Psychiatry Silver Guide

Guidance for Psychiatric Training in the UK

Version 2.0

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Contents

1 Introduction

1.1 Welcome to psychiatry!

Psychiatry addresses the complex interplay between the brain, the mind and the body. It is a fascinating and rewarding career and we at the Royal College of Psychiatrists are delighted that you have chosen this path.

This Silver Guide is designed to help you and to support your trainer, as you navigate your psychiatry training together. We have tried to make it as comprehensive as possible, but if you have questions that are not answered by the guide, we are always happy to help. You can contact us at this email address: Psychiatrytraining@rcpsych.ac.uk.

1.2 Person-centred holistic model of psychiatry

The following concepts are fundamental to the good professional practice of modern psychiatry:

- the patient as a whole person: body, mind and spirit
- a compassionate clinical approach, based on both values and evidence
- multidisciplinary model of person-centred care, including parity of esteem between mental and physical health
- shared responsibility and shared decision-making
- a model of the person which draws on the social sciences, neurosciences and the humanities
- the physical, mental and spiritual needs of patients
- safe effective prescribing
- a sustainable approach to healthcare
- legal rights, and
- impact of culture, religion and social systems on individuals.

The Curriculum Revision Working Group engaged in wide-ranging discussion when considering revisions to the curricula, highlighting the importance of:

- reflecting equal weighting of the psychological, biological and social components of the person-centred holistic model of psychiatry within the curriculum
- the cultural, religious, social and environmental context

- a holistic person-centred care approach for patients, taking into account physical, psychological, social and spiritual needs
- equipping psychiatrists for developments in the service and legal landscapes.

The person-centred holistic approach underpins the specialty of psychiatry and the key role of psychiatrists in multidisciplinary teams. We will continue to refine this definition in a wider consultation with College Officers.

1.3 The Silver Guide

The Silver Guide has been developed from the Gold Guide (GG8), with relevance to psychiatry. This guide helps explain the structures involved in training, with an overview of the psychiatry training pathway.

A number of key pieces of documentation define the objectives and skills of all psychiatrists in training including:

- Gold Guide 8th Edition (2020)
- GMC Generic Professional Capabilities Framework
- GMC Good Medical Practice (2019)
- GMC Promoting Excellence: Standards for Medical Education & Training
- Core Values for Psychiatrists (2017).

This guide provides an overview of the key curricula features, including the curricula framework and structure. Core and higher specialty/sub-specialty (endorsement) training pathways are outlined, including dual-training pairings. The guide aligns to the latest version of the Gold Guide (GG 8) and should be read in conjunction with the GMC's Generic Professional Capabilities (GPC) Framework, Good Medical Practice, and the College's Core Values for Psychiatrists.

An overview of our assessment system, including information on the MRCPsych Examination (undertaken in core psychiatry training), and workplace based assessments (WPBAs) is also provided. The guide provides advice to both Resident Doctors and trainers needing performance support to achieve the required Key Capabilities.

The achievement of all the Key Capabilities (in core and generic skills) is essential for all specialty and subspecialty (endorsement) training. Doctors in training in higher psychiatric specialties will build upon the capabilities that have been acquired in core psychiatry training throughout their training, and post completion of training.

The maintenance of all capabilities in psychiatry will be necessary for relicensing and revalidation, linking closely to the details in the GMC's Good Medical Practice document and the College's Core Values for Psychiatrists.

2 Learning methods in psychiatry

The psychiatric curricula are delivered through a variety of learning experiences. Key capabilities outlined through core, specialty and sub-specialty curricula will be achieved through a variety of learning methods.

A Resident Doctor will learn from the following types of experiences and methods throughout their psychiatric training.

Work-based learning

Most of the learning development within psychiatry is attained through work-based learning assessed by workplace-based assessments (WPBAs) which are detailed elsewhere in this guide. There should be appropriate levels of clinical supervision throughout training, to enable Resident Doctors to gain key capabilities at an appropriate rate to help prepare for work as a consultant psychiatrist.

We have identified a number of key-quality indicators for Resident Doctors and trainers to ensure that opportunities are provided for Resident Doctors in all settings.

MRCPsych Examination

Prior to entering higher-specialty training at ST4, Resident Doctors are expected to have passed the MRCPsych membership examination, comprised of two written papers and a clinical examination, also detailed later in this guide.

Reflective practice, case-based discussion/Balint groups and psychotherapy

It is recommended that psychiatric Resident Doctors participate in reflective practice. At core training, Resident Doctors are expected to undertake a short and long-case in psychotherapy under the governance of a Medical psychotherapy tutor. Resident Doctors will participate in Balint or case-based discussion groups to reflect on their psychotherapeutic training and are encouraged to continue to participate in these groups in higher psychiatric training.

Physical Health Procedures

Resident Doctors will conduct a thorough physical examination, undertaking relevant physical investigations and take responsibility for acting on their findings in a timely fashion.

They will also thoroughly assess the general health of their patients, taking into account the interplay between physical health and psychiatric needs, considering nutritional, metabolic, endocrine, and reproductive factors, and the physical impact of substance use and addiction.

In addition, all core Resident Doctors are provided with opportunities to deliver electro-convulsive therapy (ECT) to patients where required. Requirements for ECT are outlined in the college's good practice guidance, available here.

Multidisciplinary Team (MDT) meetings

Psychiatrists work alongside colleagues in nursing, clinical psychology, psychotherapy, occupational therapy, speech and language therapy, pharmacy and dietetics (amongst others) and with a number of other medical specialties such as physicians, neurologists and paediatricians, and allied health professionals.

Resident Doctors are expected to take part in MDT meetings to meet the requirements within the curricula, in particular demonstrating their capabilities in team working and working within organisational frameworks. In higher training, Resident Doctors are recommended to progress to leading MDT meetings where applicable.

Teaching and training

In addition to the MRCPsych examination, there will be opportunities throughout training for informal teaching sessions held locally, as well as at national and international meetings and conferences.

Resident Doctors are encouraged to attend relevant College faculty meetings, Resident Doctor conferences run by the Psychiatric Resident Doctors' Committee (PTC), as well as local and regional courses, including the local MRCPsych preparatory courses. (In regions where preparatory courses for MRCPsych are not available, we recommend that Resident Doctors arrange to attend a course outside of region if applicable. Course organisers should aim to accommodate Resident Doctors from outside of region, for example by hosting hybrid (virtual/face to face) course sessions.)

In addition, Resident Doctors are encouraged to engage in journal clubs to gain key capabilities in research and scholarship, and to get involved in small-group teaching sessions.

Protected professional development sessions

Higher Resident Doctors are given the opportunity to undertake **professional development sessions** (PDS) to support special interests, for example taking part in relevant committee work or projects or pursuing academic learning (outside of formal academic training). These should be agreed with their psychiatric (named clinical) supervisor when setting up placement specific personal development plans (PDPs). Resident Doctors may get up to two sessions a week (pro rata) for this purpose (see section 14.1 for more information.

Independent (self-directed) learning

Training in psychiatry is portfolio based, and Resident Doctors are encouraged to undertake independent learning outside of formal teaching and training to provide additional evidence for meeting curricula requirements.

Independent learning can include:

- reading additional materials and guidance, including journal articles
- maintaining a personal portfolio with self-assessment and reflection
- continuous development of the placement specific PDP

- use of modules within the MRCPsych eLearning platform.

3 Undertaking a specialty training programme

Once Resident Doctors have satisfactorily completed a psychiatry training programme comprising either core then higher psychiatry training (CT1 – ST6) or run-through training (ST1 – ST6), (the whole of which has been prospectively approved by the GMC) they will be eligible for a Certificate of Completion of Training (CCT).

Award of a CCT will entitle them to apply for entry to the specialist register.

Entry to specialty training programmes and subsequent award of a CCT can only be achieved through competitive selection through the relevant core and/or specialty national selection process.

For information on alternative routes, please see our routes to registration webpages.

3.1 Recruitment into training

The NHS and the UK health departments promote and implement equal opportunities policies. There is no place for unlawful discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. Advertisements for training programmes will incorporate a clear statement on equal opportunities confirming the suitability of the programme for less than full-time (LTFT) training.

Appointment processes must conform to employment law as well as to best practice in selection and recruitment. Recruitment into Psychiatric Training is dealt with by NHSE North West.

For further information on recruitment, please view the Health Education North West guidance.

3.2 Training numbers (applicable to core and specialty Resident Doctors)

Following appointment to a specialty training programme, a Dean's Reference Number (DRN) or National Training Number (NTN) will be awarded. This includes Resident Doctors working in NHS and non-NHS employment.

Core Resident Doctors will be awarded a DRN. These training numbers are for administrative purposes and do not confer any entitlement to entry to further specialty training.

An NTN will only be awarded to doctors in specialty training programmes who (subject to satisfactory progress) have an end point of the award of a CCT / CCT CP.

4 Routes to registration

4.1 Certificate of Completion of Training (CCT)

Psychiatry Resident Doctors must successfully complete a recommended three-year whole time equivalent (WTE) core psychiatry training programme before applying in open competition for a place in a higher training programme leading to a CCT in one of the six psychiatry specialties.

The **six psychiatry higher specialties** are:

- General psychiatry
- Child and adolescent psychiatry
- Forensic psychiatry
- Psychiatry of Learning disability
- Medical psychotherapy
- Old age psychiatry.

In addition, there are **three sub-specialties** of General psychiatry which are awarded as sub-specialty endorsements:

- Addiction psychiatry
- Liaison psychiatry (a sub-specialty of both General and Old age psychiatry)
- Rehabilitation psychiatry.

Resident Doctors may gain valuable experience in specialties that are not currently recognised GMC sub-specialties, such as eating disorder psychiatry, perinatal psychiatry and neuropsychiatry. This is particularly encouraged if the Resident Doctors wish to apply for consultant posts in these emerging specialties.

At core training level, Resident Doctors are able to undertake a six-month training placement in the above subspecialties. At higher training level, 6-12 month placements can be undertaken. Placements count towards progression at ARCP and CCT as curricula capabilities will be met at core and higher training within a particular specialty.

4.1.1 CCT specialty name changes

We are in the process of changing the names of the following specialties and sub-specialties:

- General psychiatry: renamed ‘Adult psychiatry’.
- Psychiatry of learning disability: renamed ’Psychiatry of intellectual disability’.
- Substance-misuse psychiatry endorsement: renamed ‘Addiction psychiatry’.

It is within the GMC’s remit to amend endorsement (sub-specialty) name changes; therefore Substance-misuse psychiatry will be renamed ‘Addiction psychiatry’ from implementation of the new curricula.

For parent specialties, the GMC are working with the Department of Health and Social Care, as amendments to CCT pathways require legislative changes. Resident Doctors will therefore continue to receive CCTs in ‘General psychiatry’ and ‘Psychiatry of learning disability’ until these changes have been made.

4.1.2 Applying for CCT

Applications for CCT are made via the College.

The application process is:

- Complete the application form on our application pages within six months of the CCT completion date (and no later than four weeks prior to completion date).
- This will alert us to the completion of training date, and we will submit a notification to the GMC outlining the completion date and CCT specialties.
- Once notified, the GMC will send an email requesting that their application process is completed. Information about this can be found on the GMC’s webpages.
- In the meantime, the College will undertake quality checks to ensure that all relevant training information is present, including confirmation of membership with the College (MRCPsych), evidence of core training and higher training, including the final ARCP (outcome 6).
- Once satisfied with the evidence provided on the ePortfolio, the College will submit a recommendation to the GMC.

It is recommended that Resident Doctors ensure they keep all evidence of their training, in particular their ARCP outcome forms, and upload onto Portfolio Online where required.

For further information about the process, visit our training pages, or contact Psychiatrytraining@rcpsych.ac.uk.

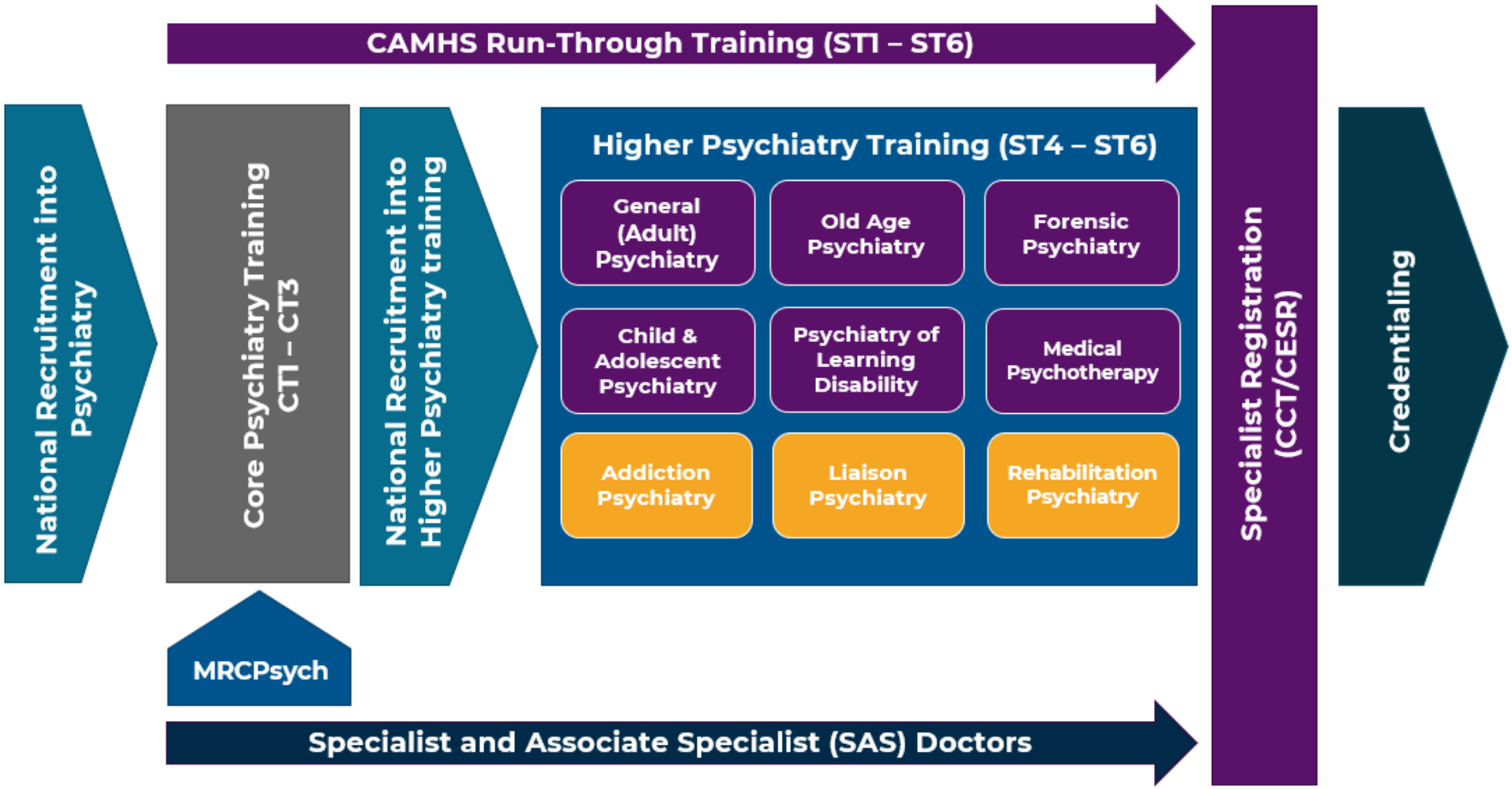


Figure 1. Psychiatry training pathway

4.2 Equivalence and non-traditional training routes

4.2.1 PORTFOLIO PATHWAY

What is Portfolio Pathway and who is eligible?

The Portfolio Pathway is an alternative route to specialist registration for doctors who have not completed a full UK training programme. It allows applicants to demonstrate that their previous or current specialist experience, qualifications, and competencies meet the requirements of the relevant specialty curriculum.

Applying via the Portfolio Pathway

The pathway is designed for doctors who have gained substantial experience and capabilities outside an approved UK training programme. Applicants must provide robust evidence showing they have achieved the high-level outcomes (HLOs) set out in the specialty curriculum. Evidence should cover both core and higher specialty capabilities unless the applicant holds membership of the Royal College of Psychiatrists (MRCPsych), in which case core capabilities are assumed. All evidence should be recent; anything older than six years will not be considered. Applications are made directly to the GMC, not through the College. Specialty-specific guidance (SSGs) and further details on the process are available on the GMC website.

We recommend contacting specialistregistration@rcpsych.ac.uk for advice before starting an application.

Eligibility

To apply you must have either a specialist qualification in the specialty you're applying in or at least six months continuous specialist training in the specialty you're applying in. You'll need to provide evidence of how you're eligible as part of your application. In your application you must show that you meet the requirements of the high-level learning outcomes in the CCT curriculum for your specialty by providing robust and objective documentary evidence.

Key Points for the Portfolio Pathway

- Evidence must demonstrate achievement of curriculum HLOs.
- MRCPsych holders only need to evidence higher specialty capabilities.
- All documentation should be uploaded to Portfolio Online.
- Guidance and support are available from the College and GMC.

5 Psychiatric specialties

5.1 Core psychiatry training

The core training programme in psychiatry is comprised of:

- completion of a recommended three years (WTE) post-foundation in a core training programme approved by the GMC from CT1 to CT3 (or at a level above CT1 to CT3)
- the MRCPsych exam, which Resident Doctors must undertake during core training, comprising:
    - two knowledge papers (Paper A and Paper B), examined online by multiple choice and extending matching questions
    - the Clinical Assessment of Skills and Capabilities (CASC) exam.

Resident Doctors must obtain a pass in all sections of the MRCPsych examination and achieve all core capabilities in an approved training programme before they can be considered to have successfully completed/exited core training. An Annual Review of Capability Progression (ARCP) **outcome 6** will then be issued to Resident Doctors.

Resident Doctors wishing to obtain a CCT in one of the six GMC approved psychiatric specialties must complete an entire programme of training (core and higher). The MRCPsych examination must be achieved by CT3/ST3 prior to entry into ST4.

Successful completion of training will be awarded with a final **ARCP outcome 6** and a recommendation to the GMC. Information for applying to CCT to the College can be found on our training pages.

5.1.1 Psychotherapy requirements for core Resident Doctors

Resident Doctors are expected to undertake a short and long case in two different modalities of psychotherapy by the end of CT3 prior to progressing to ST4.

It is recommended that the short case be a minimum of 12 sessions, usually between 12 – 20 sessions of therapy and a long case be a minimum of 20 sessions, usually between 20 and 40 sessions of therapy.

The precise number of therapy sessions is agreed with respect to the patient's needs with the clinical supervisor, alongside the modality of psychotherapy.

Evidence is required via the SAPE and PACE assessments, with governing oversight by a Medical psychotherapy tutor. Resident Doctors should demonstrate attendance at Balint (or case-based discussion) groups for a recommended period of a year, usually 30 groups, but will often attend throughout their core training.

Some psychiatrists have found it helpful to undergo their own personal psychotherapy, in addition to the experience of psychotherapy gained in psychiatry training. This benefits their own wellbeing and helps them to understand longstanding complex dynamics. (See relevant information below if you are a Medical psychotherapy ST.)

5.1.2 Addiction psychiatry requirements for core Resident Doctors

An Addiction tutors' network has been established by the Addiction faculty which will enable Resident Doctors to undertake two WPBAs (CbDs) under the supervision of an Addiction tutor across the three years of core training (WTE).

5.1.3 Electro-convulsive therapy requirements for core Resident Doctors.

It is recommended that Resident Doctors undertake ECT treatments under direct supervision by the end of CT3 prior to progressing to ST4. Evidence is required via WPBA (DoPS). Further information and guidance for ECT can be found here.

5.1.4 History of psychiatry

We recommend that psychiatrists completing their core training have an understanding of the:

- effect of world history on the lives of present generations, for example: natural catastrophes, wars and conflict, slavery, genocide, and migration
- history of psychiatric methods and diagnostic classification to achieve awareness of socio-cultural factors, policy and service development and historical contributions to developing significance of user advocacy and the charitable sector.

5.1.5 Example core rotation:

- Recommended **one year** in a General psychiatry post.
- Recommended **six months** in an Old age psychiatry post.
- Recommended **six months** in a development specialty, either Child and adolescent psychiatry or Learning Disability psychiatry post.
- Recommended **two six-month posts** from Forensic psychiatry, Medical psychotherapy, another developmental specialty or a sub-specialty not previously undertaken in a General setting (for example a crisis team) which would normally include Rehabilitation psychiatry, Liaison psychiatry, Addiction psychiatry, Perinatal psychiatry, Eating disorder psychiatry, and Neuropsychiatry.

5.2 Higher psychiatry training

The Advanced Training Programme in psychiatry requires the completion of a recommended three years of higher specialty training in one of the six GMC approved psychiatric specialties listed below from levels ST4 to ST6:

- General psychiatry
- Child and adolescent psychiatry
- Forensic psychiatry
- Psychiatry of Learning disability
- Medical psychotherapy
- Old age psychiatry.

Resident Doctors must achieve the capabilities as set out in the appropriate advanced curriculum and achieve an **ARCP outcome 6** on completion of the training programme.

5.2.1 General psychiatry

The clinical experience in the Advanced Training Programme in General psychiatry will consist of the equivalent of a recommended three years (WTE) and comprises:

- Twelve months in a General psychiatry placement (i.e. a placement that can offer both inpatient and community experience) or two six-month placements in inpatient and community settings. The inpatient experience must include managing detained patients under supervision.
- Twelve months in a more specialised general psychiatry setting which, in appropriate circumstances, may lead to an endorsement in one of the recognised sub-specialties of General psychiatry (Rehabilitation, Addiction, Liaison psychiatry). Other placements could be considered in neuro-psychiatry, perinatal psychiatry, or eating disorder psychiatry.
- Twelve months in another psychiatric specialty which can also include General psychiatry. A doctor can only undertake training in another psychiatric specialty where the training is available, i.e. Forensic psychiatry, Old age psychiatry, Medical psychotherapy, Learning disability psychiatry, Child and adolescent psychiatry.
- Resident Doctor placements in the more specialised services or some experience of other specialities will be facilitated through discussions between Resident Doctors, supervisors and the TPD.

Successful completion of a recommended 12 months (WTE) in any of the above GMC approved sub-specialties will lead to an endorsement on the GMC Specialist Register. For Resident Doctors on formal academic training programmes, it is recognised that research time can contribute in part towards this time requirement for endorsement, if agreed with the supervisors and TPD, and provided that capabilities are acceptably met at ARCP.

Experience gained in General psychiatry must include properly supervised acute and community management. Increasingly, services and training in General psychiatry are delivered in functional teams that specialise in a single area of work such as:

- psychosis or non-psychosis pathways in the community,
- acute care as an inpatient; crisis, and home treatment teams, and
- specialised services such as early interventions, assertive outreach and recovery models.

Thus, in some areas not all posts will provide all experiences as detailed. However over three years of training, Resident Doctor should gain clinical experience in assessing and treating adult patients presenting with a wide range of mental disorders, across acute and community settings. This will include both new and follow-up patients, and supervised experience of emergencies and out of hours duties. Trainers should ensure adequate overall clinical experience and that Resident Doctors are able to achieve the key curriculum requirements.

It is recommended that Resident Doctors should undertake the equivalent of at least six months (WTE) within inpatient settings. The inpatient experience must include managing patients who have been detained under supervision; and at least six months (WTE) in a community placement.

The recommended three years spent in higher training in General psychiatry will enable the continuing development of:

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training. (See guidance document: **Best practice guide to psychotherapy training in higher specialist psychiatry training** [ST 4- 6].)
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in General psychiatry
- research skills that are an integral part of training, such as critical evidence evaluation, knowledge of research frameworks, participation in research, and the use of objective clinical tools in clinical practice.

It is recommended that Resident Doctors should complete 55 (indicative) on call shifts over their time in training. If a Resident Doctor has limited opportunity to gain experience in General Adult-specific out of hours work, then additional experience may be gained through undertaking General Adult emergency work in the daytime, and by working with General Adult crisis/intensive support teams where available.

Each year Resident Doctors are recommended to participate in at least one project with a view to improve patient safety, health, and/or clinical outcomes.

This may include NHS quality improvement procedures, management, leadership, and/or involvement in ethically approved research.

Resident Doctors are also recommended to undertake management, research and/or leadership projects, as part of their placements as appropriate, as discussed and supported by their supervisors and TPDs. One post may meet different training needs in different training years depending on a Resident Doctor's progress.

Academic Resident Doctors should attend a specialist academic programme arranged within their training scheme. Attendance at relevant external conferences and study days is expected/recommended and will be supported through discussion between the Resident Doctor, the supervisors and the TPDs.

Over three years, Resident Doctors are recommended to attend relevant specialist courses (including 'train the trainer' courses), actively contribute to academic activities, and to teaching students, junior doctors and other professionals.

In preparation for consultant practice, attend relevant mental health legislative training in order to support autonomous clinical practice.

5.2.2 Old age psychiatry

The clinical experience in the Advanced Training Programme in Old age psychiatry will consist of the equivalent of three years full time experience and will consist of:

- A recommended two years (WTE) within old age services.
- Within the above, it is recommended that Resident Doctors should undertake the equivalent of at least six months (WTE) within inpatient settings. The inpatient experience should include detained patients who have been detained under supervision.
- A further recommended twelve months (WTE) may be spent in old age services, liaison services (either adult or old age, or a combination of both) or in another sub-specialty of psychiatry that should have relevance to the practice of Old age psychiatry, e.g., General psychiatry, Forensic psychiatry, Medical psychotherapy and psychiatry of Learning disability.
- Note: Successful completion of the capabilities within the Liaison psychiatry curriculum will lead to an endorsement on the GMC Specialist Register.

Resident Doctors may get experience working with older adults in the following settings:

- in-patient wards for older adults
- community mental health services
- memory services
- continuing care services

- joint psychiatric/geriatric services
- day hospital services
- sheltered and extra care sheltered settings
- residential and nursing care settings
- home treatment/crisis resolution services specifically for older adults.

The recommended three years spent in higher training in Old age psychiatry will enable the continuing development of:

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training. (See guidance document: **Best practice guide to psychotherapy training in higher specialist psychiatry training** [ST 4- 6].)
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in Old age psychiatry
- research skills that are an integral part of training, such as critical evidence evaluation, knowledge of research frameworks, participation in research, and the use of objective clinical tools in clinical practice.

It is recommended that Resident Doctors should complete 55 (indicative) on call shifts over their time in training. If a Resident Doctor has limited opportunity to gain experience in Old Age specific out of hours work, then additional experience may be gained through undertaking Old Age emergency work in the daytime, and by working with Old Age crisis/intensive support teams where available.

Each year Resident Doctors are recommended to participate in at least one project with a view to improve patient safety, health, and/or clinical outcomes. This may include NHS quality improvement procedures, management, leadership, quality improvement, and/or involvement in ethically approved research.

Resident Doctors are also recommended to undertake management, research and/or leadership projects, as part of their placements as appropriate, as discussed and supported by their supervisors and TPDs. One post may meet different training needs in different training years depending on a Resident Doctor's progress.

Academic Resident Doctors should attend a specialist academic programme arranged within their training scheme. Attendance at relevant external conferences and study days is expected/recommended and will be supported through discussion between the Resident Doctor, the supervisors and the TPDs. Over three years, Resident Doctors are recommended to attend relevant specialist courses (including 'train the trainer' courses when relevant), actively

contribute to academic activities, and to teaching students, junior doctors and other professionals.

5.2.3 Child and adolescent psychiatry (CAP)

The clinical experience in the Advanced Training Programme in Child and Adolescent Psychiatry (CAP) will consist of the equivalent of three years' full time training in approved CAP placements.

The Resident Doctor will undertake placements of **six months or one year** or as indicated under the supervision of recognised trainers in Child and adolescent psychiatry.

It is also recommended that Resident Doctors undertake one quality improvement activity during each year of training.

The clinical experience will encompass assessing and treating patients across the entire age range of 0-18 years and across the wide range of clinical presentations and mental disorders in this age range.

Clinical experience in the 0 – 5 age group (e.g. assessing babies and infants, the infant-parent relationship, and relevant therapeutic interventions) remains an integral part of higher training in CAP.

Some Resident Doctors may not have access to a Child and Adolescent Mental Health Service (CAMHS) based infant-parent mental health service. In these circum-stances, the Resident Doctors may need support from their supervisors and TPDs in getting this experience through working with services outside CAMHS (e.g. developmental paediatric teams, family-nurse-partnership teams, specialist perinatal psychiatry teams, or specialist infant-parent teams which may be within local authority services) under supervision from CAP specialists/ supervisors.

CAP higher training programmes will also include appropriate continuing development of psychological and psychotherapy/psychotherapeutic capabilities and psychotherapeutic experience working across the spectrum of CAMHS service provision with individuals, families, and groups. Not all Resident Doctors entering ST4-6 higher specialty training in CAP will have had the opportunity to undertake a CAP placement in core training. Similarly, not all Resident Doctors will have had psychotherapy experience with children and young people in core training. We therefore recommend that Resident Doctors have the supervised experience of undertaking assessment and treatment in two evidence-based psychological or psycho-therapeutic modalities (e.g. CBT – cognitive behavioural therapy, psycho-dynamic psychotherapy, and systemic family therapy) during the course of their higher training in CAP. (See guidance document: **Best practice guide to psychotherapy training in higher specialist psychiatry training** [ST 4-6].)

Academic Resident Doctors will have an academic block and an academic programme as part of the training programme with an academic supervisor; training will be in accordance with NIHR guidance.

We recommend that:

- the ST4 year should include broad-based experience in specialist community CAMHS teams
- the ST5-ST6 years should cover more specialist experiences, including a recommended six month WTE experience of Tier 4 CAMHS (specialist inpatient or day-patient services); experience of paediatric liaison and working with different paediatric services; and other specialist experiences for e.g., forensic CAMHS, CAMHS-ID, substance misuse services, and specialist eating disorder services (depending on the training scheme).
- Resident Doctors undertake management experiences and leadership projects as part of their placements as appropriate, having discussed with their supervisors and TPDs.
- One post may meet different training needs in different training years depending on a Resident Doctor's progress. Resident Doctor placements in the more specialised services will be through discussions between Resident Doctors, supervisors and the TPD.

Resident Doctors' caseloads will vary based on the placement (e.g., a Resident Doctor placed in a Tier 4 service is likely to have a smaller caseload than when placed in a community 0-18 CAMHS team).

It is important that caseloads reflect not only the wide range of clinical presentations and disorders in CAMHS, but also balanced with complexity of cases to ensure Resident Doctors achieve the key capabilities in the curriculum.

Caseloads should also enable Resident Doctors to prepare for independent practice as consultants in Child and adolescent psychiatry, being able to manage complexity and uncertainty, and diverse needs and priorities as highlighted in the curriculum.

We recommend that full time Resident Doctors on placement for a year WTE in a Community CAMHS team carry a mixed caseload of 20-30 cases (not exceeding 40 cases) through the placement.

Typically, seeing and assessing 50-75 new cases every year for a full-time Resident Doctor will help the Resident Doctor ensure adequate overall clinical experience. (This suggested number will include urgent/ emergency work which would be 'one-off assessments', work on an out-of-hours on-call rota, and their placement caseload.)

We recommend that Resident Doctors gain experience of emergency CAP, via 55 (indicative) on-call shifts (including 'out-of-hours' work); assessing and managing at least 50 cases in this context during the course of their training in CAP.

CAP ST Resident Doctors will attend a specialist academic programme arranged within their training scheme equivalent to a recommendation of 30 half-day sessions/ year. Attendance at relevant external conferences and study days is expected and will be through discussion between the Resident Doctor, the supervisors and the TPDs.

Participation in Balint groups or case-based discussion groups as part of the specialist academic programme is recommended as a good example of the way in which the Resident Doctor can develop the capabilities and skills in reflective practice and managing complexities to eventually progress towards the consultant role.

CAP ST Resident Doctors will demonstrate the development of research skills as an integral part of training in CAP and may participate in a variety of research related activities and projects in order to do so.

CAP ST Resident Doctors are **expected** to undertake at least a structured review of literature in one aspect of CAP/child mental health that is of an academic standard to be potentially published, in order to meet the capability in research and scholarship (HLO9). This will be undertaken under the supervision of a suitable academic supervisor. Psychiatric supervision and support from the Educational Supervisor and TPDs will help Resident Doctors to ensure that this activity is reviewed as completed by the ARCP in ST5.

CAP ST Resident Doctors will get two sessions per week (i.e. 8 hours in total) pro-rata to achieve the research capability and to further undertake other experiences such as academic learning outside of the programme (e.g. a Masters in Systemic Therapy / other academic courses) or other relevant projects or committee work. The activities should be agreed collaboratively between the Resident Doctor, the named clinical (psychiatric) supervisor, the educational supervisor and also the TPD as relevant.

CAP run-through programme

Resident Doctors who wish to pursue training in CAP from the outset can apply to join the CAP run-through programme when they apply for Core Psychiatry Training (through the same application process).

This programme runs from ST1-ST6. Resident Doctors should undertake a six-month WTE post in CAP, plus a six month WTE placement in a paediatrics-linked post (e.g. paediatric liaison), usually in ST2.

Resident Doctors will progress to ST4 higher training in CAP at the end of core training if they have successfully passed the MRCPsych examination, have achieved all the capabilities required by the core psychiatry training curriculum and have achieved an ARCP Outcome 6. They should also have attended the regional core psychiatry academic programmes and attained the expected psychotherapy capabilities.

From ST4-6, these Resident Doctors will follow the same training programme as other CAP ST 4-6 Resident Doctors.

Resident Doctors on the CAP run-through pilot programme during ST1-3 should participate in out-of-hours on-call rotas alongside other core Resident Doctors in psychiatry.

The CAP Run-Through pathway was approved on a permanent basis by the GMC in July 2023.

Doctors who move from a run-through programme onto an uncoupled programme would count ST1-3 as equivalent to CT1-3 in Core Psychiatry Training.

5.2.4 Psychiatry of Learning disability

The clinical experience in the Higher Training Programme in psychiatry of Learning disability is recommended to consist of the equivalent of three years full time training in approved training placements in Learning disability psychiatry. The Resident Doctor will work under the supervision of recognised clinical supervisors in psychiatry of Learning disability.

The purpose of the training programme is to facilitate the development of the knowledge, skills, values and behaviours as detailed in the specialty curriculum, that are required to work independently as a consultant psychiatrist in Learning disability.

The Resident Doctor will spend a recommended two years of full-time (or WTE) training in specialist services for adults with learning (intellectual) disability.

The final 12 months of training may encompass additional clinical experience to consolidate and develop specialist skills according to the specific needs and interests of each Resident Doctor.

There is the option of spending up to 12 months of training in specialist services for children and adolescents with intellectual disability.

Other specialist placements could include:

- Forensic Learning disability psychiatry
- Neurodevelopmental disorders across the full IQ spectrum
- General psychiatry including facilitating access to mainstream services for people with learning (intellectual) disability
- Neuropsychiatry.

These placements would require approval by the training programme director (TPD).

The recommended three years spent in higher training in learning disability psychiatry will enable the continuing development of:

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training. (See guidance document: Best practice guide to psychotherapy training in higher specialist psychiatry training [ST 4- 6].)
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in Learning disability psychiatry

- research skills that are an integral part of training, such as critical evidence evaluation, knowledge of research frameworks, participation in research, and the use of objective clinical tools in clinical practice.

Clinical experience during higher training in psychiatry of Learning disability will include working within specialist multidisciplinary teams, leading to the development of specialist expertise in the assessment and management of the range of mental, behavioural and neurodevelopmental disorders prevalent in the population of adults with learning (intellectual) disability.

Resident Doctors will understand the importance of a person-centred holistic approach, which includes a biological, psychological, psychotherapeutic and social approach and will liaise effectively with the families, carers and wider systems of support.

Resident Doctors will gain experience of working in crisis situations and out of hours through participation in on call rotas - these rotas may be in mainstream psychiatric services or in specialist learning (intellectual) disability services.

It is recommended that Resident Doctors should complete 55 (indicative) on call shifts over their time in training. If a Resident Doctor has limited opportunity to gain experience in ID-specific out of hours work, then additional experience may be gained through undertaking ID emergency work in the daytime, and by working with ID crisis/intensive support teams where available.

Higher Resident Doctor caseloads should include a broad range of clinical cases with varying - and increasing - levels of complexity, including patients across the full range of intellectual impairment.

It is important that caseloads are tailored to the training needs of individual Resident Doctors and designed to ensure that Resident Doctors achieve the key capabilities in the specialty curriculum. Factors such as complexity and intensity of support needs of individuals on the caseload will need to be taken into consideration when determining the appropriate number.

Caseloads should include an appropriate mix of new and ongoing cases and over the course of one year of training in a community placement, it is expected that Resident Doctors will complete regular new patient assessments, covering a broad spectrum of clinical presentations and diagnostic complexity.

Resident Doctors in Learning disability psychiatry will attend and present at a specialist academic programme arranged within their training scheme. Attendance at relevant external conferences and study days is also recommended and will be approved according to individual training needs and local study leave approval procedures. Over three years, Resident Doctors are recommended to attend relevant specialist courses (including ‘train the trainer’ courses when relevant), actively contribute to academic activities, and to teaching students, junior doctors and other professionals.

Academic Resident Doctors should attend a specialist academic programme arranged within their training scheme.

Each year Resident Doctors are recommended to participate in at least one project with a view to improve patient safety, health, and/or clinical outcomes. Projects may include NHS quality improvement procedures, management, leadership, and/or involvement in ethically approved research. Choice of project and super-vision arrangements should be discussed and agreed with the Resident Doctor's supervisors and TPD. One post may meet different training needs in different training years depending on a Resident Doctor's progress.

It is recommended that Resident Doctors engage in academic research with an aim to completing a research project of a standard appropriate for publication by the end of training. In addition to developing specialist skills required of a consultant psychiatrist in Learning disability, we recommend Resident Doctors to develop transferrable skills including leadership and management, emergency psychiatry, neuro-developmental assessment across the full IQ spectrum and complex decision-making.

The Annual Review of Competency Progression (ARCP) is the means by which Resident Doctors are reviewed annually to assess their progression against the standards set down in the psychiatry of Learning disability specialty curriculum.

LD run-through pilot programme

Resident Doctors who wish to pursue training in LD from the outset can apply to join the LD run-through pilot programme when they apply for Core Psychiatry Training (through the same application process).

This pilot programme runs from ST1-ST6. Core placements include:

- General Adult Psychiatry placements with opportunity to gain clinical experience in ASD/ADHD.
- Old Age Psychiatry placement with a link to neuroscience, dementia and physical health.
- Psychiatry of Learning (Intellectual) Disability placement, in line with the 6-month neurodevelopmental post recommendation in the core curriculum.

Resident Doctors will progress to ST4 higher training in LD at the end of core training if they have successfully passed the MRCPsych examination, have achieved all the capabilities required by the core psychiatry training curriculum and have achieved an ARCP Outcome 6. They should also have attended the regional core psychiatry academic programmes and attai ned the expected psychotherapy capabilities.

From ST4-6, these Resident Doctors will follow the same training programme as other LD ST 4-6 Resident Doctors.

Resident Doctors on the LD run-through pilot programme during ST1-3 should participate in out-of-hours on-call rotas alongside other core Resident Doctors in psychiatry.

Doctors who move from a run-through programme onto an uncoupled programme would count ST1-3 as equivalent to CT1-3 in Core Psychiatry Training.

5.2.5 Forensic psychiatry

The purpose of Forensic psychiatry is the assessment, care and treatment of mentally disordered offenders and others requiring similar services. Risk assessment and management and the prevention of further victimisation are core elements of this.

In order to develop the key capabilities and attain the high level outcomes required by the curriculum, it is recommended that specialty training in Forensic psychiatry lasts for the equivalent of three years full time training in Forensic psychiatric posts, and it is recommended that all substantive training posts are with recognised clinical supervisors who are on the specialty register for Forensic psychiatry.

For each Resident Doctor, we recommend that the majority of their training programme comprise placements of 12 months duration to provide the necessary continuity and consistency to develop the required key capabilities.

A recommended 12 months, but usually more, will be spent working substantively in medium secure inpatient services. Additional experience will include, but not be limited to, working in high or low secure hospitals, working in prisons, working with Forensic psychiatric patients in the community and working with female as well as male patients or offenders. Experience of writing clinical and medico-legal reports, and of giving evidence in courts, may be gained in all these settings.

This breadth of experience will be gained through both substantive clinical placements and sessional placements. There should be scope for Resident Doctors to tailor some of these placements to their own particular clinical interests, while ensuring that they are able to develop the key capabilities set out in the curriculum.

Experience of prison psychiatry may be gained through substantive placements or through sessional work. It is recommended that during the course of their training, a Forensic Resident Doctor should provide 90 half day sessions within a custodial environment and in addition should carry out assessments of patients in custody to consider transfer to hospital.

The recommended three years spent in higher training in Forensic psychiatry will enable the continuing development of:

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training. (See guidance document: **Best practice guide to psychotherapy training in higher specialist psychiatry training** [ST 4- 6].)
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in Forensic psychiatry
- research skills that are an integral part of training, such as critical evidence evaluation, knowledge of research frameworks, participation in research, and the use of objective clinical tools in clinical practice.

Each year Resident Doctors are recommended to participate in at least one project with a view to improve patient safety, health, and/or clinical outcomes. This may include NHS quality improvement procedures, management, leadership, and/or involvement in ethically approved research.

Resident Doctors are also recommended to undertake management, research and/or leadership projects, as part of their placements as appropriate, as discussed and supported by their supervisors and TPDs. One post may meet different training needs in different training years depending on a Resident Doctor's progress.

Academic Resident Doctors should attend a specialist academic programme arranged within their training scheme. Attendance at relevant external conferences and study days is expected/recommended and will be supported through discussion between the Resident Doctor, the supervisors and the TPDs. Over three years, Resident Doctors are recommended to attend relevant specialist courses (including 'train the trainer' courses when relevant), actively contribute to academic activities, and to teaching students, junior doctors and other professionals.

5.2.6 Medical psychotherapy

The clinical experience in the Advanced Training Programme in Medical psychotherapy will consist of the equivalent of three years full time experience. in a GMC approved psychotherapy scheme, quality assured by local deaneries through the schools of psychiatry.

The Resident Doctor will be recruited into an approved national training number (NTN) with a specified major modality as outlined in the training programme.

During their higher specialist training the Resident Doctor will gain and in-depth knowledge of theory and practice into their major psychotherapeutic approach acquiring expertise in this modality, and also a broad base of clinical experience with training in two other psychotherapeutic modalities.

The major approaches are psychodynamic/psychoanalytic, cognitive behavioural therapy and systemic (family) therapy.

The Resident Doctor will be based within specialist psychotherapy services throughout the duration of their training and may rotate between services during their training. Clinical placements should last for a recommended twelve months to allow for depth of clinical experience and building up of clinical practice.

Working within specialist psychotherapy services Resident Doctors will develop capabilities in:

- delivering psychotherapy to range of patients individually, in groups, and to families
- undertaking psychotherapeutic consultation assessment of patients referred for psychotherapy

- understanding the indications, benefits and risks of psychotherapeutic interventions
- the triage and management of referrals for psychotherapy
- the application of psychological approaches within a range of psychiatric settings in order to contribute to developing psychologically informed approaches and treatments across wider mental health services
- providing psychotherapy supervision, reflective practice and consultation to teams
- leadership for psychotherapy services and their development
- working with multidisciplinary colleagues across primary, secondary, tertiary and third sector care settings
- research into psychotherapeutic interventions and the psychological understanding of mental disorder.

The breadth of training experience will equip Resident Doctors to practice at as a consultant psychiatrist in Medical psychotherapy enabling the Resident Doctor to work with complexity and apply psychological understanding using a range of psychotherapeutic approaches that are holistic and person-centred.

It is recommended that Resident Doctors should complete 55 (indicative) on call shifts over their time in training. If a Resident Doctor has limited opportunity to gain experience in Medical Psychotherapy-specific out of hours work, then additional experience may be gained through undertaking Medical Psychotherapy emergency work in the daytime, and by working with Medical Psychotherapy crisis/intensive support teams where available.

Resident Doctors must ensure continued personal, professional and psychological development through participation in personal psychotherapy which may be undertaken either in one-to-one setting or in group analysis setting throughout the course of Higher Medical Psychotherapy training.

We recommend as a minimum requirement that this should be weekly psychotherapy of any modality, and this must be maintained throughout the course of training. It is recognised that this is a recommended minimum requirement, and it will be desirable for Resident Doctors to have a greater frequency of sessions.

For example:

- those undertaking group analytic training undertake twice weekly group analysis
- those training in psychoanalytic psychotherapy undertake three times a week personal therapy

- those training in psychoanalysis undertake personal therapy four to five times a week.

For Resident Doctors who major in cognitive behavioural or systemic therapy, alternatives to analytic experiences can be negotiated with their trainer and psychotherapy scheme Training Programme Director.

Further guidance and information about current financial support for personal therapy within each of the four nations is available on our website.

6 Curricula framework

6.1 Curricula structure

The curricula have been developed using the GMC's Standards for Postgraduate Medical Curricula *Excellence by Design* and the *Generic Professional Capabilities (GPC)* Framework.

The curricula have been developed using a "**Why, What, How?**" approach:

- **Why?** – The GPC Framework outlines the overarching learning outcomes under nine key domains.
- **What?** – High level outcomes (HLOs) have been developed under each GPC domain. They outline the key capabilities that Resident Doctors need to achieve under each specific domain by the end of core and specialty psychiatry training.
- **How?** – Placement-specific personal development plans (PDPs) detail the activities that can be taken to achieve the key capabilities.

It is important to recognise that these headings are used for structural organisation. The complexity of medical education and practice means that a considerable number of the capabilities set out in each curriculum will overlap between domains, moreover, depending upon circumstances, many capabilities will have additional components that are not defined here.

The framework consists of **four key components**:

- Psychiatry 'Silver Guide'.
- Core, specialty and sub-specialty curricula
- Placement-specific personal development plans (PDPs)
- ARCP decision aids.

7 Specific curricula requirements

7.1 Emergency psychiatry

7.1.1 Core and Specialty training requirements

Core Resident Doctors should complete a recommended indicative 55 on-call shifts, or equivalent (which may include out-of-hours experience). This should result in the Resident Doctor seeing at least 50 individual cases. (See Child and adolescent psychiatry section for more specific information in this specialty.)

7.2 Sustainability

We recommend that Psychiatrists completing their core and higher training have a firm understanding of the principles of practicing sustainably, including a focus on prevention, patient empowerment, efficient service delivery and low carbon outcomes.

Those completing training should be aware of the potential negative impact of healthcare on the environment including factors such as greenhouse gas emissions, excess waste and unsustainable food systems, and understand how the mental healthcare system can work to reduce these.

They should recognise the impact that physical environment may have on patients and be able to think about how access to green space, physical activity and interaction with nature can be promoted in treatment strategies.

They should be aware of the importance of prevention to health outcomes, including addressing the social determinants of health, and lastly, they should be aware of the potential burden on mental healthcare systems from climate change and extreme weather events both at population and individual level.

7.2.1 Achieving capabilities in sustainability

Core and higher specialty curricula have a capability outlined specifically around ensuring sustainable practice, which sits under HLO 1.2 “Professional Standards”.

It is recommended that Resident Doctors outline their sustainable practices in their WPBAs under the Professional Values and Behaviours domain. In addition, there will also be an example PDP outlining activities for Resident Doctors to meet this capability.

7.3 Statutory approval for Mental Health Act legislation

Statutory approval for application of Mental Health Act legislation in the relevant UK jurisdiction.

It is recommended that Resident Doctors meet the requirements to apply for relevant statutory approval where appropriate. Please note that Resident Doctors will need to seek information regarding local arrangements and requirements for approval.

8 Dual training

The GMC approves which specialties can be undertaken as ‘dual training’ leading to dual specialist registration. The list of approved dual specialties can be found on our website. Further information on dual training can be found on the GMC website.

In most cases, Resident Doctors are competitively appointed to 'dual training' specialties through a single recruitment process.

Where Resident Doctors are competitively appointed to a training programme leading to dual specialist registration, Resident Doctors are expected to complete the programmes in full and obtain the capabilities set out in both curricula. Application to the GMC for a CCT should only take place when both programmes are complete.

Where a Resident Doctor wishes to curtail the programme leading to dual certification and to apply to the GMC for a single CCT, the Resident Doctor must apply to the Postgraduate Dean for agreement to do so. If the Postgraduate Dean agrees, the dual certification programme will terminate and a single CCT will be pursued.

Resident Doctors who wish to curtail a dual programme and pursue a single CCT must ensure that they have completed/obtained the following:

- The capabilities for a single CCT as stipulated in the curriculum for that specialty.
- Confirmation from the Training Programme Director that the capabilities for a single CCT have been met.
- A final ARCP outcome 6 for a single CCT.

Completion of two CCTs can be of either four or five years' duration and all training must be in GMC approved programmes.

8.1 Training combinations with a recommended four year duration

8.1.1 General psychiatry and Old age psychiatry

We recommend:

- Two years (WTE) in designated General psychiatry posts; one year may be in a GMC approved sub-specialty of General psychiatry in either:
  - Addiction psychiatry
  - Liaison psychiatry, or
  - Rehabilitation psychiatry.
- Two years in designated Old age psychiatry posts; one year may be in the GMC approved sub-speciality of Liaison psychiatry.

A Resident Doctor who wishes to pursue a single CCT in either old age psychiatry or General psychiatry must ensure they have completed the recommended three years, which must consist of two years in either Old age psychiatry posts or General psychiatry posts plus one further year in another psychiatric specialty or sub-specialty post as listed above.

8.1.2 General psychiatry and psychiatry of Learning (Intellectual) Disability

A recommended four years (WTE) of higher training is required to complete a dual CCT in General (Adult) psychiatry and psychiatry of Learning (Intellectual) Disability.

This should normally consist of:

- Two years (WTE) in designated General (Adult) Psychiatry training posts.
- Two years (WTE) in designated Psychiatry of Learning (Intellectual) Disability training posts, providing experience across the community, inpatient and specialist intellectual disability services, including exposure to adults with complex neurodevelopmental, mental health and physcial comorbidities.

It is recommended that, across the four-year programme, resident doctors seek opportunities to gain relevant experience within integrated neurodevelopmental, liaison and interface services, including adult ADHD and autism assessment and management, where available.

On successful completion of the programme, the resident doctor will be eligible for the award of dual Certificates of Complete of Training (CCTs) and will be equipped to work as a consultant in either General (Adult) Psychiatry or Psychiatry of Learning (Intellectual) Disability, as well as across services supporting adults with complex neurodevelopmental needs.

8.2 Training combinations with a recommended five year duration

8.2.1 General psychiatry and Medical psychotherapy

We recommend:

- Two years (WTE) in designated General psychiatry posts (please see section 4.2.1); one year may be in a GMC approved sub-specialty of General psychiatry in either:
  - Addiction psychiatry
  - Liaison psychiatry, or
  - Rehabilitation psychiatry.
- Resident Doctors could also spend one year in:
  - perinatal psychiatry
  - neuropsychiatry, or
  - eating disorder psychiatry.

All core General psychiatry capabilities must be achieved.

- Three years (WTE) in designated Medical psychotherapy placements.

A Resident Doctor who wishes to pursue a single CCT in either General psychiatry or Medical psychotherapy must ensure they have completed the recommended three years, which must consist of two years in either adult psychiatry posts plus one year in another psychiatry specialty, most likely to be Medical psychotherapy or three years in designated Medical psychotherapy posts.

8.2.2 General psychiatry and Forensic psychiatry

We recommend:

- Two years in designated General psychiatry posts. One year may be in a GMC approved sub-specialty of General psychiatry in either:
  - Addiction psychiatry
  - Liaison psychiatry, or
  - Rehabilitation psychiatry.

  Alternatively, Resident Doctors could spend one year in the sub-specialties below, but this will not lead to an endorsement on the GMC Specialist Register:
  - perinatal psychiatry
  - neuropsychiatry, or

- eating disorder psychiatry.

- Three years in designated Forensic psychiatry placements.

  A Resident Doctor who wishes to pursue a single CCT in either General psychiatry or Forensic psychiatry must ensure they have completed the recommended three years, which must consist of two years in either General psychiatry posts and one year in another psychiatry specialty, most likely to be Forensic psychiatry, or three years in designated Forensic psychiatry posts.

8.2.3 Forensic psychiatry and Medical psychotherapy

We recommend:

- Two years in designated Forensic psychiatry placements.
- Two years in designated Medical psychotherapy placements.
- One year in a Forensic Medical psychotherapy setting.

A Resident Doctor who wishes to pursue a single CCT in either Forensic psychiatry or Medical psychotherapy must ensure they have completed the recommended three years, which should consist of three years in either designated Forensic psychiatry posts or three years in designated Medical psychotherapy posts.

8.2.4 Forensic psychiatry and General psychiatry

This must consist of:

- Three years in designated Forensic psychiatry placements.
- Two years in designated General psychiatry placements.

8.2.5 Child and adolescent psychiatry and Forensic psychiatry

This must consist of:

- Two years in designated Forensic psychiatry placements.
- Two years in designated Child and adolescent psychiatry placements.
- One year in a Forensic psychiatry setting for adolescents and children.

A Resident Doctor who wishes to pursue a single CCT in either Forensic psychiatry or Child and adolescent psychiatry must ensure they have completed the recommended three years, which should consist of three years in either designated Forensic psychiatry posts or three years in designated Child and adolescent psychiatry posts.

8.2.6 Child and adolescent psychiatry and Learning disability psychiatry

This must consist of:

- Two years in designated psychiatry of Learning disability placements.

- Two years in designated Child and adolescent psychiatry placements.
- One year in a psychiatry of learning disability setting for children and adolescents.

A Resident Doctor who wishes to pursue a single CCT in either psychiatry of Learning disability or Child and adolescent psychiatry should ensure they have completed a recommended three years, which should consist of three years in either designated Child and adolescent psychiatry posts or three years in psychiatry of Learning disability posts, up to one year of which may be in a psychiatry of Learning disability setting for children and adolescents or another relevant psychiatry specialty following discussion with your TPD.

8.2.7 Child and adolescent psychiatry and Medical psychotherapy

This must consist of:

- Two years in designated Child and adolescent psychiatric posts.
- Two years in designated Medical psychotherapy posts.
- One year in which there is integration between posts to achieve the curriculum competencies – for example, this could include delivering psychological therapy while working on in a CAMHS in-patient or out-patient setting.

A Resident Doctor who wishes to pursue a single CCT in either Child and adolescent psychiatry or Medical psychotherapy must ensure they have completed a recommended three years, which must consist of three years in either Child and adolescent posts and one year in another psychiatry specialty, or three years in designated Medical psychotherapy posts.

8.2.8 Forensic Psychiatry and Psychiatry of Learning (Intellectual) Disability

This must consist of

- Two years in designated Forensic psychiatric posts.
- Two years in Learning (Intellectual) Disability posts.
- One year in a placement tailored to the resident doctor's needs and interests, commonly a Foresenric setting for patients with Learning Disability.

9 Sub-specialty endorsements

In psychiatry, it is possible to be awarded a sub-specialty (endorsement) certificate and have this sub-specialty indicated on the specialist register against a doctor's name.

This applies when a doctor has successfully completed a sub-specialty programme approved by the GMC and the award is dependent on the applicant also having completed training in the 'parent' CCT specialty and gaining entry to the specialist register. This training may be undertaken at the same time as the parent specialty training programme.

Resident Doctors undertaking a GMC approved training programme in General psychiatry or a dual training programme in General psychiatry may undertake training in one of the three GMC approved sub-specialties of General psychiatry and apply for an endorsement on completion of their training programme.

The three GMC approved sub-specialties of General psychiatry are:

- Addiction psychiatry
- Liaison psychiatry
- Rehabilitation psychiatry.

Resident Doctors undertaking a GMC approved training programme in Old age psychiatry may undertake training in the GMC approved sub-specialty of Liaison psychiatry and apply for an endorsement on completion of their training.

On completion of their training programme Resident Doctors can apply for the endorsement on the GMC Specialist Register.

Resident Doctors wishing to obtain an endorsement must inform the College in advance. Training for an endorsement should be a recommended 12 months' WTE training on a GMC approved training programme.

It is possible to pursue sub-specialty training after the doctor has been entered on the specialist register, usually after competitive entry to an approved sub-specialty training programme. Details of the sub-specialty training programmes currently approved by the GMC can be found here.

Where sub-specialty training is undertaken within the envelope of a specialty training programme, Resident Doctors should apply for a sub-specialty certificate at the same time as they apply for their CCT (inclusive of those on a Combined Programme (CCT CP) pathway).

RCPsych CCT or CCT CP recommendations to the GMC should include details of any sub-specialty training programmes successfully completed by a Resident Doctor. Doctors appointed to a GMC-approved sub-specialty programme after entry to the specialist register can apply to the GMC for a sub-specialty certificate on successful completion.

10 Quality assurance of our curricula

10.1 Amendments process

In order to ensure a robust oversight of potential curricula changes, we have set out a clear process for monitoring amendments to the curricula.

The process is:

- Proposed amendments are submitted via our online proforma to our Curricula and Quality Assurance Team.
- Proposals are shared with the Specialty Advisory Committees (SACs) (where required).
- Once reviewed, proposals with recommendations from the SACs are sent to the Curriculum and Assessment Committee (CAC) and Quality Assurance Committee (QAC) for review.
- All amendments are sent to the Education and Training Committee (ETC) for sign off. Where additional information is required, this will be highlighted.
- The College curriculum team then feed back to the proposer and prepare for application to the GMC where appropriate.

A record of all amendments will be recorded on our amendments tracker, which will include a record of decisions and outcomes.

Additional information regarding quality assurance in training can be viewed on our training webpages.

10.2 Key quality indicators in psychiatry

We have developed a set of key quality indicators (KQIs) for psychiatric Resident Doctors and trainers. These are set out here.

10.2.1 Key quality indicators for Resident Doctors

1	Resident Doctors in psychiatry should be allocated to approved training posts that align to the appropriate level of training for the Resident Doctor, ensuring appropriate opportunities for achievement of curricula HLOs and key capabilities and that other relevant educational opportunities are provided.
2	Resident Doctors in psychiatry should be provided with protected time to undertake professional development sessions where applicable.
3	Resident Doctors in psychiatry should be provided with weekly one-hour psychiatric supervision sessions.
4	Resident Doctors in psychiatry should be provided with the opportunity to undertake the recommended minimum number of WPBAs with supervision appropriate to their level of training.
5	Resident Doctors in psychiatry must be assigned trained educational and clinical supervisors to oversee their training and have an appropriate

	learning agreement (placement-specific personal development plan) in place within the first month of a training post.
6	Resident Doctors in psychiatry must be provided the opportunity to reflect on their training through access to reflective practice groups.
7	Resident Doctors in psychiatry must be offered a comprehensive induction to each training post prior to starting in each role including regarding on-calls.
8	Resident Doctors in psychiatry should be offered access to study leave and supported to take it with appropriate funding commensurate with their training level.
9	Resident Doctors in psychiatry should be provided with protected time for research activities in line with curricula requirements outlined in HLO 9.
10	Resident Doctors in psychiatry should be provided with the opportunity to undertake appropriately supervised training in ECT where possible.
11	Resident Doctors in psychiatry should be provided with the opportunity and support to undertake at least one quality improvement activity.

10.2.2 Key quality indicators for trainers

1	Trainers in psychiatry should tailor the post to the appropriate level for the Resident Doctor, aligning the learning opportunities with curricula HLOs and key capabilities including ensuring a range of educational opportunities are offered.
2	Trainers in psychiatry should ensure that their Resident Doctors are given time for professional development sessions sharing the responsibility for this with the Resident Doctor.
3	Trainers should timetable supervision with their Resident Doctors at mutually convenient time, providing this time hourly each week. Trainers may agree a supervision contract and whether someone will take notes.
4	Trainers should co-author with Resident Doctors a placement specific personal development plan aligned with the curricula HLOs and key capabilities.
5	Trainers will ensure Resident Doctors have time to attend reflective practice groups as part of their working day on a regular basis.
6	Trainers will ensure Resident Doctors have a comprehensive induction to the post and team they are working in before the starter their position.
7	Trainers will be provided with a comprehensive induction and training to support their educational needs.

8	Trainers will remind Resident Doctors to take their study leave to further their development and fulfilment of the curricula capabilities.
9	Trainers will ensure Resident Doctors have time for research activities including linking Resident Doctors to relevant colleagues to complete this.
10	Trainers will ensure Resident Doctors have time to complete appropriate supervised training in ECT where possible.
11	Trainers will supervise or link Resident Doctors with appropriate colleagues to undertake a quality improvement activity.

Key Quality Indicators in psychiatry have been mapped in a quality matrix to the 10 standards outlined in '*Promoting Excellence*'. We aim to further build upon the responsibilities and key performance indicators.

It is important that trainers are able to provide effective feedback, as per the GMC Recognition of Trainer guidelines (see Section 11.2). Please refer to these and to any other sources of training on this key skill.

10.3 Quality schedule

We have developed a schedule outlining our quality activities and plans. This can be viewed in Appendix 3.

11 Roles and responsibilities

11.1 General Medical Council (GMC)

The GMC is the medical regulatory body for the UK. The work they do is set out by the by the Medical Act (1983), and covers five key areas:

- The medical register – a register of all qualified doctors in the UK.
- Standards for doctors – the GMC set out the standards of professional values, knowledge, skills and behaviours required of all doctors working in the UK. This is applicable to all psychiatric specialties and sub-specialties.
- Education and training – they set standards for undergraduate and postgraduate medical education and monitor training environments.
- Revalidation – the GMC ensure that doctors regularly keep their knowledge and skills up to date by ensuring each doctor has an annual appraisal.
- Addressing concerns – the GMC investigate concerns raised about a doctor's behaviour or practice.

11.2 Recognition of trainer status

Recognition of trainer domains

The person undertaking psychiatric supervision should be recognised as a trainer in accordance with the GMC guidelines, having demonstrated capabilities in domains 1 – 5 below. For educational supervision capability must be demonstrated in domains 1 – 7.

- Ensuring safe and effective patient care through training 2003731415
- Establishing and maintaining an environment for learning
- Teaching and facilitating learning
- Enhancing learning through assessment
- Supporting and monitoring educational progress
- Guiding personal and professional development
- Continuing professional development (CPD).

11.3 UK health departments

Policy on medical education is the responsibility of health ministers. Coordination and alignment of those policies across the UK is through the UK Medical Education Reference Group (UKMERG). Detailed policy issues are remitted to health officials, who will bring the contents to the attention of their respective health ministers.

11.3.1 Health Education England

NHS England (NHSE) supports the delivery of excellent healthcare and health improvement to the patients and public of England, by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place. It has five national functions:

- providing national leadership on planning and developing the healthcare and public health workforce
- promoting high-quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as medical Resident Doctor recruitment
- ensuring security of supply of the healthcare and public health workforce
- appointing and supporting the development of Local Education and Training Boards (LETBs)
- allocating and accounting for NHS education and training resources, and accounting for the outcomes achieved.

NHSE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards, which are statutory committees of NHSE. While NHSE is accountable for English issues only, it works with stakeholders as appropriate in areas where there may be implications for the rest of the UK.

11.3.2 NHS Education for Scotland

NHS Education for Scotland (NES) is a national special health board, established in 2002, working in partnership with its stakeholders to provide education, training and workforce development for those who work in and with NHS Scotland. NES has a Scotland-wide role in undergraduate and postgraduate education as well as continuing professional development across all professional groups, and it maintains a local perspective through centres in Edinburgh, Glasgow, Dundee, Aberdeen and Inverness with over 1,000 staff who work closely with frontline educational support roles and networks.

The overarching aim of NES is to deliver first-class medical education and training for Scotland to ensure safe, effective care for patients, both now and in future.

Working with all its partners, NES aims to achieve this by:

- organising and providing excellent training programmes that attract high-quality doctors to Scotland
- meeting and exceeding all regulatory standards through consistent application of best practice and the principles of continual improvement
- supporting the ongoing education and training of Scotland's trained doctors, together with those who support their work.

NES also supports the appraisal and revalidation of all doctors in Scotland as well as several cross-cutting and multi-professional programmes, including patient safety, quality improvement of patient care, and the development of Scotland's remote and rural workforce.

In addition, NES prepares professionals for practice in clinical psychology, pharmacy, optometry and healthcare science, and it provides access to education for nursing, midwifery and allied health professionals, healthcare chaplains and healthcare support workers as well as administrative, clerical and support staff.

The Scotland Deanery of NES was created on 1 April 2014 from the four extant deaneries in Scotland. The Scotland Deanery is responsible for managing the training of Scotland's postgraduate Resident Doctor doctors, who deliver care every day while in hospitals and general practices within NHS Scotland. Staff in the regional teams work closely with the wider NHS through the regional workforce planning groups.

The Scottish model also allows its four regions to work together as part of the Medical Directorate of NES, ensuring equity of recruitment and management approach. National policies and working committees, such as Specialty Training Boards, mean that Scotland can consistently deliver a high-quality approach.

Within the Scotland Deanery, Postgraduate Deans and General Practice Directors have identical roles and responsibilities for training; they provide strategic leadership and direction for postgraduate medical education and training to meet the requirements of the GMC. They take advice from the Colleges and Faculties to assist them.

11.3.3 Health Education and Improvement Wales

Established on 1 October 2018, Health Education and Improvement Wales (HEIW) is the only Special Health Authority within NHS Wales. HEIW sits alongside Health Boards and Trusts, and has a leading role in the education, training, development and shaping of the healthcare workforce in Wales in order to ensure high-quality care for the people of Wales.

The key functions of HEIW include:

- working closely with partners and key stakeholders, and planning ahead to ensure the health and care workforce meets the needs of the NHS and people of Wales, now and in the future
- being a reputable source of information and intelligence on the Welsh health and care workforce
- commissioning, designing and delivering high-quality, value for money education and training, in line with standards
- using education, training and development to encourage and facilitate career progression
- supporting education, training and service regulation by playing a key role in representing Wales, and working closely with regulators
- developing the healthcare leaders of today and the future
- providing opportunities for the health and care workforce to develop new skills
- promoting health and care careers in Wales, and Wales as a place to live
- supporting professional organisational development in Wales
- continuously improving what HEIW does and how it does it.

11.3.4 The Northern Ireland Medical and Dental Training Agency

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is an arm's length body sponsored by the Department of Health for Northern Ireland (DoH) to train medical and dental professionals for Northern Ireland. It achieves this through:

- the commissioning, promotion and oversight of postgraduate medical and dental education and training throughout Northern Ireland,

- the recruitment, selection and allocation of doctors and dentists to foundation, core and specialty training programmes,
- assessment of the performance of Resident Doctors through annual review and appraisal,
- close partnership with local education providers (principally Health and Social Care Trusts and general practices) to ensure that the training and supervision of Resident Doctors supports the delivery of high-quality, safe patient care.

NIMDTA is accountable for the performance of its functions to the Northern Ireland Assembly through the Minister of Health and to the GMC for ensuring that the standards set by the GMC for medical training, educational structures and processes are achieved.

It is recognised that delivering the curriculum requires the coordinated efforts of a number of parties.

Resident Doctors, Clinical, Psychiatric and Educational Supervisors, Training Programme Directors, and Postgraduate Schools of psychiatry across the UK all have responsibility for ensuring that the curriculum is delivered as intended.

11.4 Supervision

All supervisors as detailed below will have "Recognition of Trainer" status from the GMC via their annual Appraisal and Revalidation.

Supervision in postgraduate psychiatry training encompasses three core aspects:

- Clinical Supervision
- Psychiatric Supervision
- Educational Supervision.

Supervision is designed to:

- ensure safe and effective patient care,
- establish an environment for learning and educational progression,
- provide reflective space to process dynamic aspects of therapeutic relationships, maintain professional boundaries and support development of resilience, well-being and leadership.

Further information about supervision is outlined in Appendix 2.

Educational and clinical supervision standards are quality-managed and monitored locally by Postgraduate Deans against the standards defined in **GMC Promoting excellence – standards for medical education and training**, reporting back to the GMC Quality team.

11.4.1 Educator and training support

All Supervisors and TPDs should keep up to date with training requirements, including education related CPD. Specific training courses around doctors needing performance support should be built into educator's CPD programmes and accessed proactively.

Clinical Supervisors who are managing Resident Doctors with performance difficulties should be made aware of the training needs before the placement commences and receive a robust handover; joint working with the Resident Doctor's Educational Supervisor around training needs and objectives for the placement should take place, supported by the TPD, with advice sought from the relevant Statutory Educational body as required. Increased frequency of Educational Supervision meetings should support the placement.

11.4.2 Clinical Supervision

The clinical work of all Resident Doctors must be supervised by an appropriately qualified experienced psychiatrist. All Resident Doctors must be made aware day-to-day who the nominated clinical supervisory psychiatrist is in all clinical situations. This will usually be the substantive consultant whose team they are attached to but in some circumstances, this may be delegated to other consultants, to a senior Resident Doctor or to an appropriately experienced senior non-consultant grade doctor during periods of leave, out-of-hours etc.

Clinical supervision must be provided at a level appropriate to the needs of the individual Resident Doctor.

No Resident Doctor should be expected to work to a level beyond their competence and experience; no Resident Doctor should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise. Resident Doctors should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence; both Resident Doctor and supervisor should at all times be aware of their direct responsibilities for the safety of patients in their care.

The clinical supervisor:

- Should be involved with teaching and training the Resident Doctor in the workplace.
- Must support the Resident Doctor in various ways: a) direct supervision, in the ward, the community or the clinic consulting room b) close but not direct supervision, e.g., in the next-door room, reviewing cases and process during and/or after a session c) regular discussions, review of cases and feedback.
- May delegate some clinical supervision to other members of clinical team as long as the team member clearly understands the role and the Resident Doctor is informed. The Resident Doctor must know who is providing clinical supervision at all times.

- Will perform workplace-based assessments for the Resident Doctor and will delegate performance of WPBA's to appropriate members of the multi-disciplinary team.
- Will provide regular review during the placement, both formally and informally to ensure that the Resident Doctor is obtaining the necessary experience. This will include ensuring that the Resident Doctor obtains the required supervised experience in practical procedures and receives regular constructive feedback on performance.

11.4.3 Psychiatric Supervision

Psychiatrists in training will require regular reflective 1:1 supervision with a nominated consultant with specialist registration in a Psychiatric Specialty. This will usually be the nominated consultant who is also providing clinical, and sometimes educational, supervision.

Psychiatric supervision is required for all Resident Doctors throughout core and higher training in psychiatry and is recommended as one hour per week. It plays a critical role in the development of Psychiatrists in training in developing strategies for resilience, well-being, maintaining appropriate professional boundaries and understanding the dynamic issues of therapeutic relationships. It is also an opportunity to reflect on and develop leadership capabilities and is informed by psychodynamic, cognitive coaching models.

It is recommended that trainers have 0.25PA under Supporting Professional Activities in their job plans to provide psychiatric supervision.

Resident Doctors should utilise this time to set up their placement-specific personal development plans (PDPs).

The supervisor undertaking psychiatric supervision is responsible for producing the Psychiatric Supervision Report (PSR) informing the ARCP process and will ensure contributions are received from key individuals involved in the local training programme including clinical supervisors.

Those providing psychiatric supervision are expected to have undergone specific training and keep up their educational CPD in order to remain accredited.

11.4.4 Educational Supervision

An Educational Supervisor will usually be a Consultant Psychiatrist, Senior Lecturer or Professor, who has been appointed to a substantive Consultant psychiatry position. They are responsible for the educational supervision of one or more doctors in training who are employed in an approved training programme. The Educational Supervisor will require specific experience and training for the role. Educational Supervisors are also expected to maintain their educational CPD and attend refresher courses. Educational Supervisors will work with a small (up to five) number of Resident Doctors. Sometimes the Educational Supervisor will also be the Psychiatric/Clinical Supervisor, as determined by explicit local arrangements,

for example due to limited numbers of training placements/trainers being available.

All Resident Doctors will have an Educational Supervisor whose name will be notified to the Resident Doctor. The precise method of allocating Educational Supervisors to Resident Doctors, i.e., by placement, year of training etc, will be determined locally and will be made explicit to all concerned.

The Educational Supervisor

- Works with individual Resident Doctors to develop and facilitate an individual learning plan that addresses their educational needs. The learning plan will guide learning that incorporates the domains of knowledge, skills, values and behaviours.
- Will act as a resource for Resident Doctors who seek specialty information and guidance.
- Will liaise with the Local specialty Programme Tutor/Lead and other members of the department to ensure that all are aware of the learning needs of the Resident Doctor.
- Will oversee and on occasions, perform, the Resident Doctor's workplace-based assessments.
- Will monitor the Resident Doctor's attendance at formal education sessions, their completion of quality improvement projects and other requirements of the Programme.
- Should contribute as appropriate to the formal education programme.
- Will produce structured reports as required by the School/Deanery.

In order to support Resident Doctors, an Educational Supervisor will:

- Oversee the education of the Resident Doctor, act as their mentor and ensure that they are making the necessary clinical and educational progress.
- Meet the Resident Doctor at the earliest opportunity (preferably in the first week of the programme), to ensure that the Resident Doctor understands the structure of the programme, the curriculum, portfolio and system of assessment and to establish a supportive relationship. At this first meeting the educational agreement should be discussed with the Resident Doctor and the necessary paperwork signed and a copy kept by both parties. It is recommended that Resident Doctors meet with their Educational Supervisors three times throughout their placement. In particular, a meeting midway through a placement is considered important.
- Ensure that the Resident Doctor receives appropriate career guidance and planning.

- Provide the Resident Doctor with opportunities to comment on their training and on the support provided and to discuss any problems they have identified.

We advise that the Educational Supervisor is assigned to a Resident Doctor for the duration of their training period both within core and higher training.

We would generally recommend one programmed activity (PA) per week for up to five Resident Doctors, agreed within job-planning.

Training Programme Directors

The Training Programme Director is responsible for the overall strategic management and quality control of the core training programme within the Training School/Deanery.

The Deanery (Training School) and the relevant Service Provider (s) should appoint them jointly. They are directly responsible to the Deanery (School) but also have levels of accountability to the relevant service providers(s). With the increasing complexity of training and the more formal monitoring procedures that are in place, the role of the Programme Director must be recognised in their job plan, with time allocated to carry out the duties adequately.

We would generally recommend one programmed activity (PA) per week for 25 Resident Doctors, dependent on local capacity and size of programme. For example, a TPD in specialty training will:

- participate in the local arrangements developed by the Postgraduate Dean, which may include Heads of School or Chairs of Specialty Training Boards, to support the management of the specialty training programme(s), and work with delegated College / Faculty representatives (e.g. College / Faculty, Regional Advisors) and national College / Faculty training committees or Specialty Advisory Committees to ensure that programmes deliver the specialty curricula and enable Resident Doctors to gain the relevant competences, knowledge, skills, values, behaviours and experience
- take into account the collective needs of the Resident Doctors in the programme when planning individual programmes
- with relevant Directors of Medical Education provide support for Clinical, Psychiatric and Educational supervisors in the programme
- contribute to the ARCP process in the specialty
- help the Postgraduate Dean manage Resident Doctors who are running into difficulties by supporting educational supervisors in their assessments and in identifying remedial placements where required
- ensure (with the help of administrative support) that employers are normally notified at least three months in advance of the name and relevant details of the Resident Doctors who will be placed with them. From time to time,

however, it might be necessary for TPDs to recommend that Resident Doctors be moved at shorter notice

- produce timely reports on the training programme, on individual Resident Doctors and on the review of information regarding the quality of training, as required by NHSE, NES, the Wales Deanery and NIMDTA
- have career management skills (or be able to provide access to them) and be able to provide career advice to Resident Doctors in their programme
- act as positive advocates for their specialty in order to maximise recruitment (e.g., by coordinating taster sessions during foundation training, career fair representation or liaison with specialty leads and with the Colleges/Faculties.

In addition, there should be a Training Programme Director for the School/Deanery Core psychiatry Training Programme who will undertake the above responsibilities with respect to the Foundation and Core psychiatry Programmes and in addition:

- Will implement, monitor and improve the core training programmes in the Services/Trust(s) in conjunction with the Directors of Medical Education and the School/Deanery and ensure that the programme meets the requirements of the curriculum and the Service/Trust and complies with contemporary College Guidance & Standards and GMC Generic Standards for Training.
- Will take responsibility with the Psychotherapy Tutor for the provision of appropriate psychotherapy training experiences for Resident Doctors. This will include:
- Ensuring that Psychiatric Supervisors are reminded about and supported in their task of developing the Resident Doctor's capabilities in a psychotherapeutic approach to routine clinical practice.
- Advising and supporting Resident Doctors in their learning by reviewing progress in psychotherapy.
- Ensuring that there are appropriate opportunities for supervised case work in psychotherapy.

11.4.5 Medical Psychotherapy Tutor

It is a GMC requirement that every core psychiatry training scheme across the UK should have a qualified Medical Psychotherapy Tutor (RCPsych 2012) who will lead on the development of core psychotherapeutic capabilities.

The Medical Psychotherapy Tutor will have undergone higher/advanced specialist training in Medical psychotherapy with a CCT (Certificate of Completion of Training) in Medical psychotherapy (or equivalent).

The Medical Psychotherapy Tutor is responsible for the organisation and educational governance of psychotherapy training in the core psychiatry training scheme in a School of Psychiatry/equivalent in line with the GMC requirement of Medical psychotherapy leadership in core psychotherapy training (GMC Medical psychotherapy report and action plan, 2013).

It is the responsibility of the Director for Medical Education (DME) within each trust to ensure that provision of services is designed to ensure Resident Doctors have the opportunity to fulfil this training requirement.

The Medical Psychotherapy Tutor:

- Offers a clinical service in which their active and ongoing psychotherapy practice provides a clinical context for psychotherapy training in accordance with GMC requirements (2013).
- Ensures that all core Resident Doctors have the opportunity to complete the psychotherapy requirements of the core curriculum.
- Advises and supports core and higher Resident Doctors in their learning by reviewing progress in psychotherapy.
- Oversees the establishment and running of the core Resident Doctor Balint or case-based discussion group.
- Provides and oversees psychotherapy assessments for patients and is responsible for ensuring sufficient cases are provided and assessed as suitable cases for core and higher Resident Doctors. There is evidence that this is best provided within a dedicated psychotherapy service (UK Psychotherapy Training report 2018).
- Oversees the waiting list of therapy cases for core Resident Doctors and higher Resident Doctors.
- Monitors the selection of appropriate short and long therapy cases in accordance with the core curriculum.
- Selects and supports appropriate psychotherapy case supervisors to supervise and assess the Resident Doctors.
- Ensures the psychotherapy case supervisors are aware of the aims of psychotherapy training in psychiatry and are in active practice of the model of therapy they supervise according to GMC requirements (2013)
- Ensures the psychotherapy case supervisors are trained in the Psychotherapy Workplace Based Assessments (WPBAs).
- Differentiates the formative assessment of the SAPE (Structured Assessment of Psychotherapy Expertise) which the supervisor completes from the summative PACE (Psychotherapy Assessed Clinical Encounter) which the Medical Psychotherapy Tutor (or their delegate) completes for the ARCP.
- Ensures active participation of medical and non-medical psychotherapy supervisors in the ARCP process.
- Maintains and builds on the curriculum standard of core psychotherapy training in the School of psychiatry through the ARCP process.

11.4.6 Assessors

Assessors are members of the healthcare team, who perform workplace-based assessments (WPBAs) for Resident Doctor psychiatrists. Assessors do not need to be clinical, psychiatric or educational supervisors. (See WPBA guidance in Portfolio Online.)

In order to perform this role, assessors must be capable in the area of practice that they have been asked to assess and they should have received training in assessment methods. The training will include standard setting, a calibration exercise and observer training. Assessors should also have up-to-date training in equality and diversity awareness. While it is desirable that all involved in the training of doctors should have these elements of training, these stipulations do not apply to those members of the healthcare team that only complete multi-source feedback forms (mini-PAT) for Resident Doctors.

Assessors do not need to have prior knowledge of a Resident Doctor when completing a WPBA, but they should be a Consultant, ST, Associate Specialist, or Senior Nurse, Psychologist/AHP or Social Worker who feels confident to assess the case.

- For CT1/ST1-CT3/ST3 Resident Doctors; nurses, psychologists/AHPs and social workers at band 7 **or equivalent** (e.g., grade 9 for social workers) can be assessors.
- For ST4-ST6 Resident Doctors; nurses, psychologists/AHPs and social workers at band 8 **or equivalent** (e.g., grade 10 for social workers) can be assessors.
- CT1/ST1-CT3/ST3 Resident Doctors cannot assess each other, and ST4-6 Resident Doctors cannot assess each other but ST4-ST6 Resident Doctors can assess core Resident Doctors.

Resident Doctors should try and use a range of different assessors (ideally a different one for each assessment).

As always, we would recommend that Resident Doctors check with their Psychiatric Supervisor if they are unsure about the suitability of a particular assessor.

11.5 Resident Doctor responsibilities

Responsibilities for Resident Doctors include:

- Acting professionally and taking appropriate responsibility for patients under their care and for their training and development.
- Ensuring they attend the one hour of psychiatric supervision per week, which is focused on discussion of individual training matters, and development of the placement specific personal development plan, and not immediate clinical care. If this supervision is not occurring the Resident Doctor should

discuss the matter with their Educational Supervisor or Training Programme Director.

- Ensuring that they receive clinical supervision and support with their clinical caseload appropriate to their level of experience and training.
- Being aware of and ensuring that they have access to a range of learning resources including:
    - a recommended postgraduate course supporting the MRCPsych exam syllabus, supporting achievement of learning outcomes
    - a local postgraduate academic programme
    - the opportunity (and funding) to attend courses, conferences and meetings relevant to their level of training and experience
    - appropriate physical or online educational resources
    - the advice and support of an audit lead or similar
    - supervision and practical support for research with protected research time appropriate to grade.
- Making themselves familiar with all aspects of the curriculum and assessment programme and keeping a portfolio of evidence of training.
- Ensuring that they make it a priority to obtain and benefit from relevant experience in psychotherapy.
- Collaborating with their supervisor during psychiatric supervision to:
    - set up the placement-specific PDP to agree on educational objectives for each post, which should be reviewed regularly
    - maximise the educational benefit of one hour per week of psychiatric supervision sessions
    - undertake workplace-based assessments, assessed by their Clinical Supervisors, the Clinical Supervisor who undertakes psychiatric supervision and other members of the multidisciplinary team
    - reflect on feedback and use constructive criticism to improve performance
    - regularly review the placement to ensure that the necessary experience is being obtained
    - discuss pastoral issues if necessary.
- Have regular contact, with a recommended three sessions per year, with their Educational Supervisor to:
    - develop a personal learning and development plan with a signed educational agreement
    - ensure that workplace-based assessments and other means of demonstrating developing capability are appropriately undertaken

- review examination and assessment progress
- regularly refer to your portfolio to inform discussions about your achievements and training needs
- receive advice about wider training issues
- have access to long-term career guidance and support.

For higher Resident Doctors, it would be expected that organisation and initiation of meetings would sit with the Resident Doctor.

- Participate in an Annual Review of Competence Progression (ARCP) to determine their achievement of capabilities and progression to the next stage of training.
- On appointment to a specialty training programme the Resident Doctor must fully and accurately complete Form R (not required in Scotland) and return it to the Deanery with a coloured passport size photograph. (Form R is currently being integrated into Portfolio Online.)
- The return of Form R confirms that the Resident Doctor is signing up to the professional obligations underpinning training. Form R will need to be updated (if necessary) and signed on an annual basis to ensure that the Resident Doctor re-affirms their commitment to the training and thereby remains registered for their training programme.
- Resident Doctors must send to the postgraduate dean a signed copy of the Conditions of Taking up a training post, which reminds them of their professional responsibilities, including the need to participate actively in the assessment process. The return of the Form R initiates the annual assessment outcome process.
- They must inform the postgraduate dean and the Royal College of Psychiatrists of any changes to the information recorded.
- Resident Doctors should ensure they keep the following records of their training:
  - Copies of all Form Rs for each year of registering with the deanery.
  - Copies of ARCP forms for each year of assessment.
  - Any correspondence with the postgraduate deanery in relation to their training.
  - Any correspondence with the Royal College in relation to their training.
- Resident Doctors should make themselves aware of local procedures for reporting concerns about their training and personal development and if such concerns arise, they should report them in a timely manner.

11.6 Managing poor performance

For Resident Doctors where performance difficulties are highlighted, referral to specific support services should be considered. Referral should be made in discussion with the Resident Doctor and TPD and should be done in a timely manner, however if Resident Doctor insight and engagement prove challenging, an ARCP Panel recommendation may be required.

Examples of such services include:

- **Training Support/Professional Support and Wellbeing Services** – work with issues impacting on educational performance and progression, including communication skills, time management and also assessment of specific learning difficulties e.g., dyslexia.
- **Occupational Health Services** – Generic Occupational Health Services will be available through the Resident Doctor's employer and should be involved when a Resident Doctor's heath is impacting on their fitness to work. Specialist Occupational Health advice may be sought if there are issues regarding fitness to train.

- Resident Doctors with disabilities should receive **support and have appropriate Reasonable Adjustments made**, in consultation with Occupational Health, to enable them to meet their capabilities. If the necessary adjustments make it impractical for a Resident Doctor to achieve their capabilities, then this should be escalated by the TPD to the Head of School and advice sought from the Dean or designated APD.

Signs that a Resident Doctor may need performance support (adapted from Paice, 2006):

- Difficulty contacting a Resident Doctor; frequent sickness absences; lateness, not answering phone / texts / emails in a timely manner. Not informing admin and team of sick / annual / study leave, or of their whereabouts.
- Struggling with performing duties, difficulties with time management, clerking patients, dictating letters, making decisions.
- Feeling the Resident Doctor is struggling to contain their own anxiety and irritation. Unable to regulate own behaviour and unable to provide supportive containment to others.
- FLIPA:
  - struggling with being able to be **flexible** (F)
  - finding it difficult to **lead** (appropriate to the stage of training) (L)
  - difficulty being able to use **initiative** (I)
  - difficulty in being able to **prioritise** work and adapt to changing circumstances (P)
  - poor tolerance of **ambiguity**; finding it difficult to compromise and **adapt** (A).
- Being aware that other staff bypass the Resident Doctor in seeking advice.
- Difficulty with undertaking examinations; uncertainty regarding career choices, poor use of Portfolio Online (insufficient / infrequent uploads, disorganised entries, untimely WPBA arrangement) and engagement with training requirements.
- Difficulties in accepting feedback on performance, lack of insight into strengths and weaknesses, defensiveness or avoidance.

If you find yourself experiencing any of these indicators – please speak to your supervisors/trusted colleagues as help will be available.

11.6.1 Performance Support

Resident Doctors requiring performance support will be monitored and managed in psychiatric supervision and documented in the Psychiatric Supervision Report (PSR).

Additional support is provided through Educational and Clinical Supervision as required. Resident Doctors and trainers are encouraged to address performance issues early on and the placement-specific PDP will help to facilitate this.

12 Time out of training

12.1 Out of programme (OOP)

Resident Doctors can apply for a period of time out of training, known as going Out of Programme (OOP). All out of programme has to be approved by your postgraduate dean. Resident Doctors out of programme may also need approval from the RCPsych. Applications for OOP should be discussed with Resident Doctors' Training Programme Director (TPD) and Educational Supervisor (ES) as early as possible.

Approval can take up to three months, and Resident Doctors need to therefore give their employer (current and/or next) three months' notice.

Types of out of programme that Resident Doctors can apply for are as follows:

- **Out of Programme for Clinical Experience (OOPE)** – this could be to gain or enhance clinical experience relating to a specialty. OOPE doesn't count towards a CCT or CCT CP, so approval is not required from the RCPsych.
- **Out of Programme Career break (OOPC)** – This would be used to pursue other interests, or for a period of ill health. OOPC doesn't count towards a CCT or CCT CP so approval is not needed from the RCPsych.
- **Out of Programme for Research (OOPR)** – This is for a period of research (for example, time out to undertake an PhD). This will not normally exceed three years. OOPR can count towards a CCT or CCT CP and will need approval from the RCPsych.
- **Out of Programme for approved clinical training (OOPT)** – This is for clinical training which isn't part of your main training programme. OOPT is normally approved for a maximum of one year, but in exceptional circumstances can be approved for up to two years. OOPT can count towards a CCT or CCT CP and will need approval from the RCPsych.
- **Out of Programme Pause (OOPP)** – In 2019, NHSE undertook a pilot outlining a new route to taking time out of training called "OOP Pause". This allows Resident Doctors to "pause" their training, with the potential to retrospectively gain approval for time to count towards their CCT. Work is still ongoing, and further information can be found here.

12.2 Acting up as a consultant (AUC)

Acting up as a consultant psychiatrist may count towards a CCT or CCT CP where there is provision for these types of posts.

Where acting up as a consultant in the same training programme that a Resident Doctor has enrolled onto, approval from the RCPsych is not needed. If a Resident Doctor is acting up as a consultant in a different training programme, the usual process for applying out of programme (e.g. OOPT) must be followed. At the RCPsych, we refer to this as an 'OOPT-AUC'.

Up to a maximum of three months whole time equivalent (for LTFT Resident Doctor the timescale is also three months WTE) spent in an 'acting up' consultant post may count towards a Resident Doctors CCT as part of the GMC approved specialty training programme, provided the post meets the following criteria:

- The Resident Doctor follows local procedures by making contact with the Postgraduate Dean and their team who will advise Resident Doctors about obtaining prospective approval.
- The Resident Doctor is in their final year of training (or possibly penultimate year if in dual training), though it is preferable for this not to be in the final three months of training, as if any issues arise it would be difficult to address them in the limited time prior to CCT.
- The post is undertaken in the appropriate CCT specialty.
- The approval of the Training Programme Director and Postgraduate Dean is sought.
- There is agreement from the employing trust to provide support and clinical supervision to a level approved by the Resident Doctor's TPD.
- The Resident Doctor still receives one hour per week psychiatric supervision either face-to-face or over the phone by an appropriately accredited trainer.
- Resident Doctors retain their NTN during the period of acting up.
- Full time Resident Doctors should 'act up' in full time Consultant posts wherever possible. All clinical sessions should be devoted to the 'acting up' consultant post (i.e., there must be no split between training and 'acting up' consultant work).
- In exceptional circumstances, where no full time Consultant posts are available, full-time Resident Doctors may 'act up' in part-time consultant posts but must continue to make up the remaining time within the training programme.
- The post had been approved by the Regional Advisor (RA) (where appropriate) in its current form.
- If a Resident Doctor is on-call, there must be consultant supervision.
- If the period is at the end of the final year of the training programme, a recommendation for the award of a CCT will not be made until the report

from the Psychiatric and Educational Supervisors has been received towards the end of the acting up period, and there is a satisfactory ARCP outcome 6.

If the post is in a different training programme:

- the usual Out of Programme (OOPT) approval process applies, and the GMC will prospectively need to see an application form from the deanery and a college letter endorsing the AUC post.
- a programme is a formal alignment or rotation of posts which together comprise a programme of training in a given specialty or subspecialty as approved by the GMC, which are based on a particular geographical area.

For more information on time out of training and applications to the College, please contact Psychiatrytraining@rcpsych.ac.uk.

13 Assessment strategy and blueprint

13.1 Purpose

The Royal College of Psychiatrists assessment strategy has been designed to fulfil several purposes:

- Providing evidence that a Resident Doctor is a capable and safe practitioner and that they are meeting the standards required by Good Medical Practice, and the GMC's Generic Professional Capabilities Framework (GPC).
- Creating opportunities for giving formative feedback that a Resident Doctor may use to inform their further learning and professional development.
- Drive learning in important areas of capability.
- Help identify areas in which Resident Doctors require additional or targeted training.
- Providing evidence that a Resident Doctor is progressing satisfactorily by attaining the curriculum learning outcomes.

Contribute evidence to the Annual Review of Capability Progression (ARCP) at which the summative decisions regarding progress and ultimately the award of the Certificate of Completion of Training (CCT) is made.

13.2 Assessment blueprint

The assessment blueprint (outlined in the below matrix) shows the assessment methods that are mapped to each High Level Outcome (HLO) domain. It is not expected that all Resident Doctors will be assessed by all possible methods in each capability. The learning needs of individual Resident Doctors will determine which

capabilities they should be assessed in and the number of assessments that need to be performed. The Resident Doctor's Psychiatric and Educational Supervisors have a vital role in guiding the Resident Doctor and ensuring that the Resident Doctor's assessments constitute sufficient curriculum coverage.

13.2.1 Assessment matrix

The assessments have been mapped to the nine domains of the GMC's Generic Professional Capabilities Framework.

Resident Doctors are encouraged to map WPBAs to all Key Capability domains where possible. The below matrix outlines the suggested spread across all KC domains (see Appendix 1).

13.3 Assessment methodology

Our approach to the evaluation of a Resident Doctor's readiness to progress at the end of each year of training is based on both summative and formative assessment.

13.3.1 Summative assessment - MRCPsych examination

Two written papers (paper A and paper B) that comprise a summative assessment of the knowledge base that underpins psychiatric practice. Both papers must be passed before the doctor can proceed to the Clinical Examination (CASC).

The structure of the MRCPsych exam is as follows:

Paper A

Paper A is a three-hour online examination which is comprised of 150 questions, each worth one mark (150 marks in total):

- Two-thirds multiple choice questions (MCQ)
- One-third extended matching item questions (EMI).

Paper A covers the following sections of the MRCPsych Syllabus:

- Behavioural science and sociocultural psychiatry
- Human development
- Basic neurosciences
- Clinical pharmacology
- Classification and assessment in psychiatry.

The percentage split/marks are outlined below:

Behavioural science and socio-cultural psychiatry	16.67% / 25 marks

Human development	16.67% / 25 marks
Basic neurosciences	25.00% / 37 or 38 marks
Clinical psychopharmacology	25.00% / 37 or 38 marks
Classification and assessment in psychiatry	16.67% / 25 marks

Paper B

Paper B is an online paper which assesses critical review and the clinical topics in psychiatry. It is a three-hour exam with 150 questions (worth one mark each):

- One third of the paper covers critical review.
- Two thirds of the paper cover clinical topics.

Paper B covers the following sections of the MRCPsych Syllabus:

- Organisation and delivery of psychiatric services
- General psychiatry
- Old age psychiatry
- Psychotherapy
- Child and adolescent psychiatry
- Addiction psychiatry
- Forensic psychiatry
- Psychiatry of learning disability
- Critical review.

The percentage split/marks for each area are:

Organisation and delivery	5.50% / 8 marks
General	20.00% / 30 marks
Old age	9.00% / 14 marks
Psychotherapy	5.50% / 8 marks
Child and adolescent	9.00% / 14 marks
Addiction	6.50% / 10 marks
Forensic	5.50% / 8 marks
Learning disability	5.50% / 8 marks
Critical review	33.50% / 50 marks

Clinical Examination (CASC)

The Clinical Examination (Clinical Assessment of Skills and Capabilities - CASC) is a summative assessment of a doctor's competence in the core skills of psychiatric practice. CASC is an OSCE style examination consisting of two circuits, completed in one day.

The CASC is formed of 16 stations, and is structured as follows:

- Five stations focused on history taking, including risk assessment.
- Five stations focused on examination – both physical and mental state, including capacity assessment.
- Six stations focused on patient management.

The two circuits are devised as follows:

Circuit One	Six stations focused on management. One station focused on examination. One station focused on history taking. Four minutes reading. Seven-minute task.
Circuit Two	Four stations focused on examination. Four stations focused on history taking. 90 seconds reading. Seven-minute task.

The CASC exam is marked using the borderline regression method (BRM). Each station is marked by a trained examiner, who provides two sets of scores:

- Five-point 'analytic' global domain scores, ranging from 1 (poor) to 5 (excellent) for between three and five domains.
- One six-point overall global judgement which comprises of 'Excellent Pass', 'Pass', 'Borderline Pass', 'Borderline Fail', 'Fail', or 'Severe Fail'.

Further information on scoring can be viewed on the MRCPsych Examination pages.

On passing the CASC, the doctor is eligible to apply for membership of the Royal College of Psychiatrists (MRCPsych) provided other requirements are also met.

Resident Doctors must obtain a pass in the MRCPsych examination and achieve all core capabilities before they can be considered to have successfully completed core training.

13.3.2 Formative assessment - Workplace based assessment (WPBA)

This is the assessment of a doctor's performance in those areas of professional practice best tested in the workplace. The assessment of performance by WPBA continues the process established in the foundation programme and extends throughout core and higher specialty psychiatry training.

The purpose of WPBA is to provide formative feedback. To gain the full benefit of this formative feedback, Resident Doctors should ensure that their assessments take place at regular intervals throughout the period of training.

All Resident Doctors must complete at least one case-focused assessment in the first month of each placement in their training programme.

A completed WPBA accompanied by an appropriate reflective note written by the Resident Doctor and evidence of further development may be taken as evidence that a Resident Doctor demonstrates critical self-reflection.

Clinical, Psychiatric and Educational supervisors will draw attention to those Resident Doctors who aren't utilising opportunities to undertake WPBAs across the span of their training.

An individual WPBA is not a summative assessment, but outcomes from a number of WPBAs will contribute evidence to inform the Psychiatric Supervisor's report, the Educational Supervisor's Report and the summative decision of the ARCP panel at the end of each year of training

Further information on training and assessments can be found on the Training pages on the RCPsych website. Recommended numbers of WPBAs to be completed per specialty can be found in Appendix 4.

In undertaking the review of the current curricula, we haven't altered the WPBA system, but have mapped the assessment gradings within each form to the HLO themes (themselves mapped to the GMC's Generic Professional Capabilities (GPC) Framework). **HLOs and Themes**

1.1 Professional relationships

1.2 Professional standards

2.1 Communication

2.2 Clinical knowledge and skills

2.3 Complexity and uncertainty

3.1 Knowledge of legal and organisational frameworks

4.1 Health promotion and illness prevention in individuals and community

5.1 Teamworking

5.2 Leadership

6.1 Patient Safety

6.2 Quality improvement

7.1 Safeguarding

8.1 Education & Training

9.1 Conducting research and critical appraisal

Within each WPBA, assessors are asked to indicate a Resident Doctor's current level of attainment, by selecting points on the scale below.

Insufficient evidence	Needs improvement	Satisfactory	Good	Excellent
Insufficient evidence to make a judgment	Shows limited understanding and struggles with the application of knowledge, with minimal analysis and unclear communication	Displays basic understanding and adequate application of knowledge, with some analysis and clear communication.	Shows strong understanding and effective application of knowledge, with good analysis and clear communication.	Demonstrates comprehensive understanding and exceptional application of knowledge, with insightful analysis and clear communication.

Psychotherapy's case-based discussion group assessment (CbDGA), assessment of psychotherapy expertise (SAPE) or psychiatry assessment of clinical expertise (PACE) as they are all conducted under supervision, and the above scale therefore is not to be used for the psychotherapy WBPAs.

If it has not been possible to observe the Resident Doctor engaging in activities mapped to some HLOs, there is an 'Insufficient' option available.

The information gathered from WPBAs will underpin the formative conversations to be had between Resident Doctor and trainer as each placement-specific PDP progresses.

Workplace Based Assessments (WPBAs) used in training

- **Assessment of Clinical Expertise (ACE)** modified from the Clinical Evaluation Exercise (CEX), in which an entire clinical encounter is observed and rated thus providing an assessment of a doctor's ability to assess a complete case.
- **Assessment of Teaching (AoT)** enables an assessment to be made of planned teaching carried out by the Resident Doctor, which is a requirement of this curriculum.
- **Case Based Discussion (CBD)** is also used in the Foundation Programme and is an assessment made on the basis of a structured discussion of a patient whom the Resident Doctor has recently been involved with and has written in their notes.
- **Case Based Discussion Group Assessment (CBDGA)** has been developed by the College to provide structured feedback on a Resident Doctor's

attendance and contribution to case discussion groups (also known as Balint-type groups) in Core psychiatry Training.

- **Case Presentation (CP)** resident doctors in higher training will be encouraged to complete a case presentation each year to demonstrate their developing formulation skills, showing clear progression from ST4 to ST6. Case presentations can be assessed by the multidisciplinary team. This is seen as preparation for consultant practice by promoting collaborative discussion of cases with peers and MDT colleagues.
- **Direct Observation of non-Clinical Skills (DONCS)** has been developed by the College from the **Direct Observation of Procedural Skills (DOPS)**. This allows resident doctors to capture a wider range of activities and competencies not currently documented elsewhere in the portfolio. (see Appendix xx for an non exhausted list.)
- **Direct Observation of Procedural Skills (DOPS)** is also used in the Foundation Programme and is similar to mini-ACE except that the focus is on technical and procedural skills.
- Entrustability Scale should only be used within Psychiatry for Clinical Supervision and Education Supervision end of placement forms. (See Appendix 5)
- **Journal Club Presentation (JCP)** similar to CP, this enables an assessment to be made of a Journal article/research/quality improvement project presented by the Resident Doctor.
- **Mini-Assessed Clinical Encounter (mini-ACE)** modified from the **mini-Clinical Evaluation Exercise (mini-CEX)** used in the Foundation Programme, part of a clinical encounter, such as history-taking, is observed and rated.
- **Multi-Source Feedback (MSF)** is obtained using the **Mini Peer Assessment Tool (Mini-PAT)**, which is an assessment made by a cohort of co-workers across the domains of Good Medical Practice. Resident Doctors should nominate 10-12 suitable assessors who they currently work with, for the Mini-PAT assessment. Ideally this should include no more than two assessors in any one position (i.e. two consultants, two nurses, two peers, two juniors, two admin, two healthcare professionals etc). Resident Doctors should nominate their named Clinical Supervisor, that is, the consultant who is responsible for the majority of clinical supervision in their current placement, unless stated otherwise by their deanery. This may or may not be the same person as the Resident Doctor's educational supervisor. The Resident Doctor (should) discuss/agree in psychiatric supervision those who are to be nominated. A valid Mini-PAT requires at least six responses.
- Patient and Carer Feedback resident doctors must gather structured feedback as part of their development towards consultant practice. This should be completed at least once in CT and once in ST with the option to undertake it more frequently. Patient feedback can be collected in several ways: by sending patients a link to complete the form online, by offering the

form on a tablet during the appointment, or by providing a paper copy that administrative staff can later upload. Each cycle should include 6-10 pieces of Feedback. (see Appendix 5for further detail)

- **Psychotherapy Assessment of Clinical Expertise (PACE)** has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case. Should be overseen by the Psychotherapy Tutor, a Consultant Psychiatrist in Medical Psychotherapy.
- **Structured Assessment of Psychotherapy Expertise (SAPE)** has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case.
- **Supervisor's Assessment of Psychotherapy Assessment (SAPA)** has been developed by the College to provide support for evidence of satisfactory completion of a psychotherapy assessment.

13.3.3 Reflective practice

Reflective practice is important in ensuring Resident Doctors and trainers reflect on their practice, using reflection to further develop skills. We encourage reflective practice using the available reflective practice form on Portfolio Online. Further information on the importance of reflective practice can be found here.

13.3.4 HLO and key capability coverage across three years of training

By the end of core training/higher specialty training, the Resident Doctor must have met the expected standard against all of the HLOs.

In supervision, a Resident Doctor is expected to discuss the key capabilities that could be achieved in each specific placement and to plan activities, aligned to their personal development needs, to enable them to meet the standard expected for each of the HLOs at the end of each year of training.

All key capabilities do not have to be achieved in each placement / year: however, over the course of core and higher training activities should be undertaken to achieve most of the key capabilities.

As Resident Doctors progress, the cases that they are involved with will become more clinically complex: Resident Doctors should also be demonstrating greater autonomy.

13.3.5 Summative evaluation: Annual Review of Competence Progression

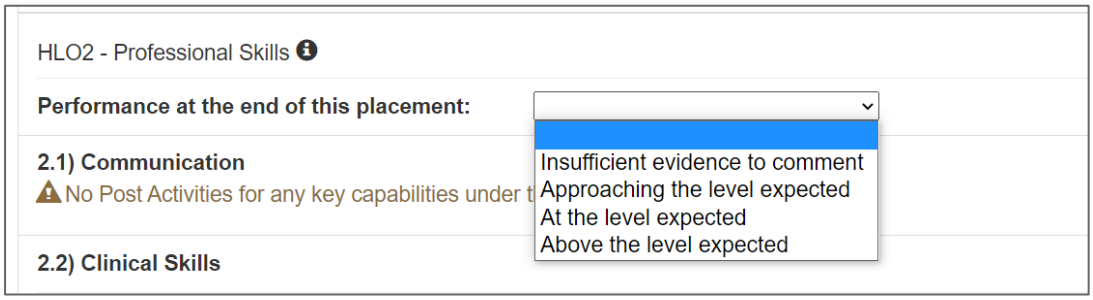
The ARCP panel reviews the evidence of achievement over the course of a year of psychiatric training. It reviews and validates the educational supervisor's recommended outcome against the Resident Doctor's performance, development and the portfolio of evidence compiled throughout the year.

ARCP is a summative evaluation of the evidence of whether a Resident Doctor has met or exceeded the minimum expected level of performance in each of the High

Level Outcomes. It decides whether the Resident Doctor may progress to the next stage of training.

Preparing for ARCP

As each placement ends, an evaluation of the Resident Doctor's current capabilities will be made by the trainer in psychiatric supervision and shown in the placement-specific PDP against each of the HLOs.



These evaluations (informed by the relevant ARCP guidance document) as well as other evidence, will then be reviewed by the Resident Doctor's Educational Supervisor or Training Programme Director and documented as part of their recommendation to the ARCP panel to help determine progression. The fundamental principle of the new curricula framework is that nothing relating to the ARCP outcome should be a surprise to the Resident Doctor at the end of the training year.

14 Protected professional development sessions

Professional development sessions (PDS) are an integral part of the psychiatry higher training programme which are currently known as 'Special Interest Sessions' throughout the higher psychiatry training curricula.

14.1 Description

Higher Resident Doctors require time separate to clinical duties to enable them to fulfil both the breadth and depth of the curriculum. These sessions provide learning opportunities that might not otherwise be available to them. It is anticipated that the Resident Doctor will undertake a range of PDS during their higher training, according to their training and development needs.

Protected PDS consist of **two sessions of four hours per week** (pro-rata for LTFT Resident Doctors) and are separate to weekly teaching programmes for higher Resident Doctors, study leave and mandatory training requirements (e.g., risk assessment/fire safety/Mental Health Act/information governance training etc). See section 5.2.3 for specific guidance for CAP Resident Doctors.

A plan for professional development sessions must be created prospectively and agreed with the Educational Supervisor/Training Programme Director as part of a Resident Doctors' personal development plan (PDP). The activities during protected PDS will align with the curriculum, specifically the HLOs and require evidence of achievement such as appropriate WBPAs.

For example, protected PDS may be used to achieve the learning objectives in research that might not be available in the Resident Doctor's clinical role and supervisors should encourage all Resident Doctors to take up this opportunity for a recommended one session per week for a year. The Resident Doctor may use the protected PDS to further develop a relevant clinical interest or address a learning need by gaining clinical experience at a specialist clinic (e.g. adult ADHD, eating disorders, adult ASD, neuropsychiatry including sleep disorders etc) or by obtaining a higher education (e.g. Post Graduate Certification) or leadership and management qualification (e.g. RCPsych Leadership and Management Scheme).

14.2 Benefits

GMC research has suggested that increased pressure on doctors has led to certain aspects of clinical service being prioritised at the expense of continuing professional development and reflection. These activities are important for the overall health system to operate efficiently and safely in the long term *(The state of medical education and practice in the UK 2018, GMC)*.

Protected professional development sessions (PDS) where training needs are protected from clinical pressures can mitigate these concerns, although the long-term benefits may be difficult to quantify. However, professional development sessions should not replace training and supervision in the Resident Doctor's usual workplace, merely complement it.

Consultant psychiatrists are independent learners who undertake continuous professional development to ensure their practice utilises the latest knowledge and skills *(Continuing Professional Development, GMC)*. The development of a personal development plan is key to building the skills required to identify learning needs and self-directed learning within the curriculum framework.

Consultant psychiatrists often hold multiple professional roles and responsibilities *(Generic Professional Capabilities Framework, GMC)*. To reflect this wide-ranging skill set Professional Development Sessions have a broad scope allowing Resident Doctors to advance clinical and non-clinical skills to support future practice.

A training programme with multiple connections to other areas of practice is desirable as it exposes Resident Doctors to patients whose needs cross specialty boundaries *(Adapting for the future, GMC)*. Furthermore, the broad ecology of skills and knowledge fostered through the flexibility afforded in PDS contributes to making the consultant workforce of the future more resilient, diverse and responsive to patient needs.

For example, a Resident Doctor undertaking Balint leadership training, would be able to better supervise colleagues, assist in training future psychiatrists as well as gain a deeper understanding of their patients' psychological formulation.

Encouraging Excellence is a key principle of postgraduate curricula *(Excellence by Design, GMC)* and professional development sessions should encourage Resident Doctors to realise their full potential. As they are personalised with a wide variety of educational opportunities available, these sessions will hopefully provide an engaging and relevant educational experience leading to excellence in learning outcomes.

Professional development sessions may also benefit recruitment and retention. Resident Doctors' highly value protected training time *(Supported and Valued, RCPsych)* and therefore less protected training time may exacerbate an already high attrition rate.

15 Study leave

Current guidance on study leave can be found on the relevant NHSE, NES, HEIW, NIMDTA websites.

16 Annual Review of Competence Progression

This section deals with how ARCP panels review supporting evidence enabling them to arrive at a judgement of progress (known as an 'Outcome').

16.1 ARCP: What is its purpose?

The ARCP provides a formal process that reviews the evidence presented by the Resident Doctor and their Educational Supervisor relating to the Resident Doctor's progress in the training programme. It enables the Resident Doctor, the Head of School/Postgraduate Dean and employers to document that the capabilities required are being gained at an appropriate rate and through appropriate experience.

It should normally be undertaken on at least an annual basis for all Resident Doctors and with no more than a maximum interval of 15 months to facilitate revalidation. The process may be conducted more frequently if there is a need to deal with performance and progression issues or, where appropriate, to facilitate acceleration of training outside of the annual review.

The ARCP fulfils the following functions:

- It provides an effective mechanism for reviewing and recording the evidence related to a Resident Doctor's performance in the training programme or in a recognised training post (e.g., locum appointment for training (LAT) – Scotland only).
- At a minimum, it must incorporate a review of the Resident Doctor's educational portfolio including a structured report from the Educational Supervisor(s), documented assessments (as required by the specialty curriculum) and achievements.
- It provides a means whereby the evidence of the outcome of formal assessments, through a variety of GMC-approved workplace-based assessment tools and other assessment strategies (including examinations that are part of the programme of assessment), is coordinated and recorded to present a coherent record of a Resident Doctor's progress.
- It provides an effective mechanism for the review of out-of-programme experience and recording its contribution (where approved) to progress. It considers any time out of training during the assessment period and from entry to the programme and determines whether the training duration needs to be extended.
- As long as adequate documentation has been presented, it makes judgements about the capabilities acquired by Resident Doctors and their suitability to progress to the next stage of training.

- As long as adequate documentation has been presented, it makes judgements about the capabilities acquired by Resident Doctors in a LAT post (Scotland only) and documents these accordingly.
- It provides advice to the Responsible Officer (RO) about revalidation of the Resident Doctor across their full scope of work to enable the RO to make a recommendation to the GMC when required and ensures that any unresolved concerns about fitness to practise are acted on.
- It provides a final statement of the Resident Doctor's successful attainment of the curriculum capabilities including fulfilment of the GMC's standards in the Generic Professional Capabilities Framework for the programme and thereby the completion of the training programme.
- It enables the Postgraduate Dean to present evidence to the relevant College/Faculty so that it can recommend the Resident Doctor to the GMC for award of the CCT or CCT CP.
- Where applicable, it provides comment and feedback on the quality of the structured Educational Supervisor's report.

16.2 ARCP Outcomes

The new training framework aims to ensure that the majority of Resident Doctors achieve ARCP Outcome 1s by addressing any areas needing extra support at the earliest possible stage.

The ARCP panel will recommend an outcome described below for each foundation/specialty/sub-specialty for each Resident Doctor, including those on integrated clinical/academic programmes.

The ARCP outcome should not be a surprise to the Resident Doctor, and Resident Doctors should be given some indication of their progress prior to the ARCP panel.

It is hoped that the setting up and regular review of the new, structured placement-specific personal development plans (PDPs) in the RCPsych online-portfolio will give Resident Doctors a timely view of their progress.

For dual training or main specialty and sub-specialty training, the GMC requires a separate outcome per specialty and sub-specialty.

It is recommended that members of the panel use a checklist to confirm that they have considered all the requirements and add any comments to explain the judgement.

While the ARCP panel must recommend the outcome for an individual Resident Doctor on the basis of the submitted evidence, it must also take into account any mitigating factors on the Resident Doctor's part such as personal circumstances.

When an Outcome 2, 3 or 4 recommendation is made by the ARCP panel, the Postgraduate Dean will confirm this in writing to the Resident Doctor, including where relevant their right to review or appeal the decision.

The ARCP process should be uniform throughout the UK and regional variations actively discouraged. Historically, variation in process has grown up through well-meaning attempts to improve quality in individual schools. However, this has resulted in a plethora of local forms and expectations. Further information on our guidance for ARCPs can be found in our ARCP recommendations paper.

17 Transferring between specialties

The Accreditation for Transferrable Competencies Framework (ATCF) has been replaced by the AoMRC's *Guidance for Flexibility in Postgraduate Training and Changing Specialties.*

18 Applying for consultant Psychiatry posts

Resident Doctors are eligible to apply for a consultant post and may be interviewed up to six calendar months (WTE) prior to their anticipated CCT/CCT CP date if progress has been satisfactory and if it is anticipated that the final ARCP outcome will recommend that training is completed by the time the suggested CCT/CCT CP date is reached.

There may be instances when the six-month period is interrupted by statutory leave. In those circumstances, it is a decision for the potential employer as to whether the Resident Doctor is eligible for the consultant post. Once a doctor has been entered on the specialist register, they are able to take up a substantive, fixed-term or honorary consultant post in the NHS.

Where ARCP Outcome 6 is not subsequently issued and the Resident Doctor has already been appointed to a consultant post, the Resident Doctor will need to inform the employer immediately to discuss the possibility of deferring the start of employment to follow award of a CCT/CCT CP.

There may be exceptional circumstances where there is a requirement for tailored training within the approved curriculum towards a specific post. An advance appointment longer than six months can then be justified where particular training requirements for the post have been identified that would need to be met in the latter stages of training leading to CCT/CCT CP. Such circumstances would require authorisation by the appropriate health department and must be outlined in the recruitment documentation and agreed by the Postgraduate Dean.

19 Less than full-time (LTFT) training

19.1 Overview

NHSE, NES, HEIW and NIMDTA have a strong commitment to helping all doctors in training to reach their full potential. All doctors in training can apply for LTFT training.

This guidance is drawn from the NHS Employers document Principles Underpinning the New Arrangements for Flexible Training (2005) and is supported by the GMC's position statement on LTFT training (2017).

Those in LTFT training must meet the same requirements in specialty and general practice training as those in full-time training, from which it will differ only in the possibility of limiting participation in medical activities by the number of hours worked per week.

The aims of LTFT training are to:

- retain in the workforce doctors who are unable or do not wish to continue their training on a full-time basis.
- promote career and personal development as well as work/life balance for doctors training in the NHS.
- ensure continued training in programmes on a time equivalence (pro rata) basis.

A balance needs to be maintained between LTFT training arrangements, the educational requirements of both full-time and LTFT Resident Doctors, and service need. As far as possible, Postgraduate Deans will seek to integrate LTFT training into full-time training by:

- using full-time posts for LTFT training placements
- using slot shares
- ensuring equity of access to study leave
- developing permanent LTFT training placements and programmes where appropriate.

In exceptional circumstances, the Postgraduate Dean may consider the establishment of personal, individualised placements that are additional to those funded through routine contract arrangements, subject to training capacity, GMC approval and resources.

Resident Doctors will:

- Reflect the same balance of work as their full-time colleagues.

- Day-time working, on-call and out-of-hours duties will normally be undertaken on a basis pro rata to that worked by full-time Resident Doctors in the same grade and specialty unless either operational circumstances at the employing organisation or the circumstances that justify LTFT training make this inappropriate or impossible, provided that legal and educational requirements are met.
- Normally move between placements within rotations on the same basis as full-time Resident Doctors.

Resident Doctors on LTFT placements are not precluded from undertaking other work although they should ensure that in undertaking this work, they practise according to the GMC's standards in Good Medical Practice and that this does not impact negatively on their training. By utilisation of their annual Form R submission, they should ensure that the Postgraduate Dean as their designated Responsible Officer is aware of all additional work undertaken within their remit of holding a licence to practise. Further information can be found on the COPMeD webpages.

Decisions by NHSE, NES, HEIW and NIMDTA only relate to educational support for the application. Employers/host training organisations must make a separate decision about the employment aspects of any request, including the proposed placement and any associated out-of-hours work. Contractual provisions are addressed in the NHS Employers document Equitable Pay for Flexible Medical Training (2005) and on their webpages regarding terms and conditions of service.

19.2 Eligibility for LTFT training

Employment legislation setting out the statutory right to request flexible working sets the recommended standards with which an employer must comply. The legislation does not set a priority order around reasons for requesting flexible working.

Building on the 2005 NHS Employers document Principles Underpinning the New Arrangements for Flexible Training, the Gold Guide should be considered as providing separate guidance to this legislation, in the context of requesting to undertake LTFT training in a training programme. This reflects the tripartite nature of current practice of supporting LTFT training between the Resident Doctor, NHSE, NES, HEIW or NIMDTA and the employer/host training organisation.

For further information on LTFT training, please see the Gold Guide.

20 Academic training, research and higher degrees

All of the specialty training curricula require Resident Doctors to understand the important value and purpose of medical research, and to develop the skills and attributes needed to critically assess research evidence. We recommend that Resident Doctors familiarise themselves with research methodology as outlined in capabilities in HLO 9 in all curricula.

Good Clinical Practice (GCP) training is one option for obtaining knowledge in this area. Further information about GCP training can be found here.

In addition, some Resident Doctors will wish to consider or develop a career in academic medicine and may wish to explore this by undertaking a period of academic training (in either research or education) during their clinical training. The following web links provide important advice on pursuing an academic clinical career:

- National Institute for Health Research Integrated Academic Training
- NHS Scotland | Scottish Academic Training (SCREDS) and PsySTAR
- HEIW | Academic Medicine
- NIMDTA | Academic Training
- Academy of Medical Sciences
- Psych Star Scheme
- Clinical Academic posts
- Out of Programme (Research), which includes PhDs and additional research opportunities

Such opportunities are available through two main routes:

Option 1: Resident Doctors can compete for opportunities to enter integrated combined academic and clinical programmes.10 Those who are appointed to such posts will need to meet the clinical requirements for appointment if they are not already in specialty training, as well as the academic requirements. Examples of integrated academic training include academic foundation programmes.

Option 2: Resident Doctors can take time out of their specialty training programme for a period of time entirely focused on research leading to either an MD or PhD (time out of programme for research (OOPR), with the agreement of the TPD and Postgraduate Dean. Resident Doctors will continue to hold their training number/contract during this time out of their clinical programme. (Other routes may be available to Resident Doctors in certain specialties such as public health.)

For more information, please view the Gold Guide.

21 Training: protected characteristics

21.1 Doctors with protected characteristics

The Equality Act (2010) outlines protected characteristics as follows:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

We are aware that other groups, including, asylum seekers and refugees, and International Medical Graduates (IMGs), are not currently included under the above headings but we have included these in our curricula.

The curricula are designed to be broad and flexible, allowing Resident Doctors flexibility in developing their capabilities. We expect Resident Doctors and trainers to take responsibility for ensuring protected characteristics are taken into account, and that reasonable adjustments are made where possible. Resident Doctors who anticipate that a protected characteristic(s) will have a potential impact on their training should discuss this with their Educational Supervisor in the first instance. Supervisors are expected to ensure that adjustments are made so that Resident Doctors can undertake and complete curricula requirements.

Postgraduate Deans, programme directors and FSDs are required to tailor individual specialty training programmes to help doctors with disabilities to meet the requirements for satisfactory completion. The outcomes set out in the curriculum should be assessed to the same standard but reasonable adjustments may need to be made to the method of education, training and assessment.

Employers must make reasonable adjustments if appointees with a disability require these.

The need to do so should not be a reason for not offering an otherwise suitable placement. They should also take into account the assessments of progress and individual appointee's educational needs wherever possible.

Applicants should inform their Training Programme Director and employer at an early stage so that a suitable rotation can be identified.

All Resident Doctors who are unable to train and work on health grounds should be managed in the first instance under their employer's occupational health arrangements and are eligible through their employer for statutory sickness absence and pay, which is dependent on their length of service.

Postgraduate Deans/Deputies will review any health matters (including occupational health advice) with Resident Doctors to ensure appropriate decisions are made regarding training.

All Resident Doctors with a full licence to practise, including those who are unable to train or work on health grounds, must comply with the requirements for revalidation and submit Form R annually.

21.2 Absences from training / certification (completion) date

Absences from training (including OOP not approved towards training), other than for study leave or annual leave, may have an impact on a doctor's ability to show competence/capability and progression through the curriculum. The GMC has therefore determined that within each 12-month period where a Resident Doctor has been absent for a total of 14 days or more (when a Resident Doctor would normally be at work), a review will be triggered of whether the Resident Doctor needs to have their core training programme end date or CCT/CCT CP date extended. Generally, when a Resident Doctor returns from extended planned leave e.g. maternity leave, they should get their revised CCT date using the RCPsych CCT calculator and upload it to Portfolio Online.

Where Resident Doctors returning from statutory leave (e.g., maternity/paternity/fostering /adoption leave) have been able to account for unused annual leave, in accordance with the GMC's 2012 position statement on time out of training, this may impact on the core training programme end date or CCT/CCT CP date when this is reviewed at the ARCP.

The GMC's Good Medical Practice states that it is the responsibility of each individual Resident Doctor to be honest and open, and to act with integrity. As such, Resident Doctors should ensure that NHSE, NES, HEIW or NIMDTA are aware of their absences through the relevant reporting processes. This information will be shared with the relevant College/ Faculty and the GMC.

22 Inter-deanery transfer (IDT)

The national **inter-deanery transfer** (IDT) process has been put in place to support medical Resident Doctors who have had an unforeseen significant change in circumstances since commencement of their current training programme that remains at the date of their IDT application. Resident Doctors are able to submit an application and required supporting documents in one of the two transfer windows that take place each year.

The national IDT eligibility criteria, application guides, supporting document templates and FAQs can be found at Inter Deanery Transfers. Resident Doctors should familiarise themselves with these documents before applying as only applications that meet the eligibility criteria, including the supporting document requirements, can be considered for a transfer.

While it is possible for Resident Doctors to move between NHSE, NES, HEIW and NIMDTA (via IDTs), there is no automatic entitlement or right for this to take place. Resident Doctors will be expected to provide evidence that they have well-founded reasons for needing to move and that it is not tenable for them to remain in their current training programme.

Transfers are contingent on the availability of a funded training post and a training number/contract in the receiving locality in NHSE NES, HEIW or NIMDTA. Post funding and the training number/contract do not follow the Resident Doctor.

Transfers will only be considered during two time period windows each year, which will be advertised in advance. The timing of these windows allows Resident Doctors, who may be required to give three months' notice, sufficient time to do so if transferring to posts commencing in August and February.

Start dates for posts will be agreed between the transferring/receiving locality in NHSE, NES, HEIW or NIMDTA and the Resident Doctor. Requests to transfer will not be considered outside of these windows except in very exceptional circumstances. It would be expected that any Resident Doctor transferring as part of this process would have appropriate educational review normally in the form of an ARCP prior to transfer.

There are situations where Resident Doctors will move across national or local office boundaries without requiring an IDT:

- Educational or training reasons - NHSE NES, HEIW and NIMDTA should provide a full range of programmes and placements for the specialties in which they offer training (or have formal arrangements for doing so that are not dependent on ad hoc transfer arrangements).
- Secondment to a different locality in NHSE, NES, HEIW or NIMDTA. This would normally be undertaken as OOPT, and such moves would be planned to fit in with the agreed training programme and training availability. Resident Doctors would keep their original training number/contract.
- Rotation between NHSE, NES, HEIW and NIMDTA as part of a planned training programme This arrangement applies in some specialties and across placements in NHSE, NES, HEIW and NIMDTA because of local arrangements or to support access to appropriate training in some specialties.
- Undertaking research in a different locality in NHSE, NES, HEIW or NIMDTA - Resident Doctors given permission by their Postgraduate Dean to take OOPR will retain their home training number/contract even if research takes place in a different locality in NHSE, NES, HEIW or NIMDTA.

Resident Doctors will have no entitlement to transfer subsequently to the locality in NHSE, NES, HEIW or NIMDTA in which they have been doing their research but will need to go through either the IDT request process (and meet the requirements of eligibility) or a competitive process.

- Undertaking sub-specialty training in a different locality in NHSE, NES, HEIW or NIMDTA - Resident Doctors who are successful in being appointed to a sub-specialty training programme in a different locality in NHSE, NES, HEIW or NIMDTA will usually have no entitlement to transfer. They will remain under the management of the home locality in NHSE, NES, HEIW or NIMDTA and return there after completion of the sub-specialty training.

Further information is outlined in the Gold Guide.

We hope you find the above information useful, however please don't hesitate to contact your PS or ES, or TPD, and the College if you have any further queries via Psychiatrytraining@rcpsych.ac.uk.

23 Useful links

- RCPsych Training Pages
- RCPsych Faculty Pages
- RCPsych Special Interest Groups
- Academy of Medical Royal Colleges
- General Medical Council

24 Glossary

Advocacy – A family member, carer or relevant other seeks to uphold a person's rights, ensure fair and equal treatment, making sure that all options are considered and that decisions are taken with consideration for the person's unique perspective and preferences.

Active listening – fully concentrating on and understanding what is being said rather than just passively 'hearing' the message – both verbal and non-verbal.

Autonomy – the right of patients to take decisions about their medical care without their health care provider trying to influence the decision.

Clinical formulation - sets out the presenting issue; the history, including factors that: predispose to, precipitate and perpetuate and protect; the concerns and the plan.

Empathetic - an action of understanding and acknowledgement, being aware of and sensitive to the feelings, thoughts and experiences of the patient.5

Holistic model / approach – understanding and applying the psychological, biological, social, cultural and spiritual context in the delivery of person-centred mental healthcare.

Person-centred – focuses on the patient as a person, with 'personhood' being its superordinate principle. Takes into account all protected characteristics in doing this.

Phenomenology – studies structures of conscious experience as experienced from the first-person point of view, along with relevant conditions of experience.

Restrictive practice/s – refers to the implementation of any practice that restricts an individual's movement, liberty and/or freedom to act independently without coercion or consequence.

Safeguarding – the process of protecting children and adults to provide safe and effective care.

Shared decision-making – is a model of consent mandated by the Montgomery ruling; it is a collaborative process through which a clinician supports a person to reach a decision about their treatment.

Stigma – is associated with discrimination and is experienced as shame or discredit.

Sustainability – designing and delivering services that prioritise prevention; empower individuals and communities; improve value and consider the carbon footprint.

Transference/counter transference – transference occurs when a patient unconsciously redirects feelings for a significant person towards the doctor and countertransference occurs when a doctor transfers emotion towards the patient.

Value – a value is anything positively or negatively weighted as a guide to decision and action.

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General psychiatry

Child and adolescent psychiatry

Forensic psychiatry

Medical psychotherapy

Old age psychiatry

Psychiatry of learning (intellectual) disability

Sub-specialty Advisory Committees (SSAC)

Addiction Curriculum Working Group

Liaison Psychiatry Curriculum Working Group

Rehabilitation Curriculum Working Group

Academic Psychiatry

Faculties and Special Interest Groups

Faculties

Academic

Addictions

Child and adolescent

Eating disorders

Forensic

General

Intellectual disability

Liaison

Medical psychotherapy

Neuropsychiatry

Old age

Perinatal

Rehabilitation and social

SIGs

Adolescent forensic

Arts psychiatry

Evolutionary psychiatry

Forensic psychotherapy

History of psychiatry

Neurodevelopmental psychiatry

Occupational psychiatry

Philosophy

Private and independent practice

Rainbow SIG (LGBTQ+)

Spirituality

Sport and exercise psychiatry

Transcultural psychiatry

Women and mental health

Volunteering and International

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Stakeholders

Health Education England

East Midlands Deanery

East of England Deanery

Kent, Surrey & Sussex

London Deanery

North East

North West Deanery

Peninsula Deanery

Severn Deanery

Thames Valley

West Midlands Deanery

Wessex Deanery

Yorkshire & Humber Deanery

Scotland Deanery

Northern Ireland Medical & Dental Training Agency

Wales Deanery

Heads of Schools

Training Programme Directors

CESR Assessors

Psychiatry Resident Doctors

British Psychological Society

Mind the Mental Health Charity

Mental Health Foundation

Sane (Mental Health Charity)

Mental Health UK

Young Minds

Time to change

Patients and Carers Committee

British Medical Association

NHS Employers

SAS Doctors

Psychiatry Support Service

Care Quality Commission (CQC)

Department for Health & Social Care (DHSC)

Academy of Medical Royal Colleges

General Medical Council (GMC)

Public Health England (PHE)

Appendix 1 – Assessment matrix

HLO Domain	1.1	1.2	2.1	2.2	2.3	3.1	4.1	5.1	5.2	6.1	6.2	7.1	8.1	9.1
Assessments														
ACE	X	X	X	X	X	X	X	X	X	X	X	X	X	X
AoT	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CbD	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CbDGA (Balint Group)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DONCS	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DOPS	X	X	X	X	X	X	X	X	X	X	X	X	X	X
JCP	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mini-ACE	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mini-PAT	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MRCPsych Exam	X	X	X	X	X	X	X			X	X			X
PACE	X	X	X	X	X									
SAPE	X	X	X	X	X									
SAPA	X	X	X	X	X									
Supervisor Reports	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Reflective Practice	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Appendix 2 – Supervision in psychiatry

Supervision Area	Clinical Supervision	Psychiatric Supervision	Educational Supervision
Who is eligible to supervise?	Currently under review.	Currently under review.	Currently under review.
Supervision Responsibility & Frequency	**Day-to-day** awareness of nominated clinical supervisor in all clinical situations.	Regular 1:1 supervision, often a nominated consultant who is also providing clinical and sometimes educational supervision. 1 hour per week mandatory for all Resident Doctors, including all LTFT residents	Responsible for educational supervision for one or more Resident Doctors (no more than five Resident Doctors). Two meetings per placement (or 4-6 per year).
Protected time requirements	As part of clinical professional responsibility as an experienced psychiatrist.	**0.25PA per week** per Resident Doctor protected time.	Usually **1 PA per week** for up to six Resident Doctors, agreed within job-planning
Supervision Level	Required for all Resident Doctors throughout core and higher training. Clinical supervision should be tailored to ensure patient safety and meet the developmental needs of individual Resident Doctors.	Required for all Resident Doctors throughout core and higher training.	Required for all Resident Doctors throughout core and higher training.
Purpose	**Aim** – to ensure patient safety and support clinical teaching and training.	**Aim** – to support professional development of psychiatrists in training. Supports strategies for developing resilience, well-being and maintaining appropriate	**Aim** – to support and monitor educational progress. Works with individual Resident Doctors to develop and facilitate an individual learning plan to develop curriculum key capabilities.

		professional boundaries, as well as developing sophisticated understanding of therapeutic relationships and psychodynamic aspects of the work. The role also includes pastoral, developmental, leadership and containing elements.	
Delegation	Clinical supervision can be delegated to other suitably qualified doctors. When delegating, it is good practice to ensure that all stakeholders are aware of their roles and responsibilities.	Psychiatric supervision must not be delegated to others except in exceptional situations of unplanned absence where arrangements must be made for a substantive consultant to provide one hour of weekly 1:1 supervision.	The Educational Supervisor liaises with their local Training Programme Director, DME and other members of department to ensure awareness of a Resident Doctor's training needs and that resources are in place to meet these.
Assessments	WBPAs (Workplace Based Assessments) Multidisciplinary Teams (MDT) can contribute to WPBAs. This can provide valuable insight into resident doctors' clinical practice communication, professionalism and team working. This should be discussed with the psychiatric supervisor and seen as complementary in the individualised learning plan of the resident doctor.	Responsible for producing the Psychiatric Supervision Report (PSR). Responsible for developing placement specific Personal Development Plans (PDPs) with their Resident Doctors, in collaboration with Educational Supervisor.	Oversees plan to complete WPBAs. Responsible for producing Educational Supervisor Report (ESR) **annually for Resident Doctors**.
CPD and recognition of trainer status	Must attend relevant local training for recognition of trainer status.	Capabilities developed during full postgraduate training in psychiatry.	Must attend relevant local training for recognition of trainer status. This

	This is typically run by Postgraduate Deaneries or equivalent bodies.	In addition, Psychiatric Supervisors are encouraged to undertake further training and attend updates run by RCPsych. Psychiatric Supervisors must have completed relevant training to receive recognition of trainer status.	is typically run by Postgraduate Deaneries or equivalent bodies.

Appendix 3 – Quality assurance in training schedule

Area of work	Annual Activity	Regular Activities	Responsibility
National Training Survey (NTS)	Input into NTS questions via the GMC quality team to ensure questions are fit for purpose to psychiatry.		Quality Assurance Committee Educational Standards Manager
	Review responses for NTS questions for psychiatry and monitor any identified outliers and trends.		
Externality	Training of College appointed External Advisors.		Quality Assurance Committee Educational Standards Manager
	Recruitment drive for External Advisors	Regular recruitment and monitoring of active EAs to attend	
	Monitor % externality at ARCP panels	Chase EA reports and present any issues to the QAC	
		Monitor trends from EA submitted reports	
ARCP Outcome Variance	Quality improvement of ARCP data and thematic analysis	Assess regional trends and highlight concerns	Quality Assurance Committee Educational Standards Manager Training Manager

College Tutors (CTs)	Annual meeting of CTs Annual CT report	Regular contact with CTs through College system	Educational Standards Manager Specialist Advisor for Quality Assurance
Recommendations to the GMC for entry to specialist register		Recommendations made as applications are received. Quality checks for CCTs include: • ARCP outcomes • Receipt of MRCPsych or equivalent • Recommended timescales met	Training Manager
Quality in Training Report (QIT)	Annual publication of quality in training report, outlining the following key areas: • ARCP outcome variance • Externality • OOP • CCT Combined Programme • MTI Scheme • Wellbeing • Impact on training (e.g. COVID-19) • Curricula review	Data analysis and collection	Educational Standards Manager

College Committee Oversight		Quarterly committee meetings: • Quality Assurance Committee • Curricula & Assessments Committee • Heads of School meetings • Education & Training Committee • Portfolio Pathway Committee • Specialty/sub-specialty advisory committees	Educational Standards Manager Training Manager Head of Training & Workforce
Time out of training (OOP)	Annually report figures in the QIT report.	Process applications as received.	Specialist Advisor for QA Educational Standards Manager
Curricula & Assessment	Annual review of curricula framework: • Psychiatry Silver Guide • Key capabilities • ARCP Decision Aids • Placement-specific PDPs	Review amendment submissions through College process.	Associate Dean for Curricula Educational Standards Manager
Post and Programme Approvals	Annual report of post and programme approvals (addition to QIT)	Specialty Advisory Committees (SACs) review applications for posts and programmes from deaneries and outline recommendations to GMC where required.	Specialist Advisor for Quality Assurance Associate Dean for Curricula Educational Standards Manager SAC Chairs

Appendix 4 – Recommended WPBAs per specialty and training year

Core psychiatry

WPBA	Recommended number required per year		
	CT1	CT2	CT3
ACE	2	3	3
Mini-ACE	4	4	4
CbD	4	4	4
CbDGA	2	-	-
CP	1	1	1
DOPS	*	*	*
Mini-PAT	2	2	2
JCP	1	1	1
AoT	*	*	*
DONCS	*	*	*
PACE	-	1**	1**
SAPE	-	1	2
Total	**16**	**17**	**18**

* No set number to be completed; they may be performed as the opportunity arises

** Two PACE assessments can be undertaken whenever appropriate for the short and long cases

- Not required

General psychiatry and endorsements

WPBA	Recommended number required per year		
	ST4	ST5	ST6
ACE	2	1	1
Mini-ACE	2	2	2
CbD	6	4	4
Mini-PAT	2	1	1
AoT	2	2	2
DONCS	3	3	3
SAPE / PACE / CbDGA / SAPA	1	1	1
Total	**18**	**14**	**14**

Old age psychiatry and endorsement

WPBA	Recommended number required per year		
	ST4	ST5	ST6
ACE	2	1	1
Mini-ACE	2	2	2
CbD	6	4	4
Mini-PAT	1	1	1
AoT	2	2	2
DONCS	3	3	3
SAPE	1	1	1
Total	**17**	**14**	**14**

Forensic psychiatry

WPBA	Recommended number required per year		
	ST4	**ST5**	**ST6**
ACE	1	1	1
Mini-ACE	3	2	2
CbD	6	5	5
Mini-PAT	1	1	1
AoT	1	1	1
DONCS	2	3	4
SAPE	0	1	0
Total	**14**	**14**	**14**

Child and adolescent psychiatry

WPBA	Recommended number required per year		
	ST4	**ST5**	**ST6**
ACE	2	2	2
Mini-ACE	3	2	2
CbD	6	5	5
Mini-PAT	2	2	2
AoT	1	1	1
DONCS	2	3	4
SAPE	1	1	0
Total	**17(16)**	**16**	**16**

Psychiatry of Learning disability

WPBA	Recommended number required per year		
	ST4	ST5	ST6
ACE	2	2	2
Mini-ACE	2	2	2
CbD	4	4	4
Mini-PAT	2	2	2
AoT	1	1	1
DONCS	3	3	3
Total	**14**	**14**	**14**

We do not recommend a minimum number of WBPA to assess psychotherapy experience, but Resident Doctors should consider using appropriate formats including CbD and CbDGA for this.

Medical psychotherapy

WPBA	Recommended number required per year		
	ST4	ST5	ST6
ACE	2	2	2
Mini-ACE	*	*	*
CbD	4	4	4
Mini-PAT	1	1	1
AoT	1	1	1
DONCS	1	1	1
SAPE	2	2	2
SAPA	1	1	1
PACE	1	1	1
Total	**13**	**13**	**13**

* There is no set number of this form of assessment; they should be performed as required.

Appendix 5 – 2025 formative assessment changes

Entrustability Scale

Entrustability scales can only be used within Psychiatry for CS and ES end of placement forms.

1.

Level	Descriptor
Level 1	Entrusted to act only in the constant presence of the supervisor
Level 2	Entrusted to act under indirect supervision, with supervisor intermittently present and monitoring at regular intervals
Level 3	Entrusted to act under indirect supervision, with supervisor remote, but present in setting, and able to provide prompt direction / assistance
Level 4	Entrusted to act independently with supervisor accessible on call and able to attend if required
Level 5	Entrusted to act independently with no supervisor involvement (always operating within local protocols)

2.

Resident doctors will be expected to start at level 1 or 2, progress to level 3 throughout training and reach level 5 by their Certificate of Completion of Training (CCT) date.

Changing the Mini PAT to a Multi-Source Feedback (MSF) Form
The existing Mini PAT has been changed to Multi-Source Feedback (MSF) to bring RCPsych in line with other Medical Specialties.

There are four possible ratings along with an option for the assessor to note not enough evidence was provided.

Insufficient evidence	Needs improvement	Satisfactory	Good	Excellent
Insufficient evidence to make a judgment	Shows limited understanding and struggles with the application of knowledge, with minimal analysis and unclear communication	Displays basic understanding and adequate application of knowledge, with some analysis and clear communication.	Shows strong understanding and effective application of knowledge, with good analysis and clear communication.	Demonstrates comprehensive understanding and exceptional application of knowledge, with insightful analysis and clear communication.

3.

Psychotherapy's case-based discussion group assessment (CbDGA), assessment of psychotherapy expertise (SAPE) or psychiatry assessment of clinical expertise

(PACE) as they are all conducted under supervision, and the above scale therefore is not to be used for the psychotherapy WBPAs.

Embedding formulation skills throughout training

Core resident must complete one CP per annum, and speciality residents also should have the opportunity to do one CP per annum, or at least one in their ST years.

Synopsis – to include:

- Biopsychosocial formulation
- How formulation including relational factors inform your diagnosis and differentials
- Any patient strengths and how these contribute to the overall intervention plan
- How the formulation has influenced the way you devise a person-centred plan

4.

Case presentations should be performed yearly as an effective way to show progression. This can be facilitated by multi-disciplinary staff.

5.

Inclusion of Multi-Disciplinary Team (MDT)
Higher resident doctors are in preparation to work as consultants. We would recommend that these resident doctors develop the practice of peer group discussion of interesting cases as well as discussion with various members of the Multi-Disciplinary Team (MDT). The case presentation for higher resident doctors can be marked by members of the MDT for example a consultant or band 8 professionals including advanced practitioners, psychologists etc.

Introduce feedback from patients and carers for Resident Doctors

Both CTs and STs must undertake feedback at least once in their CT and once in their ST years, with opportunities to do them more frequently if necessary. They may do this in any of their placements during their training years.

The portfolio platform can collect feedback from patients by several methods:

- A link can be provided to a patient who can then enter their responses
- The feedback document can be presented to the patient on a tablet (e.g. iPad) and they can immediately enter their feedback
- The patient can be given a paper form and be asked to complete it, which can then be uploaded manually by the administrative staff the resident doctors work with.
- Between 6-10 pieces of patient feedback are to be collected per cycle.

Information input directly into the platform is automatically collated. However, feedback which is collected on paper must be scanned and uploaded to the platform.

This information is then aggregated, and average scores are compared with average scores received by others. The results are shared with the clinical supervisor to discuss with their residents.,

The form uses a five-point Likert scale with both words and visual representations.

The Likert scale is:

No, not at all	No, not really	Yes, but not fully	Yes	Yes, completely

There are seven questions and a free text box.

1. Did this doctor make you feel relaxed and welcome?
2. Do you feel this doctor listened to you?
3. Did the doctor explain things to you in a way you could understand?
4. Were you involved as much as you wanted to be in decisions about your care and treatment?
5. Do you have confidence in the decisions made about your condition or treatment?
6. Do you know what to do if your condition gets worse?
7. Did the doctor treat you with respect and dignity?
6.

The resident doctors' portfolio for future should have:

- MSF from colleagues and
- MSF from patients and carers
- on the clinical supervisor (CS) and educational supervisor (ES) reports.

This is the same expectation across the psychiatric specialties and would also apply to those undertaking dual training.

7.

Patients
The feedback approach will be consistent across all the psychiatric disorders.

Assessment
Patient feedback would be an addition to the current numbers of assessments; however, this would be deemed minimal disruption and is an important part of training. The feedback should also form part of an ARCP consideration.

Benefit
Patient and carer feedback is crucial in the assessment of a resident doctor and can support with the

enhancement of communication skills

Improvement of empathy and bedside manner

Identification of areas for improvement

8.

Introduce caseload-based discussion

9. The curriculum now requires resident doctors to demonstrate a wider range of skills that are not fully captured by existing assessments. To support this, the Direct Observation of Non-Clinical Skills (DONCS) tool will be expanded beyond caseload-based discussion to include additional areas of the curriculum that are currently under-represented. The 'Skills observed' section of the DONCS will be updated to align with HLOs 1–9, enabling you to record a broader set of non-clinical skills and activities. A non-exhaustive list of examples will be provided to guide you in selecting appropriate evidence.

This development offers important benefits: it allows you to document valuable skills and experiences that may not appear elsewhere in your portfolio, and it gives you the flexibility to demonstrate key capabilities that you may still need to evidence. You are encouraged to use the expanded DONCS tool to capture these aspects of your training in a way that reflects your individual learning needs and progression.

Examples of what can be assessed using DONCS

HLO 1 – Professional values and behaviours
• Chairing a meeting • Tactful handling of difficult situations • Decision making • Time management and prioritisation • Colleagues feeling valued/ respected by resident doctors • Facilitating/ co-facilitating reflective sessions • Complaints handling
HLO 2 – Professional skills
• Conflict resolution • Communication skills – verbal and written, including legal reports/forms • Difficult conversations • SUI investigations • Representation at tribunal or coroners • Mentoring/ coaching/ supervision • Appropriate risk management • Effective handover
HLO 3 – Professional knowledge
• Discussions about finance and pensions • Caseload based discussions • Discussions about performance management • Discussions about governance • Discussions about job planning • Discussions about learning governance and NHSE/ HEIW/ NES/ NI policies and guidelines • Medicines management
HLO 4 – Health promotion and illness prevention

- Discussions in clinic/ teams –relapse prevention, indices of multiple deprivation, social determinants of health
- Governance – service development/evaluation projects
- Carers' assessments
- Personal wellbeing – burnout
- Participation in Transformation projects
- Delivering talks to GPs, local communities etc..
- Collaboration with local government, policy, third party sectors
- Working with Advocacy
- Sustainability of preventative mental health work
- Research/ quality improvement

HLO 5 – Leadership and team working

- MDT working clinical and non-clinical leadership
- Leading on a course – preparation, organisation and delivery
- Leading on Service development
- QI project related to leadership and management
- Managing complex cases with multiple teams involved
- Co-ordinate decision making in multi-disciplinary settings with varying views
- Representative roles – resident doctor rep, resident doctor education and improvement, LNC rep
- Appraisal of colleagues

HLO 6 – Safeguarding vulnerable people

- Raise concerns appropriately through systems
- Participating/ chairing a safeguarding meeting
- Organise carer support
- Communication with families
- Communication with other services e.g. Police
- Bystander intervention
- Support vulnerable staff

HLO 7 – Patient safety and quality improvement

- Attend and understand investigations
- Improve services by promoting learning
- Resident doctor rota management
- Participate in Root cause analysis
- Involvement in Complaints and investigations
- Design and work on audits, implement and learn from change
- Promote effective team working

HLO 8 – Education and training

- Organising and running teaching programme
- Education lead roles e.g. Med Ed Fellow
- Local, regional and national representation in educational activities
- Workplace based medical student teaching
- Chairing teaching sessions
- Supporting quality visits from medical schools / School of Psychiatry
- Teaching multi-disciplinary colleagues
- Being an examiner, provide feedback
- Organising conferences, surveys
- Meet statutory requirements as a trainer/educator

HLO 9 – Research and scholarship
• Projects involved in working with research and governance teams • Publishing and presenting papers • Paper assessed by academic colleagues • Measurable outcome from research activity • Note from supervisor outlining resident doctor's participation in research project • Reflective note from research process • Conduct a Systematic review • Keep up to date with best practice (CPD activities) • Demonstrate evidence based shared decision making with patients

Further examples can be found at Generic professional capabilities framework May 17 from the GMC website.