data gathering, analysis, and presentation.</td>
</tr>
<tr>
<td>Boundaries</td>
<td>PROF 1*</td>
<td>Follows guidelines to maintain personal and interpersonal boundaries in clinical practice and uses supervision to enhance understanding and to apply theoretical knowledge to clinical situations.</td>
<td>Ensures appropriate personal and interpersonal boundaries in clinical practice, seeking supervision in complex situations.</td>
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<tr>
<td>Ethics</td>
<td>PROF 1*</td>
<td>Identifies relevant ethical principles but will need support to resolve conflicting priorities to guide action.</td>
<td>Identifies relevant ethical principles but can resolve these in familiar situations and will seek support where complexity exists.</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>PROF 1, 2*</td>
<td>Follows institutional guidelines to deliver high quality care with integrity, honesty, compassion and respect for diversity.</td>
<td>Evaluates quality of care and identification of potential for error and incorporates this into continuing practice improvement.</td>
</tr>
<tr>
<td>Reflection on Limitations</td>
<td>PROF 3*</td>
<td>Identifies the importance of ongoing self-reflection in clinical practice and discusses the limitations of their expertise during supervision.</td>
<td>Reflects on limitations of their practice and expertise through ongoing self-audit and seeks supervision to address limitations or to develop a safe alternative approach.</td>
</tr>
<tr>
<td>Time Management</td>
<td>PROF 4*</td>
<td>Using supervision, external structures and regulations, balances patient care, service requirements and personal well-being.</td>
<td>Applies time management skills and prioritisation that fulfils personal and clinical interests and duties.</td>
</tr>
<tr>
<td>Others’ Unprofessional Behaviour</td>
<td>PROF 5*</td>
<td>Distinguishes between professional and unprofessional behaviours and discusses this with the supervisor or other appropriate authority.</td>
<td>Identifies and, with support, addresses unprofessional behaviours in others.</td>
</tr>
<tr>
<td>Regulatory Requirements</td>
<td>PROF 5*</td>
<td>Identifies professional regulatory requirements and can follow required procedures.</td>
<td>Complies with relevant professional regulatory requirements, and identifies other professional guidelines and codes of conduct.</td>
</tr>
</tbody>
</table>
References


Monday, April 02, 2012

Introduction
The advanced certificate for Adult Psychiatry is currently being developed to encompass the Fellowship competencies. Draft Entrustable Professional Activities (EPAs) for the Adult are listed below. These will be further progressed by the Sub-committee for Adult Psychiatry in Liaison with the CBFP project team during 2012.

Draft Adult EPAs

1. Teach and supervise
2. Collaborative risk assessment and management
3. Assess and manage treatment-refractory psychiatric disorders
4. Structured psychotherapies
5. Complex work with families and/or carers
6. Physical co-morbidity
7. Comorbid mental Health and substance use problems
8. Assess and manage adult patients across a range of disorders
   1. Recovery and rehabilitation
9. Preparation and presentation of a medicolegal case to a formal body
10. Clinical leadership, e.g., chair team meeting/ward round or case conference
11. First presentation of a mental disorder
12. Assessment and management of adults with comorbid intellectual disability or developmental disability
13. Conduct assessments of adults, collaborate with carers, referrers and health professionals and implement management via videoconferencing to rural, remote, or outlying areas.
14. Assess and manage adults with cultural and linguistic diversity.
15. Medicolegal assessment (civil)
# Scholarly Project

<table>
<thead>
<tr>
<th>REGULATION 1.0: Scholarly Project (General Council)</th>
<th>POLICY 1.0: Scholarly Project (Board of Education)</th>
<th>PROCEDURES/PROCESSES/GUIDELINES: Scholarly Project (Education committees)</th>
</tr>
</thead>
</table>
| 1.1 To attain Fellowship of the College, a trainee must satisfactorily complete a scholarly project. | 1.1 A trainee must satisfactorily complete a scholarly project.  
1.1.1 The scholarly project should address the learning goals as detailed in the guidelines.  
1.1.2 The scholarly project can be submitted for assessment at any stage of training.  
1.1.2.1 The project will be assessed to Fellowship standard regardless of when it is submitted. (See assessment guidelines.)  
1.1.3 The scholarly project should be 3000–5000 words in length. (See policy 1.3 for alternative options.) | One of the requirements for attaining Fellowship of the College is that trainees satisfactorily complete a scholarly project.  
The scholarly project has been designed to help trainees meet the Fellowship competencies, particularly in the (CanMEDS) role of Scholar.  
The scholarly project will contribute to the trainee’s ability to achieve the Scholar learning outcomes including (but not limited to):  
- critically evaluate academic material (Stage 1)  
- demonstrate knowledge of research methodologies (Stage 2)  
- generate research of peer-review quality (Stage 3).  
The specific learning goals of the scholarly project are the ability to:  
i. Conduct a critical appraisal of the literature base in an area of knowledge pertaining to psychiatry or mental health in its broader sense.  
ii. Formulate a scholarly question(s) or hypothesis(es) based on i.  
iii. Complete a project to address the question(s) or test the hypothesis(es) described in ii above.  
iv. Present the results of iii and discuss in regards to i, including a critical review of project methodology.  
The trainee’s scholarly project will be assessed according to their ability to address the learning goals i–iv above. (See assessment criteria below.)  
Trainees are advised that completing a successful scholarly project requires not only research-related knowledge but also |
Trainees need to plan ahead as early in training as possible considering the time it will take them to complete their scholarly project and the availability of their proposed supervisor.

### 1.2 Trainees may select their own scholarly project topic based on their own research interests.

Trainees are encouraged to select a scholarly project topic based on their own research interests.

- There may be research opportunities within particular training rotations but ultimately the choice of research subject lies with the trainee.

### 1.3 A scholarly project may take the form of:

1. A quality assurance project or clinical audit.
2. A systematic and critical literature review.
3. Original and empirical research (qualitative or quantitative).
5. A doctoral thesis, research Masters or Honours thesis in a field relevant to psychiatry or mental health; accepted publication in a recognised peer-reviewed English-language journal relevant to psychiatry or mental health; or equivalent other project as approved by the Scholarly Project Subcommittee.

All forms of scholarly project will be assessed according to the same criteria. (See assessment guidelines.)

Trainees have five different options for completing their scholarly project:

1. A quality assurance project or clinical audit.
2. A systematic and critical literature review.
3. Original and empirical research (qualitative or quantitative).
5. A doctoral thesis, research Masters or Honours thesis in a field relevant to psychiatry or mental health; accepted publication in a recognised peer-reviewed English-language journal relevant to psychiatry or mental health; or equivalent other project as approved by the Scholarly Project Subcommittee.

All forms of scholarly project will be assessed according to the same criteria. (See assessment criteria below.)

Trainees who have completed a doctoral thesis, research Masters or Honours thesis in a field relevant to psychiatry or mental health or have a publication accepted by a recognised peer-reviewed English-language journal relevant to psychiatry or mental health may apply for exemption from the scholarly project (see policy 1.9).

Projects will be considered for exemption in the form in which they were accepted for degree or publication.

**Authorship**
A major author is defined as an author who has made a substantial contribution to the following areas:
- study design
- data collection
- analysis and interpretation of data
- writing of the manuscript.

<table>
<thead>
<tr>
<th>1.4 The scholarly project supervisor must be involved in considering the most appropriate form for the project.</th>
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<tr>
<td>1.4.1 The (principal) scholarly project supervisor must be recognised as having appropriate expertise in the area of study; the supervisor does not have to be a Fellow of the College.</td>
</tr>
<tr>
<td>1.4.1.1 If the proposed supervisor is not a Fellow of the College, trainees should seek a Fellow as project co-supervisor to ensure adherence to College guidelines.</td>
</tr>
<tr>
<td>1.4.1.2 If the proposed supervisor is not local to the trainee, a local project co-supervisor should be sought; however, legitimate exceptions to this may be acceptable.</td>
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</table>

Trainees should consider (in consultation with their supervisor) which project option is most appropriate for their proposed research.
- Selection of the appropriate format will require the trainee to clarify:
  - the question being posed
  - the resources available to them (most importantly time and access to their proposed supervisor)
  - the particular research skills they would like to develop
  - their understanding of the relevant literature.
- Trainees should engage their scholarly project supervisor at the earliest possible stage of project development.

A clinical (rotation) supervisor may supervise a trainee’s scholarly project (provided they have appropriate expertise in the area of study) but it is expected that many trainees will need to locate a (scholarly project) supervisor with an interest in the project topic and research in general.
- Trainees may therefore have a clinical supervisor and a scholarly project supervisor.
- Some trainees may additionally seek a project co-supervisor if their proposed scholarly project supervisor is not a Fellow of the College or not local to them.
  - The co-supervisor may, where appropriate, be a trainee with specific expertise in the research area.

Trainees should discuss exceptions to seeking a local co-supervisor with their Director of Training (DOT)/Director of Advanced Training (DOAT).

Supervision of the scholarly project will take the form of regular meetings and discussions with the trainee. The supervisor will:
1.5 A maximum of two trainees will be approved for collaboration on a shared scholarly project.
   1.5.1 Trainees can apply to the Scholarly Project Subcommittee for approval to collaborate on a shared project of more than two trainees. Approval will be granted on a case-by-case basis.

Two trainees can collaborate on a scholarly project; however, each trainee must independently write up their research findings.

1.6 Trainees are encouraged to submit their scholarly project proposal to their Director of Training (DOT) and/or Director of Advanced Training (DOAT).
   1.6.1 The DOT and/or DOAT will review the scope of the project and ensure that it adheres to the College guidelines.

Before submitting a scholarly project proposal, a trainee must have:

- decided upon a project topic
- identified and engaged a project supervisor
- chosen the most appropriate form for their project
- outlined a timeframe for completion of the project.

The proposal should clearly identify:

- the project question and/or hypothesis
- the proposed research methodology.

- advise the trainee of pertinent literature to be reviewed
- help with the development of a scholarly question(s) or hypothesis(es)
- provide advice and guidance in the conduct of the research and its writing up.

In some instances, group supervision may be possible and desirable.

The supervisor may also assist the trainee with data collection and/or analysis but should not undertake or subsume the project tasks for the trainee.

Supervision should be regular but may vary in frequency (i.e., between weekly and monthly) depending on the stage of project development. (It is anticipated that supervision will be most frequent in the initial and final stages of the project.)

The College Committee for Research can assist trainees in locating scholarly project supervisors and can be contacted through the College Secretariat.
Trainees are encouraged to submit their scholarly project proposal for review by their DOT/DOAT before they seek Ethics Committee approval (if relevant).

The trainee should meet with their DOT/DOAT to discuss the proposed project and choice of supervisor.

- DOTs/DOATs should offer support by ensuring that trainees are aware of the local resources available.

DOTs/DOATs are encouraged to seek advice from their Branch Training Committee or local researchers if they are unsure about a scholarly project proposal.

<table>
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<tr>
<th>1.7 The scholarly project submitted for assessment must be based on novel research.</th>
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<tbody>
<tr>
<td>The scholarly project must contain novel research, i.e. questions and/or hypotheses not previously addressed, or research that adds in an important way to the current literature. This is not to preclude projects involving a replication study of important findings in research. In such cases, the scholarly question would be ‘Can these findings be replicated?’. Trainees may also take a new perspective on a previously asked question. Any project that has a focus on indigenous participants should follow the relevant principles of research with indigenous people, such as Kaupapa Maori research methods when working with Maori. The National Health and Medical Research Council publish guidelines for research involving Aboriginal and Torres Strait Islander peoples. Relevant references: Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research published by the National Health and Medical Research Council 2003. Guidelines for researchers on health research involving Maori and Te Ara Tika. Guidelines for Maori research ethics: A framework for researchers and ethics committee members published by the Health Research Council of New Zealand. Trainees have five options for completing a scholarly project: A quality assurance project or clinical audit Clinical audit is used to measure the true quality of an aspect of</td>
</tr>
</tbody>
</table>
a service. It is dependent on setting explicit, realistic standards for the care given. Clinical audit, however, is much more than just measuring quality. There must be a commitment to change practice where the results of the audit show that improvements should be made. The audit cycle involves:

- a cycle of assessment
- the implementation of a change
- a review of the impact of the change.

To meet the requirements of this option, the expected standard would be a project that encompasses the whole of the clinical audit cycle. For larger audits, a project limited to a defined section of the audit cycle may be considered but the commitment to changing practice, where necessary, must be demonstrated. Evidence of Ethics Committee approval should be provided where relevant.

The trainee may define a practice which he/she believes to be worthy of auditing. There may or may not be an existing policy or guideline against which the audit is made. If there is no such standard, the trainee might look at national practice standards or options from comparable services. Alternatively, the trainee may develop a set of standards as a result of the audit conducted and compare and contrast these with the literature. For example:

- The trainee may be concerned with the diagnosis of women with postnatal depression. This is a common and significant problem and non-diagnosis leads to poorer outcomes. There is literature on this topic and established prevalence using various assessment tools.
- The trainee may be concerned that in his/her service a number of women with postnatal depression are not being diagnosed, or might be interested in the tool(s) used to diagnose postnatal depression if any, or might be interested in how current tools are being used and how any of these influence outcome. He/she might review service data to confirm such an impression or to establish what tools are used and the skill with which they are applied and conclude that there is a problem and offer suggestions for improvement.
The trainee may enter the audit cycle at a later point in the audit cycle, eg. after an instrument such as the Edinburgh Postnatal Depression Scale is introduced and design and conduct a review of this strategy to improve diagnosis of postnatal depression in the service.

Clearly all these projects require the trainee to define suitable measures for the performance indicator or outcome being examined.

Areas of performance for audit may include the following:
- clinical care, eg. acute, chronic and preventive care, prescribing, referrals, investigations, length of stay, readmission rates
- access to service, eg. appointments, premises, telephone, out of hours
- communication, eg. with patients, carers, with team members outside practice
- interface, eg. discharge planning, letters, records
- professional values, eg. education, workload.

**A systematic and critical literature review**

In this section the scene will be set for the questions to be asked in the review. The topic area will be introduced and the context of the question presented. This will usually include summary statements (supported by references). For example, if the topic is treatment of panic disorder, the current epidemiology, burden and outcome of panic disorder will be summarised.

The background will refer to current and relevant literature and critical appraisal of the same, such that deficiencies in the present state of knowledge leading to the objectives and specific aims of the review are clear to the reader. For example:

- ‘It is evident that while there are several published meta-analyses of selective serotonin reuptake inhibitor (SSRI) antidepressant treatment for panic disorder, these are now dated (in the most recent the search date was to 2004) and none has included studies of more recently introduced antidepressants. The objective of this present review is to evaluate the efficacy of more recently developed

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v0.7 Scholarly Project Regulations, Policy & Procedures
Prepared for Scholarly Project Working Party approval 08/02/12
antidepressants in the treatment of panic disorder. The specific aims are to evaluate the efficacy of antidepressant Y compared to placebo pharmacotherapy and when compared to SSRIs, in the treatment of adults with panic disorder.

Questions asked commonly are of treatment efficacy, but there are many other areas of inquiry. For example:

- ‘What are predictors of long-term outcome of disorder Z?’

Questions may also refer to broader areas of psychiatry, beyond clinical practice, for example, the psychological health of adolescents following parental separation.

Trainees should ensure their question is focused, concise and specific. For example, reading in the area above might give rise to the question:

- ‘What is the evidence for increased rates of school drop-out in Australasian adolescents following parental separation?’

A simple summary of the current literature is insufficient to meet the requirements of the scholarly project. The trainee must demonstrate an ability to synthesise knowledge in the chosen area.

Trainees proceeding to a higher degree (PhD or Masters) may submit the literature review leading to a description of testable hypotheses and the methodology intended to test these. (These usually comprise the first two or three chapters of a thesis). Such trainees should provide clear evidence of their intention to proceed to the higher degree. Pilot data should be included where possible.

**An original and empirical research project**

This is the more formal research option, and could involve undertaking either a quantitative or qualitative research project.

Regardless of whether the project is quantitative or qualitative, it is essential for the discussion to include a thorough examination of the strengths and limitations of the research.

It is not expected that the research should necessarily result in a paper of a standard likely to be accepted for publication in a peer-reviewed journal; however, obviously that would be a
desirable objective. Rather, the trainee needs to demonstrate that their knowledge of undertaking research has been significantly improved by conducting the project.

Quantitative research
A quantitative research project would normally involve a series of steps as follows:

- Review of relevant literature leading to development of one or more hypotheses.
- Development of an appropriate research methodology.
- Data collection for either a pilot or more definitive study.
- Data analysis yielding a set of results.
- Discussion and conclusion.

Qualitative research
Qualitative methodologies are most suitable for exploring areas or constructs which are poorly defined and not well understood. Typically, 'in-depth' data are collected from a small number of subjects often using recorded interviews. Data analysis often involves the identification and elucidation of recurring themes. This can be done manually or, in more sophisticated studies, by computerised analysis of transcribed interviews. Results and discussion focus on how these recurring themes (which may include emotions, cognitions, attitudes, beliefs, etc.) further our understanding of the topic under study. Trainees need to be mindful that supervisors may have a more limited knowledge of qualitative methodologies and seeking co-supervision may warrant consideration.

It is acknowledged that qualitative research may differ from the more usual quantitative investigations in terms of the following:

- In qualitative research, problem statements rather than a priori hypotheses are utilised.
- In qualitative research, questions may be refined and reformulated as the study progresses and, on occasion, the research may be redirected as new understandings emerge.
- Sample sizes in qualitative research will be considerably smaller. Non-probability sampling is usual and sample size may not always be defined a priori although an approximate
A wide range of methodologies can be utilised depending upon the objectives of the research. These include phenomenological, hermeneutic, grounded theory, ethnographic/participant observation and others. In qualitative research, concepts such as objectivity, reliability and validity are much less clear-cut than in quantitative research. However, the notion of 'rigour' is applicable and every specific project must deal with how rigour is to be established. Qualitative findings may not be generalisable from the sample to a larger population; however, they should be transferable to similar groups in similar situations. Results in qualitative research may be presented in narrative rather than numerical form.

In preparing a proposal for a qualitative research project, trainees should endeavour to address the following issues:

1. Reasons for adopting a qualitative approach.
2. What is the significance of the research and to whom is it significant? An argument must be presented to support the utility of the study.
3. What methodology is proposed and what is the rationale for this choice?
4. The rationale underlying the sampling strategies should be clearly stated and appropriate for the study's objectives. Recruitment should be explained as well as approximate sample size.
5. The means of data generation must be specified. Data may derive from interview, participant observation, examination of documents, etc.
6. The project must not simply comprise the documentation of a set of Maudsley case histories in which some unifying themes are highlighted.
7. Ethical dilemmas which may arise in the course of the project should be addressed.
8. There is a tendency in this area for novice researchers to contemplate overly ambitious projects. The feasibility of the project must be addressed in terms of time constraints and
Trainees preparing a qualitative scholarly project should consider the following.

- The trainee should demonstrate an understanding of the relevant methodology including its historical and philosophical origins and the controversies surrounding its use.
- The literature relevant to both the specific subject area and the methodological framework must be reviewed in some depth. Where applicable, trainees should demonstrate knowledge of the various computerised data analysis techniques (e.g., NUDIST, Ethnograph, etc.).
- The context in which the research takes place should be described and taken into account.
- The strengths, weaknesses and limitations of the research must be discussed in depth. For example, in the case of grounded theory, the extent to which data saturation has been achieved should be discussed (i.e., the extent to which a point in data collection has been approached where no new major themes emerge). Where appropriate, the notion of ‘transferability’ should be raised, i.e., whether another informed person following the same decision trail would arrive at similar conclusions. Related notions of ‘auditability’, ‘credibility’, ‘trustworthiness’, etc. may also warrant consideration.

A case series
Trainees may submit a scholarly project based on case histories or clinical vignettes provided it has a unifying theme and is presented in the context of current knowledge in the relevant field.

Other research options
A doctoral thesis, research Masters or Honours thesis in a field relevant to psychiatry or mental health; accepted publication in a recognised peer-reviewed English-language journal relevant to psychiatry or mental health; or equivalent other project as approved by the Scholarly Project Subcommittee.
Trainees proceeding to a higher degree (PhD or Masters) may submit the literature review leading to a description of testable hypotheses and the methodology intended to test these. (These usually comprise the first two or three chapters of a thesis). Such trainees should provide clear evidence of their intention to proceed to the higher degree. Pilot data should be included where possible.

<table>
<thead>
<tr>
<th>1.8 Trainees must submit their project for assessment to the Scholarly Project Subcommittee.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8.1 The Scholarly Project Subcommittee will delegate the marking of individual projects to suitably experienced Fellows.</td>
</tr>
<tr>
<td>4.8.1.1 Fellows cannot adjudicate a project where they have a conflict of interest.</td>
</tr>
<tr>
<td>1.8.1.2 All assessment criteria must be met for a scholarly project to pass adjudication. (See assessment guidelines).</td>
</tr>
</tbody>
</table>

Adjudicating Fellows will consider each project according to the assessment criteria below. Projects will be passed outright, passed subject to revisions or failed.

In the event that a project is failed, the Chair of the Scholarly Project Subcommittee will arrange for a second independent marker who will be unaware of the initial failure of the project.

- If the second marker awards a pass then the Chair will also mark the project and have the deciding vote.
- If the second marker also fails the project then the trainee is informed that the project has failed.
  - Trainees will receive written feedback indicating which assessment criteria were not met and why.
  - Trainees must revise their manuscript to address the feedback provided and resubmit their project to the subcommittee within <<a to be determined timeframe>>.

Trainees can resubmit their project two times (three total submissions). Should the third submission fail, trainees must complete a new scholarly project.

All assessment criteria must be met for a scholarly project to pass adjudication. (The assessment criteria are the same for all forms of scholarly project.)

**Assessment criteria**

1. The project is pertinent to the theory or practice of psychiatry.
2. The presentation and content is clear and concise.
   a) Professional English is used with appropriate spelling and grammar. (Trainees are advised to have their project proofread.)
   b) The project is 3000–5000 words
c) Evidence of Ethics Committee approval is provided where relevant.

d) The content conforms to the guidelines set down for the type of project submitted.

3 There is a clear statement of the objectives of the project.
   a) Hypotheses are well formulated and appropriate to the methodology.

4 The literature review is comprehensive, contemporary and critical.

5 All references cited in the text are listed in an accepted reference style, e.g. Vancouver style.

6 The project uses methodology (and analysis) suitable to its format.

7 Relevant results are presented appropriately.

8 The discussion provides a concise summary of the main findings including a:
   a) critical review of the methodology and methods used
   b) statement about how the project contributes to the field.

9 Conclusions relate to the research question and are supported by the study results.

The scholarly project will be assessed to Fellowship standard (regardless of when it is submitted).

It is expected that projects will be assessed within <<a to be determined timeframe>> of submission.

The scholarly project must be satisfactorily completed prior to admission to Fellowship.

- It is the trainee’s responsibility to submit the scholarly project with enough time for assessment and any necessary revisions to be undertaken.

1.9 Trainees may be exempt from undertaking a scholarly project if they have completed a doctoral thesis, research Masters or Honours thesis in a field relevant to psychiatry or mental health or had an article accepted for publication in a recognised peer-reviewed English-language journal.

Trainees should submit the Application for exemption form to the Scholarly Project Subcommittee if they wish to seek exemption from the scholarly project.

Projects will be considered for exemption in the form in which they were accepted for degree or publication.
relevant to psychiatry or mental health.

1.9.1 Applications for exemption should be submitted to the Scholarly Project Subcommittee.

Working party recommendations

The CBFP Scholarly Project Working Party recommends that:

- a subcommittee (the Scholarly Project Subcommittee) be established to govern the conduct and assessment of the scholarly project with by-laws and standard operating procedures developed
  - the subcommittee reports to the Committee for Training with representatives from the Committee for Examinations and Committee for Research providing input about assessment and research, respectively
- the subcommittee will:
  - organise the introduction of the scholarly project
  - approve alternative scholarly project proposals
  - approve applications for exemption from the scholarly project
  - ratify the transparent, fair and reproducible marking guidelines
  - identify and train a pool of adjudicators
    - Faculties, Sections and Special Interest Groups from within the College should nominate members as potential scholarly project adjudicators
  - review results
- the work of the subcommittee needs to have an adequate budget and appropriate administrative support.
Scholarly Project Subcommittee

**Scholarly Project**

**Marking criteria**

<table>
<thead>
<tr>
<th>Candidate number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Scholarly Project:</td>
</tr>
<tr>
<td>Date of submission:</td>
</tr>
<tr>
<td>Examiner number:</td>
</tr>
</tbody>
</table>

**Examiners, please note:**

The following marking criteria are intended to guide your overall assessment only. There is no requirement for a candidate to achieve a 'yes' in each domain to pass the Scholarly Project.

<table>
<thead>
<tr>
<th>1</th>
<th>Clinical relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong></td>
<td>The work is pertinent to the theory or practice of psychiatry or mental health.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Presentation and content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td>The general layout is clear and professional.</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td>The content conforms to the guidelines for the type of scholarly project submitted.</td>
</tr>
<tr>
<td><strong>2.3</strong></td>
<td>Professional English is used with appropriate spelling and grammar.</td>
</tr>
<tr>
<td><strong>2.4</strong></td>
<td>Length conforms to the guidelines.</td>
</tr>
<tr>
<td><strong>2.5</strong></td>
<td>Evidence of Ethics Committee approval is provided where relevant.</td>
</tr>
<tr>
<td><strong>2.6</strong></td>
<td>The written work is the trainee's own independent undertaking. (Plagiarism declaration is attached and signed by trainee.)</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>Objectives and/or hypotheses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong></td>
<td>There is a clear statement of the objectives of the scholarly project.</td>
</tr>
<tr>
<td><strong>3.2</strong></td>
<td>Where hypotheses are appropriate to the methodology used, these are well formulated, clearly stated and testable.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Literature review</td>
</tr>
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</tr>
<tr>
<td>4</td>
<td>Is sufficiently comprehensive.</td>
</tr>
<tr>
<td>4.1</td>
<td>Is sufficiently contemporary.</td>
</tr>
<tr>
<td>4.2</td>
<td>Is sufficiently critical.</td>
</tr>
<tr>
<td>5</td>
<td>References</td>
</tr>
<tr>
<td>5.1</td>
<td>References are cited and presented in an accepted reference style, eg. Vancouver system.</td>
</tr>
<tr>
<td>5.2</td>
<td>All references cited in the text are listed.</td>
</tr>
<tr>
<td>5.3</td>
<td>All references listed were cited.</td>
</tr>
<tr>
<td>6</td>
<td>Methodology</td>
</tr>
<tr>
<td>6.1</td>
<td>There is a satisfactory account of, and justification for, the methodology proposed.</td>
</tr>
<tr>
<td>6.2</td>
<td>There is a clear and satisfactory account of the type of analysis proposed (if relevant) and justification of the tools.</td>
</tr>
<tr>
<td>7</td>
<td>Results</td>
</tr>
<tr>
<td>7.1</td>
<td>Relevant results were presented appropriately.</td>
</tr>
<tr>
<td>8</td>
<td>Discussion</td>
</tr>
<tr>
<td>8.1</td>
<td>Includes a satisfactory critical review of the methodology and analysis used, including a statement about the limitations of the project.</td>
</tr>
<tr>
<td>8.2</td>
<td>Includes a statement about how the project contributes to the field.</td>
</tr>
<tr>
<td>9</td>
<td>Conclusion</td>
</tr>
<tr>
<td>9.1</td>
<td>The conclusions drawn from the project were logical.</td>
</tr>
</tbody>
</table>

All assessment criteria are to be articulated at Fellowship standard.
Scholarly Project Subcommittee

Scholarly Project

Assessment recommendations

<table>
<thead>
<tr>
<th>Candidate number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Scholarly Project:</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>Examiner number:</td>
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</tbody>
</table>

Please indicate by ticking or crossing the appropriate box.

I recommend that the scholarly project:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Be passed without amendment</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Be passed subject to the correct of significant grammatical and/or spelling errors. (Trainee to submit revised manuscript to &lt;&lt;insert local entity&gt;&gt;)</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Be passed subject to the satisfactory revision (as determined by the Chair, Scholarly Project Subcommittee) of the matters listed below. (Trainee to submit revised manuscript to Scholarly Project Subcommittee)</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Be failed and the candidate be invited to resubmit (limit of two resubmissions).</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Be nominated for a prize. (Please specify category.)</td>
<td>☐</td>
</tr>
</tbody>
</table>

COMMENTS FOR CHAIR

Signed: ________________________________  Date: ____________________
Scholarly Project Sub委员会

Scholarly Project

Feedback to candidate

<table>
<thead>
<tr>
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</thead>
<tbody>
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<tr>
<td>Date of submission:</td>
</tr>
<tr>
<td>Examiner number:</td>
</tr>
</tbody>
</table>

General Comments

The following matters require attention

The following matters do not require attention but may be useful to the candidate for development and publication of the work.
1. Policy for Transition Arrangements for College Trainees

Transition is the process by which College trainees enrolled under the RANZCP Training Regulations 2003 or earlier transfer into training under the RANZCP Fellowship Regulations 2012.

2. Policy Statement

This policy describes the transition arrangements to transfer trainees enrolled under the RANZCP Training Regulations 2003, or earlier, into the training pathway outlined in the RANZCP Fellowship Regulations 2012.

All trainees will have transitioned to training under the RANZCP Fellowship Regulations 2012 by December 2015, at which time this policy and the regulation on Transition Arrangements for College Trainees Enrolled Prior to the Competency-Based Fellowship Program will expire.

3. Purpose

This policy sets out the mechanism for the determination of transition arrangements and transition processes for College trainees. It provides a guideline for the transition of trainees already enrolled under the RANZCP Training Regulations 2003 to training under the 2012 regulations, policies and procedures. The policy ensures that those trainees affected by the policy are treated fairly, consistently and impartially at all times, and that there is fairness and transparency in transition decisions. The policy provides clarity for all stakeholders, including trainees, supervisors, Directors of Training (DOTs), Branch Training Committees (BTCs), the Board of Education (BOE) and its Committees and the General Council.

4. Policy Details

4.1 Application of Transition policy

This policy applies to College trainees enrolled under the RANZCP Training Regulations 2003.
Once trainees have transitioned to the RANZCP Fellowship Regulations 2012, they will be required to follow the regulations, policies and procedures under the RANZCP Fellowship Regulations 2012.

By the end of 2015, all trainees will either have completed under the RANZCP Training Regulations 2003 or have transitioned to training under the RANZCP Fellowship Regulations 2012.

4.2 Transition Arrangements for Trainees Enrolled under the RANZCP Training Regulations 2003

Trainees enrolled under the RANZCP Training Regulations 2003 at the end of 2015 shall transition to training outlined in the RANZCP Fellowship Regulations 2012.

Trainees will be able to transition into Stage 2 from December 2013.

The Training and Assessment Regulations Conversion Table, published by the BOE, provides the approved, standardised model for the recognition of components of training under the RANZCP Training Regulations 2003 against components of training under the RANZCP Fellowship Regulations 2012. Trainees enrolled under the RANZCP Training Regulations 2003 shall receive a copy of the model and documentation in the form of a 2012 Regulations Training Record clearly showing the components for which they are recognised as having achieved comparable competency and the components yet to be completed.

Trainees who have transitioned from the 2003 Regulations to the 2012 Regulations and who believe that further components of their training should be recognised will need to apply for additional recognition under the Policy for Recognition of Prior Learning available under the 2012 Regulations.

4.3 Currency of Training and Transition

Trainees who have currency expiration dates within 12 months of transition may be required to undertake Workplace-Based Assessments (WBAs) and attain certification of an Entrustable Professional Activity (EPA) within their workplace to demonstrate the achievement and maintenance of the relevant competencies.

4.4 The Transition Process

The Committee for Training (CFT) is responsible for managing the process of transition for trainees using the Training and Assessment Regulations Conversion Table.

4.5 Reconsiderations and Appeals

Applicants who believe they have grounds for reconsideration of a decision made by the CFT may access the College Reviews and Appeals regulations and policies.

5. Monitoring, Evaluation and Review

The BOE shall implement, monitor and review the policy and report on anomalies and issues as these arise. The Committee for Educational Quality and Reporting (CEQR) will provide advice to the Board as to the ongoing implementation and effectiveness of this policy.

The policy will be reviewed biennially and updated as required.
6. Definitions and Abbreviations:

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Assessments and examinations required within the College CBFP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOE</td>
<td>The College Board of Education</td>
</tr>
<tr>
<td>CBFP</td>
<td>Competency-Based Fellowship Program</td>
</tr>
<tr>
<td>CEQR</td>
<td>Committee for Educational Quality and Reporting</td>
</tr>
<tr>
<td>CFE</td>
<td>Committee for Exams</td>
</tr>
<tr>
<td>CFT</td>
<td>Committee for Training</td>
</tr>
<tr>
<td>College record</td>
<td>The documented record of the College that contains all material required to be received, submitted or developed pursuant to these procedures</td>
</tr>
<tr>
<td>Committee</td>
<td>A relevant Committee of the Board of Education (Can be the Fellowship Attainment Committee or the Committee for Training)</td>
</tr>
<tr>
<td>Decision</td>
<td>Any direction, affirmation or registration of opinion, in response to a request for special consideration, in which a decision is intended to or does affect the progression of a candidate pursuant to the Regulations</td>
</tr>
<tr>
<td>Documentary information</td>
<td>Written statements and statutory declarations from relevant parties, certificates of relevant professionals.</td>
</tr>
<tr>
<td>DOT</td>
<td>Director of Training</td>
</tr>
<tr>
<td>EPA</td>
<td>Entrustable Professional Activity</td>
</tr>
<tr>
<td>FAC</td>
<td>Fellowship Attainment Committee</td>
</tr>
<tr>
<td>OCI</td>
<td>Observed Clinical Interview</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective Structured Clinical Exam</td>
</tr>
<tr>
<td>Panel</td>
<td>The panel formed to conduct the consideration of an application for RPL and to advise on RPL processes associated with the transition of trainees</td>
</tr>
<tr>
<td>Recognition of Prior Learning (RPL)</td>
<td>The process by which learning and skills acquired outside the training program are evaluated for the purpose of assigning credit</td>
</tr>
<tr>
<td>WBA</td>
<td>Workplace-Based Assessment</td>
</tr>
</tbody>
</table>

7. Associated Documents

- Regulations: Transition
  Recognition of Prior Learning
- Procedure: Transition (to be drafted)
- Forms: CBFP Training Record
- Documents: Transition Training and Assessment Regulations Conversion Table

8. References
Nil
9. **Document Control**

<table>
<thead>
<tr>
<th>Responsible department:</th>
<th>Responsible position:</th>
<th>Version:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>General Manager, Education</td>
<td>1.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible committee:</th>
<th>Date approved by General Council:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Education</td>
<td>27 March 2012</td>
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</tbody>
</table>

**Revision Record**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Revision description</th>
</tr>
</thead>
<tbody>
<tr>
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