General Medical Council

Review of training in Psychiatry of learning disability

Introduction

Our established quality assurance processes that we have in place for larger specialties are being extended to allow us greater insight into the quality of training for small specialties. However, we are aware that there are specific challenges for doctors in training in these specialties, their trainers, educational and clinical supervisors and for local education and training boards (LETBs) and deaneries in quality managing the trainee experience and its outcomes.

By small specialties, we mean those with fewer than 250 current doctors in training in post or those where, in order to protect the identity of the doctors in training concerned, we are unable to publish deanery-level trainee survey results for more than 10% of that specialty's training programmes, due to the low number of doctors in training.

We are looking to enhance the evidence we hold about the quality of training in these specialties. The review of small specialties aims to provide assurance to us (as the regulator), the public and delivery partners about the quality of training in small specialties in the UK by ensuring compliance with our standards for postgraduate training as outlined in The Trainee Doctor(PDF).

We are focusing on the delivery of postgraduate education within the specialty and consider the policies, processes and systems in place to support this. The review aims to encourage improvement of the training experience and outcomes, share good practice and show the importance and benefits of effective training pathways.

Background

Our evidence base for Psychiatry of learning disability (PLD) is limited, but includes data from the following sources:

- the national training survey (NTS)
- annual review of competence progression (ARCP) outcomes
- quality assurance (QA) visits to deaneries and local education and training boards (LETBs)
- biannual reports from deaneries/LETBs
- annual reports from the Royal College of Psychiatrists (RCPsych)

Our review took place between October 2014 and February 2015. We met with senior representatives of the Royal College of Psychiatrists, the Lead Dean for the specialty, trainers and doctors in training at several venues in the UK and a charitable organisation with a major input into the welfare of service users of the specialty. We spoke to doctors in training at an Intellectual Disability Conference in Manchester, we visited Health Education South West to speak with representatives from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and the Wales deanery training programme and spoke with doctors in training and trainers from these regions. At each location we met training programme directors, senior educational staff and programme management teams. We also joined the LETB's quality visit to South London and Maudsley. The visit was organised by Health Education South London, we joined their team and were afforded the opportunity to observe their quality management processes. Although their visit focussed on all psychiatric specialties, we had the opportunity to speak to doctors in training and trainers in PLD at the site.

We met with Mencap in December 2014. Mencap is a national organisation with funding of over £2 million a year and 600 local groups, which are individual charities in their own right. Mencap works closely with the local groups to ensure people with a learning disability and their families have support locally as well as nationally. The work of Mencap provides high-quality, flexible services that allow people to live as independently as possible. Their services include a housing wing that provides adapted housing for people with a learning disability and a national set of employment services to support people at work and/or returning to work.

Mencap explained that over 40% of people with a learning disability experience mental health problems. They commented on the increase in services being provided by the independent sector. They found that distribution of the learning disabilities community teams was patchy and that patients would benefit from a more even geographical spread across the UK so that people could be treated much nearer to their local communities. Mencap perceived there to be a gap in the general education and training of all doctors around understanding the needs of people with a learning

disability and this lack of knowledge is likely to have impacted on recruitment in to the specialty of PLD.

Mencap was one of the key interest groups that helped to develop the GMC learning disabilities website: http://www.gmc-uk.org/learningdisabilities/104.aspx. The website aims to help doctors to work more effectively with patients who have learning disabilities. We strongly encourage PLD consultants and doctors in training to visit the website. The interactive learning section shows how GMC guidance applies in practice and encourages doctors to reflect on their practice in relation to key learning points.

Royal College of Psychiatrists

The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the United Kingdom. Its responsibilities in relation to training include:

- developing the curriculum and assessment systems
- preparation and organisation of examinations
- provision of training days and guidance in relation to education and training
- provision of advice during deanery/LETB visits to Local Education Providers (LEPs); of external advice on ARCP panels; and advice and support for new training posts and programmes
- recommendation of doctors in training eligible for CCT or CESR
- production of an annual specialty report (ASR) submitted to the GMC

The Royal College's Education Training Committee oversees all aspects of education and training of psychiatrists at all stages of their career. This includes monitoring standards of training and education and overseeing and developing the MRCPsych (Member of the Royal College of Psychiatrists) examinations.

Deaneries and and local education and training boards (LETBs)

Deaneries/LETBs are responsible for the design and delivery of PLD training programmes including workplace-based experience, based on the approved curriculum and assessment system. This includes funding and managing the quality of training, supervision and support for doctors in training. The programme must enable doctors in training to meet the curriculum and assessment requirements, but can be tailored to the services of LEPs, providing a balance is maintained between service and education. (paragraphs 47-49) The curriculum calls for training schemes to provide an overall balance of hospital and community experience.

Specialty schools (or equivalents) manage the postgraduate medical training in their respective specialty within a local deanery/LETB. The schools are managed by the deanery/LETB in conjunction with the royal colleges and faculties. A key interface role between the College and deaneries/LETBs is the head of the specialty school. We found good networking between the heads of school in the sites that we visited as part of this review.

The Lead Dean

The Lead Dean for Psychiatry of learning disability is the lead for all six of the psychiatry specialties. She is involved in the overview of the specialty and has a role in enhancing quality standards in PLD training.

The Lead Dean sits on the College Education Training and Standards Committee, Recruitment Group, HEE Task Group on psychiatry and College Workforce Planning Committee and provides advice to the Dean and the President of the College on request. These groups have overview of all psychiatry specialties rather than specifically looking at PLD.

Summary

1. Psychiatry remains difficult to recruit to and has a high proportion of non-UK graduate doctors in training. We acknowledge the efforts the PLD Faculty Education and Curriculum Committee (FECC) has made to the work of the Royal College and deaneries to enhance recruitment into psychiatry. For example, investigating opportunities for dual training and looking into converting some of the vacant posts from higher specialty training in PLD into Foundation and Core training posts. We repeatedly heard that all doctors encounter people with a learning disability on a frequent basis.

2. Doctors in training navigate a complex system of care for Psychiatry of Learning Disability patients. We explored, in the visit, the interplay of training and service provision between the hospital based activity and across health and social care, the voluntary sector and independent sector.

3. The team found that the training programmes they visited were fit for purpose. Doctors in training and trainers were committed to the specialty, and the Lead Dean (at the time of the review) and the Faculty Education Curriculum Committee (FECC) Chair were enthusiastic and very committed to developing training and delivering improvements in the specialty.

4. Based on what the team heard when speaking with a range of people involved in PLD training in the UK we found the training programmes

that our visits covered to be well managed and delivered. Highly motivated trainers are working within the specialty and are having a positive impact. Trainers, doctors in training and leaders in the specialty recognise that there are challenges, for example in accessing certain aspects of clinical training now commissioned to be provided by private enterprises, as well as in-patient units and beds being removed throughout England. On the whole we also found that doctors in training said they were well supervised clinically and educationally.

5. There is uncertainty regarding the future of PLD. All the parties we spoke with voiced concerns about the rapidly changing landscape of the specialty and the swift closure of in-patient facilities in the move towards community care. Concerns were also raised about Shape of Training and how the outcomes may impact on the specialty.

6. Doctors in training were concerned about limited job prospects in the specialty at the end of training. Many doctors in training considered that completing a dual programme would increase their chances of employment. However, many doctors in training and the consultants seemed deeply committed to the speciality and expressed a preference to care for people with learning disability in their future careers.

7. As part of the review we identified examples of effective practice that we encourage (see good practice section) and challenges and opportunities for improvement (see recommendations section).

Areas of good practice

We generally note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Paragraph in *The Trainee Doctor*	Areas of good practice
1	5.2	Training was individually tailored towards the needs of each doctor in training. The bespoke nature of training was only possible due to small numbers in the specialty.
2	1.3	At the sites visited we found close supervision of doctors in training by a dedicated group of educational supervisors who appeared highly engaged in training. (paragraph 4)

3	6.32, 6.33	Consultants at the sites visited came across as committed advocates for the patient group and presented PLD as a career with good job satisfaction. (paragraph 6)
4	5.4	Audit and research was strongly encouraged during training in the specialty and there were good opportunities to pursue special interests. For example, there were strong links with Forensic Psychiatry and a module in Parliamentary affairs had recently been developed. (paragraph 20)

Requirements

No areas of non-compliance with GMC standards were identified.

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Paragraph in *The Trainee Doctor*	Recommendations
1	4.2	LETBs, postgraduate deaneries and the Royal College should continue to work together to promote the specialty, especially to medical students and doctors in training to ensure that competitive recruitment and selection enhances the quality of trainees. (paragraphs 37-38)
2	4.5	Routes for dual CCT training should be explored, and consideration should be given to what other Psychiatry specialties could be linked with PLD. The GMC and the Royal College should work together on dual training. (paragraphs 39-41)

3	5.1, 5.2, 6.10	The curriculum for the specialty should be updated to reflect the rapidly changing landscape of the specialty. This includes the closure of in-patient facilities, the move towards community care and the increasing number of independent sector organisations emerging, particularly across England. Consideration should be given as to what knowledge, skills and expertise are required of a consultant to work effectively and competently in any type of environment. (paragraph 47)
4	1.2, 5.1	Clarity should be provided on what extent of medical care PLD doctors in training should be providing for their patients. It is accepted that this will not be the same in all training programmes as the needs of the service vary on a local level. An awareness of the physical illnesses that may come with learning disabilities is essential to the specialty and it would be worth raising the profile of this. (paragraph 28)
5	Sd 3.6, Sd 5.2	LEPs should work collaboratively with the independent sector in the local region and keep in active communication so that patients can be escalated through social care with good handover and in a timely manner to minimise disruption to the service. (paragraph 27)
6	2.2, 2.3, 6.17	The governance of training placements in independent sector organisations should be clarified and what quality management structures are in place, as the current system of having informal placements may not be sustainable in the future. (paragraph 47)
7	Sd 3.4-3.5	Training provision at independent sector organisations should be strengthened through contracts, terms and conditions. If commissioners are not currently commissioning training from service providers as part of the contract, an excessive burden will fall on the NHS providers. (paragraph 49)
8		The distribution of training programmes in England should be appraised to see if they can be reconfigured to make them more evenly spread geographically, especially since certain aspects of clinical training are now being increasingly commissioned by private enterprises and in-patient units are being removed throughout England. (paragraph 22)

9	Sd 2.1-2.2	LETBs and deaneries providing PLD training programmes should ensure that there are clear processes and support mechanisms in place so that doctors in training know they will be supported if concerns are raised about their progress or they experience issues during their training and feel confident that they will be supported if they raise concerns about others. (paragraphs 29-30)

Findings

8. Overall from the evidence we reviewed and the people we spoke to, we heard that doctors in training are mostly satisfied with the quality of their training and their ability to demonstrate the required competences prior to completing their specialty training. This report focuses on highlighting a number of key themes across the UK where we heard concerns, where there is room for improvement and where issues are being effectively identified and addressed.

Training structure and content

9. People with learning disability are much more likely than the general population to experience mental health conditions because they experience more biological and psychosocial risk factors. Specialist psychiatrists who work with people with learning disability offer treatment for severe mental illness problems (e.g. dementia in people with Down's syndrome, behavioural phenotypes of genetic disorders), but also for a wide range of other mental health conditions such as autistic spectrum disorders and anxiety disorders. Because people with learning disability may not possess as much resilience to cope with mental distress, more minor disorders can have a severe effect so services usually have a much lower threshold for referral than mainstream mental health services.[1] The landscape of the specialty is changing due to a greater focus on co-morbid neurodevelopmental disorders.

10. Psychiatry of learning disability is one of the six psychiatry higher specialties. The training duration for PLD is three years in core psychiatry training, followed by a further three years of higher specialty

[1] Sourced from the Royal College of Psychiatrists website: http://www.rcpsych.ac.uk/discoverpsychiatry/studentassociates/psychiatriccareerpaths/subspecialties/learningdisability.aspx, viewed 27 February 2015

training for single certificate of completion of training (CCT). All psychiatry doctors in training are required to demonstrate competency in psychotherapy during their core psychiatry training.

11. Psychiatrists who work with people with learning disability need to have a wide range of clinical skills. It is essential to consider the system around the person (such as family, support staff) to understand clinical problems and deliver effective interventions. The clinical work is often made more complex and interesting by concurrent physical problems such as epilepsy, communication problems and challenges in accessing services. People often present non-specifically (for example with withdrawal or behaviour problems) and finding out the cause is a diagnostic challenge and encourages working with other disciplines to help with this process.[1]

12. Most specialist mental healthcare for people with learning disabilities within England is delivered in community settings, and because of the social supports available, the need for inpatient admission can be less than in mainstream services. If people do need admission, people with mild learning disabilities and mental illness often use mainstream inpatient beds. Specialist inpatient facilities are provided for people with forensic needs, and people with very severe challenging behaviour.[1]

13. Our 2014 national training survey identifies 84 doctors in Psychiatry of learning disability training across the UK, working across ten LETBs in England, as well as within the national training programme in Scotland, Northern Ireland and Wales. (Refer to appendix 2)

14. The clinical experience in the specialty training programme in PLD consists of the equivalent of three years full time experience at least two years of which are within designated PLD posts. This would comprise experience of:

    - In-patients; acute treatment and management of People with Learning Disabilities and their mental health and behavioural problems
    - Working in multidisciplinary community teams
    - Seeing patients and their carers in a variety of out patient and community settings.

    One year of this could be within designated PLD services for children.

15. The third year can comprise either PLD experience as above, or subspecialty experience. We encountered possible examples:
    - Neuropsychiatry,
    - Neurodevelopmental disorders,
    - Brain injury;

- Experience within designated Psychiatry of Learning Disability posts in Forensic Psychiatry;
- Experience within designated posts in a relevant psychiatric specialty: e.g. General Psychiatry or one of its subspecialties;
- Old age psychiatry.

16. ST4-6 years are interchangeable dependent on rotation order. Community oriented experience should precede more specialist PLD experience such as Forensic Learning Disability.

17. Doctors in training must pass the MRCPsych examination and successfully complete core training before entering advanced training. The high MRCPsych failure rate is concerning, we note that the high failure rate is largely restricted to international medical graduates.

18. PLD uses workplace based assessment (WPBA) tools designed for psychiatry. For example: assessment of clinical expertise (ACE) where the doctor's in training ability to take a full history and mental state examination and arrive at a diagnosis and management plan is observed and assessed; case based discussion (CbD) where the doctors in training discusses patient notes with an assessor to allow demonstration of clinical decision-making and the application of clinical knowledge; case and journal club presentations; directly observed procedural skills (DOPS); and mini peer assessment tool (mini-PAT) that allows co-workers to assess the doctor's in training attitudes and behaviours and ability to work well with colleagues.

19. Clinical placements in advanced training in PLD should last l2 months for a full-time trainee. This gives sufficient time for a realistic clinical experience and allows the completion of treatment programmes and time to build up and close down a clinical service.

20. Training includes opportunities to pursue special interest areas in the specialty, such as epilepsy and a special interest session in Parliamentary Affairs had recently been developed. Audit and research is strongly encouraged during training and there are several forums for presentations from doctors in training. Study leave also appeared to be supported. Doctors in training reported good exposure to multi-disciplinary team working.

21. There is inconsistency in service configuration across different regions so providing a level playing field in training across the country is a challenge and also means that doctors in training may not have the flexibility to work anywhere in the country. The distribution of service configuration seemed to rely on population density. In the past, training in the specialty was organised from teaching hospitals.

Training used to be centred in large institutions but they closed over time as the specialty moved towards community care.

22. The number of consultant posts in the specialty was determined by population size and the number of doctors in training in each region was based around historical precedent and popularity. Please refer to Annex B for the distribution of PLD training programmes nationally and number of doctors in training under each programme, according to the GMC's National Training Survey in 2014. Popular training schemes fostered strong links to medical and academic schools in their regions to attract a high calibre of doctors in training. Attractiveness of the area geographically and the number of consultant posts available in the region acted as incentives in applying for the training schemes. It would be worthwhile exploring whether the distribution of programmes can be reconfigured to make them more evenly spread geographically, especially since certain aspects of clinical training are now being increasingly commissioned by private enterprises and in-patient units are being removed throughout England. In Scotland, the four training rotations are being combined into one national programme, which would promote consistency in training and equity of access to training.

23. Doctors in training commented on the inequity of access opportunities geographically, particularly around forensic training and in-patient experience. The specialty relies heavily on the independent sector to provide exposure in these areas.

24. We came across inconsistencies in training geographically. For example, epilepsy was dealt with directly by PLD trainees in some areas but referred to neurologists in other areas; In some areas PLD patients did not have their own on-call rota, it was shared with General Adult which could sometimes lead to PLD doctors in training having to deal with General Adult patients outside their competency; other areas had an on-call rota specifically for PLD patients.
25. There are plans to improve equity of access and consistency in training across Scotland with four rotations being combined into one national programme, creating a higher level of consistency in training.

Patient safety and raising concerns

26. The changing landscape of the specialty poses a challenge for patients and their families to navigate through the system as the team caring for patients and the commissioning of services can be spread, which potentially impacts on continuity of care. The closure of in-patient facilities, the move towards community care and the increasing number of social enterprises emerging create interfaces and gaps in the service. Avon and Wiltshire Mental Health Partnership NHS Trust works

closely with commissioners and across social enterprises. They maintain a constant dialogue and work together to stay on top of any changes in the service. It is important that LEPs foster good relations and communication channels with social enterprises in the local region so that patients can be escalated through social care with good handover and in a timely manner to minimise disruption to the service.

27. We came across variations in the experience of and expectations on doctors in training around the physical care of patients. There was an unclear role in managing neurological conditions such as epilepsy and some doctors in training were expected to read ECGs and undertake medical examinations. The variations seemed to occur according to the local NHS structures in place in the region. We have concerns for the following reasons:
    - It may lead to incorrect referrals of patients between GPs, PLD doctors in training and other specialists
    - Patients may be cared for by doctors without the appropriate specialist knowledge and expertise
    - Doctors in training may be undertaking duties outside of their competency

28. An awareness of the physical illnesses that may come with learning disabilities is essential to the specialty and it would be worth raising the profile of this in the specialty. The curriculum does not provide clarity on what extent of medical care PLD doctors in training should be providing for their patients and the crossover with general practice as the needs of the service vary on a local level. We found that the level of medical care that doctors in training thought they should be providing to PLD patients did not always match expectations of the trainers.

29. We did hear scepticism from some doctors in training about the usefulness of raising concerns through the NTS because of the small numbers and subsequent constraints on reporting where there are fewer than three doctors training at one site. Fear of being identified or comments having a negative impact on training and career progress was a disincentive to be forthcoming with information, or even to fill in the survey.

30. The low number of PLD doctors in training across the UK and in each training location means that it is difficult to use the current data in the National Training Survey to identify issues specific to the specialty. We have been gathering longitudinal data through the National Training Survey since 2010. Due to the small numbers of doctors in training in PLD, there is currently limited reporting capacity for the specialty in order to preserve trainee anonymity, but this capacity will increase over time as more data aggregates.

Equality, diversity and opportunity

31. There was consensus among doctors in training and trainers about the important role equality and diversity plays towards patients in the specialty and no concerns were raised in this area.

Recruitment and selection

32. Health Education North West co-ordinates the recruitment process for all psychiatry specialties (including Psychiatry of learning disability) for CT1 and ST4 posts in England, Scotland and Wales: http://www.rcpsych.ac.uk/traininpsychiatry/nationalrecruitment.aspx. A separate national recruitment process is in place in Northern Ireland.

33. Psychiatry remains difficult to recruit to and has a high proportion of non-UK graduates. The College advised that this has not changed significantly in the past few years since Modernising Medical Careers (MMC) and despite changes in UK visa regulations.

34. The difficulty with recruitment into core psychiatry training is a widespread and a commonly identified issue. A number of initiatives to improve recruitment have been introduced by the College and LETBs or deaneries, specifically targeted at increasing awareness of psychiatry as a career choice to medical students and foundation doctors in training.

35. There are challenges in recruitment at ST4 to the specialty of Psychiatry of learning disability. The Lead Dean considered the following to be factors affecting recruitment:
    - Effect of MMC. There have only been a couple of years of recruitment directly into ST4 since uncoupling from run through training
    - Perception of PLD as an 'unattractive' specialty
    - A number of doctors in training, as high as 50%, leave after Core training
    - Pass rate of CASC is very low so exams during Core training are difficult

36. PLD was a popular specialty in Wales and recruitment for training posts was not an issue. The management team at the deanery was looking to increase the number of posts for Wales to accommodate demand. This is in contrast with other regions we visited as part of the PLD review where there were several under-filled posts.

37. Discussions with the doctors in training on their opinion why the specialty was struggling with recruitment raised the following:

- Not enough exposure to specialty early on in training – Core, Foundation, medical students
- Limited job prospects
- Threat of Shape of Training and concerns that specialty may not exist in future
- Specialty heavily reliant on independent sector

38. Almost all of the doctors that we spoke to in PLD specialist training had undertaken a PLD post as part of their rotation during Core training. The FECC was proposing converting some of the vacant posts from higher specialty training in PLD into Foundation and Core training posts to raise the profile of the specialty earlier on in training. Health Education England would need to take the decision on post conversion as it falls under their remit. It is worth noting that PLD is not currently represented in Broadening the Foundation Programme (BTFP) expansion of psychiatry posts.

39. There was a strong appetite among doctors in training, trainers, consultants and the College for boosting opportunities for dual training and unanimous agreement from those we spoke to that increased opportunity for dual training would encourage recruitment to the specialty. For example, it would increase job prospects at the end of training.

40. The only currently approved dual training programme in the specialty was Psychiatry of Learning Disability and Child and adolescent psychiatry. The FECC was investigating what other psychiatry specialties could be linked with PLD to form dual training programmes.

41. One of the challenges with dual training is that it holds the training slots in each of the two specialties for a much longer duration than for a single CCT programme. The FECC was looking into ways the posts could be used more efficiently. For example, having two dual training posts under the same LETB where the doctors in training could swap over from one specialty to the other during the period of dual training (subject to successful ARCPs).

42. Credentialing is an area currently under development in line with recommendations arising from the Shape of Training. It would be worth investigating prospects around credentialing for training in Psychiatry.

43. The Collins report, Foundation for Excellence: An Evaluation of the Foundation Programme, published in 2010 by Medical Education England (MEE), addressed the current predominance within foundation experience of adult medicine and surgery, and called for a review of this within its recommendations. The report specifically states that,

'successful completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, eg community paediatrics, general practice or psychiatry'.

44. The 2010 Centre for Workforce Intelligence (CFWI) report identified a need to increase training posts and consultant numbers by 2018 in all psychiatric specialties by 0.5-2.0% and prioritises addressing recruitment and retention of trainees. The report recommends that work continues to improve the attractiveness of the specialty. Nevertheless, the primary concern at the higher training level was about employment opportunities available post-CCT for PLD doctors in training.

45. The 2010 CFWI report also highlights some of the key issues affecting recruitment to training and filling of consultant posts, particularly highlighting that 'trainees perceive a shrinking employment market'. The report highlights the effect of the 'new ways of working' guidance, regarding exploring opportunities to deliver service through the skill mix of a multidisciplinary team.

The independent sector

46. PLD is increasingly moving into the independent sector, which provides a lot of the training opportunities. The Winterbourne report has largely affected the specialty, leading to private enterprises being commissioned to provide services and in-patient clinics being shut down across England. The changes in landscape and the service model could lead to a potential risk to patient safety if patients get lost between the different service providers.

47. Access to training opportunities to cover the full range of learning environments required in the curriculum has become increasingly difficult as a result. There were concerns that if training is falling increasingly under the independent sector whether it's manageable and how the budget would work. Reassurance is needed that doctors in training are adequately supported in learning the differences between treating PLD patients in crisis in a community setting compared to inpatient. The postgraduate lead dean questioned the safety of doctors in training working in independent sector posts, such as when they visit patients in their homes. There appeared to be a lack of governance and quality management structures for the independent sector.

48. The specialty is heavily reliant on the "good will" of independent service providers for training opportunities and placements were not guaranteed. The TPDs are relied on to organise placements locally for doctors in training, which is a significant burden of responsibility. We heard comments that arranging the training placements was becoming increasingly bureaucratic and time consuming.

49. There were concerns raised that service providers were focused on service delivery rather than the quality of training. The FECC supported the introduction of a framework in the commissioning that created an allowance and requirement for training, perhaps including an agreement in the contracts that covered training provision. Training provision in the current commissioning climate needs strengthening. If commissioners are not currently commissioning training from service providers as part of the contract, an excessive burden will fall on the NHS providers.

50. In contrast to other areas of the UK, in Wales the independent sector is still quite small and patients are still mostly treated in in-patient clinics. This is in line with the current curriculum and ensures that trainees cover all the curricula requirements in their training. This is in contrast with other regions we visited as part of the PLD review that were having difficulty accessing training at in-patient facilities. It has proven difficult for the Deanery to establish relationships with the independent sector and consultants in the independent sector in Wales. This has resulted in a lack of placements outside the hospital for doctors in training.

Acknowledgement

We would like to thank the Faculty Education Curriculum Committee, the RCPsych, the Lead Dean, Mencap and all the people we met during the visits for their cooperation and willingness to share their learning and experiences, particularly Wales deanery, Health Education South West and the representatives from Avon and Wiltshire Mental Health Partnership NHS Trust and Health Education South London for allowing us to join the LETB's quality visit to South London and Maudsley.

Appendix 1: Visit Details

Visit team

Team leader	Ian Barker
Visitor	Ann Boyle
Visitor	Tim Crocker-Buqué
Visitor	Suzanne Shale
GMC staff	Emily Saldanha, Jessica Lichtenstein
Visit Dates	15 October 2014: meeting with College 5 November 2014: meeting with Lead Dean 6 November 2014: meeting with doctors in training at Intellectual Disability Conference 27 November 2014: meeting with Faculty Education Curriculum Committee 16 December 2014: meeting with MENCAP 26 January 2015: visit to Severn LETB to speak to representatives from Avon and Wiltshire Mental Health Partnership NHS Trust 26 January 2015: London LETB's quality visit to South London and Maudsley 4 February 2015: visit to Wales Deanery

Appendix 2: Psychiatry of Learning Disability distribution of training programmes in UK

Training provider	Number of doctors in training (NTS 2014)
Health Education East Midlands	**7**
Leicestershire Partnership NHS Trust	**4**
Leicester Frith (The Mansion House)	4
Lincolnshire Partnership NHS Foundation Trust	**1**
Long Leys Court C1	1
Nottinghamshire Healthcare NHS Trust	**2**
Bassetlaw Hospital	1
Highbury Hospital	1
Health Education East of England	**10**
Cambridgeshire and Peterborough NHS Foundation Trust	**2**
Hertfordshire Partnership University NHS Foundation Trust	**6**
South Essex Partnership University NHS Foundation Trust	**2**
Health Education Wessex	**1**
Southern Health NHS Foundation Trust	**1**
Community Learning Disabilities Team	1
London Deanery	**17**
Camden and Islington NHS Foundation Trust	**1**
Central and North West London NHS Foundation Trust	**4**
East London NHS Foundation Trust	**4**
North East London NHS Foundation Trust	**1**
Oxleas NHS Foundation Trust	**1**
South London and Maudsley NHS Foundation Trust	**4**
South West London and St George's Mental Health NHS Trust	**2**

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NHS Education for Scotland (South-East Region)	**4**
Fife	**1**
Lynebank Hospital	1
Lothian	**2**
Royal Edinburgh Hospital	2
(unknown)	**1**
NHS Education for Scotland (West Region)	**2**
Lanarkshire	**1**
Kirklands Hospital	1
(unknown)	**1**
NHS West Midlands Workforce Deanery	**10**
Coventry and Warwickshire Partnership NHS Trust	**8**
(unknown)	**2**
North Western Deanery	**5**
Calderstones Partnership NHS Foundation Trust	**1**
Calderstones Hospital	1
Greater Manchester West Mental Health NHS Foundation Trust	**1**
Meadowbrook Hospital - Salford Mh	1
Pennine Care NHS Foundation Trust	**2**
Birch Hill Hospital Mental Health Services	2
(unknown)	**1**
Northern Deanery	**5**
Northumberland, Tyne and Wear NHS Foundation Trust	**2**
Northgate Hospital Site	2
Tees, Esk and Wear Valleys NHS Foundation Trust	**2**

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Lanchester Road Hospital	1
Spennymoor Health Centre	1
(Unknown)	**1**
Northern Ireland Medical & Dental Training Agency	**5**
Belfast Health and Social Care Trust	**5**
Muckamore Abbey Hospital	4
(Unknown)	1
Oxford Deanery	**5**
Southern Health NHS Foundation Trust	**5**
Slade House	4
(Unknown)	1
Severn Deanery	**5**
2gether NHS Foundation Trust	**1**
Weavers Croft	1
Avon and Wiltshire Mental Health Partnership NHS Trust	**4**
Blackberry Hill Hospital	2
New Friends Hall	1
Withywood Centre	1
Wales Deanery	**5**
Abertawe Bro Morgannwg University Lhb	**1**
Llynynwr Clinic - Swansea	1
Betsi Cadwaladr University Lhb	**1**
Bryn-Y-Neuadd Hospital - Bangor	1
Cardiff & Vale University Lhb	**3**
Whitchurch Hospital - Cardiff	1
Park View - Cardiff	2
Yorkshire and the Humber Postgraduate Deanery	**3**
Leeds and York Partnership NHS Foundation Trust	**2**

Appendix 2: Psychiatry of Learning Disability distribution of training programmes in UK

Parkside Lodge	2
South West Yorkshire Partnership NHS Foundation Trust	**1**
Grand Total	**84**

Appendix 3: Psychiatry of Learning Disability Specialty Training Pathway