Guidance for doctors

Good Medical Practice

General Medical Council

Regulating doctors
Ensuring good medical practice

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date
  - Recognise and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
  - Never discriminate unfairly against patients or colleagues
  - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good Medical Practice

Good Medical Practice came into effect on 13 November 2006.

General Medical Council

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Contents

About Good Medical Practice

Good Medical Practice sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, but it is also intended to let the public know what they can expect from doctors.

We have provided links* to other guidance and information which illustrate how the principles in *Good Medical Practice* apply in practice, and how they may be interpreted in other contexts; for example, in undergraduate education, in revalidation, or in our consideration of a doctor's conduct, performance or health through our fitness to practise procedures. There are links to:

- supplementary guidance and other information from the GMC
- cases heard by GMC fitness to practise panels, which provide examples of where a failure to follow the guidance in *Good Medical Practice* has put a doctor's registration at risk (available on-line only)
- external (non-GMC) sources of advice and information.

You can access all these documents on our website, or order printed versions of the GMC documents by contacting publications@gmc-uk.org (phone: 0161 923 6315).

*Please check the GMC website for the most up-to-date links: www.gmc-uk.org/guidance

How Good Medical Practice applies to you

The guidance that follows describes what is expected of all doctors registered with the GMC. It is your responsibility to be familiar with *Good Medical Practice* and to follow the guidance it contains. It is guidance, not a statutory code, so you must use your judgement to apply the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

In *Good Medical Practice* the terms 'you must' and 'you should' are used in the following ways:

- 'You must' is used for an overriding duty or principle.
- 'You should' is used when we are providing an explanation of how you will meet the overriding duty.
- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance.

Serious or persistent failure to follow this guidance will put your registration at risk.

See GMC guidance on the meaning of fitness to practise

Good Doctors

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues*, are honest and trustworthy, and act with integrity.

* Those a doctor works with, whether or not they are also doctors.

Good clinical care

Providing good clinical care

2 Good clinical care must include:

(a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient

(b) providing or arranging advice, investigations or treatment where necessary

(c) referring a patient to another practitioner, when this is in the patient's best interests.

2b. See paragraph 21b and GMC consent guidance

3 In providing care you must:

(a) recognise and work within the limits of your competence

(b) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs

3b. See GMC prescribing guidance paragraph 40

(c) provide effective treatments based on the best available evidence

(d) take steps to alleviate pain and distress whether or not a cure may be possible

3d. See paragraph 21b and GMC guidance on treatment and care towards the end of life

(e) respect the patient's right to seek a second opinion

(f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment

(g) make records at the same time as the events you are recording or as soon as possible afterwards

(h) be readily accessible when you are on duty

(i) consult and take advice from colleagues, when appropriate

(j) make good use of the resources available to you.

3j. See GMC management guidance

Supporting self-care

4 You should encourage patients and the public to take an interest in their health and to take action to improve and maintain it. This may include advising patients on the effects of their life choices on their health and well-being and the possible outcomes of their treatments.

4. See endnote 1

Avoid treating those close to you

5 Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship.

5. See paragraph 77 and GMC prescribing guidance paragraphs 4 and 13–16

Raising concerns about patient safety

6 If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.

6. See paragraphs 43–45, GMC management guidance, and GMC guidance on raising concerns

Decisions about access to medical care

7 The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views* to affect adversely your professional relationship with them or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance.

7. See GMC guidance on personal beliefs and GMC guidance on valuing diversity

8 If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.

8. See GMC guidance on personal beliefs

* This includes your views about a patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status.

9 You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety is or may be seriously compromised, you must follow the guidance in paragraph 6.

9. See paragraph 6

10 All patients are entitled to care and treatment to meet their clinical needs. You must not refuse to treat a patient because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making suitable alternative arrangements for treatment.

Treatment in emergencies

11 In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care.

Maintaining good medical practice

Keeping up to date

12 You must keep your knowledge and skills up to date throughout your working life. You should be familiar with relevant guidelines and developments that affect your work. You should regularly take part in educational activities that maintain and further develop your competence and performance.

12. See GMC guidance on continuing professional development and endnote 2

13 You must keep up to date with, and adhere to, the laws and codes of practice relevant to your work.

Maintaining and improving your performance

14 You must work with colleagues and patients to maintain and improve the quality of your work and promote patient safety. In particular, you must:

(a) maintain a folder of information and evidence, drawn from your medical practice

(b) reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation

(c) take part in regular and systematic audit

(d) take part in systems of quality assurance and quality improvement

(e) respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary

(f) help to resolve uncertainties about the effects of treatments

(g) contribute to confidential inquiries and adverse event recognition and reporting, to help reduce risk to patients

(h) report suspected adverse drug reactions in accordance with the relevant reporting scheme

(i) co-operate with legitimate requests for information from organisations monitoring public health – when doing so you must follow the guidance in *Confidentiality*.

14a, b. See GMC GMP framework document.

14e. See endnote 3

14g. See endnote 4

14h. See GMC prescribing guidance and endnote 5

14i. See GMC confidentiality guidance

Teaching and training, appraising and assessing

15 Teaching, training, appraising and assessing doctors and students are important for the care of patients now and in the future. You should be willing to contribute to these activities.

16 If you are involved in teaching you must develop the skills, attitudes and practices of a competent teacher.

17 You must make sure that all staff for whom you are responsible, including locums and students, are properly supervised.

18 You must be honest and objective when appraising or assessing the performance of colleagues, including locums and students. Patients will be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

19 You must provide only honest, justifiable and accurate comments when giving references for, or writing reports about, colleagues. When providing references you must do so promptly and include all information that is relevant to your colleague's competence, performance or conduct.

19. See paragraph 63 and GMC guidance on writing references

Relationships with patients

The doctor-patient partnership

20 Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs.

21 To fulfil your role in the doctor-patient partnership you must:

(a) be polite, considerate and honest
(b) treat patients with dignity
(c) treat each patient as an individual
(d) respect patients' privacy and right to confidentiality
(e) support patients in caring for themselves to improve and maintain their health
(f) encourage patients who have knowledge about their condition to use this when they are making decisions about their care.

21b. See GMC guidance on maintaining boundaries

21d. See GMC confidentiality guidance

21e. See endnote 1

Good communication

22 To communicate effectively you must:

(a) listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences

(b) share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties

22b. See GMC consent guidance paragraphs 7-36

(c) respond to patients' questions and keep them informed about the progress of their care

(d) make sure that patients are informed about how information is shared within teams and among those who will be providing their care.

22d. See GMC confidentiality guidance paragraph 7, and 25-32

23 You must make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

23. See GMC consent guidance paragraph 21

Children and young people

24 The guidance that follows in paragraphs 25–27 is relevant whether or not you routinely see children and young people as patients. You should be aware of the needs and welfare of children and young people when you see patients who are parents or carers, as well as any patients who may represent a danger to children or young people.

24. See GMC 0-18 guidance

See endnote 6

25 You must safeguard and protect the health and well-being of children and young people.

26 You should offer assistance to children and young people if you have reason to think that their rights have been abused or denied.

27 When communicating with a child or young person you must:

(a) treat them with respect and listen to their views
(b) answer their questions to the best of your ability
(c) provide information in a way they can understand.

28 The guidance in paragraphs 25–27 is about children and young people, but the principles also apply to other vulnerable groups.

Relatives, carers and partners

29 You must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died. In doing this you must follow the guidance in *Confidentiality*.

29. See endnote 7 and GMC confidentiality guidance including paragraphs 64-66

Being open and honest with patients if things go wrong

30 If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

30. See endnote 8

31 Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

Maintaining trust in the profession

32 You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.

32. See GMC guidance on maintaining boundaries

33 You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.

33. See GMC guidance on personal beliefs

34 You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests as well as your own.

35 You must be familiar with your GMC reference number. You must make sure you are identifiable to your patients and colleagues, for example by using your registered name when signing statutory documents, including prescriptions. You must make your registered name and GMC reference number available to anyone who asks for them.

35. See GMC guidance on reference numbers

Consent

36 You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. Usually this will involve providing information to patients in a way they can understand, before asking for their consent. You must follow the guidance in *Seeking patients' consent: The ethical considerations,* which includes advice on children and patients who are not able to give consent.

36. See GMC consent guidance and GMC research guidance paragraphs 15–29

Confidentiality

37 Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died. If you are considering disclosing confidential information without a patient's consent, you must follow the guidance in *Confidentiality*.

37. See GMC confidentiality guidance

Ending your professional relationship with a patient

38 In rare circumstances, the trust between you and a patient may break down, and you may find it necessary to end the professional relationship. For example, this may occur if a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderately or unreasonably. You should not end a relationship with a patient solely because of a complaint the patient has made about you or your team, or because of the resource implications* of the patient's care or treatment.

39 Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and does not contravene the guidance in paragraph 7. You must be prepared to justify your decision. You should inform the patient of your decision and your reasons for ending the professional relationship, wherever practical in writing.

39. See paragraph 7

40 You must take steps to ensure that arrangements are made promptly for the continuing care of the patient, and you must pass on the patient's records without delay.

* If you charge fees, you may refuse further treatment for patients unable or unwilling to pay for services you have already provided. You must follow the guidance in paragraph 39.

Working with colleagues

Working in teams

41 Most doctors work in teams with colleagues from other professions. Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues. You must:

41. See endnote 9

(a) respect the skills and contributions of your colleagues
(b) communicate effectively with colleagues within and outside the team
(c) make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care
(d) participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies
(e) support colleagues who have problems with performance, conduct or health.

42 If you are responsible for leading a team, you must follow the guidance in *Management for doctors*.

42. See GMC management guidance

Conduct and performance of colleagues

43 You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures.

43. See GMC confidentiality guidance paragraph 20 and *Confidentiality: Disclosing information about serious communicable diseases* paragraphs 4-5, and the following GMC guidance on: referring a doctor, raising concerns, and management

44 If there are no appropriate local systems, or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation, or the GMC for advice.

44. See GMC guidance on raising concerns

45 If you have management responsibilities you should make sure that systems are in place through which colleagues can raise concerns about risks to patients, and you must follow the guidance in *Management for doctors*.

45. See GMC management guidance

Respect for colleagues

46 You must treat your colleagues fairly and with respect. You must not bully or harass them, or unfairly discriminate against them by allowing your personal views* to affect adversely your professional relationship with them. You should challenge colleagues if their behaviour does not comply with this guidance.

46. See GMC guidance on valuing diversity

47 You must not make malicious and unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them.

Arranging cover

48 You must be satisfied that, when you are off duty, suitable arrangements have been made for your patients' medical care. These arrangements should include effective hand-over procedures, involving clear communication with healthcare colleagues. If you are concerned that the arrangements are not suitable, you should take steps to safeguard patient care and you must follow the guidance in paragraph 6.

48. See paragraph 6

* This includes your views about a colleague's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status.

Taking up and ending appointments

49 Patient care may be compromised if there is not sufficient medical cover. Therefore, you must take up any post, including a locum post, you have formally accepted, and you must work your contractual notice period, unless the employer has reasonable time to make other arrangements.

49. See GMC appointments guidance

Sharing information with colleagues

50 Sharing information with other healthcare professionals is important for safe and effective patient care.

50. See endnote 9 and GMC confidentiality guidance paragraphs 25-32

51 When you refer a patient, you should provide all relevant information about the patient, including their medical history and current condition.

52 If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects.

53 If a patient has not been referred to you by a general practitioner, you should ask for the patient's consent to inform their general practitioner before starting treatment, except in emergencies or when it is impractical to do so. If you do not inform the patient's general practitioner, you will be responsible for providing or arranging all necessary after-care.

Delegation and referral

54 Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need.

55 Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence. You must be satisfied that any healthcare professional to whom you refer a patient is accountable to a statutory regulatory body or employed within a managed environment. If they are not, the transfer of care will be regarded as delegation, not referral. This means you remain responsible for the overall management of the patient, and accountable for your decision to delegate.

Probity

Being honest and trustworthy

56 Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.

57 You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.

58 You must inform the GMC without delay if, anywhere in the world, you have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against your registration as a result of fitness to practise procedures.

58. See GMC guidance on reporting convictions

59 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice you must, without delay, inform any other organisations for which you undertake medical work and any patients you see independently.

Providing and publishing information about your services

60 If you publish information about your medical services, you must make sure the information is factual and verifiable.

61 You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

62 You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health.

Writing reports and CVs, giving evidence and signing documents

63 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.

63. See endnote 11

64 You must always be honest about your experience, qualifications and position, particularly when applying for posts.

65 You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.

65. See GMC guidance on writing references

66 If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

67 If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.

67. See paragraph 3a and GMC guidance on expert witnesses

68 You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to your work. You must disclose to anyone entitled to ask for it any information relevant to an investigation into your own or a colleague's conduct, performance or health. In doing so, you must follow the guidance in *Confidentiality*.

68. See GMC confidentiality guidance

69 You must assist the coroner or procurator fiscal in an inquest or inquiry into a patient's death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.

69. See GMC confidentiality guidance

Research

70 Research involving people directly or indirectly is vital in improving care and reducing uncertainty for patients now and in the future, and improving the health of the population as a whole.

71 If you are involved in designing, organising or carrying out research, you must:

(a) put the protection of the participants' interests first
(b) act with honesty and integrity
(c) follow the appropriate national research governance guidelines and the guidance in *Research: The role and responsibilities of doctors.*

71c. See GMC research guidance and endnote 12

Financial and commercial dealings

72 You must be honest and open in any financial arrangements with patients. In particular:

72. See GMC guidance on conflicts of interest

- **(a)** you must inform patients about your fees and charges, wherever possible before asking for their consent to treatment
- **(b)** you must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services
- **(c)** you must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you
- **(d)** you must not put pressure on patients or their families to make donations to other people or organisations
- **(e)** you must not put pressure on patients to accept private treatment
- **(f)** if you charge fees, you must tell patients if any part of the fee goes to another healthcare professional.

73 You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

(a) before taking part in discussions about buying or selling goods or services, you must declare any relevant financial or commercial interest that you or your family might have in the transaction

(b) if you manage finances, you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.

Conflicts of interest

74 You must act in your patients' best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues.

74. See GMC guidance on conflicts of interest and endnote 13

75 If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.

75. See GMC prescribing guidance paragraphs 10–12

76 If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser.

Health

77 You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78 You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79 If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

77. See paragraph 5 and GMC prescribing guidance paragraphs 4 and 13–16

78. See endnote 14 and GMC management guidance paragraphs 58–59

References

Further reading

For the most up-to-date guidance visit our website **www.gmc-uk.org/guidance**.

Supporting ethical guidance from the GMC

This guidance expands upon the principles in *Good Medical Practice* to show how the principles apply in practice:

0-18 years: guidance for all doctors (2007)

Accountability in multi-disciplinary and multi-agency mental health teams (2005)

Acting as an expert witness (2008)

Confidentiality (2009) including seven pieces of supplementary guidance

Conflicts of interest (2006)

Consent: patients and doctors making decisions together (2008)

Good practice in prescribing medicines (2008)

Good practice in research and *Consent to research* (2010)

Maintaining boundaries (2006)

Management for doctors (2006)

Personal beliefs and medical practice (2008)

Raising concerns about patient safety (2006)

Reporting criminal and regulatory proceedings within and outside the UK (2008)

Taking up and ending appointments (2008)

Treatment and care towards the end of life: good practice in decision making (2010)

Writing references (2007)

Other GMC publications

Guidance on continuing professional development (2004)

GMP – a working framework for appraisal and assessment (2008)

Guidance for doctors on using registered name and GMC reference number (2006)

Indicative Sanctions Guidance for the Fitness to Practice Panel (2009)

Referring a doctor to the GMC: A guide for individual doctors, medical directors and clinical governance managers **(see www.gmc-uk.org/concerns)**

The meaning of fitness to practise (2005)

Valuing diversity – resource guides (2006)

Royal College and other guidance

The following documents were written to contribute to the process of revalidation by describing what is expected of doctors in these specialties. Some of these documents are under review; you can check their current status with the colleges.

Good Practice: A Guide for Departments of Anaesthesia, Critical Care and Pain Management, Royal College of Anaesthetists, 3rd edition, October 2006

Good Medical Practice in Cosmetic Surgery/Procedures, Independent Healthcare Advisory Services, May 2006

Good Practice in Dental Specialties, Senate of Dental Specialties, 2004

Supplement to Good Medical Practice, Disability Rights Commission, 2007

Good Medical Practice for General Practitioners, Royal College of General Practitioners, July 2008

Revalidation in Obstetrics and Gynaecology: Criteria, Standards and Evidence, Royal College of Obstetricians and Gynaecologists, July 2002

Guidance for Revalidation and Appraisal in Ophthalmology – Criteria, Standards and Evidence, Royal College of Ophthalmologists, May 2003

Good Medical Practice in Paediatrics and Child Health: Duties and Responsibilities of Paediatricians, Royal College of Paediatrics and Child Health, May 2002

Good Medical Practice in Pathology, Royal College of Pathology, July 2002

Good Medical Practice for Physicians, Federation of Royal College of Physicians of the UK, 2004

Good Psychiatric Practice, Royal College of Psychiatrists, 2nd edition, November 2004

Individual Responsibilities – A Guide to Good Medical Practice for Radiologists, Royal College of Radiologists, May 2004

Good Surgical Practice, Royal College of Surgeons of England, February 2008

Good Medical Practice for Occupational Physicians, Faculty of Occupational Medicine, 2001

Good Public Health Practice: Standards for Public Health Physicians and Specialists in Training, Faculty of Public Health Medicine, April 2001

Good Pharmaceutical Medical Practice, Faculty of Pharmaceutical Medicine, 2003

Guidelines on Revalidation: Criteria, Standards and Evidence, College of Emergency Medicine, 2006

Endnotes

External guidance and information

You can access these documents when viewing *Good Medical Practice* on our website **(www.gmc-uk.org).**

1 Paragraph 4 and 21e
Supporting people with long term conditions to self care: A guide to developing local strategies and good practice, Department of Health (England), 24 February 2006 **(www.dh.gov.uk)**

Improved self care by people with long term conditions through self management education programmes, British Medical Association, September 2007 **(www.bma.org.uk)**

Enabling people with long term conditions to self manage their health: a resource for GPs, British Medical Association, September 2007 **(www.bma.org.uk)**

Health, Work and Well-being **(see www.workingforhealth.gov.uk)**

2 Paragraph 12
National Institute for Health and Clinical Excellence **(www.nice.org.uk)** and NHS Quality Improvement Scotland **(www.nhshealthquality.org)**

3 Paragraph 14e
See appraisal guidance and information:

Department of Health (England) appraisal information **(www.dh.gov.uk - see 'Policy and Guidance' section).**

Scottish Government: *Consultant Appraisal - A Brief Guide,* **(www.scotland.gov.uk)** and

Scottish Government: *Appraisal - A Brief Guide for Non-Consultant Career Grades* **(www.scotland.gov.uk)**

Department of Health, Social Services and Public Safety (Northern Ireland) **(www.dhsspsni.gov.uk)**

Wales appraisal information and guidance **(http://gp.cardiff.ac.uk)**

4 Paragraph 14g
National Patient Safety Agency **(www.npsa.nhs.uk)**

5 Paragraph 14h
Medicines and Healthcare products Regulatory Agency, Yellow Card Scheme **(www.mhra.gov.uk)** and British Medical Association *Reporting Adverse Drug Reactions: A Guide for healthcare professionals,* May 2006 **(www.bma.org.uk)**

6 Paragraph 24
The Children Act 2004 **(www.opsi.gov.uk)**

7 Paragraph 29
When a patient dies: Advice on developing bereavement services in the NHS, Department of Health (England), October 2005 **(www.dh.gov.uk)**

8 Paragraph 30
Apologies and Explanations, NHS Litigation Authority, Circular 02/02, Issued 11 February 2002 **(www.nhsla.com)**

9 Paragraph 41
Medical Leadership Competency Framework, NHS Institute, 2008 **(www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html)**

10 Paragraph 50
Confidentiality: NHS Code of Practice, Department of Health, November 2003 **(www.dh.gov.uk)**

11 Paragraph 63
Medical Certificates and Reports, British Medical Association, July 2004 **(www.bma.org.uk)**

12 Paragraph 71c

See research governance frameworks:

Research Governance Framework for Health and Social Care, Department of Health (England), 2005 **(www.dh.gov.uk)**

Research Governance Framework for Health and Social Care in Wales, WORD, Welsh Assembly Government, 2001 (new version due 2009) **(http://wales.gov.uk/topics/health/research/word/policyguidance/resgovernance/framework/)**

Research Governance Framework for Health and Social Care, R&D Office, Department of Health, Social Services and Public Safety **(www.centralservicesagency.com/display/rdo_research_governance)**

Research Governance Framework for Health and Community Care, Scottish Executive Health Department, 2006 **(www.show.scot.nhs.uk)**

13 Paragraph 74
The Blue Guide: Advertising and Promotion of Medicine in the UK, Medicines and Healthcare Products Regulatory Agency, 2005 **(www.mhra.gov.uk)**

14 Paragraph 78
Guidance for Clinical Health Care Workers: Protection Against Infection with Blood-borne Viruses Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis, UK Health Departments **(www.dh.gov.uk)**

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Note: Numbers refer to paragraphs.

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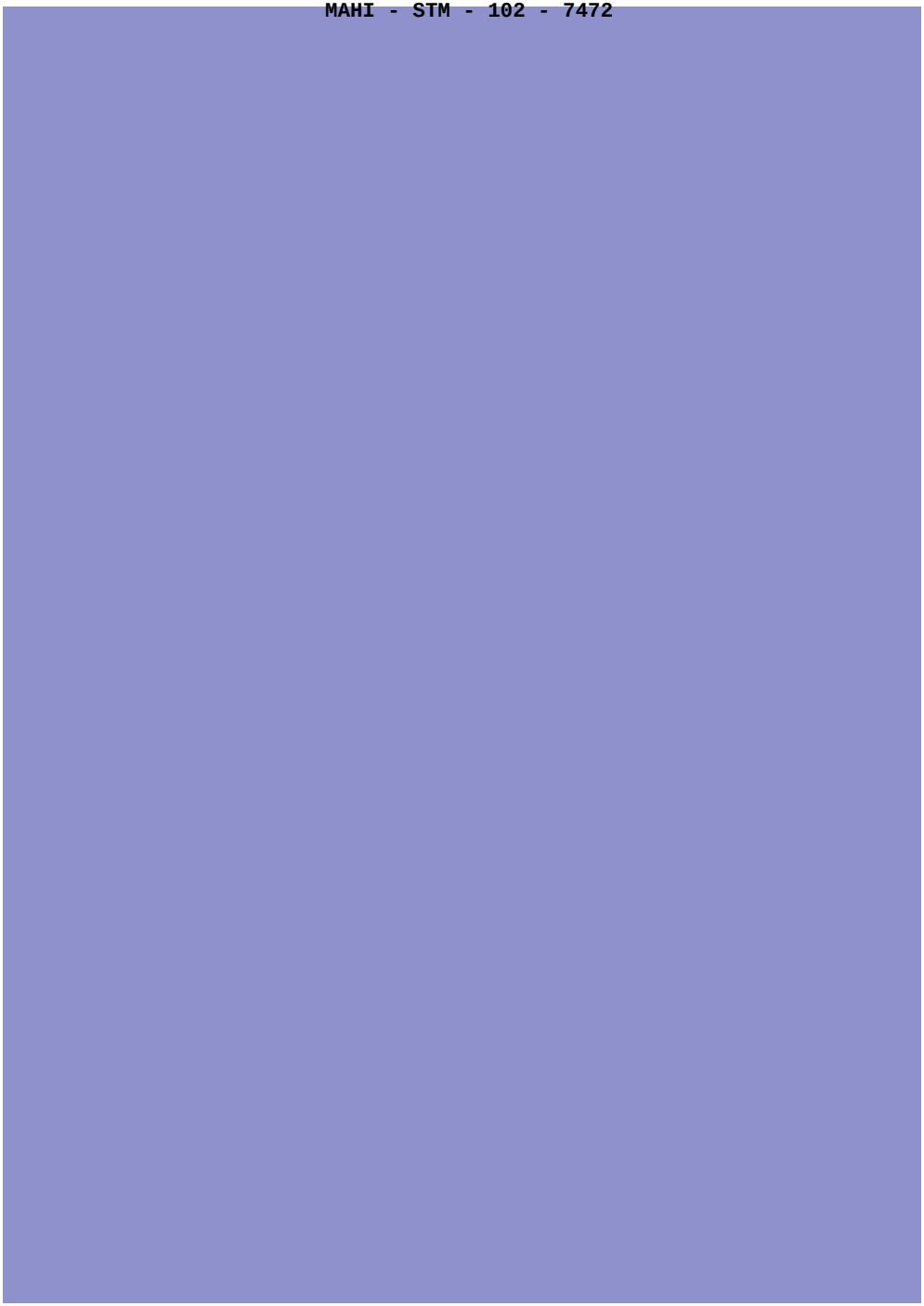

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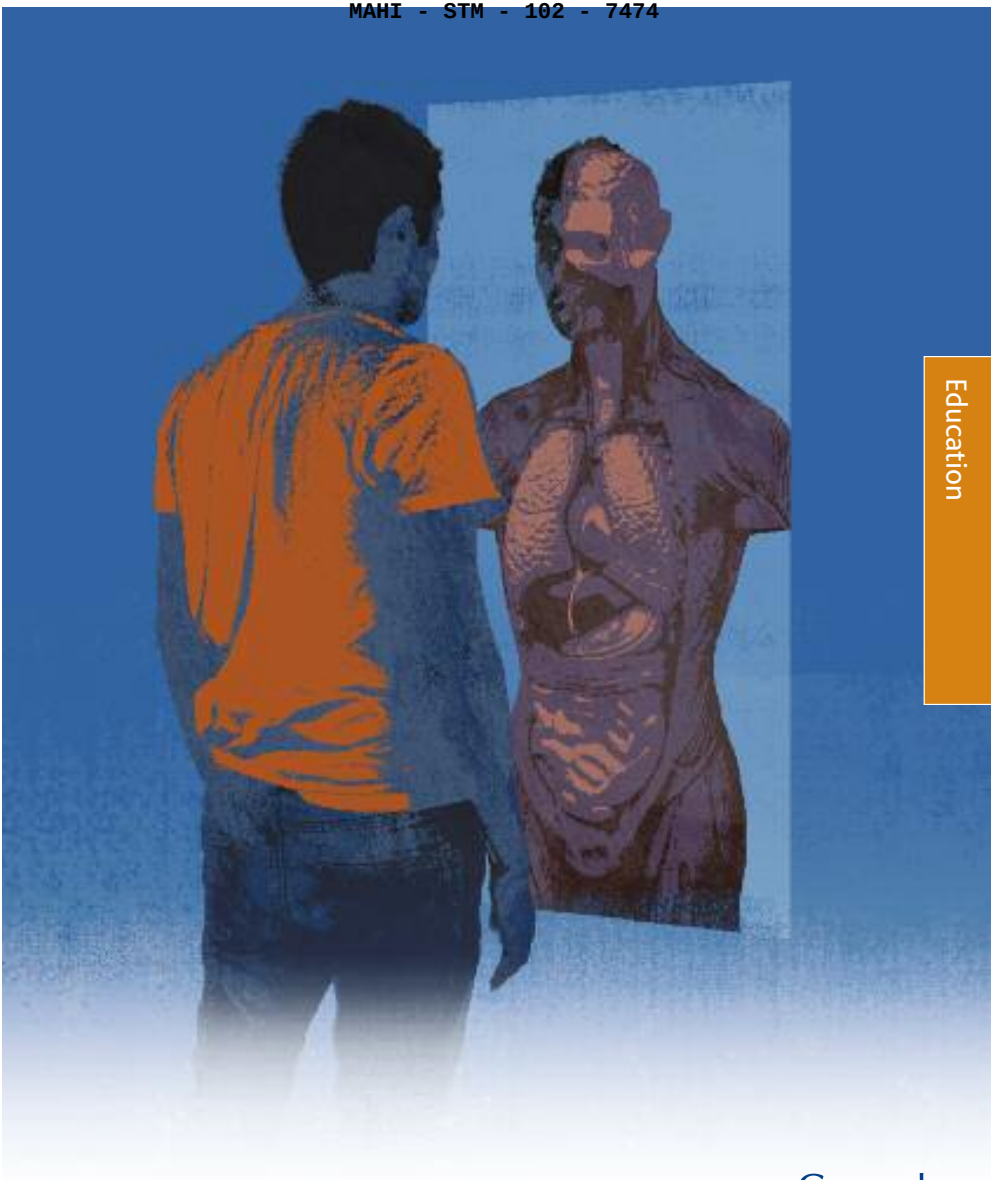

Education

Tomorrow's Doctors

Outcomes and standards for undergraduate medical education

General Medical Council

Regulating doctors
Ensuring good medical practice

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date
  - Recognise and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
  - Never discriminate unfairly against patients or colleagues
  - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Tomorrow's Doctors

Published September 2009

General Medical Council

Regulating doctors
Ensuring good medical practice

Contents

Foreword

Doctors must be capable of regularly taking responsibility for difficult decisions in situations of clinical complexity and uncertainty.

See Appendix 3, *Related documents*: 56

Medical schools equip medical students with the scientific background and technical skills they need for practice. But, just as importantly, they must enable new graduates to both understand and commit to high personal and professional values. Medicine involves personal interaction with people, as well as the application of science and technical skills.

In *Good Medical Practice* the GMC states:
'Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity.'

See GMC, *Good Medical Practice*, paragraph 1

Putting patients first involves working with them as partners in their own care and making their safety paramount. It involves dedication to continuing improvement, both in the doctor's individual practice and in the organisation and environment in which they work.

It is not enough for a clinician to act as a practitioner in their own discipline. They must act as partners to their colleagues, accepting shared accountability for the service provided to patients. They are also expected to offer leadership, and to work with others to change systems when it is necessary for the benefit of patients.[1]

In *Tomorrow's Doctors*, we cover these themes under three headings, relating to the doctor as a scientist and a scholar, as a practitioner, and as a professional. These categories cover the development of the knowledge, skills and behaviour students must demonstrate by the time they graduate. However, the categories and the specific outcomes should not be considered in isolation from each other. Doctors need to link them routinely in clinical practice.

Graduation is an early threshold in doctors' careers. New graduates cannot be expected to have the clinical experience, specialist expertise or leadership skills of a consultant or GP. But they must be able to demonstrate all the outcomes in *Tomorrow's Doctors* in order to be properly prepared for clinical practice and the Foundation Programme. The Foundation Programme builds on undergraduate education, allowing new doctors to demonstrate performance in the workplace. It includes a range of clinical experience which often involves caring for acutely ill patients.

See Appendix 3, *Related documents*: 32

The outcomes set out what the GMC expects medical schools to deliver and what the employers of new graduates can expect to receive although medical schools are free to require their graduates to demonstrate additional competences. These outcomes mark the end of the first stage of a continuum of medical learning that runs from the first day at medical school and continues until the doctor's retirement from clinical practice.

Professional regulation has changed dramatically since the first edition of *Tomorrow's Doctors* was published in 1993. The GMC has published *Good Medical Practice* and other guidance which sets out the positive standards expected of good doctors in the new world of partnership with patients and colleagues. Registration and fitness to practise procedures have been transformed. Licensing and revalidation will also support regulation, professional values and lifelong learning.

See GMC, *Good Medical Practice*

For this edition, among a number of important changes, we have responded specifically to concerns about scientific education, clinical skills, partnership with patients and colleagues, and commitment to improving healthcare and providing leadership. We have also set out standards for the delivery of medical education with a new emphasis on equality and diversity, involving employers and patients, the professional development of teaching staff, and ensuring that students derive maximum benefit from their clinical placements.

We realise that meeting these outcomes and standards will be challenging. There are implications for resources and priorities both for medical schools and for the health service. But the benefit will be a further enhancement of the knowledge, skills and behaviour which new graduates will bring to their practice.

Today's undergraduates – tomorrow's doctors – will see huge changes in medical practice. There will be continuing developments in biomedical sciences and clinical practice, new health priorities, rising expectations among patients and the public, and changing societal attitudes. Basic knowledge and skills, while fundamentally important, will not be enough on their own. Medical students must be inspired to learn about medicine in all its aspects so as to serve patients and become the doctors of the future. With that perspective and commitment, allied to the specific knowledge, skills and behaviours set out in *Tomorrow's Doctors* and *Good Medical Practice*, they will be well placed to provide and to improve the health and care of patients, as scholars and scientists, practitioners and professionals.

See GMC, *Good Medical Practice*

Professor Peter Rubin
Chair – General Medical Council

Introduction

1 The GMC, the medical schools, the NHS, doctors and students all have different and complementary roles in medical education.

2 The GMC is responsible for:

- **(a)** Protecting, promoting and maintaining the health and safety of the public.
- **(b)** Promoting high standards of medical education.
- **(c)** Deciding on the knowledge, skills and behaviours required of graduates.
- **(d)** Setting the standard of expertise that students need to achieve at qualifying examinations or assessments.
- **(e)** Making sure that:
  - **i.** the teaching and learning opportunities provided allow students to meet our requirements
  - **ii.** the standard of expertise we have set is maintained by medical schools at qualifying examinations.
- **(f)** Appointing inspectors of qualifying examinations and assessments to report on the standard of examinations and assessments, and on the quality of teaching and learning.
- **(g)** Appointing visitors to medical schools and proposed medical schools, to report on the quality of teaching and learning.

(h) Recognising, continuing to recognise or no longer recognising individual UK Primary Medical Qualifications (PMQs), in the light of the outcome of quality assurance activities.

(i) Maintaining a list of bodies that, having satisfactorily demonstrated that they meet our requirements, are entitled to award PMQs.

(j) Removing bodies which have failed to meet our requirements from the list of those that are entitled to award PMQs.

(k) Considering applications under Section 10A(2)(f) of the Medical Act 1983 for arrangements for a person with a disability not to be disadvantaged unfairly by the disability when participating in a programme for provisionally registered doctors.

(l) From the introduction of the licence to practise, granting graduates provisional registration with a licence to practise, subject to their fitness to practise not being impaired.

3 Medical schools are responsible for:

- **(a)** Protecting patients and taking appropriate steps to minimise any risk of harm to anyone as a result of the training of their medical students.
- **(b)** Managing and enhancing the quality of their medical education programmes.
- **(c)** Delivering medical education in accordance with principles of equality.
- **(d)** Selecting students for admission.
- **(e)** Providing a curriculum and associated assessments that meet:
  - **i.** the standards and outcomes in *Tomorrow's Doctors*
  - **ii.** the requirements of the EU Medical Directive.
- **(f)** Providing academic and general support to students.
- **(g)** Providing support and training to people who teach and supervise students.
- **(h)** Providing appropriate student fitness to practise arrangements.
- **(i)** Ensuring that only students who demonstrate the outcomes set out in *Tomorrow's Doctors* are permitted to graduate.
- **(j)** Managing the curriculum and ensuring that appropriate education facilities are provided in the medical school and by other education providers.[2]

4 NHS organisations[3] are responsible for:

(a) Making available the facilities, staff and practical support needed to deliver the clinical parts of the curriculum.

(b) Ensuring that performance of teaching responsibilities is subject to appraisal.

(c) Including, when appropriate, a contractual requirement for doctors to carry out teaching.

(d) Releasing doctors and other staff to complete the training needed to be teachers, and to take part in professional development and quality assurance activities.

(e) Taking part in the management and development of the clinical education they carry out.

(f) Supporting medical schools in complying with *Tomorrow's Doctors*.

(g) Providing quality-control information to the medical school about their education provision.

5 Doctors are responsible for:

(a) Following the principles of professional practice that are set out in *Good Medical Practice*, including being willing to contribute to the education of students.

(b) Developing the skills and practices of a competent teacher if they are involved in teaching.

(c) Supervising the students for whom they are responsible, to support their learning and ensure patient safety.

(d) Providing objective, honest and timely assessments of the students they are asked to appraise or assess.

(e) Providing feedback on students' performance.

(f) Meeting contractual requirements, including any that relate to teaching.

5a. See GMC, *Good Medical Practice*

5b. See GMC, *Good Medical Practice*, paragraphs 15-19; Appendix 3, *Related documents*: 39

6 Students are responsible for:

(a) Their own learning, including achieving all the outcomes set out in *Tomorrow's Doctors*, whatever their personal preferences or religious beliefs.

(b) Ensuring patient safety by working within the limits of their competence, training and status as medical students.

(c) Raising any concerns about patient safety, or any aspect of the conduct of others which is inconsistent with good professional practice.

(d) Providing evaluations of their education for quality management purposes.

(e) Keeping to the guidance *Medical students: professional values and fitness to practise* developed by the GMC and the Medical Schools Council.

6c. See GMC, *Good Medical Practice*, paragraphs 6, 43-45; GMC, *Raising concerns about patient safety*

6e. See GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*

Outcomes for graduates

Overarching outcome for graduates

7 Medical students are tomorrow's doctors. In accordance with *Good Medical Practice*, graduates will make the care of patients their first concern, applying their knowledge and skills in a competent and ethical manner and using their ability to provide leadership and to analyse complex and uncertain situations.

7. See GMC, *Good Medical Practice*, 'Duties of a Doctor' (also inside front cover of *Tomorrow's Doctors*)

Outcomes 1 – The doctor as a scholar and a scientist

8 The graduate will be able to apply to medical practice biomedical scientific principles, method and knowledge relating to: anatomy, biochemistry, cell biology, genetics, immunology, microbiology, molecular biology, nutrition, pathology, pharmacology and physiology. The graduate will be able to:

8. See Appendix 3, *Related documents*: 1, 2, 3, 8, 11

(a) Explain normal human structure and functions.
(b) Explain the scientific bases for common disease presentations.
(c) Justify the selection of appropriate investigations for common clinical cases.
(d) Explain the fundamental principles underlying such investigative techniques.
(e) Select appropriate forms of management for common diseases, and ways of preventing common diseases, and explain their modes of action and their risks from first principles.

(f) Demonstrate knowledge of drug actions: therapeutics and pharmacokinetics; drug side effects and interactions, including for multiple treatments, long-term conditions and non-prescribed medication; and also including effects on the population, such as the spread of antibiotic resistance.

(g) Make accurate observations of clinical phenomena and appropriate critical analysis of clinical data.

8f. See Appendix 3, *Related documents*: 9, 10

9 Apply psychological principles, method and knowledge to medical practice.

9. See Appendix 3, *Related documents*: 4, 12

(a) Explain normal human behaviour at an individual level.

(b) Discuss psychological concepts of health, illness and disease.

(c) Apply theoretical frameworks of psychology to explain the varied responses of individuals, groups and societies to disease.

(d) Explain psychological factors that contribute to illness, the course of the disease and the success of treatment.

(e) Discuss psychological aspects of behavioural change and treatment compliance.

(f) Discuss adaptation to major life changes, such as bereavement; comparing and contrasting the abnormal adjustments that might occur in these situations.

(g) Identify appropriate strategies for managing patients with dependence issues and other demonstrations of self-harm.

9g. See Appendix 3, *Related documents*: 7

10 Apply social science principles, method and knowledge to medical practice.

(a) Explain normal human behaviour at a societal level.

(b) Discuss sociological concepts of health, illness and disease.

(c) Apply theoretical frameworks of sociology to explain the varied responses of individuals, groups and societies to disease.

(d) Explain sociological factors that contribute to illness, the course of the disease and the success of treatment – including issues relating to health inequalities, the links between occupation and health and the effects of poverty and affluence.

(e) Discuss sociological aspects of behavioural change and treatment compliance.

11 Apply to medical practice the principles, method and knowledge of population health and the improvement of health and healthcare.

11. See Appendix 3, *Related documents*: 5, 57

11a. See Appendix 3, *Related documents*: 37, 38

- **(a)** Discuss basic principles of health improvement, including the wider determinants of health, health inequalities, health risks and disease surveillance.
- **(b)** Assess how health behaviours and outcomes are affected by the diversity of the patient population.
- **(c)** Describe measurement methods relevant to the improvement of clinical effectiveness and care.
- **(d)** Discuss the principles underlying the development of health and health service policy, including issues relating to health economics and equity, and clinical guidelines.
- **(e)** Explain and apply the basic principles of communicable disease control in hospital and community settings.
- **(f)** Evaluate and apply epidemiological data in managing healthcare for the individual and the community.
- **(g)** Recognise the role of environmental and occupational hazards in ill-health and discuss ways to mitigate their effects.
- **(h)** Discuss the role of nutrition in health.
- **(i)** Discuss the principles and application of primary, secondary and tertiary prevention of disease.[4]
- **(j)** Discuss from a global perspective the determinants of health and disease and variations in healthcare delivery and medical practice.

12 Apply scientific method and approaches to medical research.

12. See GMC, *Research*

- **(a)** Critically appraise the results of relevant diagnostic, prognostic and treatment trials and other qualitative and quantitative studies as reported in the medical and scientific literature.
- **(b)** Formulate simple relevant research questions in biomedical science, psychosocial science or population science, and design appropriate studies or experiments to address the questions.
- **(c)** Apply findings from the literature to answer questions raised by specific clinical problems.
- **(d)** Understand the ethical and governance issues involved in medical research.

Outcomes 2 – The doctor as a practitioner

13 The graduate will be able to carry out a consultation with a patient:

13. See Appendix 3, *Related documents*: 6

- **(a)** Take and record a patient's medical history, including family and social history, talking to relatives or other carers where appropriate.
- **(b)** Elicit patients' questions, their understanding of their condition and treatment options, and their views, concerns, values and preferences.
- **(c)** Perform a full physical examination.
- **(d)** Perform a mental-state examination.
- **(e)** Assess a patient's capacity to make a particular decision in accordance with legal requirements and the GMC's guidance.
- **(f)** Determine the extent to which patients want to be involved in decision-making about their care and treatment.
- **(g)** Provide explanation, advice, reassurance and support.

13e. See GMC, *Consent: patients and doctors making decision together*, paragraphs 71-74

14 Diagnose and manage clinical presentations.

- **(a)** Interpret findings from the history, physical examination and mental-state examination, appreciating the importance of clinical, psychological, spiritual, religious, social and cultural factors.
- **(b)** Make an initial assessment of a patient's problems and a differential diagnosis. Understand the processes by which doctors make and test a differential diagnosis.
- **(c)** Formulate a plan of investigation in partnership with the patient, obtaining informed consent as an essential part of this process.
- **(d)** Interpret the results of investigations, including growth charts, x-rays and the results of the diagnostic procedures in Appendix 1.
- **(e)** Synthesise a full assessment of the patient's problems and define the likely diagnosis or diagnoses.
- **(f)** Make clinical judgements and decisions, based on the available evidence, in conjunction with colleagues and as appropriate for the graduate's level of training and experience. This may include situations of uncertainty.
- **(g)** Formulate a plan for treatment, management and discharge, according to established principles and best evidence, in partnership with the patient, their carers, and other health professionals as appropriate. Respond to patients' concerns and preferences, obtain informed consent, and respect the rights of patients to reach decisions with their doctor about their treatment and care and to refuse or limit treatment.

(h) Support patients in caring for themselves.

(i) Identify the signs that suggest children or other vulnerable people may be suffering from abuse or neglect and know what action to take to safeguard their welfare.

(j) Contribute to the care of patients and their families at the end of life, including management of symptoms, practical issues of law and certification, and effective communication and teamworking.

14j. See GMC, *Withholding and withdrawing life prolonging treatments*

15 Communicate effectively with patients and colleagues in a medical context.

15. See GMC, *Good Medical Practice,* paragraphs 22, 23, 27, 29, 41; Appendix 3, *Related documents*: 6, 24, 36, 40, 41

(a) Communicate clearly, sensitively and effectively with patients, their relatives or other carers, and colleagues from the medical and other professions, by listening, sharing and responding.

(b) Communicate clearly, sensitively and effectively with individuals and groups regardless of their age, social, cultural or ethnic backgrounds or their disabilities, including when English is not the patient's first language.

(c) Communicate by spoken, written and electronic methods (including medical records), and be aware of other methods of communication used by patients. The graduate should appreciate the significance of non-verbal communication in the medical consultation.

(d) Communicate appropriately in difficult circumstances, such as when breaking bad news, and when discussing sensitive issues, such as alcohol consumption, smoking or obesity.
(e) Communicate appropriately with difficult or violent patients.
(f) Communicate appropriately with people with mental illness.
(g) Communicate appropriately with vulnerable patients.
(h) Communicate effectively in various roles, for example, as patient advocate, teacher, manager or improvement leader.

16 Provide immediate care in medical emergencies.

(a) Assess and recognise the severity of a clinical presentation and a need for immediate emergency care.
(b) Diagnose and manage acute medical emergencies.
(c) Provide basic first aid.
(d) Provide immediate life support.
(e) Provide cardio-pulmonary resuscitation or direct other team members to carry out resuscitation.

17 Prescribe drugs safely, effectively and economically.

- **(a)** Establish an accurate drug history, covering both prescribed and other medication.
- **(b)** Plan appropriate drug therapy for common indications, including pain and distress.
- **(c)** Provide a safe and legal prescription.
- **(d)** Calculate appropriate drug doses and record the outcome accurately.
- **(e)** Provide patients with appropriate information about their medicines.
- **(f)** Access reliable information about medicines.
- **(g)** Detect and report adverse drug reactions.
- **(h)** Demonstrate awareness that many patients use complementary and alternative therapies, and awareness of the existence and range of these therapies, why patients use them, and how this might affect other types of treatment that patients are receiving.

17. See GMC, *Good Practice in Prescribing Medicines;* Appendix 3, *Related documents*: 9, 10

18 Carry out practical procedures safely and effectively.

- **(a)** Be able to perform a range of diagnostic procedures, as listed in Appendix 1 and measure and record the findings.
- **(b)** Be able to perform a range of therapeutic procedures, as listed in Appendix 1.
- **(c)** Be able to demonstrate correct practice in general aspects of practical procedures, as listed in Appendix 1.

19 Use information effectively in a medical context.

(a) Keep accurate, legible and complete clinical records.

(b) Make effective use of computers and other information systems, including storing and retrieving information.

(c) Keep to the requirements of confidentiality and data protection legislation and codes of practice in all dealings with information.

(d) Access information sources and use the information in relation to patient care, health promotion, giving advice and information to patients, and research and education.

(e) Apply the principles, method and knowledge of health informatics to medical practice.

19. See Appendix 3, *Related documents*: 43

19c. See GMC, *Confidentiality*

19d. See GMC, *Good Medical Practice*, paragraph 12

Outcomes 3 – The doctor as a professional

20 The graduate will be able to behave according to ethical and legal principles. The graduate will be able to:

20. See GMC, *Good Medical Practice* and in particular paragraphs 56-59; Appendix 3, *Related documents*: 55, 56, 58

(a) Know about and keep to the GMC's ethical guidance and standards including *Good Medical Practice*, the 'Duties of a doctor registered with the GMC' and supplementary ethical guidance which describe what is expected of all doctors registered with the GMC.

(b) Demonstrate awareness of the clinical responsibilities and role of the doctor, making the care of the patient the first concern. Recognise the principles of patient-centred care, including self-care, and deal with patients' healthcare needs in consultation with them and, where appropriate, their relatives or carers.

(c) Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients' dignity and privacy, and understand the importance of appropriate consent.

(d) Respect all patients, colleagues and others regardless of their age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status. Graduates will respect patients' right to hold religious or other beliefs, and take these into account when relevant to treatment options.

20d. See GMC, *Good Medical Practice,* paragraphs 7-10; GMC, *Personal beliefs;* Appendix 3, *Related documents*: 38, 46

(e) Recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others' perceptions.

(f) Understand and accept the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their dependants and the public – including vulnerable groups such as children, older people, people with learning disabilities and people with mental illnesses.

(g) Demonstrate knowledge of laws, and systems of professional regulation through the GMC and others, relevant to medical practice, including the ability to complete relevant certificates and legal documents and liaise with the coroner or procurator fiscal where appropriate.

21 Reflect, learn and teach others.

21. See *Good Medical Practice,* paragraphs 12-19

(a) Acquire, assess, apply and integrate new knowledge, learn to adapt to changing circumstances and ensure that patients receive the highest level of professional care.

(b) Establish the foundations for lifelong learning and continuing professional development, including a professional development portfolio containing reflections, achievements and learning needs.

(c) Continually and systematically reflect on practice and, whenever necessary, translate that reflection into action, using improvement techniques and audit appropriately – for example, by critically appraising the prescribing of others.

(d) Manage time and prioritise tasks, and work autonomously when necessary and appropriate.

(e) Recognise own personal and professional limits and seek help from colleagues and supervisors when necessary.

(f) Function effectively as a mentor and teacher including contributing to the appraisal, assessment and review of colleagues, giving effective feedback, and taking advantage of opportunities to develop these skills.

22 Learn and work effectively within a multi-professional team.

22. See *Good Medical Practice*, paragraph 41; Appendix 3, *Related documents*: 17, 20

(a) Understand and respect the roles and expertise of health and social care professionals in the context of working and learning as a multi-professional team.

(b) Understand the contribution that effective interdisciplinary teamworking makes to the delivery of safe and high-quality care.

(c) Work with colleagues in ways that best serve the interests of patients, passing on information and handing over care, demonstrating flexibility, adaptability and a problem-solving approach.

(d) Demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others.

22d. See Appendix 3, *Related documents*: 42

23 Protect patients and improve care.

(a) Place patients' needs and safety at the centre of the care process.

23a. See Appendix 3, *Related documents*: 15

(b) Deal effectively with uncertainty and change.

(c) Understand the framework in which medicine is practised in the UK, including: the organisation, management and regulation of healthcare provision; the structures, functions and priorities of the NHS; and the roles of, and relationships between, the agencies and services involved in protecting and promoting individual and population health.

(d) Promote, monitor and maintain health and safety in the clinical setting, understanding how errors can happen in practice, applying the principles of quality assurance, clinical governance and risk management to medical practice, and understanding responsibilities within the current systems for raising concerns about safety and quality.

23d. See Appendix 3, *Related documents*: 57

(e) Understand and have experience of the principles and methods of improvement, including audit, adverse incident reporting and quality improvement, and how to use the results of audit to improve practice.

(f) Respond constructively to the outcomes of appraisals, performance reviews and assessments.

(g) Demonstrate awareness of the role of doctors as managers, including seeking ways to continually improve the use and prioritisation of resources.

(h) Understand the importance of, and the need to keep to, measures to prevent the spread of infection, and apply the principles of infection prevention and control.

(i) Recognise own personal health needs, consult and follow the advice of a suitably qualified professional, and protect patients from any risk posed by own health.

(j) Recognise the duty to take action if a colleague's health, performance or conduct is putting patients at risk.

Standards for the delivery of teaching, learning and assessment

24 The following paragraphs set out the standards expected for the delivery of teaching, learning and assessment in medical education. The standards are grouped under nine 'domains'. For each domain there are one or more broad 'standards'. Under these are the more technical 'criteria' by which we will judge whether medical schools are meeting these standards, and the 'evidence' used for this. The 'detailed requirements and context' expand upon the criteria, and these paragraphs contain some important principles and requirements.

25 Statements using 'must' or 'will' mean something is mandatory. Statements using 'should' may be taken into account in the quality assurance process when the GMC considers whether the overall criteria have been met.

Domain 1 – Patient safety

Standards

26 The safety of patients and their care must not be put at risk by students' duties, access to patients and supervision on placements[5] or by the performance, health or conduct of any individual student.

26. See Appendix 3, *Related documents*: 15

27 To ensure the future safety and care of patients, students who do not meet the outcomes set out in *Tomorrow's Doctors* or are otherwise not fit to practise must not be allowed to graduate with a medical degree.

27. See GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*

Criteria

28 Systems and procedures will:

28. See Domain 6

(a) ensure that medical students undertake only appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision

(b) identify and address immediately any concerns about patient safety arising from the education of medical students

(c) identify and address immediately any concerns about a medical student whose conduct gives cause for concern or whose health is affected to such a degree that it could harm the public, where possible through providing support to the student

(d) ensure that medical students who are not fit to practise are not allowed to graduate with a medical degree

(e) inform students, and those delivering medical education, of their responsibility to raise concerns if they identify risks to patient safety, and provide ways to do this.

Evidence

29 Evidence for this domain will include:

- medical school quality data (including inspections, reports of other visits and surveys)
- medical school guidance on fitness to practise policies and their implementation
- data from other education providers
- data from other healthcare regulators and organisations.

Detailed requirements and context

30 The medical school has a duty to ensure that systems are in place to minimise harm to anyone taking part in the training of medical students. Therefore, all those who teach, supervise, counsel, employ or work with medical students are responsible for protecting patients. The medical school must ensure that teachers and others are provided with relevant contextual information about what stage students are at in their training, what they are expected to do, and, if necessary, any concerns about a student. Medical schools must consider providing initial training in a clinical skills facility to minimise the risk to patients.

31 Although medical students may not be directly observed or supervised during all contact with the public – whether in hospitals, in general practice or in the community – there must be a general oversight of students on placement to ensure patient safety. Closer supervision will be provided when students are at lower levels of competence, ensuring that they are not put in situations where they are asked to work beyond their current competence without appropriate support.

32 The four UK health departments are responsible for deciding how students may have access to patients on NHS premises. Students are responsible for following guidance issued by the UK health departments and other organisations about their access to patients in NHS hospitals and community settings. They also need to be aware of any departmental guidance for healthcare workers which may have an effect on their practice in due course.

33 As future doctors, students have a duty to follow the guidance in *Good Medical Practice* from their first day of study and must understand the consequences if they fail to do so. In particular, students must appreciate the importance of protecting patients, even if this conflicts with their own interests or those of friends or colleagues. If students have concerns about patient safety, they must report these to their medical school. Medical schools must provide robust ways for concerns to be reported in confidence and communicate these to students.

33. See paragraph 133; also see GMC, *Good Medical Practice*

34 Students must be aware that:

- under Section 49 of the Medical Act 1983 it is an offence for a doctor to pretend to hold registration when they do not
- from the introduction of the licence to practise, it is an offence under Section 49A of the Act for a doctor to pretend to hold a licence when they do not.

35 Clinical tutors and supervisors[6] must make honest and objective judgements when appraising or assessing the performance of students, including those they have supervised or trained. Patients may be put at risk if a student is described as competent without having reached or maintained a satisfactory standard.

36 Guidance is given in the joint GMC and Medical Schools Council publication *Medical students: professional values and fitness to practise* about how medical schools should handle concerns about a medical student's performance, health or conduct. The most appropriate form for a medical school's fitness to practise procedures will be decided by the medical school, taking into account the university's structure and statutes. But they should include provision for immediate steps to be taken to investigate any concerns to identify whether they are well-founded and to protect patients. There should also be a flow of information between medical schools and other education providers to ensure that clinical tutors and supervisors are appropriately informed.

36. See paragraphs 145-147; also see GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*

34 General Medical Council

37 From the introduction of the licence to practise, a student awarded a recognised PMQ is eligible for provisional registration with a licence to practise with the GMC, subject to their fitness to practise not being impaired. By awarding a medical degree, the awarding body[7] is confirming that the medical graduate is fit to practise as a Foundation Year One doctor to the high standards that we have set in our guidance to the medical profession, *Good Medical Practice*. Therefore, university medical schools have a responsibility to the public, to employers and to the profession to ensure that only those students who are fit to practise as doctors are allowed to complete the curriculum and gain provisional registration with a licence to practise. This responsibility covers both the thorough assessment of students' knowledge, skills and behaviour towards the end of the course, and appropriate consideration of any concerns about a student's performance, health or conduct.

37. See Domain 5; also see GMC, *Good Medical Practice*

Domain 2 – Quality assurance, review and evaluation

Standard

38 The quality of medical education programmes will be monitored, reviewed and evaluated in a systematic way.

Criteria

39 The medical school will have a clear framework or plan for how it organises quality management and quality control, including who is responsible for this.

40 Management systems will be in place to plan and monitor undergraduate medical education (including admissions, courses, placements, student supervision and support, assessment and resources) to ensure that it meets required standards of quality.

41 The medical school will have agreements with providers of each clinical or vocational placement, and will have systems to monitor the quality of teaching and facilities on placements.

42 The medical school will produce regular reports about different stages or aspects of the curriculum and its delivery, and these will be considered at appropriate management levels of the medical school. There will be systems to plan, implement and review enhancements or changes to the curriculum or its delivery.

43 Quality data will include:

(a) evaluations by students and data from medical school teachers and other education providers about placements, resources and assessment outcomes
(b) feedback from patients
(c) feedback from employers about the preparedness of graduates.

44 Concerns about, or risks to, the quality of any aspect of undergraduate medical education will be identified and managed quickly and effectively.

Evidence

45 The evidence for this domain will include:

- university and medical school quality assurance documentation, including policies, handbooks and minutes of meetings
- documentation about expected standards of curriculum delivery, including placement agreements with other education providers
- monitoring reports and reports of inspections or visits
- quality-control data including student evaluations.

Detailed requirements and context

46 General guidance on quality assurance is given in the Quality Assurance Agency (QAA) *Code of practice for the assurance of academic quality and standards in higher education.* Medical schools should draw on this when designing systems and procedures for quality assurance, management and control.

46. See Appendix 3, *Related documents*: 60

47 Quality management policies and procedures at a medical school will vary according to the university's structure and statutes. But these must include clear information about roles and responsibilities, committee structures, lines of reporting and authority, and the timing of monitoring reports and reviews.

48 Apart from the medical school officers and committees, all education providers of clinical placements, and all clinical tutors and supervisors, students, employers and patients should be involved in quality management and control processes. Their roles must be defined and information made available to them about this.

49 Quality management must cover all aspects of undergraduate medical education, not just teaching. This covers planning, monitoring and the identification and resolution of problems, and includes the following areas:

- admission to medical school
- the learning experience (including induction, teaching, supervision, placements, curriculum)
- appraisal of, and feedback to, students
- pastoral and academic support for students
- assessment of students
- educational resources and capacity (including funding and facilities).

50 As part of quality management, there must be agreements in place with providers of each clinical or vocational placement. These agreements should set out roles and responsibilities, the learning objectives for the placement, and arrangements to ensure that medical students have appropriate learning opportunities to meet the learning outcomes.

50. See paragraphs 157, 165.

51 There must be procedures in place to check the quality of teaching, learning and assessment, including that in clinical/vocational placements, and to ensure that standards are being maintained. These must be monitored through a number of different systems, including student and patient feedback, and reviews of teaching by peers. Appraisals should cover teaching responsibilities for all relevant consultant, academic and other staff, whether or not employed by the university.

52 There must also be systems in place to check the quality and management of educational resources and their capacity, and to ensure that standards are maintained. These must include the management and allocation of funding, clear plans for the planning and management of facilities, and monitoring of student numbers on placements to prevent overcrowding.

53 Any problems identified through gathering and analysing quality-control data should be addressed as soon as possible. It should be clear who is responsible for this. There should also be documentation covering:

- the actions taken
- the feedback given to students and staff on what is being done
- how the problems were resolved.

54 Given the importance of assessment, including placement-based assessments, there must be specific quality-control standards and systems in place to ensure the assessments are 'fit for purpose'.

54. See Domain 5

55 The quality assurance system should ensure that, through the regular reporting upwards on all aspects of undergraduate medical education, the medical school can keep these under constant review, and introduce changes and enhancements. This will include, but should not be limited to, the reviews of faculties, schools or degree programmes prescribed by university procedures.

Domain 3 – Equality, diversity and opportunity

Standard

56 Undergraduate medical education must be fair and based on principles of equality.

56. See Appendix 3, *Related documents*: 44

Criteria

57 The medical school will have policies which are aimed at ensuring that all applicants and students are treated fairly and with equality of opportunity, regardless of their diverse backgrounds.

58 Staff will receive training on equality and diversity to ensure they are aware of their responsibilities and the issues that need to be taken into account when undertaking their roles in the medical school.

59 Reasonable adjustments will be made for students with disabilities in accordance with current legislation and guidance.

59. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled students*; Appendix 3, *Related documents*: 30, 45

60 The medical school will routinely collect and analyse data about equality and diversity issues to ensure that policies are being implemented and any concerns are identified.

61 The medical school will act promptly over any concerns about equality and diversity, implementing and monitoring any changes to policy and practice.

Evidence

62 Evidence for this domain will include:

- medical school policies and action plans about equality and diversity
- information about staff training in equality and diversity, including data on attendance/compliance
- monitoring data about student applications: evidence of addressing equality and diversity matters within admissions processes, progression, assessment and arrangements made for supervision, covering sex, race, disability, sexual orientation, religion or belief, gender identity and age
- information about 'reasonable adjustments' made for students with disabilities and the procedures in place to review the effectiveness of the adjustments
- reports and minutes of meetings.

Detailed requirements and context

63 This domain is concerned with ensuring that students and applicants to medical schools are treated fairly and impartially, with equality of opportunity, regardless of factors that are irrelevant to their selection and progress. It is also concerned with encouraging diversity within the student population to reflect modern society.

64 Specific advice on disabled applicants and students is given in the *Gateways* guidance. Medical schools should have policies on disability which take into account this guidance, relevant legislation and good practice elsewhere. These should cover the assessment of an applicant's ability to meet the 'outcomes for graduates', and the provision of reasonable adjustments and support for a student. Schools should consult each individual concerned to identify the most appropriate adjustments and have them in place before the student's course begins. Schools should review the effectiveness of the adjustments once the student has had time to benefit from their introduction.

64. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled studentss;* Appendix 3, *Related documents*: 27

65 Medical schools should have clear policies, guidance and action plans for tackling discrimination and harassment, and for promoting equality and diversity generally. Medical schools should ensure that these meet the current relevant legal requirements of their country and that they are made available to students.

66 Medical schools' policies for the training, conduct and assessment of students should have regard for the variety of cultural, social and religious backgrounds of students, while maintaining consistency in educational and professional standards.

67 Medical schools should have clear guidance on any areas where a student's culture or religion may conflict with usual practice or rules, including when on placements – for example, dress codes or the scheduling of classes and examinations.

68 Monitoring data must be collected, used and stored in keeping with current legislation and guidance about data protection, confidentiality and privacy.

69 All providers of education and work experience must demonstrate their commitment to equality and diversity.

70 An important part of ensuring equality and diversity is the support provided to students.

70. See Domain 6

Domain 4 – Student selection

Standard

71 Processes for student selection will be open, objective and fair.

71. See Appendix 3, *Related documents*: 26

Criteria

72 The medical school will publish information about the admission system, including guidance about the selection process and the basis on which places at the school will be offered.

73 Selection criteria will take account of the personal and academic qualities needed in a doctor as set out in *Good Medical Practice* and capacity to achieve the outcomes set out in *Tomorrow's Doctors*.

73. See GMC, *Good Medical Practice*; Appendix 3, *Related documents*: 58

74 Selection processes will be valid, reliable and objective.

75 Those responsible for student selection will include people with a range of expertise and knowledge. They will be trained to apply selection guidelines consistently and fairly. They will also be trained to be able to promote equality and diversity (people's different backgrounds and circumstances) and follow current equal opportunities legislation and good practice, including that covering disabled applicants.

75. See Appendix 3, *Related documents*: 27

76 Students admitted will pass any health and other checks (such as criminal record checks) required by the medical school's fitness to practise policy. The purpose and implications of each of these checks, and the points at which they are made, should be made clear to applicants and students.

76. See Appendix 3, *Related documents*: 29

Evidence

77 Evidence for this domain will include:

- information about medical school selection processes
- data about applicants and selected students
- minutes of committees and reports.

Detailed requirements and context

78 Medical schools should base their policies and procedures on relevant guidance, recognised best practice, and research into effective, reliable and valid selection processes which can have the confidence of applicants and the public.

79 Medical schools should also take account of relevant legislation and the *Gateways* guidance in their student selection processes. This includes the requirement to make reasonable adjustments for students with disabilities where the disability would not prevent the applicant from meeting the outcomes for graduates. Schools should be wary of not offering a place on the basis of a judgement about hypothetical barriers to achievement and employment specifically associated with an applicant's disability.

79. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled students*

80 The assessment of any risks associated with an applicant's fitness to practise in relation to their health or conduct should be separated from other processes of selection.

Domain 5 – Design and delivery of the curriculum, including assessment

Standard

81 The curriculum must be designed, delivered and assessed to ensure that graduates demonstrate all the 'outcomes for graduates' specified in *Tomorrow's Doctors*.

Criteria

82 A clear curriculum plan will set out how the 'outcomes for graduates' will be met across the programme as a whole. The curriculum will include opportunities for students to exercise choice in areas of interest.

83 The curriculum will be structured to provide a balance of learning opportunities and to integrate the learning of basic and clinical sciences, enabling students to link theory and practice.

84 The curriculum will include practical experience of working with patients throughout all years, increasing in duration and responsibility so that graduates are prepared for their responsibilities as provisionally registered doctors. It will provide enough structured clinical placements to enable students to demonstrate the 'outcomes for graduates' across a range of clinical specialties, including at least one Student Assistantship[8] period.

84. See Appendix 3, *Related documents*: 28

85 Students will have regular feedback on their performance.

86 All the 'outcomes for graduates' will be assessed at appropriate points during the curriculum, ensuring that only students who meet these outcomes are permitted to graduate. Assessments will be fit for purpose – that is: valid, reliable, generalisable,[9] feasible and fair.

87 Students will receive timely and accurate guidance about assessments, including assessment format, length and range of content, marking schedule and contribution to overall grade.

88 Examiners and assessors will be appropriately selected, trained, supported and appraised.

89 There will be systems in place to set appropriate standards for assessments to decide whether students have achieved the curriculum outcomes.

90 Assessment criteria will be consistent with the requirements for competence standards set out in disability discrimination legislation. Reasonable adjustments will be provided to help students with disabilities meet these competence standards. Although reasonable adjustments cannot be made to the competence standards themselves, reasonable adjustments should be made to enable a disabled person to meet a competence standard.

Evidence

91 Evidence for this domain will include and principally be:

- the curriculum plan
- schemes of assessment
- supporting documentation, including the proportion of the curriculum devoted to Student Selected Components (SSCs).

There must also be supplementary information about the delivery of teaching and clinical placements, the operation of assessments and evaluations from students.

Detailed requirements and context

Curriculum design and structure:

Criteria, paragraph 82: *A clear curriculum plan will set out how the 'outcomes for graduates' will be met across the programme as a whole. The curriculum will include opportunities for students to exercise choice in areas of interest.*

92 It is for each medical school to design its own curriculum to suit its own circumstances, consistent with *Tomorrow's Doctors*. Both curriculum design and delivery must take into account modern educational theory and current research.

93 The overall curriculum must allow students to meet the outcomes specified in the first part of *Tomorrow's Doctors*. This is to ensure that graduates have the necessary knowledge, skills and behaviours to practise as a provisionally registered doctor. Medical schools must demonstrate the way in which these outcomes are met.

94 The curriculum must allow for student choice for a minimum of 10% of course time.

95 SSCs must be an integral part of the curriculum, enabling students to demonstrate mandatory competences while allowing choice in studying an area of particular interest to them.

96 The purpose of SSCs is the intellectual development of students through exploring in depth a subject of their choice.

97 SSC learning outcomes must be mapped to outcomes in *Tomorrow's Doctors*, and contained within the assessment blueprint for the programme, thus helping to make SSCs transparently relevant and clarify how SSCs contribute to the programme.

98 The assessment of these elements of the curriculum must be integrated into the overall assessment of students.

99 Information on the extent and nature of choice available in each SSC, and details on how they will be assessed and contribute to the overall assessment of students, must be publicly available for prospective and current students.

Teaching and learning:

Criteria, paragraph 83: *The curriculum will be structured to provide a balance of learning opportunities and to integrate the learning of basic and clinical sciences, enabling students to link theory and practice.*

100 Students must have different teaching and learning opportunities that should balance teaching in large groups with small groups. They must have practical classes and opportunities for self-directed learning. Medical schools should take advantage of new technologies, including simulation, to deliver teaching.

101 The structure and content of courses and clinical attachments should integrate learning about basic medical sciences and clinical sciences. Students should, wherever possible, learn in a context relevant to medical practice, and revisit topics at different stages and levels to reinforce understanding and develop skills and behaviours.

101. See Appendix 3, *Related documents*: 17, 20

102 Medical schools must ensure that students work with and learn from other health and social care professionals and students. Opportunities should also be provided for students to learn with other health and social care students, including the use of simulated training environments with audiovisual recording and behavioural debriefing. This will help students understand the importance of teamwork in providing care.

Clinical placements and experience:

Criteria, paragraph 84: *The curriculum will include practical experience of working with patients throughout all years, increasing in duration and responsibility so that graduates are prepared for their responsibilities as provisionally registered doctors. It will provide enough structured clinical placements to enable students to demonstrate the 'outcomes for graduates' across a range of clinical specialties, including at least one Student Assistantship[8] period.*

103 The curriculum must include early and continuing contact with patients. Experiential learning in clinical settings, both real and simulated, is important to ensure graduates' preparedness for Foundation Year One (F1) training. Over the curriculum it should increase in complexity, and the level of involvement and responsibility of the student should also increase.

104 From the start, students must have opportunities to interact with people from a range of social, cultural, and ethnic backgrounds and with a range of disabilities, illnesses or conditions. Such contact with patients encourages students to gain confidence in communicating with a wide range of people, and can help develop their ability to take patients' histories and examine patients.

105 The involvement of patients in teaching must be consistent with *Good Medical Practice* and other guidance on consent published by the GMC.

105. See GMC, *Good Medical Practice;* GMC, *Consent: patients and doctors making decisions together*

106 Clinical placements must be planned and structured to give each student experience across a range of specialties, rather than relying entirely upon this arising by chance. These specialties must include medicine, obstetrics and gynaecology, paediatrics, surgery, psychiatry and general practice. Placements should reflect the changing patterns of healthcare and must provide experience in a variety of environments including hospitals, general practices and community medical services. Within each placement there must be a plan of which outcomes will be covered, how this will be delivered, and the ways in which students' performance will be assessed and students given feedback.

106. See Domain 2

107 Medical schools should ensure that appropriate arrangements are made for students with disabilities on placements. Students should be encouraged to feed back to the medical school on their experience, for example, in relation to the provision of reasonable adjustments, guidance and pastoral support, and the working culture. Medical schools should ensure appropriate feedback is communicated to the placement provider and that they intervene, where appropriate, to ensure students receive the support they require.

108 During the later years of the curriculum, students should have the opportunity to become increasingly competent in their clinical skills and in planning patient care. They should have a defined role in medical teams, subject to considerations of patient safety, and this should become more central as their education continues.

108. See Domain 1

109 In the final year, students must use practical and clinical skills, rehearsing their eventual responsibilities as an F1 doctor. These must include making recommendations for the prescription of drugs and managing acutely ill patients under the supervision of a qualified doctor. This should take the form of one or more Student Assistantships in which a student, assisting a junior doctor and under supervision, undertakes most of the duties of an F1 doctor.[10]

110 Students must be properly prepared for their first allocated F1 post. Separate from and following their Student Assistantship, they should, wherever practicable, have a period working with the F1 who is in the post they will take up when they graduate. This 'shadowing' period allows students to become familiar with the facilities available, the working environment and the working patterns expected of them, and to get to know their colleagues. It also provides an opportunity to develop working relationships with the clinical and educational supervisors they will work with in the future. It should consist of 'protected time' involving tasks that enable students to use their medical knowledge and expertise in a working environment, distinct from the general induction sessions provided for new employees and Foundation Programme trainees. The 'shadowing' period should normally last at least one week and take place as close to the point of employment as possible.

Feedback and assessment:

Criteria, paragraph 85: *Students will have regular feedback on their performance.*

Criteria, paragraph 86: *All the 'outcomes for graduates' will be assessed at appropriate points during the curriculum, ensuring that only students who meet these outcomes are permitted to graduate. Assessments will be fit for purpose – that is: valid, reliable, generalisable,[9] feasible and fair.*

Criteria, paragraph 87: *Students will receive timely and accurate guidance about assessments, including assessment format, length and range of content, marking schedule and contribution to overall grade.*

Criteria, paragraph 88: *Examiners and assessors will be appropriately selected, trained, supported and appraised.*

Criteria, paragraph 89: *There will be systems in place to set appropriate standards for assessments to decide whether students have achieved the curriculum outcomes.*

Criteria, paragraph 90: *Assessment criteria will be consistent with the requirements for competence standards set out in disability discrimination legislation. Reasonable adjustments will be provided to help students with disabilities meet these competence standards. Although reasonable adjustments cannot be made to the competence standards themselves, reasonable adjustments should be made to enable a disabled person to meet a competence standard.*

111 Students must receive regular information about their development and progress. This should include feedback on both formative and summative assessments. Clinical logbooks and personal portfolios, which allow students to identify strengths and weaknesses and to focus their learning, can provide this information. Using these will emphasise the importance of maintaining a portfolio of evidence of achievement, which will be necessary once they have become doctors and their licence to practise is regularly revalidated. All doctors, other health and social care workers, patients and carers who come into contact with the student should have an opportunity to provide constructive feedback about their performance. Feedback about performance in assessments helps to identify strengths and weaknesses, both in students and in the curriculum, and this allows changes to be made.

112 Medical schools must ensure that all graduates have achieved all the outcomes set out in *Tomorrow's Doctors*, that is:

- each of the five outcomes under 'The doctor as a scholar and a scientist'
- each of the seven outcomes under 'The doctor as a practitioner'
- each of the four outcomes under 'The doctor as a professional'
- every practical procedure listed in Appendix 1.

This must involve summative assessments during the course that cumulatively demonstrate achievement of each outcome. The medical school must have schemes of assessment that map the outcomes to each assessment event and type, across an appropriate range of disciplines and specialties ('blueprinting'). Students' knowledge, skills and professional behaviour must be assessed. There must be a description of how individual assessments and examinations contribute to the overall assessment of curricular outcomes, which must be communicated to staff and students.

113 Assessments must be designed and delivered to provide a valid and reliable judgement of a student's performance. This means that methods of assessment must measure what they set out to measure, and do so in a fair and consistent way. A range of assessment techniques should be used, with medical schools deciding which are most appropriate for their curriculum.

114 Students must have guidance about what is expected of them in any examination or assessment. No question format will be used in a summative assessment that has not previously been used in a formative assessment of the student concerned.

115 Examiners[11] must be trained to carry out their role and to apply the medical school's assessment criteria consistently. They should have guidelines for marking assessments, which indicate how performance against targeted curricular outcomes should be rewarded.

58 General Medical Council

116 Medical schools must have mechanisms to ensure comparability of standards with other institutions and to share good practice. The mechanisms must cover the appointment of external examiners. The duties and powers of external examiners must be clearly set out.

117 Medical schools must have appropriate methods for setting standards in assessments to decide whether students have achieved the 'outcomes for graduates'. There must be no compensatory mechanism which would allow students to graduate without having demonstrated competence in all the outcomes.

118 Those responsible for assessment must keep to relevant legislation and aim to apply good practice relating to the assessment of those with a disability. Medical schools should also take account of the *Gateways* guidance.

119 Medical schools should be guided by the QAA *Code of practice for the assurance of academic quality and standards in higher education*.

118. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled students*

119. See Appendix 3, *Related documents*: 60

120 Medical schools must use evidence from research into best practice to decide how to plan and organise their assessments: from blueprinting and choosing valid and reliable methods to standard-setting and operational matters. Medical schools must be able to explain clearly their schemes of assessment and demonstrate a wide understanding of them among their staff. Medical schools must therefore have staff with expertise in assessment or access to such staff in other institutions to advise on good practice and train staff involved in assessment.

121 Undergraduate medical education is part of a continuum of education and training which continues through postgraduate training and continuing professional development. While it is essential that the outcomes are achieved by all graduates, medical schools should also make arrangements so that graduates' areas of relative weakness are fed into their Foundation Programme portfolios so they can be reviewed by the educational supervisor. This information should draw on assessments in relation to the outcomes and include graduating transcripts.

Domain 6 – Support and development of students, teachers and the local faculty

Standard

122 Students must receive both academic and general guidance and support, including when they are not progressing well or otherwise causing concern. Everyone teaching or supporting students must themselves be supported, trained and appraised.

Criteria

123 Students will have comprehensive guidance about the curriculum, their placements, what is expected of them and how they will be assessed.

124 Students will have appropriate support for their academic and general welfare needs and will be given information about these support networks.

125 Students will have access to career advice, and opportunities to explore different careers in medicine. Appropriate alternative qualification pathways will be available to those who decide to leave medicine.

126 Students will be encouraged to look after their own health and given information about their responsibilities in this respect as a trainee doctor. They will feel confident in seeking appropriate advice, support and treatment in a confidential and supportive environment.

127 Medical schools will have robust and fair procedures to deal with students who are causing concern on academic and/or non-academic grounds. Fitness to practise arrangements and procedures will take account of the guidance issued by the GMC and the Medical Schools Council. Students must have clear information about these procedures.

127. See GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*

128 Everyone involved in educating medical students will be appropriately selected, trained, supported and appraised.

Evidence

129 Evidence for this domain will include:

- medical school documentation about student support arrangements
- regulations and procedures
- documentation about support and training provided to staff and other education providers
- inspection reports
- medical school quality management reports.

Detailed requirements and context

Academic and pastoral support and guidance:

Criteria, paragraph 123*: Students will have comprehensive guidance about the curriculum, their placements, what is expected of them and how they will be assessed.*

Criteria, paragraph 124: *Students will have appropriate support for their academic and general welfare needs and will be given information about these support networks.*

Criteria, paragraph 125: *Students will have access to career advice, and opportunities to explore different careers in medicine. Appropriate alternative qualification pathways will be available to those who decide to leave medicine.*

130 Medical schools must give students comprehensive guidance about the curriculum and how their performance will be assessed. This must include:

- information about the objectives of clinical placements and how they are assessed
- briefing about practical arrangements for assessments
- the medical school's policies on cheating, plagiarism and the importance of probity.

Students should also be able to get academic advice and guidance from identified members of staff if they need it in a particular subject.

131 Students must have appropriate support for their academic and general welfare needs at all stages. Medical schools must produce information about the support networks available, including named contacts for students with problems. Students taking SSCs that are taught in other departments or by other medical schools, and those on clinical attachments or on electives, must have access to appropriate support.

132 Guidance and support in making reasonable adjustments can be found in the *Gateways* guidance and should also be sought from an appropriate member of staff, such as a disability officer. Implementing reasonable adjustments promptly and reviewing their effectiveness may remedy the difficulties faced by the student. It is important that the medical school gives sufficient time for the student to reap the benefit of the adjustment (and receive the necessary training to use the adjustment, where required) before reviewing the situation.

133 Support and guidance must be provided for students who raise concerns about the health or conduct of anyone else, in order to protect them from victimisation. The process for raising such concerns must be made clear to students.

132. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled students*; GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*, paragraph 48.

133. See Appendix 3, *Related documents*: 18

134 Schools must have a careers guidance strategy. Generic resources should include an outline of career paths in medicine and the postgraduate specialties, as well as guidance on application forms and processes. Specific guidance should be provided for personalised career planning. The careers strategy should be developed and updated with the local postgraduate deanery.

135 A small number of students may discover that they have made a wrong career choice. Medical schools must make sure that these students, whose academic and non-academic performance is not in question, are able to gain an alternative degree or to transfer to another degree course.

136 Students who do not meet the necessary standards in terms of demonstrating appropriate knowledge, skills and behaviour should be advised of alternative careers to follow.

Students' health:

Criteria, paragraph 126: *Students will be encouraged to look after their own health and given information about their responsibilities in this respect as a trainee doctor. They will feel confident in seeking appropriate advice, support and treatment in a confidential and supportive environment.*

137 It is important to differentiate between disability and ill-health in relation to fitness to practise. Having an impairment does not mean that a person is in a permanent state of poor health.

137. See GMC and others, *Gateways to the professions: advising medical schools: encouraging disabled students*, section 3.2

138 Medical schools must stress to students the importance of looking after their own health, encourage them to register with a general practitioner and emphasise that they may not be able to assess their own health accurately. They must tell students about the occupational health services, including counselling, that are available to them.

139 Medical students who may be experiencing difficulties due to a disability, illness or condition should be encouraged to get appropriate help so that they might receive informed advice and support, including reasonable adjustments where appropriate. Students who misuse drugs or alcohol should also be provided with appropriate advice and support.

140 *Good Medical Practice* requires doctors to take responsibility for their own health in the interests of public safety, and medical students should also follow this guidance. Students should protect patients, colleagues and themselves by being immunised against serious communicable diseases where vaccines are available. If a student knows that they have a serious condition which could be passed on to patients, or that their judgement or performance could be significantly affected by a condition or illness (or its treatment), they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, their clinical contact with patients should be altered. Students should not rely on their own assessment of the risk to patients.

140. See GMC, *Good Medical Practice*

141 Guidance on the responsibilities of students and the medical school is in the *Medical School Charter*, produced jointly by the Medical Schools Council and the Medical Students Committee of the British Medical Association.

141. See Appendix 3, *Related documents*: 19

142 Medical schools and students must also be aware of the four UK health departments' guidance on exposure-prone procedures.

143 Medical students who are ill have the same rights to confidentiality as other patients. Doctors providing medical care for students must consider their duties under the GMC's *Confidentiality* guidance. Passing on personal information without permission may be justified if failure to do so may result in death or serious harm to the patient or to others. Doctors should not pass on information without the student's permission, unless the risk to patients is so serious that it outweighs the student's rights to privacy. They must remember that students will be in close contact with patients from an early stage of their training.

143. See GMC, *Confidentiality*

144 Doctors providing medical care for students should consult an experienced colleague, or get advice from a professional organisation, if they are not sure whether passing on information without a medical student's permission is justified.

Student progression and fitness to practise procedures:

Criteria, paragraph 127: *Medical schools will have robust and fair procedures to deal with students who are causing concern on academic and/or non-academic grounds. Fitness to practise arrangements and procedures will take account of the guidance issued by the GMC and MSC. Students must have clear information about these procedures.*

145 Medical schools must provide appropriate support, advice and adjustments. They must also have robust and fair arrangements and procedures, including an appeals process, to deal with students who are causing concern – either on academic or non-academic grounds, including ill-health or misconduct. Medical schools must tell students about these arrangements and procedures so that they understand their rights and obligations. The medical school should decide on the most appropriate form of procedures, taking into account its statutes and circumstances.

145. See GMC and Medical Schools Council, *Medical students: professional values and fitness to practise*

146 If a student's fitness to practise is called into question because of their behaviour or their health, the medical school's arrangements must take account of the joint GMC and MSC guidance: *Medical students: professional values and fitness to practise*. The arrangements should cover both informal and formal procedures, and include clear policies on disclosure of information and evidence to students, to staff and outside the medical school, such as to deaneries and the GMC.

147 The GMC can agree arrangements for disabled graduates so that they are not disadvantaged unfairly by their disability when participating in F1 training, under Section 10A(2)(f) of the Medical Act 1983. Medical schools should contact us at the earliest opportunity should they consider that such arrangements may become necessary for any of their students. The educational aspects of postgraduate medical training are subject to an anticipatory duty to make reasonable adjustments for disabled trainees. It is expected that doctors with a range of disabilities and health conditions should be able to meet the outcomes for F1.

Support for educators:

Criteria, paragraph 128: *Everyone involved in educating medical students will be appropriately selected, trained, supported and appraised.*

148 Medical schools must make sure that everyone involved in educating medical students has the necessary knowledge and skills for their role. This includes teachers, trainers, clinical supervisors and assessors in the medical school or with other education providers. They should also make sure that these people understand *Tomorrow's Doctors* and put it into practice. The medical school must ensure that appropriate training is provided to these people to carry out their role, and that staff-development programmes promote teaching and assessment skills. All staff (including those from other education providers) should take part in such programmes.

149 Every doctor who comes into contact with medical students should recognise the importance of role models in developing appropriate behaviours towards patients, colleagues and others. Doctors with particular responsibility for teaching students must develop the skills and practices of a competent teacher and must make sure that students are properly supervised.

Domain 7 – Management of teaching, learning and assessment

Standard

150 Education must be planned and managed using processes which show who is responsible for each process or stage.

Criteria

151 A management plan at medical school level will show who is responsible for curriculum planning, teaching, learning and assessment at each stage of the undergraduate programme, and how they manage these processes.

152 Teachers from the medical school and other education providers will be closely involved in curriculum management, represented at medical school level and responsible for managing their own areas of the programme.

153 Employers of graduates, and bodies responsible for their continuing training, will be closely involved in curriculum planning and management.

Evidence

154 Evidence for this domain will include:

- medical school policies
- management plans
- agreements with providers of clinical or vocational placements.

Detailed requirements and context

155 Medical schools should have supervisory structures that involve individuals with an appropriate range of expertise and knowledge. Lines of authority and responsibility must be set out. This will allow medical schools to plan curricula and associated assessments, put them into practice and review them. Having people with educational expertise in a medical education unit can help this process.

156 It must be clear who is responsible for the day-to-day management of parts of the curriculum, such as courses and placements, and how those responsible report to higher management levels. Medical school teachers and other education providers and their staff should be involved in managing their own areas of the curriculum, and should be represented on medical school committees and groups.

157 The medical school must have agreements with the other education providers who contribute to the delivery of the curriculum. These should specify the contribution, including teaching, resources and the relevant curriculum outcomes, and how these contributions combine to satisfy the requirements set out in *Tomorrow's Doctors*.

158 The four UK health departments have the role of ensuring that NHS organisations work with medical schools so that students receive appropriate clinical training.

Domain 8 – Educational resources and capacity

Standard

159 The educational facilities and infrastructure must be appropriate to deliver the curriculum.

Criteria

160 Students will have access to appropriate learning resources and facilities including libraries, computers, lecture theatres, seminar rooms and appropriate environments to develop and improve their knowledge, skills and behaviour.

161 Facilities will be supported by a facilities management plan which provides for regular review of the fitness for purpose of the facilities with recommendations and improvements made where appropriate. When reviewing facilities, medical schools should include their suitability for students with disabilities.

162 There will be enough staff from appropriate disciplines, and with the necessary skills and experience, to deliver teaching and support students' learning.

Evidence

163 Evidence for this domain will include:

- medical schools' facilities management plans
- data on facilities usage
- internal quality management reports.

Detailed requirements and context

164 Medical schools must have a plan for the management of resources and facilities. This plan should map to the curriculum to ensure that resources and facilities are effectively used. The plan should also provide for the regular review of facilities to ensure they are still appropriate. Facilities should be accessible for students and others with a disability. Students must be able to comment about the facilities and suggest new resources that should be provided, and schools should consider these comments and feed back their conclusions.

165 The four UK health departments have a duty to make facilities in NHS hospitals and other premises available for students to receive clinical training. Resources will be covered in the agreements between medical schools and other education providers who contribute to the delivery of the curriculum. The agreements will set out the process by which the medical schools can be clear about the allocation of the financial resources received to support undergraduate medical education.

166 Students must have opportunities to develop and improve their clinical and practical skills in an appropriate environment (where they are supported by teachers) before they use these skills in clinical situations. Skills laboratories and centres provide an excellent setting for this training.

167 Learning in an environment that is committed to care, based on evidence and research, can help medical students to understand the importance of developing research and audit skills to improve their practice. It also helps to make sure that those responsible for their learning are aware of current developments in clinical theory and practice.

Domain 9 – Outcomes

Standards

168 The outcomes for graduates of undergraduate medical education in the UK are set out in *Tomorrow's Doctors*. All medical students will demonstrate these outcomes before graduating from medical school.

168. See Appendix 3, *Related documents:* 13, 14

169 The medical schools must track the impact of the outcomes for graduates and the standards for delivery as set out in *Tomorrow's Doctors* against the knowledge, skills and behaviour of students and graduates.

Criteria

170 The programme of undergraduate medical education employs a curriculum which is demonstrated to meet the outcomes for graduates.

171 The programme requires that graduates are able to demonstrate the outcomes.

172 Quality management will involve the collection and use of information about the progression of students. It will also involve the collection and use of information about the subsequent progression of graduates in relation to the Foundation Programme and postgraduate training, and in respect of any determinations by the GMC.

173 Students must have access to analysis of the results of assessments and examinations at the school.

Evidence

174 Evidence for this domain will include:

- medical school quality data – including data from staff, other education providers and students, and data concerning the progression of graduates
- documentation that demonstrates the use of this information in quality management.

Appendix 1 – Practical procedures for graduates

Diagnostic procedures

Procedure	Description in lay terms
1. Measuring body temperature	… using an appropriate recording device.
2. Measuring pulse rate and blood pressure	… using manual techniques and automatic electronic devices.
3. Transcutaneous monitoring of oxygen saturation	Applying, and taking readings from, an electronic device which measures the amount of oxygen in the patient's blood.
4. Venepuncture	Inserting a needle into a patient's vein to take a sample of blood for testing, or to give an injection into the vein.
5. Managing blood samples correctly	Making sure that blood samples are placed in the correct containers, and that these are labelled correctly and sent to the laboratory promptly and in the correct way. Taking measures to prevent spilling and contamination.
6. Taking blood cultures	Taking samples of venous blood to test for the growth of infectious organisms in the blood. Requires special blood containers and laboratory procedures.
7. Measuring blood glucose	Measuring the concentration of glucose in the patient's blood at the bedside, using appropriate equipment and interpreting the results.
8. Managing an electrocardiograph (ECG) monitor	Setting up a continuous recording of the electrical activity of the heart. Ensuring the recorder is functioning correctly, and interpreting the tracing.

Diagnostic procedures (continued)

Procedure	Description in lay terms
9. Performing and interpreting a 12-lead electrocardiograph (ECG)	Recording a full, detailed tracing of the electrical activity of the heart, using a machine recorder (electrocardiograph). Interpreting the recording for signs of heart disease.
10. Basic respiratory function tests	Carrying out basic tests to see how well the patient's lungs are working (for example, how much air they can breathe out in one second).
11. Urinalysis using Multistix	Testing a sample of urine for abnormal contents, such as blood or protein. The urine is applied to a plastic strip with chemicals which change colour in response to specific abnormalities.
12. Advising patients on how to collect a mid-stream urine specimen	Obtaining a sample of urine from a patient, usually to check for the presence of infection, using a method which reduces the risk of contamination by skin bacteria.
13. Taking nose, throat and skin swabs	Using the correct technique to apply sterile swabs to the nose, throat and skin.
14. Nutritional assessment	Making an assessment of the patient's state of nutrition. This includes an evaluation of their diet; their general physical condition; and measurement of height, weight and body mass index.
15. Pregnancy testing	Performing a test of the urine to detect hormones which indicate that the patient is pregnant.

Therapeutic procedures

Procedure	Description in lay terms
16. Administering oxygen	Allowing the patient to breathe a higher concentration of oxygen than normal, via a face mask or other equipment.
17. Establishing peripheral intravenous access and setting up an infusion; use of infusion devices	Puncturing a patient's vein in order to insert an indwelling plastic tube (known as a 'cannula'), to allow fluids to be infused into the vein (a 'drip'). Connecting the tube to a source of fluid. Appropriate choice of fluids and their doses. Correct use of electronic devices which drive and regulate the rate of fluid administration.
18. Making up drugs for parenteral administration	Preparing medicines in a form suitable for injection into the patient's vein. May involve adding the drug to a volume of fluid to make up the correct concentration for injection.
19. Dosage and administration of insulin and use of sliding scales	Calculating how many units of insulin a patient requires, what strength of insulin solution to use, and how it should be given (for example, into the skin, or into a vein). Use of a 'sliding scale' which links the number of units to the patient's blood glucose measurement at the time.
20. Subcutaneous and intramuscular injections	Giving injections beneath the skin and into muscle.
21. Blood transfusion	Following the correct procedures to give a transfusion of blood into the vein of a patient (including correct identification of the patient and checking blood groups). Observation for possible reactions to the transfusion, and actions if they occur.

Therapeutic procedures (continued)

Procedure	Description in lay terms
22. Male and female urinary catheterisation	Passing a tube into the urinary bladder to permit drainage of urine, in male and female patients.
23. Instructing patients in the use of devices for inhaled medication	Providing instructions for patients about how to use inhalers correctly, for example, to treat asthma.
24. Use of local anaesthetics	Using drugs which produce numbness and prevent pain, either applied directly to the skin or injected into skin or body tissues.
25. Skin suturing	Repairing defects in the skin by inserting stitches (normally includes use of local anaesthetic).
26. Wound care and basic wound dressing	Providing basic care of surgical or traumatic wounds and applying dressings appropriately.
27. Correct techniques for 'moving and handling', including patients	Using, or directing other team members to use, approved methods for moving, lifting and handling people or objects, in the context of clinical care, using methods that avoid injury to patients, colleagues, or oneself.

General aspects of practical procedures

Aspect	Description in lay terms
28. Giving information about the procedure, obtaining and recording consent, and ensuring appropriate aftercare	Making sure that the patient is fully informed, agrees to the procedure being performed, and is cared for and watched appropriately after the procedure.
29. Hand washing (including surgical'scrubbing up')	Following approved processes for cleaning hands before procedures or surgical operations.
30. Use of personal protective equipment (gloves, gowns, masks)	Making correct use of equipment designed to prevent the spread of body fluids or cross-infection between the operator and the patient.
31. Infection control in relation to procedures	Taking all steps necessary to prevent the spread of infection before, during or after a procedure.
32. Safe disposal of clinical waste, needles and other 'sharps'	Ensuring that these materials are handled carefully and placed in a suitable container for disposal.

Appendix 2 – What the law says about undergraduate education

UK law

1 The powers and duties of the GMC in regulating medical education are set out in the Medical Act 1983.

2 From the introduction of the licence to practise, graduates who hold a UK primary medical qualification (PMQ) are entitled to provisional registration with a licence to practise, subject to demonstrating to the GMC that their fitness to practise is not impaired.

3 Standards for the delivery of the Foundation Programme, and outcomes for the training of provisionally registered doctors seeking full registration, are published under the title *The New Doctor*.

3. See GMC, *The New Doctor*

4 UK PMQs include degrees of Bachelor of Medicine and Bachelor of Surgery awarded by bodies or combinations of bodies recognised by the GMC. These are the organisations or combinations that may hold qualifying examinations. (Also, valid UK PMQs may be held by individuals who were awarded these qualifications by bodies that were at the time, but are no longer, empowered to award PMQs.)

European Union law

5 European Directive 2005/36/EC allows European Union (EU) nationals who hold an EU PMQ or specialist qualification to practise as doctors anywhere in the EU.

6 Article 24 of the Directive says the period of basic medical training must be at least six years of study or 5,500 hours of theoretical and practical training provided by, or under the supervision of, a university. From the introduction of the licence to practise, 'basic medical training' is the period leading up to full registration with a licence to practise.

7 The EU Directive says basic medical training must provide assurance that individuals acquire the following knowledge and skills:

'Adequate knowledge of the sciences on which medicine is based and a good understanding of the scientific methods including the principles of measuring biological functions, the evaluation of scientifically established facts and the analysis of data.'

'Sufficient understanding of the structure, functions and behaviour of healthy and sick persons, as well as relations between the state of health and physical and social surroundings of the human being.'

'Adequate knowledge of clinical disciplines and practices, providing him with a coherent picture of mental and physical diseases, of medicine from the points of view of prophylaxis, diagnosis and therapy and of human reproduction.'

'Suitable clinical experience in hospitals under appropriate supervision.'

These quotes have been taken from EU Directive 2005/36, Article 24.

Appendix 3 – Related documents

Undergraduate medical education: Outcomes

1 Academy of Medical Royal Colleges Intercollegiate Group on Nutrition. *Proposed Learning Objectives for the Undergraduate Medicine Nutrition Curriculum.* 2008. **www.icgnutrition.org.uk**

2 The Education Committee of the Anatomical Society of Great Britain and Ireland. 'A core syllabus in anatomy for medical students – Adding common sense to need to know.' *European Journal of Anatomy.* 2007; 11 (Supplement 1): 3-18. **www.anatsoc.org.uk**

3 Association of American Medical Colleges and Howard Hughes Medical Institute. *Scientific Foundation for Future Physicians*. 2009. **www.hhmi.org**

4 Behavioural and Social Sciences Teaching in Medicine (BeSST). *Psychology Core Curriculum for Undergraduate Medical Education*. Awaiting publication. **www.heacademy.ac.uk/besst**

5 Heads of Academic Departments of Public Health in the United Kingdom (HOADs) (original authors D Chappel, G Maudsley, R Bhopal and S Ebrahim, and re-edited by Stephen Gillam and Gillian Maudsley). *Public Health Education for Medical Students – A guide for medical schools*. Department of Public Health and Primary Care, University of Cambridge. 2008. **www.phpc.cam.ac.uk**

6 von Fragstein M., Silverman J., Cushing A., Quilligan S., Salisbury H., Wiskin C. 'UK consensus statement on the content of communication curricula in undergraduate medical education.' *Medical Education.* 2008; 42:11:1100-1107. **www3.interscience.wiley.com**

7 International Centre for Drug Policy. *Substance Misuse in the Undergraduate Medical Curriculum*. 2007. **www.sgul.ac.uk**

8 Joint Committee on Medical Genetics. *Learning Outcomes in Genetics for Medical Students.* 2006. **www.geneticseducation.nhs.uk**

9 Maxwell SRJ, Walley T. 'Teaching safe and effective prescribing in UK Medical Schools: a core curriculum for tomorrow's doctors.' *British Journal of Clinical Pharmacology.* 2003; 55:496-503. **www.bps.ac.uk**

10 Medical Schools Council. *Outcomes of the Medical Schools Council Safe Prescribing Working Group.* 2007. **www.medschools.ac.uk**

11 Royal College of Obstetricians and Gynaecologists. *National Undergraduate Curriculum in Obstetrics and Gynaecology, Report of a Working Party*. 2009. **www.rcog.org.uk**

12 Royal College of Psychiatrists. *Report of the Royal College of Psychiatrists' Scoping Group on Undergraduate Education in Psychiatry*. 2009. **www.rcpsych.ac.uk**

13 Scottish Deans' Medical Education Group. *The Scottish Doctor. Learning Outcomes for the Medical Undergraduate in Scotland: A Foundation for Competent and Reflective Practitioners.* 2008. **www.scottishdoctor.org**

14 The Tuning Project (Medicine). *Learning Outcomes/Competences for Undergraduate Medical Education in Europe.* Medical Education in Europe (MEDINE), the University of Edinburgh, Education and Culture DG of the European Commission, Tuning Educational Structures in Europe. 2008. **www.tuning-medicine.com**

15 World Health Organisation World Alliance for Patient Safety. *WHO Patient Safety Curriculum Guide for Medical Schools.* World Health Organisation. Awaiting publication. **www.who.int**

Undergraduate medical education: Delivery

16 Association for the Study of Medical Education. Series of publications on *Understanding Medical Education*. From 2006. **www.asme.org.uk**

17 Hugh Barr. *Undergraduate Interprofessional Education*. General Medical Council. 2003. **www.gmc-uk.org/education**

18 British Medical Association Medical Students Committee. *Whistle-blowing*. 2008. **www.bma.org.uk**

19 British Medical Association Medical Students Committee and Medical Schools Council. *Medical school charter*. 2006. **www.bma.org.uk**

20 Department of Health (England) and UK Centre for the Advancement of Interprofessional Education. *Creating an Interprofessional Workforce: An Education and Training Framework for Health and Social Care in England.* 2007. **www.caipe.org.uk**

21 General Medical Council. *Guidance on UK medical education delivered outside the UK*. 2008. **www.gmc-uk.org/education**

22 General Medical Council and others. *Gateways to the Professions. Advising medical schools: encouraging disabled students*. 2008. **www.gmc-uk.org/education**

23 General Medical Council and Medical Schools Council. *Medical Students: Professional Values and Fitness to Practise.* 2009. **www.gmc-uk.org/education**

24 Christine Hogg. *Patient-Centred Care: Tomorrow's Doctors.* General Medical Council. 2004. **www.gmc-uk.org/education**

25 Jan Illing and others. *How prepared are medical graduates to begin practice?* General Medical Council. 2008. **www.gmc-uk.org**

26 Medical Schools Council. *Guiding Principles for the Admission of Medical Students.* 2006. **www.medschools.ac.uk**

27 Medical Schools Council. *Recommendations on Selection of Students with Specific Learning Disabilities, including Dyslexia.* 2005. **www.medschools.ac.uk**

28 Medical Schools Council. *The Ten Key Principles for joint working between the Universities and the NHS*. 2004. **www.medschools.ac.uk**

29 Medical Schools Council, the Council of Heads and Deans of Dental Schools, the Association of UK University Hospitals and the Higher Education Occupational Physicians Group. *Medical and Dental Students: Health clearance for Hepatitis B, Hepatitis C, HIV and Tuberculosis.* 2008. **www.medschools.ac.uk**

30 Anne Tynan. *Today's Disabled Students: Tomorrow's Doctors.* General Medical Council. 2006. **www.gmc-uk.org/education**

31 World Federation for Medical Education. *Basic Medical Education: WFME Global Standards for Quality Improvement*. 2003. **www2.sund.ku.dk/wfme**

Postgraduate medical training

32 Academy of Medical Royal Colleges and the UK health departments. *The Foundation Programme Curriculum.* 2007. **www.foundationprogramme.nhs.uk**

33 General Medical Council. *The New Doctor.* 2007. **www.gmc-uk.org/education**

34 Postgraduate Medical Education and Training Board. *Educating Tomorrow's Doctors – Future models of medical training; medical workforce shape and trainee expectations.* 2008. **www.pmetb.org.uk**

35 Postgraduate Medical Education and Training Board. *Generic standards for training.* 2008. **www.pmetb.org.uk**

36 Postgraduate Medical Education and Training Board. *Patients' Role in Healthcare – The future relationship between patient and doctor*. 2008. **www.pmetb.org.uk**

Medical education and training: all stages

37 Academy of Medical Royal Colleges. *Health Inequalities Curriculum Competency Project.* 2009. **www.aomrc.org.uk**

38 British Medical Association. *Equality and diversity education*. 2008. **www.bma.org.uk**

39 British Medical Association Board of Medical Education. *Doctors as teachers.* 2006. **www.bma.org.uk**

40 British Medical Association Medical Education Subcommittee. *Role of the patient in medical education.* 2008. **www.bma.org.uk**

41 Andreas Hasman, Angela Coulter, Janet Askham. *Education for Partnership. Developments in medical education.* Picker Institute Europe. 2006. **www.pickereurope.org**

42 NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges. *Medical Leadership Competency Framework.* 2008. **www.institute.nhs.uk**

Medical practice

43 Academy of Medical Royal Colleges. *A Clinician's Guide to Record Standards*. 2008. **www.rcplondon.ac.uk**

44 British Medical Association Equal Opportunities Committee. *Career barriers in medicine*. 2004. **www.bma.org.uk**

45 British Medical Association Equal Opportunities Committee. *Disability equality in the medical profession*. 2007. **www.bma.org.uk**

46 British Medical Association Equal Opportunities Committee and Patient Liaison Group. *Disability equality within healthcare: the role of healthcare professionals*. 2007. **www.bma.org.uk**

47 General Medical Council. *Confidentiality: Protecting and providing information.* 2004. **www.gmc-uk.org/guidance**

48 General Medical Council. *Consent: Patients and doctors making decisions together.* 2008. **www.gmc-uk.org/guidance**

49 General Medical Council. *Good Medical Practice.* 2006. **www.gmc-uk.org/guidance**

50 General Medical Council. *Good practice in prescribing medicines.* 2008. **www.gmc-uk.org/guidance**

51 General Medical Council. *Personal beliefs and medical practice.* 2008. **www.gmc-uk.org/guidance**

52 General Medical Council. *Raising concerns about patient safety.* 2006. **www.gmc-uk.org/guidance**

53 General Medical Council. *Research: The role and responsibilities of doctors.* 2002. **www.gmc-uk.org/guidance**

54 General Medical Council. *Withholding and withdrawing life-prolonging treatments.* 2002. **www.gmc-uk.org/guidance**

55 Ros Levenson, Steve Dewar, Susan Shepherd. *Understanding Doctors: Harnessing Professionalism.* King's Fund and Royal College of Physicians. 2008. **www.kingsfund.org.uk**

56 Medical Schools Council. *The Consensus Statement on the Role of the Doctor. 2008.* **www.medschools.ac.uk**

57 NHS Institute for Innovation and Improvement. *Improvement Leaders' Guides.* 2007. **www.institute.nhs.uk**

58 Royal College of Physicians. *Doctors in society. Medical professionalism in a changing world.* 2005. **www.rcplondon.ac.uk**

59 Royal College of Physicians. *Palliative Care Services: meeting the needs of patients.* 2007. **www.rcplondon.ac.uk**

Higher education

60 Quality Assurance Agency. *Code of practice for the assurance of academic quality and standards in higher education.* Various dates for sections. **www.qaa.ac.uk**

Appendix 4 – Glossary

Appraisal	A positive process to provide feedback on the performance of a student or a member of staff to chart their continuing progress, and to identify their development needs.
Assessment	All activity aimed at judging students' attainment of curriculum outcomes, whether for summative purposes (determining progress) or formative purposes (giving feedback). An 'examination' is an individual assessment test.
Clinical tutor or clinical supervisor	Any doctor or other healthcare professional responsible for the supervision or assessment of a student on a placement.
Curriculum	A detailed schedule of the teaching and learning opportunities that will be provided.
Elective	A period of clinical experience that is chosen by the student and is often taken outside the UK.
Examiners	All those responsible for marking, assessing or judging students' performance, regardless of the terminology used in any particular medical school.
Integrated teaching	A system where the clinical and basic sciences are taught and learned together. This allows students to see how scientific knowledge and clinical experience are combined to support good medical practice.

Other education providers	Organisations involved in the delivery of undergraduate medical education outside the medical school itself, including their staff, GP tutors, clinical tutors, NHS staff, and others in the local health economy or independent sector with specific roles in educational supervision.
Placement	A structured period of supervised clinical experience and learning in a health or social care setting (including community health services and non-NHS settings).
Primary medical qualification (PMQ)	A first medical degree awarded by a body or combination of bodies that is recognised by the GMC for this purpose, or that was empowered to issue PMQs at the time the degree was awarded.
Revalidation	The regular demonstration by doctors that they are up to date, and fit to practise medicine.
Scheme of assessment	The examinations and assessments that make sure all students have successfully achieved and demonstrated the knowledge, skills and behaviour set out in the curriculum.
Self-directed learning	A process in which students are responsible for organising and managing their own learning activities and needs.
Student Assistantship	A period during which a student acts as assistant to a junior doctor, with defined duties under appropriate supervision.

Student-selected components (SSCs)	Parts of the curriculum that allow students to choose what they want to study. These components may also offer flexibility concerning how, where and when study will take place.

Endnotes

1 See *High Quality Care for All – NHS Next Stage Review Final Report.*

2 The term 'other education providers' means organisations involved in the delivery of undergraduate medical education outside the medical school itself, including their staff, GP tutors, clinical tutors, NHS staff, and others in the local health economy or independent sector with specific roles in educational supervision.

3 'NHS organisations' includes acute, primary care and mental health organisations, and the boards and authorities which oversee their work.

4 Primary prevention of disease is understood to refer to the prevention of disease onset. Secondary prevention of disease is understood to refer to the detection of disease in symptom-free individuals. Tertiary prevention of disease is understood to refer to the prevention of disease progression, and to palliation or rehabilitation.

5 The term 'placement' means a structured period of supervised clinical experience and learning in a health or social care setting (including community health services and non-NHS settings).

6 The terms 'clinical tutor' and 'clinical supervisor' mean any doctor or other healthcare professional responsible for the supervision or assessment of a student on a placement.

7 This includes universities and non-university bodies with appropriate degree-awarding powers that are recognised by the GMC.

8 A Student Assistantship means a period during which a student acts as assistant to a junior doctor, with defined duties under appropriate supervision.

9 A generalisable assessment is one where candidates' scores are not influenced by specific circumstances such as variability in examination conditions or examiners.

10 When acting as a Student Assistant, a student must not carry out any procedure or take responsibility for anything which requires provisional registration and, from the introduction of the licence to practise, a licence.

11 'Examiners' here means all those responsible for marking, assessing or judging students' performance, regardless of the terminology used in any particular medical school.

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Note: Numbers refer to page numbers

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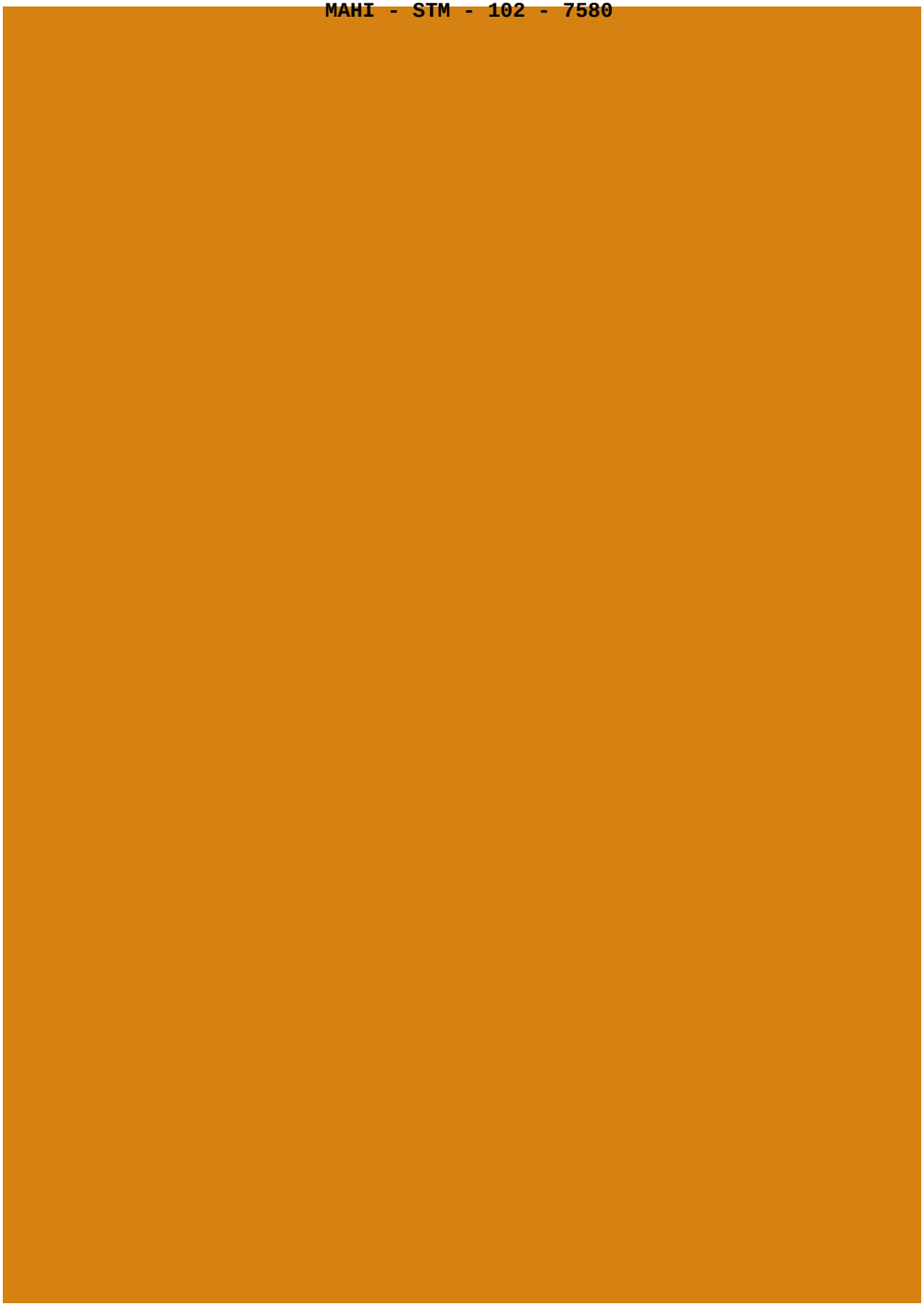

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The Trainee Doctor

Foundation and specialty, including GP training

Working with doctors Working for patients

General Medical Council

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
- Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

The Trainee Doctor

Published July 2011.

Contents

Introduction

1 The General Medical Council (GMC) is responsible for the regulation of education and training throughout a doctor's career, from medical school through the Foundation Programme and specialty training, including general practice training programmes, to continuing professional development.

2 The GMC sets the duties of a doctor registered with the organisation. All doctors, whether they are postgraduate trainees, or undertaking roles in medical education and training, are personally responsible for their professional practice and must be able to justify their decisions and actions.

3 The GMC sets the standards for the delivery of foundation and specialty training, including GP training, and quality assures the delivery of training against those standards (for the remainder of this document the term 'specialty training' will include GP training). A single point of regulatory responsibility from admission to medical school, through postgraduate training, to continued practice until retirement will ensure consistency of expectations and standards.

4 Training should prepare and encourage doctors to become life-long learners, during foundation and specialty training, and further as part of continuing medical education and professional development. Training takes place under supervision, appropriate to the level of competence of the trainee, which increasingly, as the trainee progresses through the stages of training, will develop towards independent practice.

5 This document integrates the *Generic standards for specialty including GP training* with *The New Doctor* standards for training in the Foundation Programme. The management of different stages of training should be integrated, and there is benefit from aligning and rationalising the standards documentation where possible; there has been a clear

message from our partners that this is desirable. Additionally, standards for trainers have been published and are included as a sub-set of the standards under Domain 6 – Support and development of trainees, trainers and local faculty.

6 The standards must be applied wherever foundation and specialty training take place, including the National Health Service (NHS), other service providers, industry, and the independent sector. Any provision of foundation and specialty training which forms part of or the whole of a programme arranged/agreed by the postgraduate dean will be subject to these standards.

7 The bodies responsible for managing the quality of foundation and specialty training and meeting these standards are postgraduate deaneries. In many cases the deanery will only be able to demonstrate these standards by working with local education providers (LEPs), the medical Royal Colleges and Faculties and specialty associations. Where responsibility is shared, this is specified under each standard in this document.

8 The document also sets out the *Standards for deaneries* that the GMC will hold postgraduate deaneries accountable for in accordance with the *Medical Act 1983*. The *Standards for deaneries* provides clarity on the responsibilities of every postgraduate dean and deanery in the UK, in relation to its quality management arrangements. The document also includes the principles for commissioning.

9 Supplementary documentation does continue to apply, and where necessary has been updated.

What evidence will be used to determine whether these standards have been met?

10 Evidence will be needed from several sources to determine whether these standards have been met. These sources will include:

- **a** data collected by postgraduate deaneries as part of their quality management processes and LEPs as part of the quality control responsibilities
- **b** surveys of trainees and trainers. We shall examine key issues identified in annual UK-wide trainee and national trainer surveys. The trainee survey will include questions specific to foundation, specialty, and, where relevant, GP training
- **c** evidence from progression statistics, for example assessments including examinations, and career progression after successfully completing the programme. These will form part of the evidence describing educational outcomes of programmes
- **d** data collected by other healthcare regulators and inspecting authorities across the UK, the facilities provided and, in particular, issues affecting patient safety and patient care
- **e** data collected from other GMC functions, including fitness to practise and registration
- **f** risk-based visits carried out by the GMC to postgraduate deaneries and LEPs, whether as part of the planned cycle of quality assurance and improvement or as the result of a visit triggered by evidence of failure or concerns regarding poor practice.

11 Periodically, the GMC will analyse evidence from these sources to draw together a picture of the state of foundation and specialty training throughout the UK. This will show performance against standards by postgraduate deaneries, LEPs, medical Royal Colleges and Faculties and specialty associations and will seek to show which factors are most significant in predicting good and poor educational outcomes within training programmes and at the end of training.

12 This benchmarking analysis will be the basis for the further development of the standards.

Developmental standards

13 Where evidence exists that a particular practice or facility improves the quality of foundation and specialty training, the GMC will consider the case for developing a new standard which would become mandatory in due course. Postgraduate deaneries and LEPs would be given sufficient time to implement the necessary changes to achieve the new standard. Developmental standards would be designed using information from the following principal sources:

- **a** approvals – posts, programmes, trainers, curricula and assessment systems
- **b** visits to deaneries
- **c** surveys of trainees and trainers
- **d** validated research on training in the UK
- **e** feedback from LEPs
- **f** similar information from other jurisdictions and from the education sector
- **g** feedback from patients and the public.

14 The GMC encourages quality development beyond the level required by the standards.

Contextual information

Language used in this document

15 For these standards, the GMC has adopted the framework of domains defined as:

a classification of areas in which certain standards must be achieved.

16 This document uses the following definition of standards.

Standards are a means of describing the level of quality that organisations involved in the delivery of foundation and specialty education and training are expected to meet. The performance of organisations can be assessed for this level of quality; the standards must be met.

17 The document also sets out mandatory requirements which underpin the standards, must be achieved, and are defined as:

the minimum requirements for postgraduate education and training considered by the GMC to be necessary to fulfil its responsibilities as regulator and achievable in today's UK health services.

18 The term 'should' is used when the mandatory requirement will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the standards.

19 The GMC will use these requirements to make differentiated judgements which indicate whether standards are being fully met. A fully met standard does not preclude the deanery or LEP having issues, concerns or problems that impact on posts, programmes or courses. However, there may be circumstances where standards are mostly, but not completely, achieved. The ability to recognise organisations which have met or not met standards is essential.

20 The GMC's *Quality Improvement Framework* explains how we will quality assure undergraduate and postgraduate medical education and training in the UK until 2012. The section on approval against the standards sets out the process if quality standards are not met, which may include withdrawal of approval.

21 Most of the mandatory requirements within this document apply across postgraduate training and are relevant to both foundation and specialty training. However, there are some mandatory requirements which may be applicable only to either foundation or specialty training.

22 If the mandatory requirement does not specify which period of postgraduate training it applies to, it applies to all postgraduate training. If the mandatory requirement is not applicable to all postgraduate training, it will specify which period it applies to, whether foundation or specialty training.

Relationship with the GMC's other standards

23 *The Trainee Doctor* applies alongside the *Standards for curricula and assessment systems* which relate to foundation and specialty training.

24 The *Standards for deaneries* have been included in this document. By meeting all the standards and requirements set for postgraduate deaneries, all parties involved with the *Quality Improvement Framework* can have confidence that the deanery has discharged its duties fully and with due care and attention.

25 The document also includes the outcomes for provisionally registered doctors, and the legal framework for programmes for provisionally registered doctors.

26 The GMC's standards and outcomes for undergraduate medical education are set out in *Tomorrow's Doctors* 2009 and the same framework of domains is used. The Foundation Programme and subsequent specialty training build on undergraduate education, allowing new doctors to demonstrate performance in the workplace and, under the supervision of more experienced doctors, enable them to take increasing responsibility for patients.

27 Current versions of the GMC's standards can always be found on the GMC's website: www.gmc-uk.org.

Relevance to *Good medical practice*

28 The principles of *Good medical practice* are designed to underpin all clinical and professionally related activity undertaken by doctors. Those principles apply equally to the training environment – particularly how doctors are taught the curriculum and use assessment – as they do to service delivery. Therefore a specific requirement is made at section 5.3 to the effect that those delivering the curriculum should ensure that: trainees must be reminded about the need to have due regard to, and to keep up to date with, the principles of *Good medical practice*.

Standards for postgraduate training

Domain 1 – Patient safety

Purpose
This domain is concerned with the essential safeguards on any action by trainees that affects the safety and wellbeing of patients.

This domain is concerned with ensuring provisionally registered doctors' fitness to be signed off for full registration with the General Medical Council.

Responsibility
LEPs (hospitals and other institutions where training takes place), postgraduate deaneries, trainers, trainees. Medical schools and postgraduate deaneries are responsible for sign off for full registration.

Evidence
Surveys, visits, deanery quality management data, data from healthcare regulators or inspectorates, deanery or local guidance on fitness to practise policies and their implementation.

Standards
The responsibilities, related duties, working hours and supervision of trainees must be consistent with the delivery of high-quality, safe patient care.

There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors.

Mandatory requirements

1.1 Trainees must make the care of patients their first concern.

1.2 Trainees must be appropriately supervised according to their experience and competence, and must only undertake appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision. Trainees must never be put in a situation where they are asked to work beyond the limits of their competence without appropriate support and supervision from a clinical supervisor.

1.3 Those supervising the clinical care provided by trainees must be clearly identified; be competent to supervise; and be accessible and approachable at all times while the trainee is on duty.

1.4 Before seeking consent both trainee and supervisor must be satisfied that the trainee understands the proposed intervention and its risks, and is prepared to answer associated questions the patient may ask. If they are unable to do so they should have access to a supervisor with the required knowledge. Trainees must act in accordance with the GMC's guidance *Consent: patients and doctors making decisions together* (2008).

1.5 Shift and on-call rota patterns must be designed so as to minimise the adverse effects of sleep deprivation.

1.6 Trainees in hospital posts must have well organised handover arrangements, ensuring continuity of patient care at the start and end of periods of day or night duties every day of the week.

1.7 There must be robust processes for identifying, supporting and managing trainees whose progress or performance, health, or conduct is giving rise to concern.

1.8 Immediate steps must be taken to investigate serious concerns about a trainee's performance, health or conduct, to protect patients. The trainee's educational supervisor and the deanery must be informed. The GMC must also be informed when a problem is confirmed in line with *Good medical practice* and the GMC's fitness to practise requirements.

1.9 Those responsible for training, including educational supervisors, must share information with relevant individuals and bodies, including postgraduate deaneries and employers, about trainee doctors that is relevant to their development as doctors. This must take place between the medical school (in the case of provisionally registered doctors) and the deanery, and during and at the end of posts and programmes. Trainees should be told the content of any information about them that is given to someone else, and those individuals should be specified. Where appropriate, and with the trainee's knowledge, relevant information must be given to the educational supervisor for their next placement so that appropriate training, support and supervision can be arranged.

Foundation training mandatory requirements

1.10 All those who teach, supervise, give counselling to, provide reports or references about, employ or work with foundation doctors must protect patients by providing explicit and accountable supervision, and honest and justifiable reports about the foundation doctor's competence, performance and conduct.

1.11 Foundation doctors must always have direct access to a senior colleague who can advise them in any clinical situation. Foundation doctors must never be left in a situation where their only help is outside the hospital or the place where they work.

1.12 Foundation doctors who are a risk to patients must not be allowed to continue training and must not be signed off for full registration with the GMC. Information about these foundation doctors should be passed to the GMC for consideration about fitness to practise, in accordance with local processes.

Domain 2 – Quality management, review and evaluation

Purpose
This domain deals with governance issues and how the GMC's standards will be used for review, assurance and improvement. It refers to the quality management systems and procedures of postgraduate deaneries, and quality control by LEPs.

Responsibility
Postgraduate deans, within an overall local quality management system, and drawing on the resources of local representatives of medical Royal Colleges and Faculties, specialty associations, employers and others as appropriate for all training posts and programmes.

Evidence
Data from the deanery, College/Faculty, LEPs, or other data and visits to deaneries.

Standard
Training must be quality managed, monitored, reviewed, evaluated and improved.

Mandatory requirements

2.1 Programmes, posts, trainers, associated management, data collection concerning trainees, and local faculty[1] must comply with the European Working Time Regulations, *Data Protection Act*, and *Freedom of Information Act*.

2.2 Postgraduate deaneries, working with others as appropriate, must have processes for local quality management, and for quality control through LEPs. This must include all postgraduate posts, programmes and trainers and ensure that the requirements of the GMC's standards are met.

2.3 The quality management of programmes and posts must take account of the views of those involved, including trainees, local faculty and, where appropriate, patients and employers.

Domain 3 – Equality, diversity and opportunity

Purpose
This domain deals with equality and diversity matters across the whole of postgraduate training, including widening access and participation, the provision of information, programme design and job adjustment.

Responsibility
Postgraduate deans, LEPs, trainers and trainees, medical royal colleges and faculties, and specialty associations other colleagues working with trainees and local faculty.

Evidence
Surveys, demographic data, deanery quality management data, policies and visits.

Standard
Training must be fair and based on principles of equality.

Mandatory requirements

3.1 At all stages foundation and specialty training programmes must comply with employment law, the Equality Act 2010, the Human Rights Act and any other relevant legislation that may be enacted and amended in the future, and be working towards best practice. This will include compliance with any public duties to eliminate discrimination, promote equality and foster good relations.

3.2 Information about training programmes, their content and purpose must be publicly accessible either on, or via links to, postgraduate deaneries and the GMC's websites.

3.3 Postgraduate deaneries must take all reasonable steps to adjust programmes for trainees with well-founded individual reasons for being unable to work full time, to enable them to train and work less than full time within the GMC's standards and requirements. Postgraduate deaneries must take appropriate action to encourage LEPs and other training providers to provide adequate opportunity for trainees to train less than full time.

3.4 Appropriate reasonable adjustments must be made for trainees with disabilities, special educational or other needs.

3.5 Equality and diversity data, including evidence on trainee recruitment, appointment, and satisfaction, must be collected and analysed at recruitment and during training and the outcome of the analysis made available to trainees and trainers.

3.6 Data about training medical staff in issues of equality and diversity should be collected routinely and fed into the quality management system where appropriate.

3.7 When drafting or reviewing policy or process the deanery and LEPs must consider the ramifications of such action for trainees or applicants and ensure that they are fair to all.

Domain 4 – Recruitment, selection and appointment

Purpose
The purpose of this domain is to ensure that the processes for entry into postgraduate training programmes are fair and transparent.

Responsibility
Postgraduate deans, medical Royal Colleges and Faculties, specialty associations, UK Foundation Programme Office, local faculty and, through these, employers.

Evidence
Deanery data, trainee surveys, national and local recruitment processes.

Standard
Processes for recruitment, selection and appointment must be open, fair, and effective.

Mandatory requirements

4.1 Candidates will be eligible for consideration for entry into specialty training if they:

- **a** are a fully registered medical practitioner with the GMC or are eligible for any such registration
- **b** hold a licence to practise or are eligible to do so
- **c** are fit to practise
- **d** are able to demonstrate the competences required to complete foundation training. This covers candidates who have completed foundation training, candidates who apply before completion and those who have not undertaken foundation training but can demonstrate the competences in another way.

4.2 The selection process must:

- **a** ensure that information about places on training programmes, eligibility and selection criteria and the application process is published and made widely available in sufficient time to doctors who may be eligible to apply
- **b** use criteria and processes which treat eligible candidates fairly
- **c** select candidates through open competition
- **d** have an appeals system against non-selection on the grounds that the criteria were not applied correctly, or were discriminatory
- **e** seek from candidates only such information (apart from information sought for equalities monitoring purposes) as is relevant to the published criteria and which potential candidates have been told will be required.

4.3 Selection panels must consist of persons who have been trained in selection principles and processes.

4.4 Selection panels must include a lay person.

4.5 There must be comprehensive information provided for those within postgraduate programmes about choices in the programme and how they are allocated.

Foundation training mandatory requirement

4.6 The appointment process should demonstrate that foundation doctors are fit for purpose and able, subject to an appropriate induction and ongoing training, to undertake the duties expected of them in a supportive environment. The process should build on experiences gained at medical schools to support fitness for purpose in the working environment.

Domain 5 – Delivery of approved curriculum including assessment

Purpose

This domain is concerned with ensuring that the requirement of the curricula set by medical Royal Colleges and Faculties, and specialty associations or others developing curricula, and approved by the GMC, are being met at the local level and that each post enables the trainee to attain the skills, knowledge and behaviours as envisaged in the given approved curriculum.

Responsibility

Postgraduate deans in partnership with LEPs, trainers, trainees, medical Royal Colleges and Faculties/specialty associations and employers.

Evidence

Approvals, surveys, deanery data, visits.

Standard

The requirements set out in the approved curriculum and assessment system must be delivered and assessed.

a Education and training

Mandatory requirements

5.1 Sufficient practical experience must be available within the programme to support acquisition of knowledge, skills and behaviours and demonstration of developing competency as set out in the approved curriculum.

5.2 Each programme must show how the posts within it, taken together, will meet the requirements of the approved curriculum and what must be delivered within each post.

5.3 Trainees must be reminded about the need to have due regard to, and to keep up to date with, the principles of *Good medical practice*.

5.4 Trainees must be able to access and be free to attend regular, relevant, timetabled, organised educational sessions and training days, courses, resources and other learning opportunities of educational value to the trainee that form an intrinsic part of the training programme, and have support to undertake this activity whenever possible.

Foundation training mandatory requirement

5.5 In organised educational sessions, foundation doctors must not be on duty, and should give their pagers to someone else so that they can take part.

b Assessment

Mandatory requirements

5.6 The overall purpose of the approved assessment system as well as each of its components must be documented and in the public domain and must be implemented.

5.7 Assessments must be appropriately sequenced and must match progression through the career pathway.

5.8 Individual approved assessments within the system should add unique information and build on previous assessments.

5.9 Trainees must only be assessed by someone with appropriate expertise in the area to be assessed.

Foundation training mandatory requirements

5.10 Assessments may be carried out in a variety of ways, but must be carried out to the same standard. This will allow trainees with a disability to show that they have achieved the outcomes. Those responsible for assessment must be aware of and apply legislation and good practice relating to the assessment of those with a disability.

5.11 There must be a clear, documented and published system for dealing with trainees who have not completed training successfully, including:

- **a** appeals procedures
- **b** processes for identifying and providing any further training needed
- **c** counselling for those foundation doctors who are not able to progress to full registration.

5.12 Systems and processes must be in place to ensure that the responsibility for signing the certificate of experience is clear.

5.13 The person appointed to confirm that a foundation doctor has met all the necessary outcomes of training must ensure that all the required outcomes of training have been met and that the foundation doctor practises in line with the principles of professional practice set out in *Good medical practice*.

5.14 A named representative of the university, normally but not necessarily the postgraduate dean, must be responsible for filling in the certificate of experience based on the confirmation of satisfactory service, or equivalent, signed by educational supervisors. The legal responsibility for confirming the requirements of full registration for UK graduates remains with their medical school.

5.15 There must be valid methods for assessing foundation doctors' suitability for full registration, completion of foundation training, and application and entry to specialty training. This must include a clear, documented and published process for assessing foundation doctors' performance, and what evidence and information will inform a judgement about the performance of a foundation doctor, to complete and put forward:

- **a** confirmation of satisfactory service or equivalent at the end of each placement within a programme that covers the outcomes met during the placement, the outcomes not met during the placement, and the outcomes not dealt with during that placement
- **b** a certificate of experience for doctors who have completed the first year of the programme successfully enabling them to apply for full registration.

5.16 A range of methods of assessment should contribute to the overall judgement about the performance of a foundation doctor, including evidence of direct observation of the foundation doctor's performance; reports from colleagues about the foundation doctor's performance; discussions with the foundation doctor about their performance; and the foundation doctor's portfolio. Other sources of evidence providing insight into competence should be recorded and may include feedback from patients who have been in contact with the foundation doctor and the outcome of audits.

5.17 The evidence on which the completion of the certificate of experience and the achievement of the foundation year two competence document is based must be clearly identified by educational supervisors. At the end of each placement within the Foundation Programme, the educational supervisor, in conjunction with the deanery, must assess whether the foundation doctor has met the necessary outcomes.

c Performance feedback

Mandatory requirements

5.18 Trainees must have regular feedback on their performance within each post.

5.19 All doctors and other health and social care professionals who have worked with trainees should have an opportunity to provide constructive feedback about the trainee's performance.

5.20 Trainees must maintain a personal record of educational achievement to describe and record their experiences, and to identify strengths and weaknesses, which should include summaries of feedback from the educational supervisor, significant achievements or difficulties, reflections of educational activity, and the results of assessments.

Domain 6 – Support and development of trainees, trainers and local faculty

Purpose
This domain covers the structures and support, including induction, available to trainees, trainers and local faculty.

Responsibility
Postgraduate deaneries, trainers and local faculty, LEPs, employers, and trainees.

Evidence
Surveys, deanery quality management data, visits.

Standard
Trainees must be supported to acquire the necessary skills and experience through induction, effective educational and clinical supervision, an appropriate workload, relevant learning opportunities, personal support and time to learn.

a Induction

Mandatory requirements

6.1 Every trainee starting a post or programme must be able to access a departmental induction to ensure they understand the approved curriculum; how their post fits within the programme; their duties and reporting arrangements; their role in the inter-professional and inter-disciplinary team; workplace and departmental policies and to meet key staff.

6.2 At the start of every post within a programme, the educational supervisor (or representative) must discuss with the trainee the educational framework and support systems in the post and the respective responsibilities of trainee and trainer for learning. This discussion should include the setting of aims and objectives that the trainee is expected to achieve in the post.

b Educational supervision

Mandatory requirements

6.3 Trainees must have, and be told the name and contact details of, a designated educational supervisor.

6.4 Trainees must sign a training/learning agreement at the start of each post.

6.5 Trainees must have a logbook and/or a learning portfolio relevant to their current programme, which they discuss with their educational supervisor (or representative).

6.6 Trainees must meet regularly with their educational supervisor (or representative) during their placement: at least at the beginning and end of each placement for foundation doctors; and at least every three months for specialty trainees, to discuss their progress, outstanding learning needs and how to meet them.

6.7 Trainees must have a means of feeding back, in confidence, their concerns and views about their training and education experience to an appropriate member of local faculty or the deanery, without fear of disadvantage and in the knowledge that privacy and confidentiality will be respected.

6.8 There must be a review of progress and appraisal within each post, and a process for transfer of information by supervisors of trainees between placements.

6.9 Trainees must have relevant, up-to-date, and ready access to career advice and support.

c Training

Mandatory requirements

6.10 Working patterns and intensity of work by day and by night must be appropriate for learning (neither too light nor too heavy), in accordance with the approved curriculum, add educational value and be appropriately supervised.

6.11 Trainees must be enabled to learn new skills under supervision, for example during theatre sessions, ward rounds and outpatient clinics.

6.12 Training programmes must include placements which are long enough to allow trainees to become members of the team and allow team members to make reliable judgements about their abilities, performance and progress.

6.13 While trainees must be prepared to make the needs of the patient their first concern, trainees must not regularly carry out routine tasks that do not need them to use their medical expertise and knowledge, or have little educational value.

6.14 Trainees must regularly be involved in the clinical audit process, including personally participating in planning, data collection and analysis.

6.15 Access to occupational health services for all trainees must be assured.

6.16 Trainees must be able to access training in generic professional skills at all stages in their development.

6.17 Trainees must have the opportunity to learn with, and from, other healthcare professionals.

6.18 Trainees must not be subjected to, or subject others to, behaviour that undermines their professional confidence or self-esteem.

6.19 Access to confidential counselling services should be available to all trainees when needed.

6.20 Information must be available about less than full time training, taking a break, or returning to training following a career break for any reason including health or disability.

6.21 Trainees must receive information on, and named contacts for, processes to manage and support doctors in difficulty.

Foundation training mandatory requirement

6.22 Prior to taking up their first foundation year one (F1) placement, new doctors should, wherever practicable, have a period working with the F1 doctor who is in the post they will take up. The 'shadowing' period should normally last at least one week and take place as close to the

point of employment as possible, and is distinct from the general induction sessions provided for new employees and foundation doctors.

d Study leave

Mandatory requirements

6.23 Trainees must be made aware of their eligibility for study leave and how to apply for it and be guided on appropriate courses and funding.

6.24 Where eligible, trainees must be able to take study leave up to the maximum permitted in their terms and conditions of service.

6.25 The process for applying for study leave must be fair and transparent, and information about a deanery-level appeals process must be readily available.

e Academic training

Mandatory requirements

6.26 Trainees must be made aware of the academic opportunities available in their programme or specialty.

6.27 Trainees who believe that their particular skills and aptitudes are well-suited to an academic career, and are inclined to pursue it, should receive guidance in that endeavour.

6.28 Specialty trainees who elect and who are competitively appointed to follow an academic path must be sited in flexible approved programmes of academic training that permit multiple entry and exit points (from standard training programmes) throughout training.

Standards for trainers

All doctors who have completed specialty training can and do act as supervisors[2]. Many doctors develop the role to become educational supervisors. These standards apply to all such doctors; however, the requirements may specify where they apply only to educational supervisors or others with educational responsibilities.

Standard

Trainers must provide a level of supervision appropriate to the competence and experience of the trainee.

Mandatory requirements

6.29 Trainers must enable trainees to learn by taking responsibility for patient management within the context of clinical governance and patient safety.

6.30 Trainers must understand and demonstrate ability in the use of the approved in-work assessment tools and be clear as to what is deemed acceptable progress.

6.31 Trainers must regularly:

- **a** review the trainee's progress through the training programme
- **b** adopt a constructive approach to giving feedback on performance
- **c** ensure the trainee's progress is recorded
- **d** identify their development needs
- **e** advise on career progression
- **f** understand the process for dealing with a trainee whose progress gives cause for concern.

Standard

Trainers must be involved in, and contribute to, the learning culture in which patient care occurs.

Mandatory requirements

6.32 Trainers must ensure that clinical care is valued for its learning opportunities; learning, assessment and teaching must be integrated into service provision.

6.33 Trainers must liaise as necessary with other trainers both in their clinical departments and within the organisation to ensure a consistent approach to education and training and the sharing of good practice across specialties and professions.

Standard

Trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and sufficient time to train, supervise, assess and provide feedback to develop trainees.

Mandatory requirements

6.34 Organisations providing medical education and training must ensure that trainers have adequate support and resources to undertake their training role.

6.35 Postgraduate deaneries must have structures and processes to support and develop trainers, and must provide trainers with information about how to access training and support to help them to undertake their roles and responsibilities effectively.

6.36 Trainers with additional educational roles, for example training programme director or director of medical education, must be selected against a set of criteria, have specific training for their role, demonstrate ability as effective trainers and be appraised against their educational activities.

6.37 GP trainers must be trained and selected in accordance with the *Medical Act 1983*.

Standard

Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees.

Mandatory requirements

6.38 Trainers must have knowledge of, and comply with, the GMC's regulatory framework for medical training.

6.39 Trainers must ensure that all involved in training and assessment of their designated trainee understand the requirements of the programme.

Domain 7 – Management of education and training

Purpose

This domain covers organisational management at administrative and executive level.

Responsibility

Postgraduate deans, medical Royal Colleges and Faculties/specialty associations, LEPs, employing organisations and others as appropriate.

Evidence
Deanery and LEP data, surveys, policies, strategic business and management plans, service level agreements with organisations employing trainee doctors relating to education and training.

Standard
Education and training must be planned and managed through transparent processes which show who is responsible at each stage.

Mandatory requirements

7.1 Postgraduate training programmes must be supported by a management plan with a schedule of responsibilities, accountabilities, and defined processes to ensure the maintenance of GMC standards in the arrangement and content of training programmes. For foundation training this also includes the responsibilities of universities and foundation schools.

7.2 All employing organisations, as LEPs of postgraduate training, must consider postgraduate training programmes at board level. It is highly desirable that they have an executive or non-executive director at board level, responsible for supporting postgraduate training programmes, setting out responsibilities and accountabilities for training and for producing processes to address underperformance in postgraduate training.

7.3 There must be clear accountability, a description of roles and responsibilities, and adequate resources available to those involved in administering and managing training and education at institutional level, such as directors of medical education and board level directors with executive responsibility, such as medical director, finance director, or director of clinical governance.

Foundation training mandatory requirement

7.4 Foundation year one doctors must have written approval from their university to accept a programme that completes their basic medical education, evidenced either through participation in the academic and national recruitment to the foundation programme process, or, if appointed locally to a training post in the Foundation Programme, by a letter from the medical school confirming approval to take up the post or programme, and the arrangements for signing the Certificate of Experience. If a provisionally registered doctor is appointed to a Locum Appointment for Training (LAT) post, the postgraduate deanery or foundation school linked to the graduating medical school must be involved in the recruitment to the LAT post and ensure it meets the standards and content set out in *The Trainee Doctor*.

Domain 8 – Educational resources and capacity

Purpose

This domain addresses both the physical requirements for facilities to support postgraduate training and also the service, workload, management, supervisory and educational capacity of the organisation providing the training.

Responsibility

Employers to provide; postgraduate deans to secure; medical royal colleges and faculties/specialty associations and others developing curricula to clarify in the approved documentation.

Evidence

Deanery and LEP/other organisation data, data from other regulators, surveys, visits.

Standard

The educational facilities, infrastructure and leadership must be adequate to deliver the curriculum.

Mandatory requirements

8.1 The overall educational capacity of the organisation and any unit offering postgraduate training posts or programmes within it must be adequate to accommodate the practical experiences required by the curriculum.

8.2 There must be access to educational facilities, facilities for a range of investigations and resources (including access to the internet in all workplaces) of a standard to enable trainees to achieve the outcomes of the training programme as specified in the approved curriculum.

8.3 There must be a suitable ratio of trainers to trainees. The educational capacity in the department or unit delivering training must take account of the impact of the training needs of others (for example, undergraduate medical students, other undergraduate and postgraduate healthcare professionals and non-training grade staff).

8.4 Trainers, including clinical supervisors and those involved in medical education, must have adequate time for training identified in their job plans.

8.5 Educational resources relevant to, and supportive of, the training programme must be available and accessible, for example technology enhanced learning opportunities.

8.6 Trainees must have access to meeting rooms, teaching accommodation and audiovisual aids.

8.7 Trainees must be enabled to develop and improve their clinical and practical skills, through technology enhanced learning opportunities such as clinical skills laboratories, wet labs and simulated patient environments. Foundation doctors must have these opportunities, where they are supported by teachers, before using these skills in clinical situations.

Domain 9 – Outcomes

Purpose
This domain is concerned with the outcomes of training programmes and the achievements of trainees.

Responsibility
The GMC, postgraduate deans, LEPs, medical Royal Colleges and Faculties/ specialty associations, educational supervisors and trainees.

Evidence
Trainee progression data, for example assessment and examination results; data about sign-off procedures and registration; data on trainee recruitment, appointment and satisfaction with the results analysed by ethnicity, place of qualification, disability, gender and part time training/work; trainee survey results.

Standard
The impact of the standards must be tracked against trainee outcomes and clear linkages should be made to improving the quality of training and the outcomes of the training programmes.

The outcomes for provisionally registered doctors and competences for the Foundation Programme are published in this document and in the *Foundation Programme Curriculum*. All doctors must demonstrate these outcomes and competences before successfully completing the Foundation Programme.

Mandatory requirements

9.1 Organisations providing postgraduate training must demonstrate they are collecting and using information about the progression of trainees to improve the quality of training.

9.2 Trainees must have access to analysis of outcomes of assessments and exams for each programme and each location benchmarked against other programmes.

9.3 Those responsible for managing postgraduate medical education are required to report to the GMC on the outcomes of training.

Standards for deaneries

29 The *Standards for deaneries* were introduced following the positive response to proposals on quality management as set out in the *Quality Assurance Framework Consultation* (September 2007). Quality management (QM) is the term used to describe the arrangements by which a postgraduate deanery discharges its responsibility for the standards and quality of foundation and specialty training. Through its QM activities, a deanery satisfies itself that LEPs are meeting the GMC standards through robust reporting and quality control mechanisms. Each standard has its own accompanying set of requirements which articulate how deaneries are able to demonstrate achievement of the relevant standard.

30 The GMC's *Standards for deaneries* provide clarity on the responsibilities of every postgraduate dean and deanery in the UK, in relation to its QM arrangements. By meeting all of the standards and requirements set out herein, all parties involved with the *Quality Improvement Framework* can have confidence that the deanery has discharged its duties fully and with due care and attention.

Standard 1

The postgraduate deanery must adhere to, and comply with, GMC standards and requirements.

1.1 Local QM should aim to improve the quality of foundation and specialty training as well as ensuring that it meets national standards.

1.2 The deanery QM activities must be set and reported within the framework of the published GMC standards and requirements for foundation and specialty training.

1.3 The deanery must draw upon the principle of educational governance.

1.4 The deanery must effectively discharge its responsibilities for implementation of programmes within the principles of good regulation.

1.5 The deanery must provide an annual report to the GMC to the requirements set by the GMC.

Standard 2

The postgraduate deanery must articulate clearly the rights and responsibilities of the trainees.

2.1 Trainees must have full opportunity to raise, individually or collectively, matters of proper concern to the deanery without fear of disadvantage and in the knowledge that privacy and confidentiality will be respected.

2.2 Sources of impartial help, advice, guidance and support should be available and advertised widely.

2.3 Trainees and deaneries share responsibility for ensuring that they seek prospective approval by the GMC for training where appropriate and necessary.

2.4 All trainees should comply with any QM processes such as completion of the trainee survey and taking part in any QM interviews, coordinated by the deanery and/or the GMC.

Standard 3

The postgraduate deanery must have structures and processes that enable the GMC standards to be demonstrated for all foundation and specialty training, and for the trainees, within the sphere of their responsibility.

3.1 The deanery must have structures, groups and committees that enable the full and active involvement of the specialist bodies: the medical Royal Colleges, Faculties and specialty associations.

3.2 The deanery must have in place effective mechanisms for working with the medical Royal Colleges, Faculties and specialty associations for the review and development of assessment systems.

3.3 The committees and groups set up by the deanery must be fit for purpose, ensuring attainment of GMC standards, but also promoting the dissemination of good practice.

3.4 The monitoring of foundation and specialty programmes, posts and trainers by the deanery must take due account of external national, local and specialty guidance, the deanery strategic plan, and the deanery business/operational plan.

3.5 The monitoring of foundation and specialty programmes and posts by the deanery should identify the level of risk and plan accordingly.

3.6 The review of foundation and specialty programmes and posts must take full account of all those involved, including trainees, trainers and, where appropriate, patients.

3.7 The deanery must promote the maximum response to all of the national surveys conducted by the GMC.

3.8 The deanery must provide a clear documented response to all of the national surveys through the annual report to the GMC.

3.9 The deanery must ensure that actions are followed up to remedy any shortcomings, and that records are kept and made available on request by the GMC.

3.10 The monitoring of foundation and specialty programmes and posts by the deanery must routinely involve external advisers.

Standard 4

The postgraduate deanery must have a system for the use of external advisers.

4.1 There must be external input at key stages of the specialty including GP training involving 'independent and impartial advisers'. The number of such external advisers required will depend on the size of the deanery and, where relevant, the number of specialty programmes.

4.2 External advisers may be medical or lay, depending on the area for advice and/or scrutiny. Medical advisers will have expertise appropriate for the specialty programme, course or school being considered and will normally be drawn from the medical Royal Colleges, Faculties or specialty associations.

4.3 The external advisers will verify that standards are being attained by trainees and so help deaneries maintain the quality of the provision.

4.4 The external advisers scrutinising the assessment processes should be able to confirm that they are sound and fairly operated.

4.5 External advisers should record good practice that they have identified. This should promote comparability of the trainee experience between deaneries, in the same specialty.

4.6 There must be clear identification of roles, powers and responsibilities assigned to external advisers by the deanery.

4.7 Deaneries should incorporate their responses to the external advisers' comments and considerations into the annual report to the GMC.

Standard 5

The postgraduate deanery must work effectively with others.

5.1 The deanery must ensure effective liaison with other organisations, particularly the LEPs, and medical Royal Colleges/Faculties.

5.2 The deanery must ensure active and meaningful involvement and engagement of key stakeholders: trainees, trainers, patients, and the service or employer.

5.3 The deanery should have systems and structures that enable each LEP to contribute to the delivery, maintenance and development of specialty including GP training programmes and posts.

Outcomes for provisionally registered doctors with a licence to practise

31 The *Medical Act 1983* empowers the GMC to recognise programmes for provisionally registered doctors with a licence to practise. To be recognised, a programme must provide a provisionally registered doctor with an acceptable foundation for future practice as a fully registered medical practitioner.

32 The GMC determined that from 1 August 2007, doctors with provisional registration with a licence to practise in foundation year one (F1 doctors) must demonstrate the following outcomes in order to be eligible to apply for full registration.

33 These outcomes must be demonstrated on different occasions and in different clinical settings as a professional in the workplace demonstrating a progression from the competence required of a medical student. They do not preclude doctors gaining additional appropriate experience; in fact progression is encouraged.

34 The GMC has approved the content of programmes for provisionally registered doctors by approving the *Foundation Programme Curriculum* published by the Academy of Medical Royal Colleges Foundation Committee. The outcomes have been mapped onto the *Foundation Programme Curriculum*. A programme delivering the *Foundation Programme Curriculum* will enable F1 doctors to meet these outcomes for full registration, subject to satisfactory provision by postgraduate deaneries in the United Kingdom, which will be determined as part of our *Quality Improvement Framework*.

35 The outcomes are structured under the seven headings of *Good medical practice*.

Good clinical care

36 F1 doctors must:

- **a** demonstrate that they recognise personal and professional limits, and ask for help from senior colleagues and other health and social care professionals when necessary
- **b** know about and follow our guidance on the principles of *Good medical practice* and the standards of competence, care and conduct expected of doctors registered with the GMC. Our ethical guidance is available on our website at www.gmc-uk.org/guidance
- **c** demonstrate that they are taking increasing responsibility, under supervision and with appropriate discussion with colleagues, for patient care, putting the patient[3] at the centre of their practice by:
  - **i** obtaining an appropriate and relevant history and identifying the main findings
  - **ii** carrying out an appropriate physical and mental health examination
  - **iii** using their knowledge and taking account of relevant factors including physical, psychological and social factors to identify a possible differential diagnosis
  - **iv** asking for and interpreting the results of appropriate investigations to confirm clinical findings in a timely manner
  - **v** establishing a differential diagnosis where possible and considering what might change this

vi demonstrating knowledge of treatment options and the limits of evidence supporting them

vii asking for patients' informed consent (under supervision) in accordance with GMC guidance[4]

viii helping patients to make decisions on their immediate and longer-term care (including self care) taking into account the way the patient wants to make decisions (through shared decision-making, or by the doctor explaining the options and the patient asking the doctor to decide, or by the doctor explaining the options and the patient deciding)

ix using medicines safely and effectively (under supervision) including giving a clear explanation to patients

x demonstrating an understanding of the safety procedure involved in prescribing controlled drugs

xi keeping (or arranging for the keeping of) accurate and clear clinical records that can be understood by colleagues

xii demonstrating that they can perform core clinical and procedural skills safely. These core clinical and procedural skills are set out in the following section

xiii demonstrating knowledge and application of the principles and practice of infection control to reduce the risk of cross-infection

d demonstrate that they are recognising and managing acutely ill patients under supervision. This includes showing that they are able to manage a variety of situations where a patient requires resuscitation

e demonstrate that they promote, monitor and maintain health and safety in the clinical setting. They must also be able to show that they have knowledge of systems of quality assurance, including clinical governance, and demonstrate an application of the principles of risk management to their medical practice. This includes knowledge and explanation of the procedure for reporting adverse incidents and the procedures for avoiding them. This also includes following safe practices relating to dangers in the workplace

f manage their own time under supervision, and develop strategies with other healthcare workers to maximise efficient use of time

g demonstrate that they are able to take appropriate action if their own health, performance or conduct, or that of a colleague (including a more senior colleague), puts patients, colleagues or the public at risk

h demonstrate that they can recognise and use opportunities to promote health and prevent disease and show that they are aware of worldwide health priorities and concerns about health inequalities.

Maintaining good medical practice

37 F1 doctors must:

a develop a portfolio that includes a variety of evidence (including workplace-based assessments, involvement in educational and clinical teaching sessions, and reflections on experiences with patients and colleagues) to demonstrate:

- **i** achievement of the requirements in this guidance, including workplace-based assessments
- **ii** ability to identify, document and meet their educational needs

iii learning through reflection on their practice
iv knowledge of the theory of audit, including change management

b be able to explain how to contribute to audit and how the results of audit can improve their practice and that of others
c embrace the importance of continuing professional development and self-directed learning and demonstrate this through the assessment process. This will include the need to respond constructively to appraisals and performance reviews.

Teaching and training, appraising and assessing

38 F1 doctors must:

a teach their peers and medical and other health and social care students under guidance, if required to do so, using appropriate skills and methods
b contribute to the appraisal, assessment or review of students and other colleagues they work with.

Relationships with patients

39 F1 doctors must:

a demonstrate knowledge of the theory and demonstrate the ability to ensure that effective relationships with patients are established and maintained. This includes creating an environment where the doctor can encourage and support the patient to share all information relevant to the consultation
b introduce themselves to patients and colleagues with appropriate confidence and authority ensuring that patients and colleagues understand their role, remit and limitations

c demonstrate that they recognise that patients are knowledgeable about themselves and the effect their health has on their daily life. They should use this expertise to encourage and support patients to be involved in their own care. Relatives, or others caring for those with long-term health conditions, are often knowledgeable in this area too. F1 doctors should be aware that carers, supporters and advocates (who speak on behalf of patients) often have to be included in the information given to patients. In the case of people with communication difficulties or difficulties processing information, carers, supporters and advocates must be kept informed about diagnosis and medical care, subject to GMC guidance on confidentiality

d demonstrate that they encourage and support effective communication with people, both individually and in groups, including people with learning disabilities and those who do not have English as their main language

e demonstrate that they are sensitive and respond to the needs and expectations of patients, taking into account, only where relevant, the patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status

f demonstrate that they respect and uphold patients' rights to refuse treatment or take part in teaching or research

g demonstrate sound knowledge concerning confidentiality (including GMC guidance on confidentiality, Caldicott and data protection issues).

Working with colleagues

40 F1 doctors must:

- **a** work effectively as a member of a team, including supporting others, handover and taking over the care of a patient safely and effectively from other health professionals
- **b** demonstrate respect for everyone they work with (including colleagues in medicine and other healthcare professions, allied health and social care workers and non-health professionals) whatever their professional qualifications, age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status
- **c** demonstrate that they can communicate in different ways, including spoken, written and electronic methods. They must use communication methods that meet the needs and contexts of individual patients and colleagues, including those within the team, or in other disciplines, professions and agencies where appropriate
- **d** share appropriate information, where necessary, with a patient's permission, with other members of the healthcare team to provide the best possible information and treatment
- **e** demonstrate that they listen to and take into account the views of other health professionals and agencies and, where appropriate, share information with other professionals and agencies in accordance with GMC guidance on consent.

Probity

41 F1 doctors must:

- **a** be honest in their relationships with patients (and their relatives and carers), professional colleagues and employers
- **b** be able to complete or arrange for the completion of legal documents correctly such as those certifying sickness and death (or arranging for these documents to be filled in) and liaise with the coroner or procurator fiscal where appropriate
- **c** demonstrate knowledge of and be able to apply relevant legislation to their day-to-day activities.

Health

42 F1 doctors must:

- **a** demonstrate knowledge of their responsibilities to look after their health, including maintaining a suitable balance between work and personal life, and knowing how to deal with personal illness to protect patients
- **b** take responsibility, in line with *Good medical practice*, for their own health in the interests of public safety. If they know, or have reasons to believe, that they have a serious condition which could be passed on to patients, or that their judgement or performance could be significantly affected by a condition or illness (or its treatment), they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, they should change their clinical contact with patients. They must not rely on their own assessment of the risk to patients.

Core clinical and procedural skills for provisionally registered doctors[5]

1 Venepuncture
2 IV cannulation
3 Prepare and administer IV medications and injections
4 Arterial puncture in an adult
5 Blood culture from peripheral sites
6 Intravenous infusion including the prescription of fluids
7 Intravenous infusion of blood and blood products
8 Injection of local anaesthetic to skin
9 Injection – subcutaneous (eg insulin or LMW heparin)
10 Injection – intramuscular
11 Perform and interpret an ECG
12 Perform and interpret peak flow
13 Urethral catheterisation (male)
14 Urethral catheterisation (female)
15 Airway care including simple adjuncts (eg Guedel airway or laryngeal masks)

The legal framework for programmes for provisionally registered doctors

43 The powers and duties of the GMC in regulating medical education are set out in the *Medical Act 1983*.

44 Provisional registration is awarded for the purposes of completing an acceptable programme for provisionally registered doctors. The only acceptable programme for provisionally registered doctors that the GMC has recognised is the Foundation Programme. Provisionally registered doctors are only permitted to take up posts in the Foundation Programme.

45 From the introduction of the licence to practise, any person whose fitness to practise is not impaired and who holds one or more primary United Kingdom qualification and has satisfactorily completed an acceptable programme for provisionally registered doctors, is entitled to be registered under section 3 of the 1983 Act as a fully registered medical practitioner.

46 All training programmes for provisionally registered doctors must deliver the outcomes and meet the standards in *The Trainee Doctor*.

47 From 1 August 2007, F1 doctors are required to meet the outcomes in *The Trainee Doctor* before being eligible to apply for full registration.[6]

48 Provisionally registered doctors will be able to demonstrate they have met the outcomes for full registration by successfully completing the requirements of the F1 *Foundation Programme Curriculum* published by the Academy of Medical Royal Colleges Foundation Committee.[7]

49 To obtain full registration a programme for provisionally registered doctors of 12 months' duration must be completed.[8]

50 Satisfactory completion of a programme for provisionally registered doctors is confirmed by the completion of the Certificate of Experience, in the form determined by the GMC[9] and available on the GMC website. Universities, or their designated representative in postgraduate deaneries or foundation schools, will be required to certify that provisionally registered doctors have met the outcomes for full registration set by the GMC and have completed a programme for provisionally registered doctors of 12 months before full registration is granted.

51 Bodies that may provide, arrange or be responsible for programmes for provisionally registered doctors are postgraduate deaneries in England, Northern Ireland (the Northern Ireland Medical and Dental Training Agency), Scotland and Wales (the School of Postgraduate Medical and Dental Education at Cardiff University)[10], and local education providers.[11] Postgraduate deaneries will be held accountable under the *Quality Improvement Framework* for meeting the standards in *The Trainee Doctor*.

52 Locum Appointment for Service (LAS) posts, which are used for service delivery and do not provide training that meets the standards and content in *The Trainee Doctor*, will not enable foundation doctors to meet the requirements for satisfactory completion of F1 or the Foundation Programme. LAS posts must not be undertaken by provisionally registered doctors.

Endnotes

1 The GMC uses the term 'local faculty' to denote those involved in the delivery of postgraduate medical education locally: training programme directors, directors of medical education, clinical tutors, GP trainers, college tutors, and others with specific roles in educational supervision and clinical supervision where this relates to training.

2 A clinical supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged.

An educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The educational supervisor is responsible for the trainee's educational agreement.

3 In this document, the term 'patient' or 'carer' should be understood to mean the term 'patient', 'patient and parent', 'guardian', 'carer', and/ or 'supporter' or 'advocate' where relevant and appropriate.

4 See GMC guidance *Consent: patients and doctors making decisions together*, 2008, paragraphs 26–27.

5 The core clinical and procedural skills were amended on 29 July 2009. The amended requirements are effective from August 2010 when the revised *Foundation Programme Curriculum* came into effect.

6 See section 10A(2)(c) of the 1983 Act. The GMC agreed the outcomes on 6 December 2006.

7 The GMC approved the *Foundation Programme Curriculum* in November 2009.

8 See section 10A(2)(a) of the 1983 Act.

9 Section 10A(e) empowers the GMC to determine the arrangements for certification that a person has satisfactorily completed a programme for provisionally registered doctors.

10 Section 10A(2)(b) of the 1983 Act.

11 Determined by the Postgraduate Board on 2 February 2011 under section 10A(2)(b) of the 1983 Act.

Appendix – Principles for commissioning

The GMC updated and adopted the 'Principles for commissioning' prior to the merger of the Postgraduate Medical Education and Training Board with the GMC.

The GMC would expect the following principles to be adopted by any organisation responsible for the commissioning of foundation and specialty including GP training in the UK.

The commissioning organisation must:

- have a commissioner, identified to the GMC, responsible for foundation and specialty including GP training
- have the quality of delivery of foundation and specialty including GP training as their prime priority
- have the authority to manage the quality of delivery of the training and to decommission a provider when the required standards are not met
- be accountable to the regulator for the quality management of the approved programmes in the GMC *Quality Improvement Framework*.

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General Medical Council

Outcomes for provisionally registered doctors with a licence to practise

(The Trainee Doctor)

Working with doctors Working for patients

General Medical Council

Outcomes for provisionally registered doctors with a licence to practise (The Trainee Doctor)

July 2015

About the outcomes for provisionally registered doctors

The outcomes for provisionally registered doctors with a licence to practise and the associated list of core clinical and procedural skills were agreed in December 2006. They were published in *The Trainee Doctor* (2011).

The Trainee Doctor also included standards for postgraduate training, which have been replaced by *Promoting excellence: standards for medical education and training* published in July 2015.

Outcomes for provisionally registered doctors

1 The *Medical Act 1983* empowers the General Medical Council (GMC) to recognise programmes for provisionally registered doctors with a licence to practise. To be recognised, a programme must provide a provisionally registered doctor with an acceptable foundation for future practice as a fully registered medical practitioner.

2 The GMC determined that from 1 August 2007, doctors with provisional registration with a licence to practise in foundation year one (F1 doctors) must demonstrate these outcomes in order to be eligible to apply for full registration.

3 These outcomes must be demonstrated on different occasions and in different clinical settings as a professional in the workplace demonstrating a progression from the competence required of a medical student. They do not preclude doctors gaining additional appropriate experience; in fact progression is encouraged.

4 The GMC has approved the content of programmes for provisionally registered doctors by approving the Foundation Programme Curriculum published by the Academy of Medical Royal Colleges Foundation Committee. The outcomes have been mapped onto the Foundation Programme Curriculum. A programme delivering the Foundation Programme Curriculum will enable F1 doctors to meet these outcomes.

Good clinical care

5 F1 doctors must:

a demonstrate that they recognise personal and professional limits, and ask for help from senior colleagues and other health and social care professionals when necessary

b know about and follow our guidance on the principles of *Good medical practice* and the standards of competence, care and conduct expected of doctors registered with the GMC. Our ethical guidance is available on our website at www.gmc-uk.org/guidance

c demonstrate that they are taking increasing responsibility, under supervision and with appropriate discussion with colleagues, for patient care, putting the patient* at the centre of their practice by:

- obtaining an appropriate and relevant history and identifying the main findings
- carrying out an appropriate physical and mental health examination

* In this document, the term 'patient' or 'carer' should be understood to mean the term 'patient', 'patient and parent', 'guardian', 'carer', and/ or 'supporter' or 'advocate' where relevant and appropriate.

- using their knowledge and taking account of relevant factors including physical, psychological and social factors to identify a possible differential diagnosis
- asking for and interpreting the results of appropriate investigations to confirm clinical findings in a timely manner
- establishing a differential diagnosis where possible and considering what might change this
- demonstrating knowledge of treatment options and the limits of evidence supporting them
- asking for patients' informed consent (under supervision) in accordance with GMC guidance
- helping patients to make decisions on their immediate and longer-term care (including self care) taking into account the way the patient wants to make decisions (through shared decision-making, or by the doctor explaining the options and the patient asking the doctor to decide, or by the doctor explaining the options and the patient deciding)
- using medicines safely and effectively (under supervision) including giving a clear explanation to patients
- demonstrating an understanding of the safety procedure involved in prescribing controlled drugs
- keeping (or arranging for the keeping of) accurate and clear clinical records that can be understood by colleagues
- demonstrating that they can perform core clinical and procedural skills safely. These core clinical and procedural skills are set out in the following section
- demonstrating knowledge and application of the principles and practice of infection control to reduce the risk of cross-infection

d demonstrate that they are recognising and managing acutely ill patients under supervision. This includes showing that they are able to manage a variety of situations where a patient requires resuscitation

e demonstrate that they promote, monitor and maintain health and safety in the clinical setting. They must also be able to show that they have knowledge of systems of quality assurance, including clinical governance, and demonstrate an application of the principles of risk management to their medical practice. This includes knowledge and explanation of the procedure for reporting adverse incidents and the procedures for avoiding them. This also includes following safe practices relating to dangers in the workplace

f manage their own time under supervision, and develop strategies with other healthcare workers to maximise efficient use of time

g demonstrate that they are able to take appropriate action if their own health, performance or conduct, or that of a colleague (including a more senior colleague), puts patients, colleagues or the public at risk

h demonstrate that they can recognise and use opportunities to promote health and prevent disease and show that they are aware of worldwide health priorities and concerns about health inequalities.

Maintaining good medical practice

6 F1 doctors must:

a develop a portfolio that includes a variety of evidence (including workplace-based assessments, involvement in educational and clinical teaching sessions, and reflections on experiences with patients and colleagues) to demonstrate:

- achievement of the requirements in this guidance, including workplace-based assessments
- ability to identify, document and meet their educational needs
- learning through reflection on their practice
- knowledge of the theory of audit, including change management

b be able to explain how to contribute to audit and how the results of audit can improve their practice and that of others

c embrace the importance of continuing professional development and self-directed learning and demonstrate this through the assessment process. This will include the need to respond constructively to appraisals and performance reviews.

Teaching and training, appraising and assessing

7 F1 doctors must:

a teach their peers and medical and other health and social care students under guidance, if required to do so, using appropriate skills and methods

b contribute to the appraisal, assessment or review of students and other colleagues they work with.

Relationships with patients

8 F1 doctors must:

a demonstrate knowledge of the theory and demonstrate the ability to ensure that effective relationships with patients are established and maintained. This includes creating an environment where the doctor can encourage and support the patient to share all information relevant to the consultation

b introduce themselves to patients and colleagues with appropriate confidence and authority ensuring that patients and colleagues understand their role, remit and limitations

c demonstrate that they recognise that patients are knowledgeable about themselves and the effect their health has on their daily life. They should use this expertise to encourage and support patients to be involved in their own care. Relatives, or others caring for those with long-term health conditions, are often knowledgeable in this area too. F1 doctors should be aware that carers, supporters and advocates (who speak on behalf of patients) often have to be included in the information given to patients. In the case of people with communication difficulties or difficulties processing information, carers, supporters and advocates must be kept informed about diagnosis and medical care, subject to GMC guidance on confidentiality

d demonstrate that they encourage and support effective communication with people, both individually and in groups, including people with learning disabilities and those who do not have English as their main language

e demonstrate that they are sensitive and respond to the needs and expectations of patients, taking into account, only where relevant, the patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status

f demonstrate that they respect and uphold patients' rights to refuse treatment or take part in teaching or research

g demonstrate sound knowledge concerning confidentiality (including GMC guidance on confidentiality, Caldicott and data protection issues).

Working with colleagues

9 F1 doctors must:

a work effectively as a member of a team, including supporting others, handover and taking over the care of a patient safely and effectively from other health professionals

b demonstrate respect for everyone they work with (including colleagues in medicine and other healthcare professions, allied health and social care workers and non-health professionals) whatever their professional qualifications, age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status

c demonstrate that they can communicate in different ways, including spoken, written and electronic methods. They must use communication methods that meet the needs and contexts of individual patients and colleagues, including those within the team, or in other disciplines, professions and agencies where appropriate

d share appropriate information, where necessary, with a patient's permission, with other members of the healthcare team to provide the best possible information and treatment

e demonstrate that they listen to and take into account the views of other health professionals and agencies and, where appropriate, share information with other professionals and agencies in accordance with GMC guidance on consent.

Probity

10 F1 doctors must:

a be honest in their relationships with patients (and their relatives and carers), professional colleagues and employers

b be able to complete or arrange for the completion of legal documents correctly such as those certifying sickness and death (or arranging for these documents to be filled in) and liaise with the coroner or procurator fiscal where appropriate

c demonstrate knowledge of and be able to apply relevant legislation to their day-to-day activities.

Health

11 F1 doctors must:

a demonstrate knowledge of their responsibilities to look after their health, including maintaining a suitable balance between work and personal life, and knowing how to deal with personal illness to protect patients

b take responsibility, in line with *Good medical practice*, for their own health in the interests of public safety. If they know, or have reasons to believe, that they have a serious condition which could be passed on to patients, or that their judgement or performance could be significantly affected by a condition or illness (or its treatment), they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, they should change their clinical contact with patients. They must not rely on their own assessment of the risk to patients.

Core clinical and procedural skills for provisionally registered doctors*

1 Venepuncture
2 IV cannulation
3 Prepare and administer IV medications and injections
4 Arterial puncture in an adult
5 Blood culture from peripheral sites
6 Intravenous infusion including the prescription of fluids
7 Intravenous infusion of blood and blood products
8 Injection of local anaesthetic to skin
9 Injection – subcutaneous (eg insulin or LMW heparin)
10 Injection – intramuscular
11 Perform and interpret an ECG
12 Perform and interpret peak flow
13 Urethral catheterisation (male)
14 Urethral catheterisation (female)
15 Airway care including simple adjuncts (eg Guedel airway or laryngeal masks)

The legal framework for programmes for provisionally registered doctors

12 The powers and duties of the GMC in regulating medical education are set out in the Medical Act 1983.

13 Provisional registration is granted for the purposes of completing an acceptable programme for provisionally registered doctors.

14 From the introduction of the licence to practise, any person whose fitness to practise is not impaired and who holds one or more primary United Kingdom qualification and has satisfactorily completed an acceptable programme for provisionally registered

* The core clinical and procedural skills were amended on 29 July 2009 and effective from August 2010.

doctors, is entitled to be registered under section 3 of the 1983 Act as a fully registered medical practitioner.

15 All training programmes for provisionally registered doctors must deliver the outcomes and meet the GMC's standards for medical education and training.

16 From 1 August 2007, F1 doctors are required to meet the outcomes for provisionally registered doctors with a licence to practise before being eligible to apply for full registration.*

17 Provisionally registered doctors will be able to demonstrate they have met the outcomes by successfully completing the requirements of the F1 Foundation Programme Curriculum published by the Academy of Medical Royal Colleges Foundation Committee.

18 To obtain full registration a programme for provisionally registered doctors of 12 months' duration must be completed.†

19 Satisfactory completion of a programme for provisionally registered doctors is confirmed by the completion of the Certificate of Experience. Universities, or their designated representative in postgraduate deaneries, local education and training boards or foundation schools, will be required to certify that provisionally registered doctors have met the outcomes set by the GMC and have completed a programme for provisionally registered doctors of 12 months before full registration is granted.

20 Bodies that may provide, arrange or be responsible for programmes for provisionally registered doctors are postgraduate deaneries in England (local education and training boards), Northern Ireland (the Northern Ireland Medical and Dental Training Agency), Scotland and Wales (the School of Postgraduate Medical and Dental Education at Cardiff University)‡, and local education providers.§

21 Locum Appointment for Service (LAS) posts, which are used for service delivery and do not provide training that meets the GMC's standards and outcomes, will not enable foundation doctors to meet the requirements for satisfactory completion of F1 or the Foundation Programme. LAS posts must not be undertaken by provisionally registered doctors.

* See section 10A(2)(c) of the 1983 Act. The GMC agreed the outcomes on 6 December 2006.
† See section 10A(2)(a) of the 1983 Act.
‡ See Section 10A(2)(b) of the 1983 Act.
§ Determined by the GMC on 2 February 2011 under section 10A(2)(b) of the 1983 Act.

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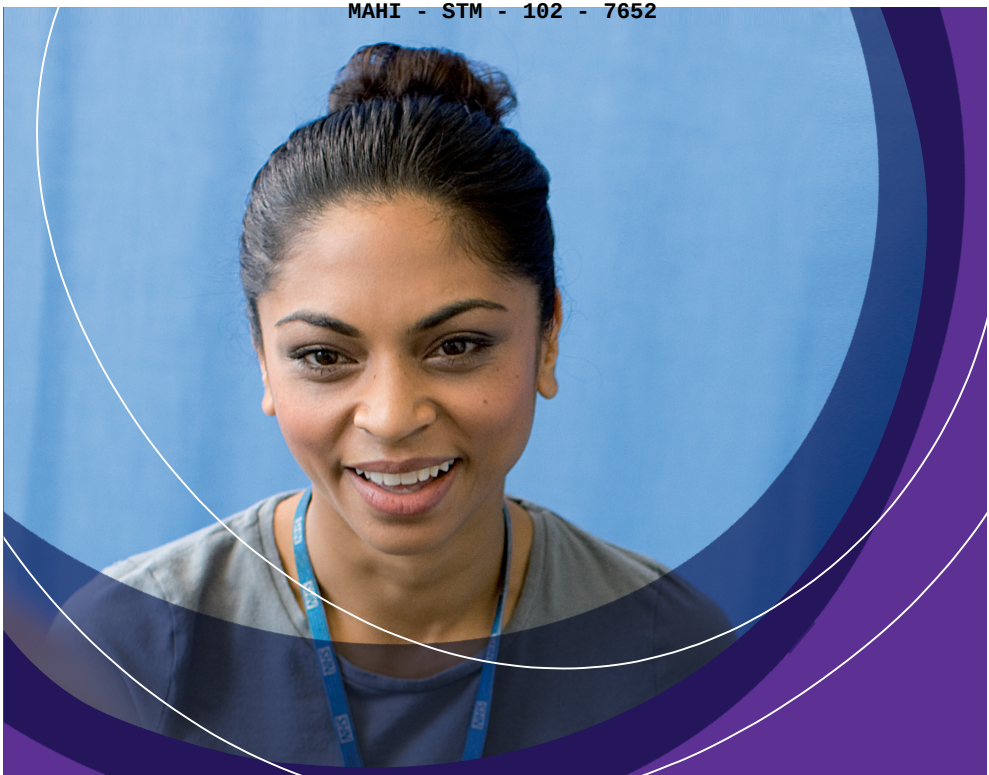

Good medical practice

General Medical Council

The duties of a doctor registered with the GMC

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
- Work in partnership with patients.
  - Listen to, and respond to, their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good medical practice

This guidance has been edited for plain English.

Published 25 March 2013
Comes into effect 22 April 2013.

This guidance was updated on 29 April 2014 to include paragraph 14.1 on doctors' knowledge of the English language. It was further updated on 29 April 2019 to remove the sub-heading 'honesty' from immediately before paragraph 65.

You can find the latest version of this guidance on our website at **www.gmc-uk.org/guidance**.

For the full website addresses of references in this guidance, please see the online version on our website.

Contents

About this guidance

Good medical practice includes references to explanatory guidance. A complete list of explanatory guidance is at the end of the booklet.

All our guidance is available on our website, along with:

- learning materials, including interactive case studies which bring to life the principles in the guidance and show how they might apply in practice
- cases heard by medical practitioners tribunals, which provide examples of where a failure to follow the guidance has put a doctor's registration at risk.

Professionalism in action

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues,[1] are honest and trustworthy, and act with integrity and within the law.

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

3 *Good medical practice* describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with *Good medical practice* and the explanatory guidance[2] which supports it, and to follow the guidance they contain.

4 You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

5 In *Good medical practice*, we use the terms 'you must' and 'you should' in the following ways.

- 'You must' is used for an overriding duty or principle.
- 'You should' is used when we are providing an explanation of how you will meet the overriding duty.
- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.

6 To maintain your licence to practise, you must demonstrate, through the revalidation process, that you work in line with the principles and values set out in this guidance. Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk.

Domain 1: Knowledge, skills and performance

Develop and maintain your professional performance

7 You must be competent in all aspects of your work, including management, research and teaching.[3, 4, 5]

8 You must keep your professional knowledge and skills up to date.

9 You must regularly take part in activities that maintain and develop your competence and performance.[6]

10 You should be willing to find and take part in structured support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.

11 You must be familiar with guidelines and developments that affect your work.

12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

13 You must take steps to monitor and improve the quality of your work.

Apply knowledge and experience to practice

14 You must recognise and work within the limits of your competence.

14.1 You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.[7]

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs.[8]

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs[9]

b provide effective treatments based on the best available evidence

c take all possible steps to alleviate pain and distress whether or not a cure may be possible[10]

d consult colleagues where appropriate

e respect the patient's right to seek a second opinion

f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.[9]

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.[4, 11, 12]

18 You must make good use of the resources available to you.[3]

Record your work clearly, accurately and legibly

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.[14]

21 Clinical records should include:

- **a** relevant clinical findings
- **b** the decisions made and actions agreed, and who is making the decisions and agreeing the actions
- **c** the information given to patients
- **d** any drugs prescribed or other investigation or treatment
- **e** who is making the record and when.

Domain 2: Safety and quality

Contribute to and comply with systems to protect patients

22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

- **a** taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
- **b** regularly reflecting on your standards of practice and the care you provide
- **c** reviewing patient feedback where it is available.

23 To help keep patients safe you must:

- **a** contribute to confidential inquiries
- **b** contribute to adverse event recognition
- **c** report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
- **d** report suspected adverse drug reactions
- **e** respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.[14]

Respond to risks to safety

24 You must promote and encourage a culture that allows all staff to raise concerns openly and safely.[3, 15]

25 You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

a If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

b If patients are at risk because of inadequate premises, equipment[13] or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance[15] and your workplace policy. You should also make a record of the steps you have taken.

c If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.[14, 16]

26 You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.

27 Whether or not you have vulnerable[17] adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.[18, 19]

Risks posed by your health

28 If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.

29 You should be immunised against common serious communicable diseases (unless otherwise contraindicated).

30 You should be registered with a general practitioner outside your family.

Domain 3: Communication, partnership and teamwork

Communicate effectively

31 You must listen to patients, take account of their views, and respond honestly to their questions.

32 You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.[21]

33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

Working collaboratively with colleagues

35 You must work collaboratively with colleagues, respecting their skills and contributions.[3]

36 You must treat colleagues fairly and with respect.

37 You must be aware of how your behaviour may influence others within and outside the team.

38 Patient safety may be affected if there is not enough medical cover. So you must take up any post you have formally accepted, and work your contractual notice period before leaving a job, unless the employer has reasonable time to make other arrangements.

Teaching, training, supporting and assessing

39 You should be prepared to contribute to teaching and training doctors and students.

40 You must make sure that all staff you manage have appropriate supervision.

41 You must be honest and objective when writing references, and when appraising or assessing the performance of colleagues, including locums and students. References must include all information relevant to your colleagues' competence, performance and conduct.[22]

42 You should be willing to take on a mentoring role for more junior doctors and other healthcare professionals.[3]

43 You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times.[3]

Continuity and coordination of care

44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers[8, 14]

b check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.

45 When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.[8]

Establish and maintain partnerships with patients

46 You must be polite and considerate.

47 You must treat patients as individuals and respect their dignity and privacy.[16]

48 You must treat patients fairly and with respect whatever their life choices and beliefs.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care,[21] including:

- **a** their condition, its likely progression and the options for treatment, including associated risks and uncertainties
- **b** the progress of their care, and your role and responsibilities in the team
- **c** who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care

d any other information patients need if they are asked to agree to be involved in teaching or research.[12]

50 You must treat information about patients as confidential. This includes after a patient has died.[14]

51 You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a advising patients on the effects of their life choices and lifestyle on their health and well-being

b supporting patients to make lifestyle changes where appropriate.

52 You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.[23]

Domain 4: Maintaining trust

Show respect for patients

53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.[16]

54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.[23]

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

a put matters right (if that is possible)

b offer an apology

c explain fully and promptly what has happened and the likely short-term and long-term effects.

Treat patients and colleagues fairly and without discrimination

56 You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety, dignity or comfort may be seriously compromised, you must follow the guidance in paragraph 25b (see section *Domain 2: Safety and quality*).

57 The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle have contributed to their condition.

58 You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.

59 You must not unfairly discriminate against patients or colleagues by allowing your personal views[24] to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c (see section *Domain 2: Safety and quality*) if the behaviour amounts to abuse or denial of a patient's or colleague's rights.

60 You must consider and respond to the needs of disabled patients and should make reasonable adjustments[25] to your practice so they can receive care to meet their needs.

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.

62 You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.[26]

63 You must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK.

64 If someone you have contact with in your professional role asks for your registered name and/or GMC reference number, you must give this information to them.

Act with honesty and integrity

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66 You must always be honest about your experience, qualifications and current role.

67 You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.[4]

Communicating information

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69 When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.[14, 27]

70 When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.[22] You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

Openness and legal or disciplinary proceedings

72 You must be honest and trustworthy when giving evidence to courts or tribunals.[28] You must make sure that any evidence you give or documents you write or sign are not false or misleading.

- **a** You must take reasonable steps to check the information is correct.
- **b** You must not deliberately leave out relevant information.

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in *Confidentiality*.

74 You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness.[28]

75 You must tell us without delay if, anywhere in the world:

- **a** you have accepted a caution from the police or been criticised by an official inquiry
- **b** you have been charged with or found guilty of a criminal offence
- **c** another professional body has made a finding against your registration as a result of fitness to practise procedures.[29]

76 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently.

Honesty in financial dealings

77 You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.[30]

78 You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.

79 If you are faced with a conflict of interest, you must be open about the conflict, declaring your interest formally, and you should be prepared to exclude yourself from decision making.

80 You must not ask for or accept – from patients, colleagues or others – any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.

Endnotes

1 Colleagues include anyone a doctor works with, whether or not they are also doctors.

2 You can find all the explanatory guidance on our website.

3 *Leadership and management for all doctors* (2012) GMC, London

4 *Good practice in research* (2010) GMC, London

5 *Developing teachers and trainers in undergraduate medical education* (2011) GMC, London

6 *Continuing professional development: guidance for all doctors* (2012) GMC, London

7 This paragraph was added on 29 April 2014. Section 35C(2)(da) of the *Medical Act 1983*, inserted by the *Medical Act 1983 (Amendment) (Knowledge of English) Order 2014*.

8 *Delegation and referral* (2013) GMC, London

9 *Good practice in prescribing and managing medicines and devices* (2013) GMC, London

10 *Treatment and care towards the end of life: good practice in decision-making* (2010), GMC, London

11 *Making and using visual and audio recordings of patients* (2011) GMC, London

12 *Consent to research* (2013) GMC, London

13 Follow the guidance in paragraph 23c if the risk arises from an adverse incident involving a medical device.

14 *Confidentiality: good practice in handling patient information* (2017) GMC, London

15 *Raising and acting on concerns about patient safety* (2012) GMC, London

16 Maintaining boundaries (2013) GMC, London

- *Intimate examinations and chaperones* (paragraphs 47, 25c)
- *Maintaining a professional boundary between you and your patient* (paragraph 53)
- *Sexual behaviour and your duty to report* (paragraphs 53, 25c)

17 Some patients are likely to be more vulnerable than others because of their illness, disability or frailty or because of their current circumstances, such as bereavement or redundancy. You should treat children and young people under 18 years as vulnerable. Vulnerability can be temporary or permanent.

18 *0–18 years: guidance for all doctors* (2007) GMC, London

19 *Protecting children and young people: the responsibilities of all doctors* (2012) GMC, London

20 Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.

21 *Decision making and consent* (2020) GMC, London

22 *Writing references* (2012) GMC, London

23 *Personal beliefs and medical practice* (2013) GMC, London

24 This includes your views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

25 'Reasonable adjustments' does not only mean changes to the physical environment. It can include, for example. Being flexible about appointment time or length, and making arrangements for those with communication difficulties such as impaired hearing. For more information see the EHRC website.

26 *Ending your professional relationship with a patient* (2013) GMC, London

27 *Doctors' use of social media* (2013) GMC, London

28 *Acting as a witness in legal proceedings* (2013) GMC, London

29 *Reporting criminal and regulatory proceedings within and outside the UK* (2013) GMC, London

30 *Financial and commercial arrangements and conflicts of interest* (2013) GMC, London

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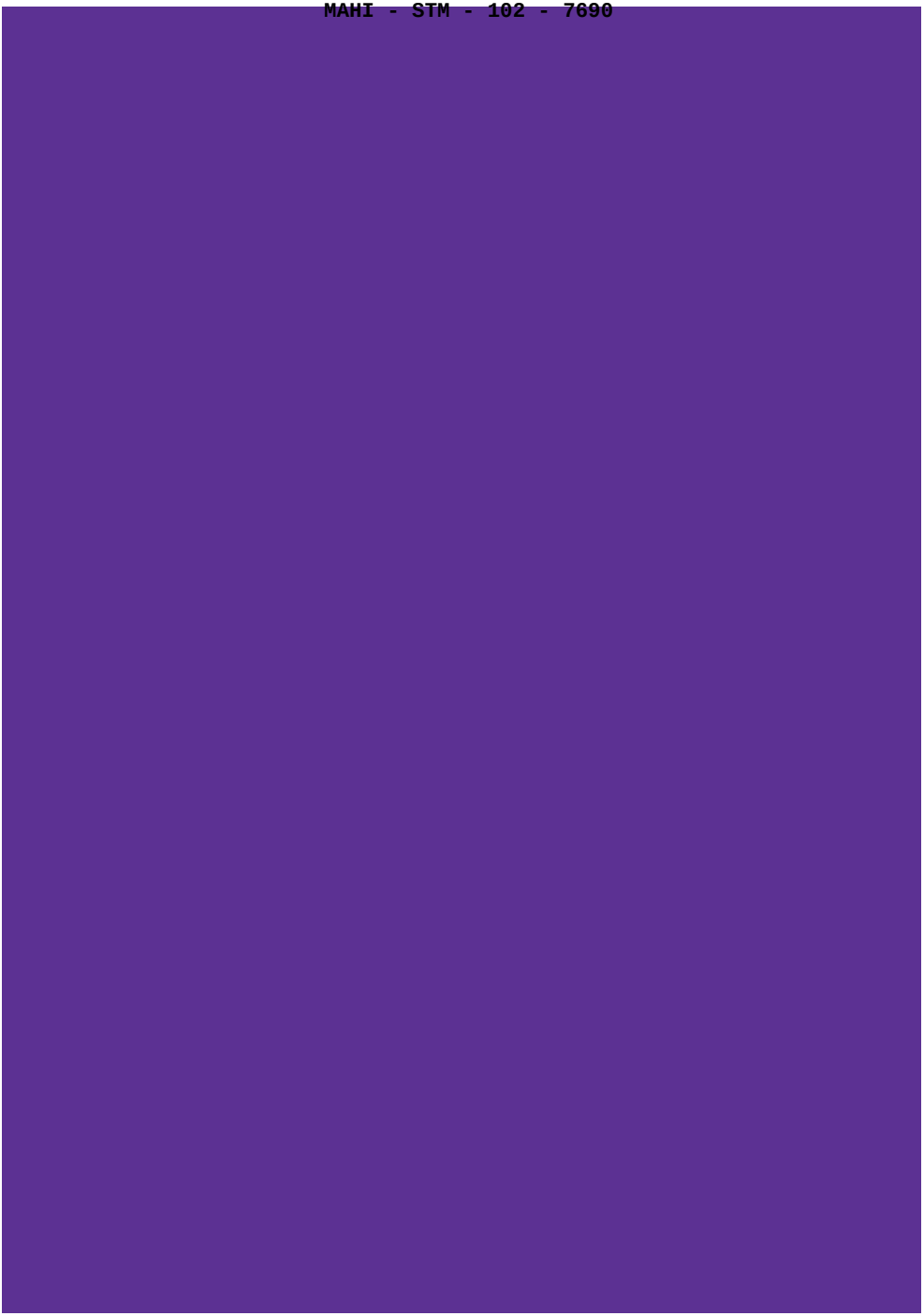

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General Medical Council

Promoting excellence:

standards for medical education and training

Working with doctors Working for patients

General Medical Council

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Promoting excellence: standards for medical education and training

Published 15 July 2015.
Comes into effect 1 January 2016.

You can find the latest version of this guidance on our website at **www.gmc-uk.org/education/standards.asp**.

Contents

About these standards

The General Medical Council (GMC) sets the standards and requirements for the delivery of all stages of medical education and training.

Promoting excellence: standards for medical education and training sets out ten standards that we expect organisations responsible for educating and training medical students and doctors in the UK to meet.

The standards and requirements are organised around five themes. Some requirements – what an organisation must do to show us they are meeting the standards – may apply to a specific stage of education and training.

Promoting excellence: standards for medical education and training replaces the 'standards for delivery of teaching, learning and assessment for undergraduate medical education' in *Tomorrow's Doctors* (2009), and the 'standards for postgraduate training' in *The Trainee Doctor* (2011).

Patient safety is the first priority

Patient safety is at the core of these standards. Just as good medical students and doctors make the care of their patients their first concern, so must the organisations that educate and train medical students and doctors. In non-clinical learning environments, there should also be a culture of promoting patient safety.

We set out the professional values, knowledge, skills and behaviours required of all doctors working in the UK in *Good medical practice*.[1] We also expect medical students to meet these standards when they have contact with patients. The learner's* ability to develop the appropriate professional values, knowledge, skills and behaviours is influenced by the learning environment and culture in which they are educated and trained.

Patient safety runs through our standards and requirements. Patient safety is inseparable from a good learning environment and culture that values and supports learners and educators. Where our standards previously focused on protecting patients from any risk posed by medical students and doctors in training, we will now make sure that education and training takes place where patients are safe, the care and experience of patients is good, and education and training are valued.

* Learners are medical students and doctors in training.

The ten standards

THEME 1
Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.*

THEME 5
Developing and implementing curricula and assessments

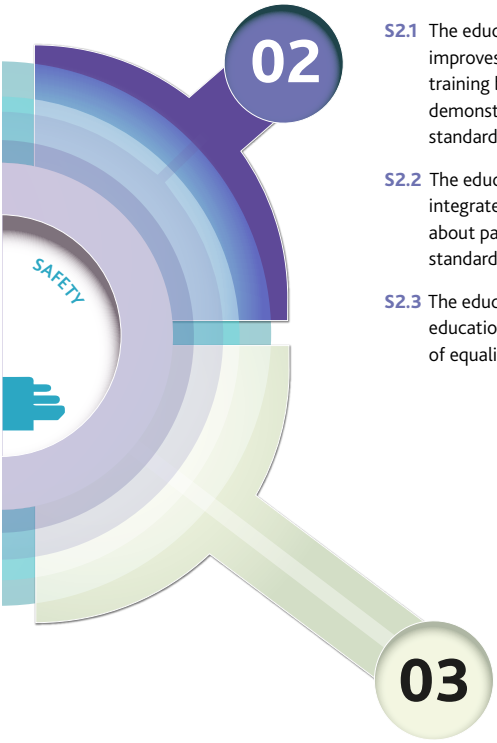
S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

THEME 4
Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.



THEME 2
Educational governance and leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

THEME 3
Supporting learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

* For undergraduate education, the learning outcomes for graduates (*Tomorrow's Doctors*)[2] and for postgraduate training, the curriculum approved by the General Medical Council.

Theme 1: Learning environment and culture

Purpose

This theme is about making sure that the environment and culture for education and training meets learners' and educators' needs, is safe, open, and provides a good standard of care and experience for patients.

Education and training should be a valued part of the organisational culture. Learners will have a good educational experience and educators will be valued where there is an organisational commitment to, and support for, learning. High quality organisations will promote excellence in education.

The clinical learning environment is multiprofessional, so an effective learning culture will value and support learners from all professional groups.

Responsibility

Local education providers (LEPs) – specifically the leadership at board level or equivalent – provide the learning environment and culture. They are accountable for how they use the resources they receive to support medical education and training. They are responsible for taking action when concerns are raised that impact on patient safety. They work with postgraduate deaneries, local education and training boards (LETBs) and medical schools in recognising and rewarding trainers.[3]

Postgraduate deaneries, LETBs and medical schools make sure that medical education and training takes place in an environment and culture that meets these standards, within their own organisation and through effective quality management of contracts, agreements and local quality control mechanisms. They work together to respond when patient safety and training concerns are associated.

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.*

* For undergraduate education, the learning outcomes for graduates are set out in *Tomorrow's Doctors*.[2] For postgraduate training, the curriculum is approved by the General Medical Council.

Requirements

R1.1 Organisations* must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.[4]

R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.

R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.

R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.

R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training.

* Organisations that are responsible for the learning environment and culture.

R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes.

R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor.

Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session.* Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.

* This will normally be a doctor, but on some placements it may be appropriate for a senior healthcare professional to take on this role.

R1.9 Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.

R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.

R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent.[5] Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.

R1.12 Organisations must design rotas to:

- **a** make sure doctors in training have appropriate clinical supervision
- **b** support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK
- **c** provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme
- **d** give doctors in training access to educational supervisors
- **e** minimise the adverse effects of fatigue and workload.

R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out:

- **a** their duties and supervision arrangements
- **b** their role in the team
- **c** how to gain support from senior colleagues
- **d** the clinical or medical guidelines and workplace policies they must follow
- **e** how to access clinical and learning resources.

As part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.

R1.14 Handover* of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.

R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience.

* Handover at the start and end of periods of day or night duties, every day of the week.

R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.

R1.17 Organisations must support every learner to be an effective member of the multiprofessional team by promoting a culture of learning and collaboration between specialties and professions.

R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum.

R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.

R1.20 Learners must have access to technology enhanced and simulation-based learning opportunities within their training programme as required by their curriculum.

* Resources and facilities may include: IT systems so learners can access online curricula, workplace-based assessments, supervised learning events and learning portfolios; libraries and knowledge services; information resources; physical space; support staff; and patient safety orientated tools.

R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme.

R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service.

Theme 2: Educational governance and leadership

Purpose

This theme is about making sure that organisations have effective systems of educational governance and leadership to manage and control the quality of medical education and training.

These systems should treat learners according to principles of safety, equality and fairness. They should ensure appropriate assessment, manage learners' progression, and share outcomes of education and training programmes. It is in the public and patients' interests that there is effective, robust, transparent and fair oversight of education and training.

Information should be shared across educational and clinical governance systems to identify risk to patient safety and the quality of education and training, and to ensure transparency and accountability.

Responsibility

All organisations must demonstrate leadership of medical education and training through effective educational governance. Working together, they should integrate educational, clinical and medical governance to keep patients and learners safe and create an appropriate learning environment and organisational culture.

Postgraduate deaneries and LETBs manage the quality and funding of postgraduate training programmes provided by LEPs in their regions.

Medical schools (and the universities of which they are a part) manage and control the quality of education leading to the award of their primary medical qualifications. They make sure LEPs appropriately educate their medical students by providing appropriate placements.

LEPs control the organisational culture and the quality of education and training in their local organisations. An executive must be accountable for educational governance, and those in educational leadership roles must have demonstrable educational credibility and capability.

Colleges, faculties and specialty associations develop and maintain curricula and assessment frameworks according to the standards for curricula and assessment set by the GMC.[6] Colleges, faculties and specialty associations are responsible for the quality of approved curricula and exams. They work in partnership with national bodies, postgraduate deaneries, LETBs and LEPs to select learners to training programmes.

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Requirements

R2.1 Organisations* must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training.

R2.2 Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns.

* Organisations that are responsible for educational governance.

R2.3 Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned.

R2.4 Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training.

R2.5 Organisations must evaluate information about learners' performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity.

R2.6 Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met.

R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.

R2.8 Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.

R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.

R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.

R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.

R2.12 Organisations must have systems to manage learners' progression, with input from a range of people, to inform decisions about their progression.

R2.13 Medical schools must have one or more doctors at the school who oversee medical students' educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.[3]

R2.14 Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.[3]

R2.15 Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.[3]

R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner's professionalism, progress, performance, health or conduct that may affect a learner's wellbeing or patient safety.[7]

R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.

R2.18 Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.

R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.

R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.

Theme 3: Supporting learners

Purpose

This theme is about making sure learners get effective educational and pastoral support, so they can demonstrate what is expected in *Good medical practice* and achieve the learning outcomes required by their curriculum.

Responsibility

Postgraduate deaneries, LETBs, and medical schools provide and manage structures and systems of support for learners. They provide appropriate support to ensure the health and wellbeing of their learners.

LEPs provide support and learning opportunities for learners, making available the facilities, staff and practical support needed to deliver the clinical parts of the curriculum or training programme.

Learners are responsible for their own learning and achieving the learning outcomes required by their curriculum. They should take part in structured support opportunities for learners. Learners must make care of patients their first concern and must not compromise safety and care of patients by their performance, health or conduct. Learners have a duty to follow the guidance in *Good medical practice* and must understand the consequences if they fail to do so.

Standard

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Requirements

R3.1 Learners must be supported to meet professional standards, as set out in *Good medical practice* and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.

R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support, including:

- **a** confidential counselling services
- **b** careers advice and support
- **c** occupational health services.

Learners must be encouraged to take responsibility for looking after their own health and wellbeing.

R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.

R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010*.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.

R3.5 Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.

R3.6 When learners progress from medical school to foundation training they must be supported by a period of shadowing† that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.

R3.7 Learners must receive timely and accurate information about their curriculum, assessment and clinical placements.

* The *Equality Act 2010* does not apply to Northern Ireland. The *Equality Act 2010* is in force in the rest of the UK, but the *Disability Discrimination Act 1995* and the *Special Educational Needs and Disability (NI) Order 2005* remain in force in Northern Ireland.

† Shadowing is coordinated and arranged across the UK as part of the transition from medical school to the Foundation Programme.

R3.8 Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and aptitudes and are inclined to do so.

R3.9 Medical students must have appropriate support while studying outside medical school, including on electives, and on return to the medical programme.

R3.10 Doctors in training must have access to systems and information to support less than full-time training.

R3.11 Doctors in training must have appropriate support on returning to a programme following a career break.

R3.12 Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.

R3.13 Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.

R3.14 Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.

R3.15 Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.

R3.16 Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.

Theme 4: Supporting educators

Purpose

This theme is about making sure that educators have the necessary knowledge and skills for their role, and get the support and resources they need to deliver effective education and training.

Responsibility

Postgraduate deaneries, LETBs, and medical schools make sure that educators have the necessary knowledge and skills, support and resources they need for their role. Postgraduate deans and medical schools – as education organisers* – have to meet GMC requirements[3] for formally recognising and approving medical trainers in four specific roles.†

LEPs provide support and resources for educators. LEPs must work with postgraduate deaneries, LETBs and medical schools in recognising and rewarding trainers.[3]

* Education organisers are the bodies responsible for recognising trainers.

† The four roles are: those who oversee medical students' progress at each medical school; lead coordinators for undergraduate education at each LEP; and named educational supervisors and named clinical supervisors for postgraduate training. The four roles will be fully recognised by 31 July 2016.

Educators are responsible for engaging positively with training, support and appraisal relating to their role, and are accountable for the resources they receive to support education and training. They must act in line with professional guidance for all doctors – they must be positive role models demonstrating good medical practice.[8] They are expected to maintain and continue to develop knowledge and skills on an ongoing basis through continuing professional development. Educators are involved in and contribute to the learning environment and culture.

Medical trainers in the four specific roles are responsible for complying with the arrangements set out by medical schools and postgraduate deans to meet GMC requirements for recognising and approving trainers.[3]

Standards

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

Requirements

R4.1 Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.

R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.

R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities.

R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.

R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.[3]

Theme 5: Developing and implementing curricula and assessments

Purpose

The GMC's statutory responsibilities for regulating curricula and assessments are different according to the stage of training. This theme is about making sure medical school and postgraduate curricula and assessments are developed and implemented to meet GMC outcome or approval requirements.

Responsibility

The GMC sets the learning outcomes required of medical students when they graduate[2] and the standards that medical schools must meet when teaching, assessing and providing learning opportunities for medical students.

Medical schools develop and implement curricula and assessments to make sure that medical graduates can demonstrate these outcomes. Medical schools, in partnership with LEPs, also make sure that clinical placements give medical students the learning opportunities they need to meet these outcomes. Medical schools are responsible for the quality of assessments including those done on their behalf. Medical schools make sure only medical students who demonstrate all the learning outcomes are permitted to graduate.

Colleges, faculties, specialty associations and other organisations develop postgraduate curricula and assessments, and the GMC approves them against the standards for curricula and assessment systems.[6]

Postgraduate deaneries and LETBs make sure that LEPs are meeting the requirements for delivering postgraduate curricula and assessments, and that training programmes and placements enable the doctor in training to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Standards

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

Requirements

Undergraduate curricula

R5.1 Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole programme.

R5.2 The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.

R5.3 Medical school curricula must give medical students:

- **a** early contact with patients that increases in duration and responsibility as students progress through the programme
- **b** experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor
- **c** the opportunity to support and follow patients through their care pathway
- **d** the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics
- **e** learning opportunities that integrate basic and clinical science, enabling them to link theory and practice
- **f** the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates
- **g** learning opportunities enabling them to develop generic professional capabilities
- **h** at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.

Undergraduate programmes and clinical placements

R5.4 Medical school programmes must give medical students:

- **a** sufficient practical experience to achieve the learning outcomes required for graduates
- **b** an educational induction to make sure they understand the curriculum and how their placement fits within the programme
- **c** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation
- **d** experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum
- **e** the opportunity to work and learn with other health and social care professionals and students to support interprofessional multidisciplinary working
- **f** placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.

Undergraduate assessment

R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.

R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.

R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.

R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student's performance and being able to justify their decision.

Postgraduate curricula

The development of postgraduate curricula is addressed in the standards for curricula and assessment.[6]

Postgraduate training programmes and clinical placements

R5.9 Postgraduate training programmes must give doctors in training:

- **a** training posts that deliver the curriculum and assessment requirements set out in the approved curriculum
- **b** sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum
- **c** an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme
- **d** the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation
- **e** the opportunity to work and learn with other members on the team to support interprofessional multidisciplinary working
- **f** regular, useful meetings with their clinical and educational supervisors
- **g** placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress
- **h** a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible.[9] Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.

Postgraduate assessment

R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.

R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training's performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.

Reasonable adjustments

R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the *Equality Act 2010*, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.

References

1 General Medical Council (2013) *Good medical practice* available at: **www.gmc-uk.org/gmp** (accessed 22 June 2015)

2 General Medical Council (2015) *Outcomes for graduates (Tomorrow's Doctors)* available at: **www.gmc-uk.org/undergrad_outcomes** (accessed 22 June 2015)

3 General Medical Council (2012) *Recognising and approving trainers: the implementation plan* available at: **www.gmc-uk.org/education/10264.asp** (accessed 22 June 2015)

4 General Medical Council (2012) *Raising and acting on concerns about patient safety* available at: **www.gmc-uk.org/raisingconcerns** (accessed 22 June 2015), paragraph 9

5 General Medical Council (2008) *Consent: patients and doctors making decisions together* available at: **www.gmc-uk.org/consent** (accessed 22 June 2015)

6 General Medical Council (2010) *Standards for curricula and assessment systems* available at: **www.gmc-uk.org/education/postgraduate/standards_for_curricula_and_assessment_systems.asp** (accessed 22 June 2015)

7 General Medical Council (2013) *Supporting medical students with mental health conditions* available at **www.gmc-uk.org/education/undergraduate/23289.asp** (accessed 22 June 2015)

8 General Medical Council (2012) *Leadership and management for all doctors* available at: **www.gmc-uk.org/leadership** (accessed 22 June 2015)

9 Academy of Medical Royal Colleges (2014) *A charter for postgraduate medical training: value of the doctor in training* available at: **www.aomrc.org.uk/publications/reports-a-guidance** (accessed 22 June 2015)

Glossary

Clinical governance

Clinical governance is the system through which National Health Service (NHS) organisations are accountable for continuously monitoring and improving the quality of their care and services, and for safeguarding the high standard of care and services.

Doctor in training

This is the GMC's preferred term for a doctor participating in an approved postgraduate training programme (Foundation Programme or specialty including general practice training).

Education organisers

Education organisers are postgraduate deans and medical schools who are responsible for recognising trainers in four specific roles, in accordance with our requirements for recognising and approving trainers. Education organisers work together to recognise trainers where there is overlap between the groups of trainers.

Educational governance

Educational governance is the systems and standards through which organisations control their educational activities and demonstrate accountability for and the continuous improvement of the quality of education.

Educational governance may be part of a wider, integrated governance framework comprising elements such as clinical audit, risk management and organisational development, which fall within the responsibility of other regulators, and are outside the direct scope of these standards. However, an indicator of how effective educational governance is could be how well integrated these elements are within the overall governance of the organisation.

Educators

Individuals with a role in teaching, training, assessing and supervising learners. This includes:

- **a** individuals in a recognised and approved trainer role
- **b** other doctors or healthcare professionals involved in education and training in the course of their daily clinical or medical practice
- **c** academic staff from a range of disciplines with a role in education and training.

Educators may also include patients and members of the public who have roles in medical teaching or training, and other people whose knowledge, experience or expertise is used in teaching or training.

Lead coordinators at each LEP

One or more doctors at each LEP who are responsible for coordinating the training of medical students, supervising their activities and making sure these activities are of educational value.

All lead coordinators at each LEP must be recognised by their medical school by 31 July 2016.

Learners

Learners are medical students receiving education leading to a primary medical qualification and doctors in postgraduate training leading to a certificate of completion of training (CCT). Doctors and students undertaking other forms of training and education, such as a fellowship, will also be learning, but are not covered by these standards for medical education and training. These standards do not cover continuing professional development that all doctors across the UK do to keep their knowledge and skills up to date throughout their working life.

Learning outcomes

The competences that a learner must acquire by the end of a period of education or training. The learning outcomes required of medical students when they graduate are set by the GMC.

Local education and training boards (LETBs)

In England, the roles of the postgraduate dean and deanery sit within LETBs.

Local education providers (LEPs)

LEPs are the organisations responsible for the learning environment and culture (usually clinical) in which training is taking place, whether in primary, secondary, community or academic placements. LEPs include health boards, NHS trusts, independent sector organisations and any other service providers that host and employ medical students and doctors in training.

Medical trainer

A medical trainer is an appropriately trained and experienced doctor who is responsible for educating and training medical students or doctors in training within an environment of medical practice.

Four medical trainer roles are performed only by recognised or approved trainers who are registered doctors holding a licence to practise. The arrangements do not cover other doctors whose practice contributes to teaching, training, assessing or supervising medical students or doctors in training, but whose role does not need to be formally recognised.

Named clinical supervisor

A named clinical supervisor is a trainer who is responsible for overseeing a specific doctor in training's clinical work throughout a placement in a clinical or medical environment and is appropriately trained to do so. The named clinical supervisor leads on providing a review of the doctor in training's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.

All named clinical supervisors must be recognised by their postgraduate dean by 31 July 2016.

Named educational supervisor

A named educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specific doctor's educational progress during a placement or a series of placements. The named educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The named educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about the doctor's progression at the end of a placement or a series of placements.

All named educational supervisors must be recognised by their postgraduate dean by 31 July 2016.

Organisations

Organisations that manage or deliver medical education or training to learners, usually medical schools, postgraduate deaneries or LETBs, LEPs and colleges, faculties and specialty associations. These organisations must meet our standards for medical education and training.

Overseeing students' progress

One or more doctors at a medical school who are responsible for overseeing students' progression. They might be NHS consultants or clinical academics acting as block or course coordinators.

Those responsible for overseeing students' progress at each medical school must be recognised by their medical school by 31 July 2016.

Placement

A structured period of experience and learning in a particular specialty or area of practice in a health or social care setting.

Postgraduate dean

In England, the roles of the postgraduate dean and deanery sit within LETBs. In Northern Ireland, these roles are held by the Northern Ireland Medical and Dental Training Agency. In Scotland, the postgraduate deans and the Scotland Deanery are part of NHS Education for Scotland. In Wales, the postgraduate dean is part of the Wales Deanery (School of Postgraduate Medical and Dental Education), Cardiff University. These are the UK bodies that the GMC has authorised to manage approved training programmes and the training posts within them according to GMC standards.

Primary medical qualification

In relation to UK graduates, a first medical degree awarded by a body or combination of bodies that is recognised by the GMC for this purpose, or that was empowered to issue primary medical qualifications at the time the degree was awarded.

Recognised trainers

Medical trainers formally recognised by postgraduate deans and medical schools according to our requirements for recognising and approving medical trainers in four specific roles.

Our statutory role to approve general practice trainers remains in place.

Student

A medical student is an undergraduate receiving training or learning from a trainer, and who is working towards an undergraduate medical degree, even if they already hold a non-medical degree. Students are not registered with the GMC and cannot perform activities legally restricted to registered doctors with a licence to practise.

Training programme

A formal alignment or rotation of posts that together comprise a programme of postgraduate training in a given specialty or subspecialty. A programme may deliver the full curriculum through linked stages to a CCT, or the programme may deliver different component elements of the approved curriculum.

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General Medical Council

First, do no harm

Enhancing patient safety teaching in undergraduate medical education

A joint report by the General Medical Council and the Medical Schools Council

Medical Schools Council

General Medical Council

A shared commitment

Medical schools, represented by the Medical Schools Council (MSC), commit to the following principle.

Undergraduate medical education should continue to prepare students to appreciate the role of systems and processes in ensuring patient safety. Students need to understand the rationale for these safety systems and processes, the importance of complying with them, and the risks to safety associated with attempts to circumvent them.

They need to understand the types and causes of errors in healthcare and be familiar with key safety-improvement tools such as root cause analysis. They also need to work well in teams, and to value the contribution of good team-working to safer care.

Their education should provide them with suitable motivation and skills to design, implement and improve safety systems and processes throughout their career.

The Medical Schools Council

The General Medical Council (GMC) commits to supporting the development of excellence in the teaching of patient safety. It does this by continuing to look for and to share best practice through its quality assurance process, and implementing *Promoting excellence*[1] – a new set of standards that will support schools to keep safety at the heart of undergraduate medical education.

The University of Buckingham and the University of Central Lancashire, which are not yet fully accredited by the GMC and therefore are also not currently MSC members, also commit to the principle.

Contents

Foreword

Today's increasingly complex healthcare systems offer huge benefits to patients, but also place them at risk – the scale of which has only recently become apparent. Despite the best efforts of healthcare professionals, estimates suggest as many as 1 in 10 hospital patients in the UK suffer harm during the delivery of care.[2]

Reducing the burden of this harm is a huge challenge for healthcare systems, and one in which success will depend to a large part on education. As the doctors of tomorrow, today's medical students will be equipped with the knowledge, skills and behaviours to practise safely and to improve the safety of the systems in which they work.

A shared commitment towards patient safety

The GMC and the MSC recognise that clinical and non-clinical learning environments must do all they can to promote the value of patient safety.

In the past, those who organise and provide healthcare have been slow to recognise that this is a safety critical industry that not only requires systems to reduce the likelihood of harm to patients but also requires an education and training system that cultivates a different approach to care in which safety and quality are central.

That is why the safety of patients is at the core of the GMC's new standards for education and training;[1] this includes the expectation that training should take place in an open and honest learning culture.[3]

UK medical schools recognise this and are developing a number of initiatives to put the discipline of patient safety at the forefront of the minds of new medical graduates.

The GMC will support them in this endeavour by continuing to look for and share best practice relating to patient safety – particularly as we implement the new standards for medical education and training.

We are delighted in this report to underline our shared commitment to make the teaching of patient safety a key priority.

As well as highlighting and reinforcing the commitment from medical schools to teach patient safety, we hope this report will serve as a useful snapshot of current progress, and focus attention on areas where future work could be concentrated.

Taking on new challenges in a developing area

Incorporating the relatively new and still developing discipline of patient safety into established curricula has brought challenges – the discussions which informed this report with medical schools, doctors, medical students and other groups show that while there has been great progress, there is some way still to go. First among these challenges is the need to embed an open and transparent safety culture into the clinical environments where students learn.

In this report we have focused on undergraduate patient safety teaching. The lessons that students learn in medical school set the tone for the rest of their education and training.

However, postgraduate training and continuing professional development are also critical in developing the safety leaders of the future. At each stage, progress made by one group will translate into a stronger safety culture in the learning environment itself, and make it easier for future groups to learn.

The work we have done for this report has shown that much of the journey so far has been achieved through individual contributions, from enthusiasts within medical schools and from doctors in training and students themselves.

To highlight some of these contributions, this report includes examples of medical school initiatives, as well as details of patient safety projects from medical students and doctors in training. In addition, we have included suggestions for reforms to improve safety that were submitted to the GMC 2015 annual conference.

We very much hope this short report recognises the great work that is underway and inspires others to move forward with this vital work.

Niall Dickson
GMC, Chief Executive

Dr Katie Petty-Saphon
MSC, Chief Executive

What has prompted the move towards teaching patient safety?

While 'first, do no harm' is one of the earliest lessons that new medical students learn, this principle has traditionally been applied at the level of an individual doctor's actions.

The relatively new field of patient safety looks more broadly at the way healthcare is delivered. As defined by the World Health Organisation (WHO), the discipline of patient safety is the 'coordinated efforts to prevent harm, caused by the process of health care itself, from occurring to patients' (see **www.who.int/patientsafety/about**).

The rise of the patient safety movement itself, and the case for formal training for medical students in patient safety, are both commonly traced back to the seminal Institute of Medicine report *To Err Is Human* (1999).[4]

Steps in the development of patient safety science and its adoption into mainstream healthcare thought have included:[5]

- a realisation that error is not necessarily associated with incompetence, and that punishment or blame have not been effective in reducing harm
- a focus on the culture in which healthcare professionals work, and the contribution that openness and transparency, with patients and between professionals, makes to safer care
- an increasing interest in the discipline of human factors, or ergonomics, as a way to better understand the systems in which professionals work and the way that system factors contribute to harm
- a recognition that healthcare has lessons to learn from other high-risk industries, which have found effective ways to reduce harm through building a safety culture, working better in teams and sharing lessons learnt from adverse events and near misses.

As the discipline has evolved, medical educators have worked to define how patient safety should be included in curricula. A key milestone in this was the publication of the WHO *Patient Safety Curriculum Guide for Medical Schools* in 2009,[6] which drew heavily on the Australian *National Patient Safety Education Framework*.[7, 8]

The four country context in the UK

The rise of patient safety as a discipline is global, and developments in patient safety education and training are reflected across the four nations of the UK.

A key document for the National Health Service (NHS) in England was the Berwick review *A promise to learn – a commitment to act*.[9] Recommendation 5 of the Berwick review was:

Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

Following the Berwick review, the National Quality Board's *Human Factors in Healthcare* concordat committed to including human factors principles and practices into core education and training curricula in the NHS in England.[10]

The 2015 Department of Health report *Culture change in the NHS* put forward a vision of medical students as the 'eyes and ears of the service today and the safety leaders of the future'.[11]

Health Education England has established a Commission on Education and Training for Patient Safety. It will make recommendations to make sure that all healthcare staff and, in particular those in training, are fully aware of all aspects of patient safety, including raising concerns and responding to those concerns.

In Scotland, work is under way towards a national agreement on the way that quality improvement and patient safety teaching will be delivered. To this end, the Scottish Government, the Scottish Deans Medical Education Group and NHS Education for Scotland are working with Scottish medical schools and the Scottish Foundation School to assess how their curricula deliver patient safety teaching.

Health and social care professionals in Northern Ireland have formed a task group as part of the Department of Health, Social Services and Public Safety's Quality 2020 initiative. The task group aims to agree the content and introduction of a common curriculum for patient safety, for undergraduate and postgraduate teaching and training programmes in health and social care.*

Other schemes that contribute to patient safety include:

- Healthcare Improvement Scotland's Scottish Patient Safety Programme
- NHS Wales' 1000 Lives Plus programme
- Northern Ireland's Quality 2020 initiative
- NHS England's Sign up to Safety campaign, Patient Safety Collaboratives and the Q initiative led by the Health Foundation.

* See www.gmc-uk.org/education/good_practice.asp

Why have we written this report?

The GMC and the MSC agree on the importance of patient safety teaching for medical students, and on the need to:

- set high standards
- support medical schools' patient safety initiatives.

This report summarises recent engagements between the GMC, the MSC, medical schools, doctors, medical students, patients and members of the public on the subject of patient safety teaching.

The MSC and the GMC met medical school education leads to discuss patient safety teaching in a workshop. Subsequently, the GMC, assisted by four medical schools, held two workshops on undergraduate patient safety teaching at the 2015 GMC annual conference – see **www.gmc-uk.org/about/26044.asp**. Notes from these meetings, attendee feedback cards and electronic voting on questions to the audience have all fed into this report.

We also asked medical schools to submit teaching initiatives to inform this report. Some of these initiatives are featured in the following two sections.

The GMC believes that sharing examples of practices that work well in one medical school will help other medical schools to drive up standards. To this end, it has begun sharing good practice examples through its Sharing good practice web page – see **www.gmc-uk.org/education/good_practice.asp**. The GMC has considered the medical schools' initiatives for inclusion as good practice examples. Once the details are agreed with medical schools, they will be published on the GMC's Sharing good practice web page.

The GMC will also ask all medical schools for more information on patient safety teaching through their 2015 medical schools' annual returns.

Opportunities and challenges of teaching patient safety

Patient safety is a relatively new discipline for undergraduate medical education, and one that has brought both opportunities and challenges for medical schools.

To help outline these challenges, we held a meeting with medical school education leads and then brought medical schools together with doctors, doctors in training, medical students, patients and members of the public at the 2015 GMC conference.

We summarise their thoughts on the following pages.

Designing the curriculum

Medical school education leads and attendees at the GMC conference told us that curricula need to address several key areas, including:

- interprofessional working, including with non-clinical managers
- the science of human error, and the system and human factors involved, including an appreciation of the role a professional's own wellbeing plays in errors, and how professionals can be supported after having made an error
- the processes involved in clinical governance, including root cause analysis and other tools used to learn from incidents, and the role of morbidity and mortality meetings and other ways to disseminate learning
- the importance of quality improvement science in making care safer
- lessons learnt from other industries that have built a strong safety culture, including the characteristics displayed by leaders in those industries
- the importance of challenging unsafe practice and the ways in which this can be done effectively.

Much of this material is covered in the WHO *Multi-professional Patient Safety Curriculum Guide*,[*, 12] which we have used later in this report as a framework to highlight selected examples from medical schools.

Several medical schools have mapped their safety teaching to the WHO curriculum guide, including for example, the Universities of Edinburgh and Aberdeen and St George's, University of London.[†]

* The *Multi-professional Patient Safety Curriculum Guide* was released in 2011, building on the content of the 2009 *Patient Safety Curriculum Guide for Medical Schools*.

† For more information, see www.eemec.med.ed.ac.uk/pages/patient-safety and the 2015 GMC conference slides at www.gmc-uk.org/Promoting_patient_safety___workshop_slides_AM_60166887.pdf.

The hidden curriculum

We heard from medical school education leads and attendees at the GMC conference that key elements of patient safety science were often not taught explicitly, but rather covered as part of general training in clinical methods. This hidden curriculum might promote the idea of safe practice being about the management of individual behaviour, and the pursuit of personal perfection, rather than the wider focus embraced by patient safety science.

Several schools have redesigned their curricula to make their patient safety curriculum more explicit, or are in the process of doing so.

Brighton and Sussex medical school highlights the importance of patient safety through a day-long conference for its medical students, featuring experts from medicine and other industries.

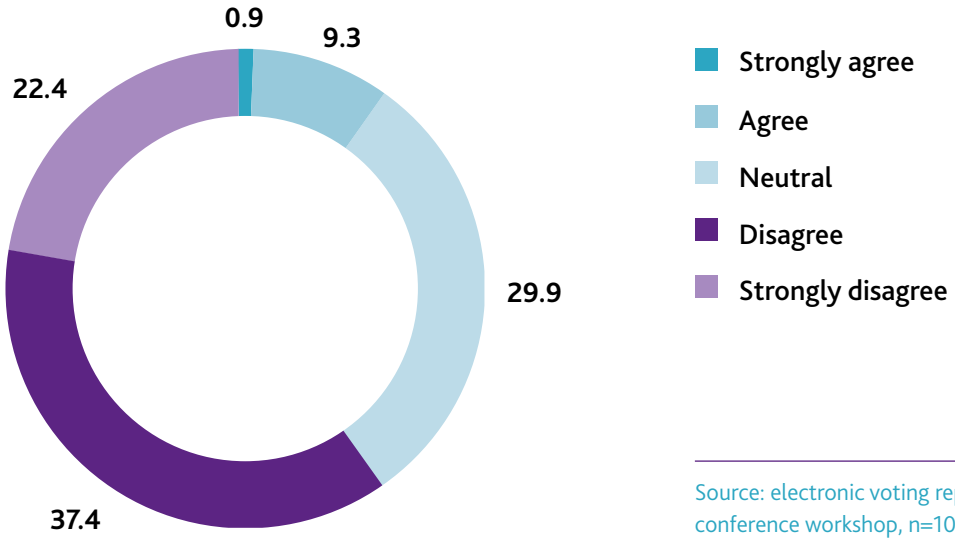
The University of Aberdeen has adopted a spiral design for its patient safety curriculum, as a way to develop awareness initially and then build on medical students' growing clinical experience to reinforce key patient safety learning later on.

Imperial College London and Plymouth University both use a blend of learning and teaching strategies across the five years of their programmes to teach patient safety. They also make use of quality improvement projects as an additional aspect of the curriculum to teach the importance of understanding the contribution of systems of care to safety.

Challenges of teaching patient safety

A strong theme in our discussions at the GMC conference related to student engagement. We heard that medical students, particularly those at the start of their education, found it difficult to identify with patient safety as a discipline, so they did not prioritise it. In part this was because those with little clinical experience found it hard to relate to patient safety when presented as an abstract academic concept. The lack of explicit assessment of patient safety was also highlighted as an obstacle, as was competition for student attention from other areas of the curriculum, such as basic science.

Medical students prioritise learning about patient safety (%)

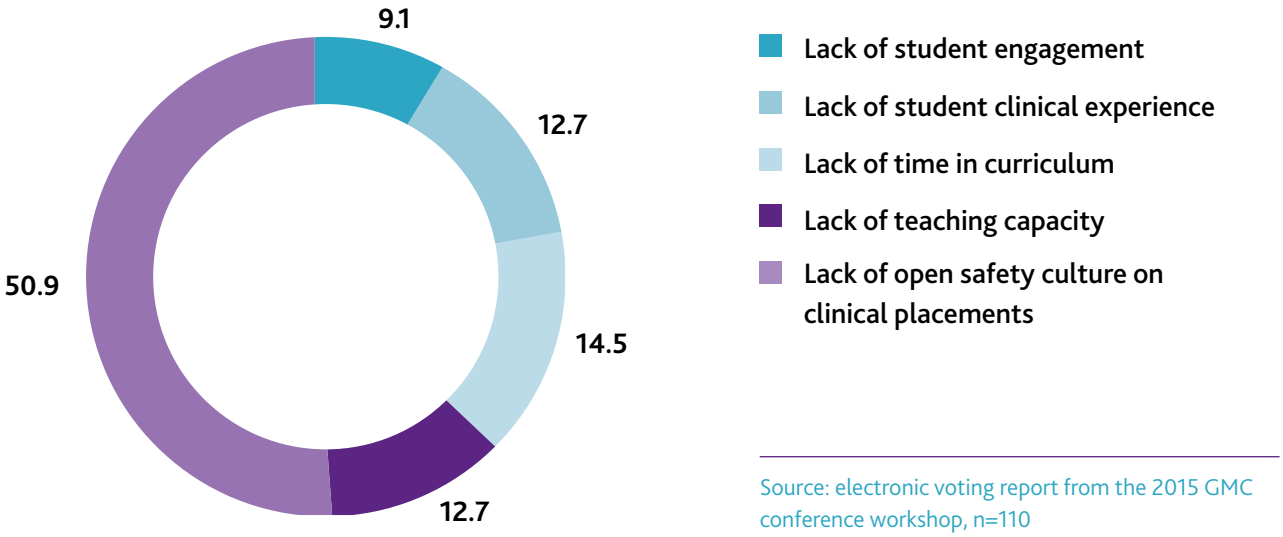


Source: electronic voting report from the 2015 GMC conference workshop, n=107

Faculty development was also identified as a barrier. This is not surprising given the relatively new inclusion of patient safety as an area of the undergraduate curriculum.

These concerns reflect areas identified by earlier work, such as a 2009 report by the Patient Safety Education Study Group.[13]

The greatest challenge to undergraduate patient safety teaching is (%)



Source: electronic voting report from the 2015 GMC conference workshop, n=110

Positive responses to teaching patient safety

We heard from medical school education leads and attendees at the GMC conference, that medical students responded positively to several ways of teaching patient safety. These include:

- learning from patients, particularly through patients' stories
- learning from narrative accounts of medical errors and adverse events, and applying tools such as root cause analysis to identify lessons that could be learnt from them
- integrating safety teaching into clinical placements, with an explicit focus on safety applied to students' actual or simulated experiences through expert debriefing and facilitated critical reflection.

> "We need deeper integration of students into clinical teams to encourage them to consider risks to patient safety."

Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

Selecting medical students who will prioritise patient safety

The MSC has produced guidance recommending that safety-conducive attitudes, such as teamwork and communication skills, should be identified at the point of recruitment to undergraduate medical education.

Selecting for Excellence was an independent project initiated by the MSC. The project looked at the selection of medical students in detail and developed guidance on the core values, skills and attributes needed to study medicine.

The guidance makes it clear that an attitude conducive to patient safety should be one of the things medical schools assess at selection. For more information on Selecting for Excellence, visit **www.medschools.ac.uk/AboutUs/Projects/Widening-Participation/Selecting-for-Excellence/Pages/Selecting-for-Excellence.aspx**.

Through the MSC, medical schools are also sharing best practice in the examination of patient safety and professionalism. One example of this is the development of a shared bank of examination questions by the Medical Schools Council Assessment Alliance.

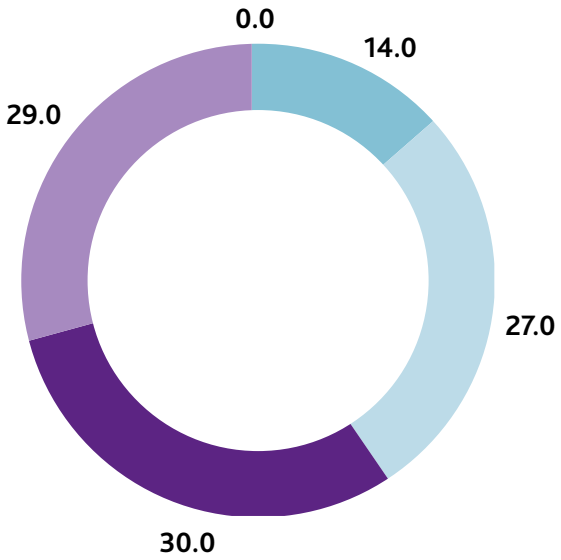
The wider learning environment

The GMC's new standards for education and training make clear that both undergraduate and postgraduate training must take place in an appropriate environment and culture where patient safety is the first concern.

We heard from medical schools and from GMC conference delegates about many areas in which the learning environment could help or hinder patient safety teaching. These included the visibility and effectiveness of clinical governance processes, especially the format of incident reporting, and the feedback staff receive from this process.

Role modelling was identified as a very powerful driver of learning. Where senior doctors and other professionals exhibited safety-conscious behaviours, attitudes and values, medical students were seen to adopt these more easily. Practical examples included discussion of errors and near misses on ward rounds, and support for, rather than complaints about, safety systems such as the *WHO surgical safety checklist* (available at **www.who.int/patientsafety/safesurgery/ss_checklist**).

Students currently receive their medical education and training in an open and just safety culture that enables them to speak up if they see patients receiving poor care (%)



Source: electronic voting report from the 2015 GMC conference workshop, n=73

We heard that identifying and supporting positive role models for patient safety could promote learning. Facilitating the expression of positive behaviours, through structured sessions such as Schwartz rounds,* and through student attendance at mortality and morbidity meetings, was also felt to be helpful.

Effective patient safety teaching is ultimately dependent upon a suitable learning environment, but we heard too that a proactive and innovative approach to education can also influence the environment positively.

> “Our students will inevitably be assessment driven. We need to use this appropriately as a tool to drive engagement in patient safety topics.”

Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

* You can find more information about Schwartz rounds at www.pointofcarefoundation.org.uk/Schwartz-Rounds.

Curriculum topics and medical schools' examples

The WHO *Multi-professional Patient Safety Curriculum Guide* (the WHO curriculum guide) is a blueprint for patient safety teaching at undergraduate level. It draws on the work of experts from a range of disciplines and international perspectives. Many medical schools have used it as a basis for designing their own curricula.

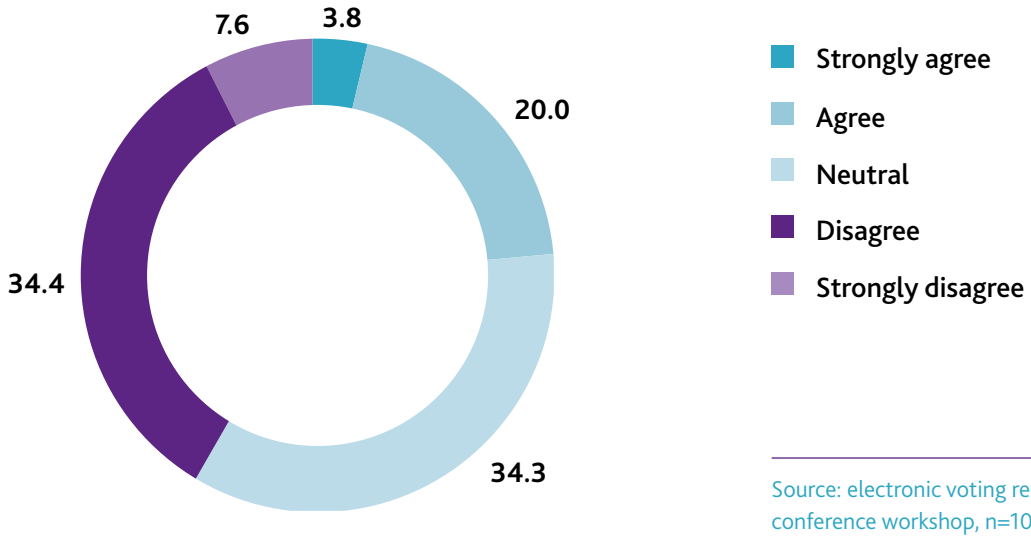
> "Patient safety needs to be embedded in real clinical experience so that it doesn't become an abstract concept in the classroom."

Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

Seeking opportunities for innovation and improvement

We asked medical schools to submit examples of patient safety teaching initiatives, using the WHO curriculum guide as a framework. We mapped these examples, and information submitted separately to the GMC through medical schools' annual returns and from education quality visits, against the WHO curriculum guide to see which areas had been best covered and to highlight topics where there was greatest opportunity for innovation and improvement.

Patient safety is well covered in existing curricula (%)



Source: electronic voting report from the 2015 GMC conference workshop, n=105

The WHO curriculum guide contains 11 topics, split into eight theoretical areas and three that are more practice based.

WHO curriculum guide topics

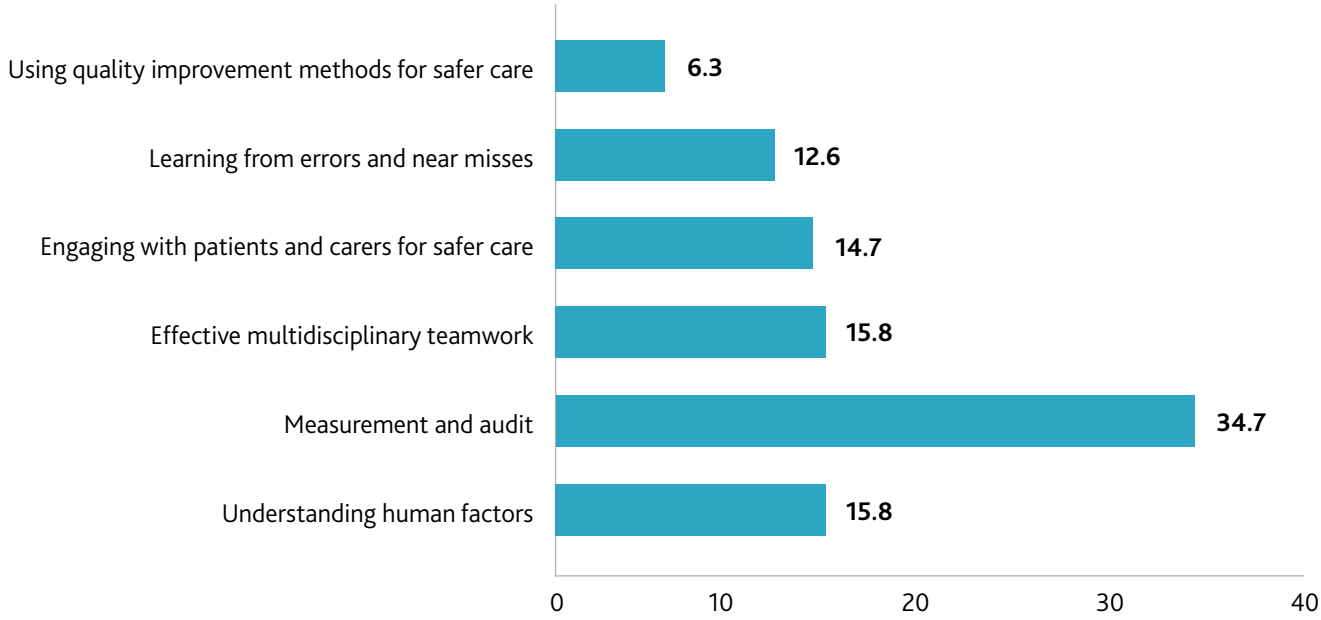
1 What is patient safety?
2 Why applying human factors is important for patient safety
3 Understanding systems and the effect of complexity on patient care
4 Being an effective team player
5 Learning from errors to prevent harm
6 Understanding and managing clinical risk
7 Using quality-improvement methods to improve care
8 Engaging with patients and carers
9 Infection prevention and control
10 Patient safety and invasive procedures
11 Improving medication safety

Of the first eight topics, medical schools volunteered many examples of notable practice related to topics 2, 4, 5, 7 and 8. For some topics, these examples went beyond the subject matter covered in the WHO curriculum guide. For instance, several schools gave examples of teaching on learning from errors that not only covered the science of error and how to learn lessons from mistakes, but also developed understanding of the enablers and barriers to an effective reporting culture, and prompted students themselves to report issues witnessed during clinical placements.

Inexperienced students find it harder to engage with patient safety principles

Medical schools told us that introducing patient safety as a key part of the curriculum can be a challenge, particularly to new students who have gained little experience of clinical practice. This corresponded with what we heard during our workshops and what we know from recent academic work.

In which of the following elements of patient safety do graduating medical students feel most confident? (%)



Source: electronic voting report from the 2015 GMC conference workshop, n=95

> “Share the experiences of senior teachers and how they open up real-life examples. Normally there is a discrepancy between teacher’s talk/advice and how they themselves react.”

Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

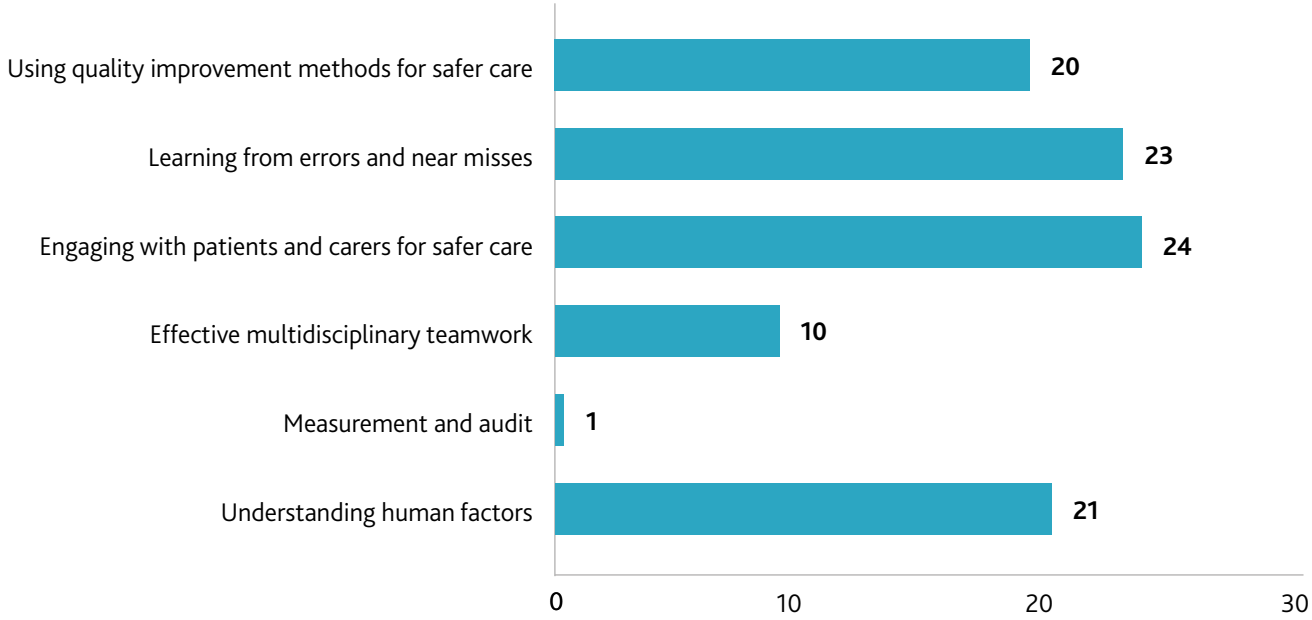
We heard that teaching students the importance of a systems-based approach to understanding the cause of healthcare-associated harm, and the principles of risk management, was also difficult, particularly where students were not equipped with sufficient experience to see how these subjects relate to clinical practice.

We heard specifically that students were more engaged when these topics were taught starting with case examples and then working back to theory.

Topics 9–11 of the WHO curriculum guide (infection prevention and control, patient safety and invasive procedures, and improving medication safety) represent an opportunity to put the more theoretical knowledge of the preceding topics into practice. The WHO curriculum guide recommends that they be considered together.

These areas have represented core teaching for UK medical schools for some time. We heard that much of what students learn on these topics is practical, and that behaviours and attitudes prevalent in the hospitals and GP practices where students have placements are important influences.

In which of the following elements of patient safety do graduating students feel least confident? (%)



Source: electronic voting report from the 2015 GMC conference workshop, n=99

Medical schools' examples of undergraduate patient safety teaching initiatives

Medical schools shared with us many examples of innovative or particularly effective initiatives in patient safety teaching. We have included some of these over the next few pages, mapped as closely as possible to the topics of the WHO curriculum guide. Some of the material in the WHO guidance is closely related, and in some cases medical schools' initiatives covered more than one of these topics. In these cases we have chosen the topic we felt fitted the example best.

This was not an exhaustive survey or audit of medical school curricula, and there may be other areas of notable practice in undergraduate patient safety teaching that we did not hear about.

We have invited all medical schools to share the initiatives below, and other projects they feel work well as good practice examples, on the GMC website at **www.gmc-uk.org/education/good_practice.asp**.

What is patient safety?

- The University of Exeter medical school uses a public health perspective to introduce patient safety to medical students in their first term. This first session, designed with a hospital chief executive and led by a public health consultant, frames the scale of avoidable harm as a major public health issue. It introduces error as a feature of healthcare provision that should be expected, and studied, and the need to consider human factors to improve systems that are inherently unsafe.

- Recognising that pre-clinical students often find it harder to engage with patient safety teaching, students at Warwick medical school designed a peer-led introductory patient safety programme for first and second year colleagues. The programme features the stories of some high-profile medical errors and the lessons learnt, and contains interactive workshops in which participants identify errors in a case study and discuss the *WHO surgical safety checklist* in the context of surgical patient and site identification errors, amongst other topics. The programme organisers report that self-reported student understanding of key patient safety concepts nearly doubled after the programme.

- The University of Manchester medical school invites a series of prominent healthcare system experts to discuss current issues facing the NHS, particularly in the context of patient safety and compassionate care. These events give students the chance to meet, hear and question opinion leaders and gain a national perspective on patient safety issues.

- Brighton and Sussex medical school highlights the importance of patient safety through a day-long conference for its medical students, featuring experts from medicine and from other industries. The programme covers patient, organisation and clinical perspectives, as well as sessions on how incidents are investigated and how lessons identified can be translated into practice.

Why applying human factors is important for patient safety

- The University of Aberdeen medical school builds understanding of non-technical skills through practice observation and the use of a behavioural rating scale. Students are introduced to human factors and non-technical skills through didactic teaching, but then learn to use a locally developed system to rate observed behaviours exhibited by doctors in clinical settings and by themselves in simulated exercises. The use of the rating scale develops a language with which students can better understand and express key safety-critical behaviours, and analyse the performance of colleagues.

- The patient safety and human factors aspects of doctors' mental health and wellbeing, including addictive behaviour, are incorporated in the teaching at St George's, University of London medical school.

> "Our medical students will all have experience of having been a patient themselves, or supporting a patient relative. We should draw on this more through education when talking about the patient perspective."

Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

Understanding systems and the effect of complexity on patient care

- As part of an interprofessional patient safety education package, the University of Leicester medical school has developed a video teaching aid that emphasises how complex systems interact to produce errors. The video recreates a real-life patient experience, following her through the development of an acute stroke and subsequent admission to hospital. Errors become apparent at each stage of her journey, and students work in small groups to identify and reflect on these.

- The University of Sheffield medical school offers year 2 students a patient safety symposium, delivered by a psychologist and an emergency physician. The symposium addresses the patient perspective on medical errors through local and national narrative examples. Through these stories the session highlights the role of systems and complexity on patient care.

- The University of Cambridge medical school Year 6 Clinical Course includes a series of workshops that emphasise the importance of systems interactions in safe care. One workshop covers time management and includes an exercise where students have to prioritise a series of clinical tasks, while new tasks are constantly being added. In a second workshop, students work through a series of emergency department scenarios such as having to do multiple jobs simultaneously and manage the expectations of different team members. The workshops are facilitated by doctors in training as well as senior faculty members.

Being an effective team player

- Plymouth University Peninsula Schools of Medicine and Dentistry puts final year nursing and medical students into a team-based simulation programme to prepare them for working in teams in professional practice. A key element for learning from the programme is debriefing, and the programme leaders have developed and evaluated a debriefing model that students rate highly. Both medical and nursing students report better understanding of each other's roles and responsibilities.
- Year 2 medical students at the University of Southampton medical school do six weekend shifts as a healthcare support worker, supported by three tutorials in small groups to reflect on their learning. Key areas of reflection include teamworking and what makes a good multidisciplinary team, leadership, professional behaviour and understanding how these areas contribute to patient safety.

Understanding and learning from errors

- Students at The University of Sheffield medical school are introduced to the science of human error in the first two years of their course. In year 3, they discuss local examples of adverse events with a hospital patient safety manager, and then move on to perform an error analysis, building on the material covered in the first two years by working through real-life examples.

Understanding and managing clinical risk

- Investigation of a critical incident in hospital has been a core element of the final year MBBS course at the University of Dundee medical school since 2011. All students receive a tutorial and complete online learning on how to review an incident, after which they are assigned a real incident to investigate. Students work in teams but write individual reports, which form part of their final year portfolio.
- Year 5 medical students at the University of Aberdeen medical school consider the causes of avoidable harm through reading and critical discussion of major public inquiries. In recent years students have discussed the Mid Staffordshire public inquiry report and Health Improvement Scotland's report on the Aberdeen Royal Infirmary in small groups, using a systems approach and focusing on the features of a safety culture.

Using quality-improvement methods to improve care

- All year 3 medical students at Imperial College London medical school undertake a group project to identify and assess safety and quality deficiencies in the clinical environment where they are placed. Students use audit, surveys or existing organisational data to identify safety issues, and work together to propose effective, efficient solutions to improving care. They present their proposals to the site as part of a competition. Many of the students' proposals have been taken on by clinical teams to improve the local quality of care.
- Cardiff University medical school has developed a changing practice module for year 5 medical students that includes a human factors workshop run by junior doctors, and an Ask One Question project based on the Institute for Healthcare Improvement (IHI) Open School initiative.[14] Students shadow patients and ask them what would improve their experience, and then write a report advising on key areas for improvement. They must also complete selected courses from the IHI Open School catalogue.[15] The school plans to extend the Ask One Question project to students in years 1 and 2.

Engaging with patients and carers

- The University of Leeds medical school runs a session on the involvement of patients in patient safety. The session, facilitated by faculty members and patients, includes reflective discussion on the challenges of patient safety, and how to engage with patients to allow a partnership approach to providing safe care. Supporting materials include patient narratives of safety incidents, and there are plans to include patient examples of excellent care as well.

- Medical students at Queen's University Belfast learn about adverse events, systems and the patient perspective on patient safety through following WHO Patients for Patient Safety champion Margaret Murphy tell the story of the events surrounding the death of her son, Kevin.[16] Kevin's story covers not only the factors leading to errors in the handling of his care, but also the response to these errors, and the importance of a culture of openness.

- Year 3 students at Cardiff University medical school examine patient journeys by following a real patient from admission to hospital through the course of their stay. They then track their progress in the community and reflect on gaps in systems and processes. Their reflections are facilitated in small groups.

> "You cannot teach patient safety without patients, that is the simple truth."
>
> Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

Infection prevention and control; patient safety and invasive procedures; and improving medication safety

- Swansea University's teaching on prescribing for year 1 and year 2 medical students acknowledges the potential for errors and covers strategies for reducing risk. Students are encouraged to consider the situations where mistakes in drug calculations may arise, and where communication between team members may lead to a drug administration error despite the prescription being correct. Teaching in later years is designed to cover the drugs with the highest risk of causing harm.

- Before graduating, medical students at Barts and the London School of Medicine and Dentistry receive lectures on key patient safety topics, including the lessons learnt from the Mid Staffordshire inquiry. One lecture covers the concept of a never event and discusses in detail the events on the NHS England Never Events list.

- All Scottish medical schools require students to complete a Cleanliness Champions programme[17] developed by NHS Education for Scotland that standardises infection control teaching, or cover the Cleanliness Champions curriculum in their own programmes.

- Brighton and Sussex medical school delivers a three-week preparation for practice module at the end of the curriculum. This multiprofessional programme looks at safety teaching from the perspective of the doctor in training.

  During two practical days the students undertake a simulated ward round, practical handover and safe prescribing, in addition to participating in a lessons learnt session. Using a variety of interactive, practical and simulation-based sessions the programme builds on existing knowledge and skills while supporting the transition from year 5 medical student to Foundation doctor.

Safety ideas from the GMC 2015 annual conference

If you could only make one change

At the GMC conference, delegates were asked 'What single change would do most to improve patient safety?' We have grouped the answers into the following themes.

- Better support for whistleblowers, perhaps with a national non-medical organisation accepting anonymous raising of concerns to build confidence.
- Role-modelling of an open, safety culture by leaders in healthcare, making it easier for those in the system to raise concerns and to be open about mistakes.
- Culture change through education.
- More objective standards for qualification and revalidation, including the use of examinations.
- Development of the idea that it is inevitable that doctors will make mistakes, but intolerance of failure to learn from them.
- Better understanding, training and implementation of disciplinary policies and procedures, to promote openness and reduce fear of repercussions or the sense that nothing will change.
- Strengthening the connection between the regulator and the regulated, and building trust in the GMC that has clearer connections to working doctors.
- A visible, independent patient safety advocate and champion for each department, whose accountability lies outside the department.
- Encouraging time for teams to meet and discuss issues in the way they deliver care.

Patient safety poster competition

As part of the GMC conference, medical students and doctors in training were asked to design a poster on a patient safety project in which they had been involved.

The competition attracted a large number of entries. After carefully reviewing all the entries, the GMC selected the following posters to be shown on its website.

- Cognitive aids, care bundle implementation.
- Education, reporting and learning.
- Handover, teamwork and communication.
- Pathway and process improvements.

At the conference, delegates were invited to vote for their favourite poster and prizes were awarded for first and second place based on the votes received. Dr Arwa Abdel-Aal won first prize in the competition for her poster on the dissemination of learning points from serious untoward incidents through animated videos.

Second prize went to Dr Sinead Millwood for her poster about developing a platform for learning from mistakes.

You can see the winning posters and read a blog by Dr Abdel-Aal at **www.gmc-uk.org/about/26334.asp.**

What we do

The role of the GMC

We're an independent organisation that helps to protect patients and improve medical education and practice across the UK. We set the educational standards for all UK doctors through undergraduate and postgraduate education and training. We promote high standards and make sure that medical education and training reflects the needs of patients, medical students and doctors in training, and the healthcare systems across the UK.

To test whether or not medical schools meet our standards for undergraduate education, we carry out monitoring and inspections, including talking to medical students about their experiences, and responding directly to any concerns raised.

In the UK, medical schools develop their own curricula to meet outcomes we set. Our standards for undergraduate medical education, *Tomorrow's Doctors* (2009), stress a number of patient safety outcomes for UK medical graduates.[18] For example, outcomes under the heading *The doctor as a professional* cover areas such as understanding error and incident reporting.

The graduate will be able to:

23 (d) Promote, monitor and maintain health and safety in the clinical setting, understanding how errors can happen in practice, applying the principles of quality assurance, clinical governance and risk management to medical practice, and understanding responsibilities within the current systems for raising concerns about safety and quality.

The importance of patient safety as a discipline features more prominently in our 2015 revised standards for medical education and training. Where the standards previously focused on protecting patients from any risk posed by medical students and doctors in training, we will now make sure that education and training take place where patients are safe, the care and experience of patients are good, and education and training are valued.

For example, requirement 1.3 in the new standards states:

R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.

Patient safety is also a key feature of the Generic Professional Capabilities framework that the GMC is developing for all postgraduate medical training curricula.*

Work from this project will be taken into account as we develop learning outcomes and standards.

> “Lots of clinicians know what could improve patient safety but do not have the resources, support and time to do it.”
>
> Response from a delegate at the GMC 2015 annual conference when asked for ideas to improve patient safety teaching.

The role of the MSC

The Medical Schools Council represents the interests and ambitions of 33 UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. The MSC works with medical schools to develop a consensus as to what constitutes excellent practice in all domains of a medical school’s work, including education.

As the representative body for UK medical schools, the MSC does not quality assure nor monitor medical schools. Instead it provides medical schools with information and undertakes policy work on their behalf. This enables the schools to develop unique solutions to the issues that all medical schools encounter in a way that reflects their individual circumstances as autonomous institutions committed to providing excellence in education.

* The Generic Professional Capabilities framework is under consultation.

References

[1] General Medical Council, *Promoting excellence: standards for medical education and training*, 2015. Available at **www.gmc-uk.org/education/standards.asp** (accessed 18 August 2015).

[2] Department of Health, *An organisation with a memory,* 2000. Available at **www.aagbi.org/sites/default/files/An%20organisation%20with%20a%20memory.pdf** (accessed 18 August 2015).

[3] General Medical Council, *Promoting excellence: standards for medical education and training*, 2015. Theme 1: Learning environment and culture – R1.4. Available at **www.gmc-uk.org/education/27390.asp** (accessed 18 August 2015).

[4] National Research Council, *To Err Is Human: Building a Safer Health System*, Washington, DC: The National Academies Press, 2000. Available at **www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system** (accessed 18 August 2015).

[5] Emmanuel L, Berwick D, Combes J, et al. *What Exactly Is Patient Safety?* 2008. Available at **www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety-2/vol1/Advances-Emanuel-Berwick_110.pdf** (accessed 18 August 2015).

[6] World Health Organisation, *Patient Safety Curriculum Guide for Medical Schools*, 2009. Available at **www.who.int/patientsafety/education/curriculum/EN_PSP_Education_Medical_Curriculum/en/** (accessed 18 August 2015).

[7] Australian Council for Safety and Quality in Health Care, *National Patient Safety Education Framework*, Canberra: Commonwealth of Australia, 2005. Available at **www.safetyandquality.gov.au/wp-content/uploads/2012/06/National-Patient-Safety-Education-Framework-2005.pdf** (accessed 18 August 2015).

[8] Walton M, Shaw T, et al. Developing a national patient safety education framework for Australia. *BMJ Quality & Safety* 2006; **15**:437–442.

[9] National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act*, London: Department of Health, August 2013. Available at **www.gov.uk/government/publications/berwick-review-into-patient-safety** (accessed 18 August 2015).

[10] National Quality Board, *Human Factors in Healthcare*, 2013. Available at **www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf** (accessed 18 August 2015).

[11] Department of Health, *Culture change in the NHS*, London: The Stationery Office, February 2015. Available at **www.gov.uk/government/publications/culture-change-in-the-nhs** (accessed 18 August 2015).

[12] World Health Organisation, *Multi-professional Patient Safety Curriculum Guide, Geneva: WHO*, 2011. Available at **www.who.int/patientsafety/education/curriculum/tools-download/en/** (accessed 18 August 2015).

[13] Patient Safety Education Study Group, *Patient safety in health care professional educational curricula: examining the learning experience*, 2009. Available at **www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS030PSRPReportFINAL0609.pdf** (accessed 18 August 2015).

[14] Institute for Healthcare Improvement, *"Ask One Question" Challenge*. Available at **www.ihi.org/education/ihiopenschool/chapters/pages/askonequestion.aspx** (accessed 18 August 2015).

[15] Institute for Healthcare Improvement, *Open School*. Available at **www.ihi.org/education/ihiopenschool/Pages/default.aspx** (accessed 18 August 2015).

[16] World Health Organisation, *A story by a champion of the Patients for Patient Safety from Ireland*. Available at **www.who.int/patientsafety/patients_for_patient/videos/en/** (accessed 18 August 2015).

[17] NHS Education for Scotland, *Cleanliness Champions*. Available at **www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/educational-programmes/cleanliness-champions.aspx** (accessed 18 August 2015).

[18] General Medical Council, *Tomorrow's Doctors: Outcomes 3 – The doctor as a professional.* Available at **www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009_outcomes3.asp** (accessed 18 August 2015).

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Excellence by design:

standards for postgraduate curricula

Working with doctors Working for patients

General Medical Council

Excellence by design: standards for postgraduate curricula

Published 22 May 2017.
Comes into effect May 2017.

You can find the latest version of this guidance on our website at
www.gmc-uk.org/education/postgraduate/standards_for_curricula.asp

Contents

About these standards

All postgraduate curricula* must meet our standards and requirements for approval. The standards also apply to any changes or revisions made to curricula. They may also be applied to other learning and assessment frameworks or tests of competence, curricula and educational or training approval processes where appropriate.

GMC-approved postgraduate curricula must be applicable and relevant to the UK as a whole. They must have outcomes that receive the full support of the four countries in the UK.

There must be sufficient flexibility to enable organisations to manage training locally, to better reflect their educational and service capacity and capability, provided curricular outcomes are met.

These standards require curricula to describe fewer, high-level generic, shared and specialty-specific outcomes, which will support all doctors better in understanding what is expected of them in their training programme. They require curricula to identify common areas of training and to have a greater focus on the generic professional capabilities common to all doctors. These requirements will help improve the flexibility of postgraduate medical training as described in our flexibility review in March 2017. †

* The standards and requirements apply to both general practice and specialty curricula. In this document, references to specialty curricula or requirements include general practice.

† General Medical Council (2017) *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training* available at www.gmc-uk.org/education/30540.asp.

These standards work in conjunction with *Promoting excellence: standards for medical education and training*.* Together, they provide an integrated standards framework for the development, approval and provision of postgraduate medical education and training in the UK.

Applying these standards

During our approval processes, organisations † must describe and give evidence to show how our standards and requirements set out in this document have been addressed in the design and development of the proposed curriculum.

For a curriculum to be meaningful, it must address many interdependent factors, such as:

- clinical safety
- expected levels of performance
- maintenance of standards
- patient expectations
- equality and diversity requirements
- strategic workforce issues and system coherence
- operational and professional perspectives.

Our curriculum approval process will make sure all of these different dimensions have been appropriately considered and addressed effectively during the development process.

* The standards and requirements apply to both general practice and specialty curricula. In this document, references to specialty curricula or requirements include general practice.

† Organisations are defined broadly in this document to allow for future changes, but it is most likely the organisations developing postgraduate curricula will be medical colleges and faculties.

Themes and key principles

THEME 1: **Purpose**

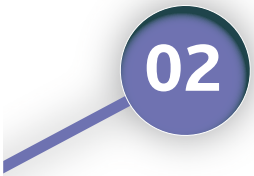
01

Why is the curriculum needed?

05

THEME 5:
Quality assurance and improvement

How will the performance and development of the curriculum and programme of assessment be monitored and reviewed?



THEME 2:

Governance and strategic support

What processes were used to develop the curriculum?

THEME 3:

Programme of learning

What does a doctor need to experience and achieve to progress or complete training?

THEME 4:

Programme of assessment

How will doctors demonstrate attainment of the intended learning outcomes?

Overview of the standards

THEME 1: Purpose

- Based on a clear analysis of service needs and best contemporary and future clinical practice
- Purpose statement
- Intent and rationale
- Scope of practice, capabilities, and expected levels of performance
- Any notable exclusions

THEME 2: Governance and strategic support

- Approaches to curriculum design and development
- Stakeholder engagement, input and support
- Robust governance processes
- Strategic workforce support
- Four-country endorsement and feasibility

THEME 3: Programme of learning

- Generic, shared and specialty-specific outcomes
- Educational approaches and methods
- Breadth of experience required
- Critical progression points
- Criteria for satisfactory completion

THEME 4: Programme of assessment

- Assessment processes aligned to stated learning outcomes
- Defined levels of performance at critical progression points
- Assessment guidance and decision aides for critical progression points and satisfactory completion

THEME 5: Quality assurance and improvement

- Data collection, monitoring and analysis
- Equality and diversity monitoring
- Quality management and improvement
- Kept up to date and redundant content removed

Principles for all curricula

Patient safety is the first priority

Patient safety is the first priority and is at the core of these education standards. Just as all doctors must make the care of patients their first concern, so must the organisations that design and develop postgraduate curricula.

To be approved, curricula must identify and explain how key areas of patient and population needs, patient safety and relevant risk are identified, defined and addressed. This should include a focus on safety-critical content, clarity on expected levels of performance and the necessary breadth of experience needed for safe professional practice.

The learning experience itself should not affect patient safety unnecessarily. The curriculum, therefore, should also include other relevant guidance, expectations and requirements for the provision of safe and effective learning, such as mandatory training required to address safety themes.

Upon satisfactory completion of training programmes, we expect learners to be able to work safely and competently in the defined area of practice and be able to manage or mitigate relevant risks effectively.

The safety of patients is a key theme in our *Generic professional capabilities framework*[*] which covers core capabilities aimed at keeping patients safe. The framework outlines generic professional capabilities and expectations related to clinical responsibility and governance systems, individual roles and responsibilities in relation to safety, team interactions and the importance of raising concerns.

* Find out more about our *Generic professional capabilities framework* at www.gmc-uk.org/education/postgraduate/GPC.asp

Learning outcomes allow local education providers to use courses, techniques and approaches that best meet their local arrangements and resources. But where serious patient safety concerns have been identified related to specific training requirements, these risks must be mitigated through explicit mandatory curricular requirements. These must be proportionate and limited to where there are no other appropriate or acceptable ways to protect patients. Examples might include specific resuscitation courses, specific kinds of simulation interventions or requirements for enhanced clinical supervision.

Maintaining standards across the UK

To protect the public and maintain trust in the medical profession, GMC-regulated training must make sure standards are maintained consistently across the UK. Curricula must set out the expected levels of performance of doctors achieving a Certificate of Completion of Training (CCT).

Encouraging excellence

Patient safety and competent practice are both essential, but we expect curricula and training to also promote and encourage excellence in postgraduate education, training and professional practice.

To support this endeavour, we require *Good medical practice*[*] and the *Generic professional capabilities framework* to be embedded in all GMC-approved curricula. We also expect all curricula to describe the professional

* General Medical Council (2013) *Good medical practice* available at www.gmc-uk.org/guidance/good_medical_practice.asp.

capabilities and the expected levels of performance as high-level generic, shared and specialty-specific learning outcomes.

Organisations should encourage learners and give them opportunities to aspire to excellence. Organisations should provide guidance about how higher levels of performance and achievement might be recognised.

Embedding fairness

The principles of fairness, equality and diversity must be embedded in the development processes and learning outcomes of the curriculum.

Organisations developing postgraduate curricula must demonstrate that they have met their statutory obligations under equality legislation, including providing reasonable adjustments. Organisations must also consider the impact of the learning outcomes on the progression of learners, including how groups of people who share protected characteristics might be affected.

Organisations must also give particular consideration to making sure entry-to-training requirements at all transition points, assessments and progression decisions are fair and robust.

Key to meeting these standards will be taking account of our equality and diversity guidance.*

* General Medical Council (2015) *Approving changes to curricula, examinations and assessments: equality and diversity requirements* available at www.gmc-uk.org/education/postgraduate/EandD_college.asp – describes the responsibilities of organisations designing curricula. It defines terms like protected characteristics and reasonable adjustments.

To make sure progression is fair and transparent, organisations must monitor, analyse and publish data on the impact and outcomes of the training where appropriate. We need this information for our quality assurance processes.

Current and future workforce and service needs

There has to be a balance between curricula designed for the learner and the profession and the expectation that it can evolve to meet current and future advances, service needs and opportunities. Curricula must support and align with strategic workforce needs and meet the needs of the service and its patients. The *Generic professional capabilities framework* is a key approach that will ensure common, universal content across all curricula. We are committed to reviewing the *Generic professional capabilities framework* periodically to keep it up to date.

Regular review of curricula allows redundant content to be removed and new content to be introduced consistently across the medical workforce. We need to approve these changes. This more responsive approach means postgraduate training will be able to adapt to current and emerging patient and population needs.

Theme 1: Purpose

Purpose of this theme

This theme is about making sure the curriculum is based on patient and population needs as well as strategic service needs and is formally endorsed by the four countries of the UK.

The purpose statement must clearly address patient and service needs. It must set out specialty-specific capabilities, including scope of practice and the levels of performance expected of those completing training.

It must identify generic and shared content and allow flexibility and transferability of outcomes. It should support recognition of capabilities between and across specialties.

The purpose statement should also include any notable exclusions or limitations to the training or scope of practice.

Standards

CS1.1 The curriculum has a stated and clear purpose based on scope of practice, service, and patient and population needs.

CS1.2 The curriculum considers interdependencies across related specialties and disciplines. It demonstrates that it has addressed the expectations of the service and healthcare system.

CS1.3 The curriculum supports flexibility and transferability of learning.

Requirements

The purpose statement must meet the following requirements.

CR1.1 Explain the need for the curriculum based on an analysis of patient, population, professional, workforce and service needs.

CR1.2 Give the purpose and objective of the curriculum, including how it links to each stage of critical progression.

CR1.3 Describe the scope of practice of those completing the curriculum including notable exclusions.

CR1.4 Specify the high level outcomes so it is clear what capabilities must be demonstrated, and to what level, to complete training.

CR1.5 Demonstrate the curriculum has four-country endorsement of the purpose statement.

CR1.6 Demonstrate how the key interdependencies between the curriculum and other training programmes, professions or areas of practice have been identified and addressed.

CR1.7 Explain how the curriculum supports flexibility and transferability of learning outcomes and levels of performance across related specialties and disciplines.

Theme 2: Governance and strategic support

Purpose of this theme

This theme is about making sure curricula are developed through demonstrable and robust processes that are informed by relevant groups.

Standards

CS2.1 The curriculum is developed and regularly reviewed through clear governance processes.

CS2.2 The curriculum results in feasible, practical and sustainable training programmes that can be implemented by organisations responsible for training and service provision.

CS2.3 The curriculum and development process make sure education and training is fair and is based on principles of equality and diversity.

Requirements

Development processes

Organisations developing curricula must meet the following requirements.

CR2.1 Explain how the curriculum and its learning outcomes were developed, including input from key groups.

CR2.2 Explain the rationale for the learning outcomes.

CR2.3 Explain how the curriculum is feasible, practical and sustainable.

CR2.4 Describe how the curriculum and its programme of assessment will be communicated to learners, the public, and to those providing the education and training.[1, 2]

Input and feedback

Organisations developing curricula must meet the following requirements.

CR2.5 Describe how input and involvement was sought from relevant groups including patients, employers and learners.[3, 4] Engagement and consultation should be proportionate to the change being made and tailored to the relevant group. It must include input from all the following groups:

- **a** employers, service providers and organisations responsible for planning learning and development
- **b** patients, relevant patient groups, carers and lay people
- **c** education or training providers and statutory education bodies
- **d** learners, including specific input from doctors who share protected characteristics
- **e** professionals and professional bodies, including those involved in relevant research and policy areas, where appropriate
- **f** those with expertise in curricular design and assessment.

Equality and diversity

CR2.6 Organisations must demonstrate that they meet their legal obligations under equality legislation and that they have considered equality, diversity and fairness in the development of the curricula and programme of assessment.

Theme 3: Programme of learning

Purpose of this theme

This theme is about making sure the curriculum clearly describes the expected learning outcomes for the area of practice and appropriate learning methods and approaches.

There must be clear guidance about the appropriate breadth of experience and expected level of performance, for satisfactory completion and at critical progression points during the training programme, particularly focusing on safe transitions where patient or training risk may increase.

Taken together, these describe a programme of learning.

Standards

CS3.1 The curriculum describes the generic, shared and specialty-specific outcomes, as capabilities, expected levels of performance and the breadth of experience that learners must demonstrate to progress or complete training.

CS3.2 *Good medical practice* and the *Generic professional capabilities framework* are mapped in the curriculum.

CS3.3 The curriculum must indicate what is needed for learners to show competence, but it should also recognise proficiency or excellence in relevant areas of practice.

Requirements

The curriculum must meet the following requirements.

CR3.1 Identify the learning outcomes that learners must demonstrate to complete training and to move through critical progression points.

CR3.2 Match the learning outcomes, educational approaches, breadth of experience and expected levels of performance to the stated purpose of the curriculum.

CR3.3 Include *Good medical practice* and the content of the *Generic professional capabilities framework*.

CR3.4 Provide guidance on the appropriate educational methods and approaches, breadth of experience and learning opportunities necessary to ensure safe training and to meet the learning outcomes.

CR3.5 Provide guidance that describes the responsibilities, capabilities and expected levels of performance of medical educators to make sure they are professionally credible and competent.

CR3.6 Explain how learners will receive meaningful and timely feedback.

Theme 4: Programme of assessment

Purpose of this theme

This theme is about making sure the organised set of assessments planned for the curriculum – the programme of assessment – and its individual components are based on fair and robust assessment principles and processes. However, the way they are demonstrated may vary depending on the training context or on the type of individual assessment or assessment approach being used.

Key to meeting these standards will be our assessment guidance that describes good practice in developing programmes of assessment.*

Standards

CS4.1 The programme of assessment is valid, fair, acceptable, feasible and effective. It supports assessors to make reliable judgements and is blueprinted to the curriculum, including the generic, shared and specialty-specific learning outcomes.

CS4.2 It has a positive educational impact and the assessment burden is proportionate.

CS4.3 The programme of assessment discriminates effectively between different levels of performance, and includes critical progression points including completion of training.

* General Medical Council (2017) *Designing and maintaining postgraduate assessment programmes* available at www.gmc-uk.org/education/postgraduate/assessment_guidance.asp

CS4.4 The programme of assessment incorporates summative assessments which allow learners to demonstrate they have met the learning outcomes in the curriculum, including generic, shared and specialty-specific outcomes.

CS4.5 The programme of assessment provides principles to inform the management of learners who have not met the required learning outcomes at critical progression points.

CS4.6 The programme of assessment offers opportunities for formative assessment and feedback to support learning, linked to learning outcomes.

Requirements

Developing the programme of assessment

The programme of assessment must meet the following requirements.

CR4.1 Describe clearly how assessments that contribute to decisions about a learner's progress (summative assessments) have been:

- **a** selected and integrated to produce valid and reliable judgements [5, 6]
- **b** produced so the purpose of each individual element within the programme of assessment and its contribution to the programme of assessment as a whole is clear and the overall assessment burden is proportionate [3, 5]
- **c** subject to appropriate validation or piloting [3]
- **d** blueprinted to the learning outcomes described in the curriculum, so it is clear how and when learning outcomes are demonstrated [7]

e sequenced and applied across the curriculum, particularly around critical progression points, to ensure patient and training safety [7]

f appropriately standard set to clearly describe expected levels of performance, using a methodology that is consistent, robust and fair over time [8]

g supported by appropriate guidance for learners, examiners and assessors so assessments are conducted consistently and fairly [2, 4, 9]

h clearly distinguished from formative or developmental assessments that promote learning and feedback or assessments which combine formative and summative functions. [1]

CR4.2 Provide guidance on how poor performance should be managed including advice on addressing underperformance safely and fairly and making sure concerns about performance are escalated appropriately. [1, 2, 5, 10]

CR4.3 Integrate information about the learner's performance across the programme of assessment to evidence decisions at critical progression points and completion of the training programme. [5, 10]

CR4.4 Provide a rationale that explains the impact of the assessments, including on doctors who share protected characteristics. [2, 3, 5, 9, 10]

Monitoring the quality of the programme of assessment

Organisations developing curricula and programmes of assessment must meet the following requirements.

CR4.5 Monitor and continuously improve the quality of assessment.* [4, 6, 10]

CR4.6 Provide data about assessments to meet regulatory requirements for quality management and quality assurance processes. [4, 6, 10]

CR4.7 Publish the quality performance metrics of high-stakes summative or progression assessments to promote transparency and openness. [6]

CR4.8 Describe how those involved in assessments should provide meaningful and timely feedback to candidates, including on summative assessments. [1]

Assessors

CR4.9 As part of the programme of assessment, guidance must be provided about the nature, role and responsibilities of assessors and examiners. [9]

CR4.10 Organisations must set out appropriate requirements and guidance to enable assessors and examiners to make professional judgements about learners' performance and behaviour to an agreed standard. [9]

* This does not require organisations developing curricula to take responsibility for the quality of assessments conducted in the workplace by local education providers. This falls under the standards and requirements outlined in *Promoting excellence: standards for medical education and training* and will be addressed locally through our quality assurance framework.

CR4.11 There must be clear and regular processes for calibrating and benchmarking examiners so they assess to agreed standards, and for reviewing their performance. [8, 9]

CR4.12 Organisations must make sure assessors and examiners are able to distinguish consistently between different levels of performance and behaviour. [8, 9]

CR4.13 Organisations must indicate where professional development is required including on the equality and diversity issues that are relevant to their role as assessors and fair decision-making. [9]

Theme 5: Quality assurance and improvement

Purpose of this theme

This theme is about making sure the curriculum, and its programme of assessment are monitored, regularly reviewed, improved and quality assured. Information gathered through governance and monitoring processes must inform changes to the curriculum, including the programme of assessment. This includes feedback from education and service providers and others that implement training programmes.

Organisations should consider aspects of the curriculum that are redundant and should be removed or that need to be revised. Organisations should also consider how they will implement new or amended curricula or programmes of assessment.

Our quality assurance framework will determine how the curricula and programme of assessment are monitored and quality assured. We will use *Promoting excellence: standards for medical education and training* to quality assure how the curricula and related training programmes have been implemented locally.

Standards

CS5.1 The curriculum is regularly reviewed and there are processes in place to make sure it is monitored and improved to keep it up to date.

CS5.2 Redundant elements of the curricula are removed.*

* Changes to the curriculum, including removing redundant elements, are subject to our approval.

Requirements

Organisations developing curricula must meet the following requirements.

CR5.1 Set out plans for how the curriculum or changes will be introduced, including a clear plan for the transition of learners.*

CR5.2 Demonstrate how the curriculum will be evaluated and monitored through quality management and quality improvement processes. Include information about:

- **a** the arrangements that will be used to gather data and how it will be used to inform improvements to the curriculum and programme of assessment
- **b** the mechanisms that will be used to keep the curriculum up to date and current, including how innovations in the area of practice or training will be incorporated and out-of-date elements will be removed.

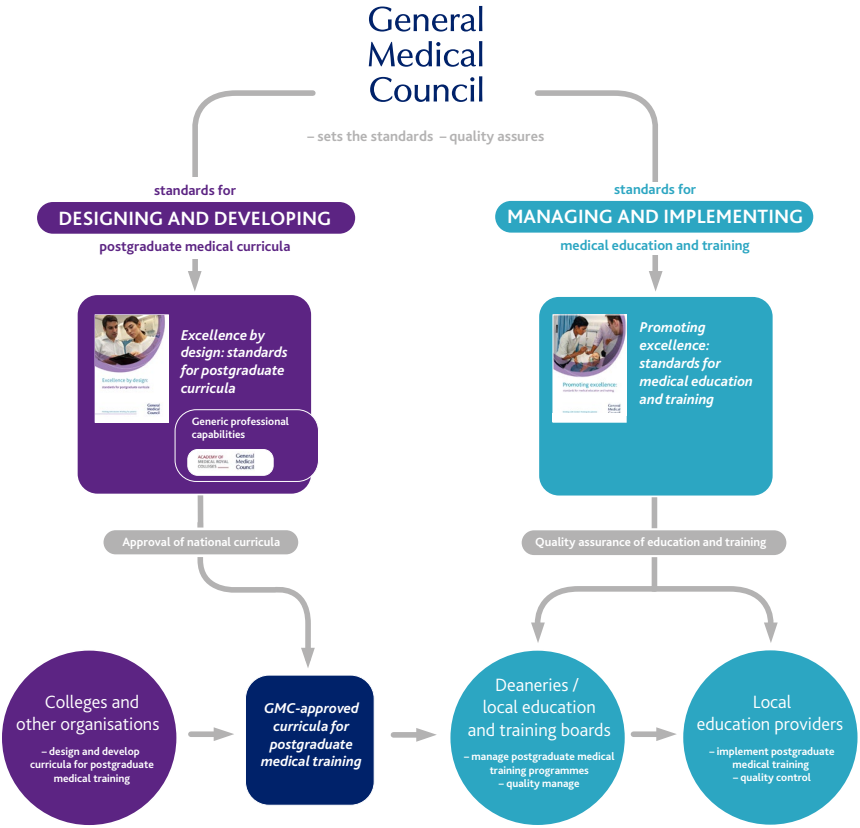
CR5.3 Set out how the impact of the learning outcomes on the progression of different groups of doctors will be evaluated, including on those who share protected characteristics.

* General Medical Council (2012) *Moving to the current curriculum* available at www.gmc-uk.org/education/postgraduate/27072.asp

Responsibilities and relationships

Roles, responsibilities and interdependencies

The diagram below shows the two sets of standards for postgraduate medical training, and the roles, responsibilities and interdependencies among organisations.



The quality assurance framework* shows how the quality assurance, quality management, and quality control functions work together for quality improvement.

Promoting excellence: standards for medical education and training applies to both undergraduate and postgraduate medical education and training.

Our role in medical education and training

We set educational standards for all doctors in undergraduate and postgraduate education and training in the UK. We do this, in part, by approving postgraduate medical education and training – this includes approving curricula and associated training posts, programmes and assessments.

We assure the quality of medical education and training by carrying out rigorous reviews and regular monitoring activities to make sure our *Promoting excellence* standards are being met by local education providers. These quality assurance processes help us identify and deal quickly with any concerns, to make sure doctors in training receive safe and effective training and appropriate clinical supervision in settings that provide safe patient care.

* Details about the quality assurance framework and how we monitor the quality of education and training are on our website – www.gmc-uk.org/education/qaf.asp and www.gmc-uk.org/education/27080.asp

Responsibilities in designing curricula

The General Medical Council

Alongside our functions described above about our role in medical education and training, we:

- set the professional standards for all UK doctors through *Good medical practice* and other professional guidance
- oversee and maintain the generic outcomes of the *Generic professional capabilities framework*. We do this in partnership with the Academy of Medical Royal Colleges (AoMRC)
- approve posts and programmes of learning for postgraduate training programmes
- quality assure regulated and approved curricula by monitoring and checking to make sure our educational standards are maintained
- provide system leadership in determining critical interdependences across, between and within programmes of learning.

The four UK governments and their related organisations

- Identify and prioritise strategic, system, service or workforce needs including, through their related organisations, the funding, planning, commissioning and quality management of training programmes.

Funders, commissioners and employers

- Identify and prioritise service and workforce needs, and work with colleges to help predict future workforce needs.
- Support and provide sponsorship, funding and opportunities for education, training and professional development including the quality management of local programmes of learning.

Colleges, faculties or other credible professional bodies

- Design and develop a curriculum and associated programmes of assessment.
- Maintain and monitor a curriculum and associated programmes of assessment.
- Make sure the curriculum and associated programmes of assessment meet obligations under equality legislation on fairness, equality and diversity.
- Contribute to and support the GMC in its quality assurance and statutory responsibilities.
- Work with deaneries and Health Education England (HEE) local teams on quality management issues.

Deaneries and HEE local teams

- Implement *Generic professional capabilities framework* in training.
- Provide quality management of locally implemented education and training.

Local educational providers

- Implement elements or complete programmes of learning at the local level.
- Provide local quality control and participate in local quality management of education and training.

Statutory education bodies

- Responsible for commissioning or management of postgraduate training.
- May hold some of the responsibilities of government related organisations, funders, commissioners and employers, or professional bodies, as described above.

Glossary

Assessor

An assessor provides an assessment and is responsible for interpreting the learner's performance in that assessment. Assessors should be appropriately trained and should normally be competent (preferably expert) in the area being assessed, and capable of making appropriate professional judgements. This includes examiners as a specific type of assessor.

Assessors also include the day-to-day trainer, who may conduct assessments on a daily basis in the workplace.

Blueprint

A blueprint is a template used to define the content of a test that may be designed as a matrix or a series of matrices. This can help to make sure the assessments used in the assessment system cover all the outcomes required by the curriculum.

Critical progression point

A critical progression point is a point in a curriculum where a learner transitions to higher levels of professional responsibility or enters a new or specialist area of practice, including successful completion of training. These transitions are often associated with an increase in potential risk to patients or those in training, so they need to be carefully managed and decisions to progress need to be based on robust evidence of satisfactory performance.

Curriculum

A curriculum is a statement of the intended aims and objectives, content, experiences, learning outcomes and processes of a programme or course of learning, including a description of the structure and expected methods of

learning, teaching, assessment, feedback and supervision. The curriculum should set out a programme of learning and specify what learning outcomes the learner will achieve. How these outcomes will be assessed through a coherent programme of assessment and how learners will be determined as having successfully completed a programme of learning must also be described.

Doctor in training

A doctor in training is a doctor participating in an approved postgraduate medical training programme (Foundation Programme or specialty including general practice training).

Educator

Educators are individuals with a role in teaching, training, assessing and supervising learners. This includes:

- individuals in a recognised and approved trainer role
- other doctors or healthcare professionals involved in education and training in the course of their daily clinical or medical practice
- academic staff from a range of disciplines with a role in education and training.

Educators may also include patients and members of the public who have roles in medical teaching or training, and other people whose knowledge, experience or expertise is used in teaching or training.

Experience

We refer to the necessary or appropriate breadth of experience to describe when a doctor in training has had enough experience to be able to practise

safely and competently at an expected level of performance, eg with a particular procedure, simulation, or patients. This is not intended to indicate experience measured in specific numbers or time, but sufficient practice to have acquired and consolidated the learning outcomes described.

Generic professional capabilities framework

The *Generic professional capabilities framework* is a matrix of educational outcomes and descriptors that states common core content required in all postgraduate curricula. The *Generic professional capabilities framework* describes minimum GMC regulatory requirements which are essential and critical capabilities underpinning core professional practice in the UK. Along with *Good medical practice* they must be included in all postgraduate curricula to achieve GMC approval.

Learner

Learners are medical students receiving education leading to a primary medical qualification and doctors in postgraduate training leading to a certificate of completion of training (CCT).

Learning outcomes

Learning outcomes are the knowledge, skills, capabilities, behaviours and expected levels of performance a learner must acquire and demonstrate by the end of a period of education or training. They may be generic, shared, or specialty specific.

Generic outcomes are those that are common across all specialties.

Shared outcomes are common components of training across groups or families of specialties. The flexibility review identified this as an area of work to be developed.

Medical college or faculty

A medical college or faculty is a professional body responsible for the development of the professional standards and expectations for one or more medical specialties.

The medical colleges and faculties develop curricula and assessment programes for specialty training and professional examinations, and also provide continuing professional development support and advice for their members.

Medical trainer

A medical trainer is an appropriately trained and experienced doctor who is responsible for educating, training and assessing medical students or doctors in training within an environment of medical practice.

Four medical trainer roles are performed only by recognised or approved trainers who are registered doctors holding a licence to practise. The arrangements do not cover other doctors whose practice contributes to teaching, training, assessing or supervising medical students or doctors in training, but whose role does not need to be formally recognised.

Organisations developing curricula

Most likely, the organisations that will develop postgraduate curricula will be medical colleges and faculties. But there is nothing to prevent other credible organisations developing a curriculum for approval by the GMC.

Postgraduate dean

In England, the roles of the postgraduate dean and management of postgraduate training sit within Health Education England. In Northern

Ireland, these roles are held by the Northern Ireland Medical and Dental Training Agency. In Scotland, the postgraduate deans and the Scotland Deanery are part of NHS Education for Scotland. In Wales, the postgraduate dean is part of the Wales Deanery (School of Postgraduate Medical and Dental Education), Cardiff University.

These are the UK bodies we have authorised to manage approved training programmes and the training posts.

Programme of assessment

A programme of assessment is the organised set of assessments planned for the curriculum, which demonstrates how the learning outcomes must be achieved, articulating clearly the professional standards and specific levels of performance expected at critical progression points and for successful completion.

Programme of learning

A programme of learning is the organised experiences, methods and educational approaches used to create appropriate learning opportunities for those in training so they can achieve the stated learning outcomes of the approved postgraduate curricula. The purpose of a programme of learning is to allow those in training to develop and acquire the necessary experience, learning outcomes and capabilities as outlined in the approved postgraduate curricula.

Quality assurance

The quality assurance (QA) of medical education and training in the UK includes all the policies, standards, systems and processes in place to maintain and enhance quality. We carry out systematic activities to assure

the public and patients that medical education and training meets the required regulatory standards.

Quality control and management

In the context of our quality assurance framework, quality control (QC) covers the arrangements through which local education providers make sure medical students and doctors in training receive education and training that meets local educational and professional standards. Medical colleges and faculties also have a role in quality control in terms of making sure the national examinations they run are in line with assessment best practice.

Medical schools, postgraduate deaneries and HEE local teams are responsible for managing undergraduate and postgraduate training programmes and the progress of students and doctors in training according to our education standards. Medical schools, postgraduate deaneries and HEE local teams will have quality management (QM) systems to satisfy themselves that the local education providers delivering their local programmes are meeting our standards. These systems normally involve reporting and monitoring mechanisms.

Training programme

A training programme is a formal alignment or rotation of posts that together comprise a programme of postgraduate training in a given specialty or subspecialty. A programme may deliver the full curriculum through linked stages to a CCT, or the programme may deliver different component elements of the approved curriculum.

References

All references are to GMC (2017) *Designing and maintaining postgraduate assessment programmes*.

1 Content decisions: formative and summative; p18

2 Setting out expectations: learners; p30

3 Evidencing format decisions: acceptability, feasibility, cost effectiveness; p22

4 Evidencing content quality: setting up structures to ensure the quality of assessment; p25

5 Setting out the purpose of the programme of assessment; p9

6 Evidence about assessment structure: statistical analysis; p41

7 Linking curriculum content and assessment; p14

8 Evidence about assessment structure: standard setting; p38

9 Setting out expectations: examiners and assessors; p33

10 Evidencing the impact of assessments; p45

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General Medical Council

Designing and maintaining postgraduate assessment programmes

Working with doctors Working for patients

General Medical Council

Contents

About this guidance

What's the purpose of this guidance?

1 This guidance is supplementary to our curriculum standards, *Excellence by design*. It gives advice for those making decisions in organisations (typically colleges and faculties) about how programmes of assessment are designed and maintained.

2 *Excellence by design* emphasises five principles.

- Safety – assessments assure the profession, patients and the public that doctors are safe.
- The maintenance of professional standards.
- Excellence – enables learners to develop the skills, knowledge and performance for excellent patient care.
- Fairness – affords all learners opportunities to demonstrate outcomes and considers their performance consistently in line with clear and transparent criteria.
- Meeting patient and population needs – current and future.

3 The standards require curricula to describe fewer, high-level generic, shared and specialty-specific outcomes, which will support all doctors better in understanding what is expected of them in their training programme. They require curricula to identify shared areas of training and to have a greater focus on the generic professional capabilities common to all doctors. These requirements for approval will enable improvement in the flexibility, relevance and consistency of postgraduate medical training.

- Generic outcomes are those that are common across all specialties.
- Shared outcome are those common components of training across groups or families of specialties. The flexibility review identified this as an area of work to be developed.
- Specialty-specific outcomes are defined those that relate to specific areas of specialist practice.

4 Our standards also require assessment to be proportionate and impose a reasonable and necessary amount of assessment activity on learners and their trainers.

5 The guidance sets out the steps and principles that you should follow when:

- planning and designing a programme of assessment

- determining expected levels of performance for critical progression points (points or transitions in (or between) all training programmes that may represent significant risk to patients, the service and those in training) and satisfactory completion of training

- maintaining its quality and validity in practice.

6 It also suggests approaches that you could use, but these are not prescriptive. By focusing further on the fundamental principles and practical considerations outlined in *Excellence by design* it is hoped this guidance will support organisations as they develop their assessment philosophy, strategy and programme of assessment.

7 While this guidance does not describe or advise on the approvals process, the principles contained in this document are the same as those underpinning our curriculum standards *Excellence by design* and associated approvals process.

Who is this guidance for?

8 This guidance gives advice and information for colleges and faculties to support those making decisions about the programme of assessment in their curricula. It is written with the intention of assisting in the design, development and management of the programme of assessment. The guidance relates to the applicable section of the standards and explores what approaches and evidence might be helpful to consider and provide when submitting a curriculum to the formal approvals process.

9 This guidance may also be relevant to other organisations involved in medical education in the UK. Local training bodies conducting assessments in the workplace are subject to the standards in *Promoting excellence* (see especially R1.18 and S1.2).

What we mean by assessment

10 We define assessment as all activity aimed at judging a learner's attainment of curriculum outcomes, whether for summative (determining satisfactory progression in or completion of training), or formative (developmental) purposes. An outcome can be defined as a level of performance or behaviour that a trainee is expected to achieve as part of their development according to their stage of training within their curriculum. This can include an area of professional practice that may be trusted to a learner to execute unsupervised, once he or she has demonstrated the required competence. An examination is an example of an individual assessment test.

11 Assessments need to:

- identify learners who have not demonstrated the expected level of performance, attainment or achievement needed to progress in or complete training

- give learners appropriate opportunities to receive timely feedback that provides a basis for action, so that they can understand what is expected at their level of practice and provide them with evidence and guidance as to how they can act to improve their performance and continue to develop. As well as reaching minimum standards for safe competent practice, learners should be encouraged and have the opportunities to excel at all stages and levels of training.

What's new in this guidance?

Programme of assessment

12 A programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the approved curriculum. The programme of assessment should include the overall assessment philosophy, the assessment strategy and practical operational aspects such as guidance to assessors and expected levels of performance.

13 The programme of assessment is likely to be comprised of several different individual types of assessment. These may include national examinations, summative assessments, assessments in practice and formative or developmental assessments such as supervised learning events. The choice of methods relates to what learning outcome is being assessed and why, and the consequences or importance of the assessment being performed. A range of assessments may be needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, must be linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

Safe management of critical progression points in training

14 Critical progression points are points of increased training risk must be identified and safely managed through the requirements, assessments and guidance set out in the approved curricula and programme of assessment.

15 These critical progression points will include when transitioning to higher levels of professional responsibility or entering a new or specialist area of practice or when a trainee is being considered or deemed to have satisfactorily completed the programme of training.

16 As well as progression at critical points, ensuring that learners receive annual review of their progress and performance is also required.

Greater emphasis on validity

17 Validity is seen as the key consideration in current assessment theory (Health Professional Assessment Consultancy (HPAC) 2016). We define validity as 'interpretations and uses of tests that make sense and are supported by appropriate evidence' (adapted from Kane 2013:3). A detailed description of validity theory is provided in HPAC's report.

Assessment strategy based on the validity model

18 HPAC (2016:11) note this approach means that organisations that award qualifications (such as those leading to a certificate of completion of training (CCT)) are required to 'provide evidence that their awards are granted to individuals who have achieved defined recognisable standards in the various domains of competence'. Validity theory identifies three stages in this process.

- Purpose: setting out of the explicit purpose of particular assessments, clearly communicating their contribution to the wider programme of assessment and

decision making process particularly in relation to progression and satisfactory completion of training (what is being tested and why) (covered in part 1)

- Evidence: collecting five key types of evidence about the assessment or programme of assessment:
  - the choice, content and format of assessments – are the assessment methods that have been chosen appropriate for the declared outcome being assessed? (covered in part 1)
  - the practical conduct of the assessment, eg whether those assessing and being assessed understand what they are required to do or demonstrate, or whether exams are scored or conducted correctly and effectively (covered in part 2)
  - the internal structure, incorporating issues including the psychometric performance of a test – eg is an examination sufficiently reliable, for example? (covered in part 2)
  - the relationships between different assessments within the programme of assessment – do assessments that intend to test similar things do so in practice? Are they all necessary, what particular value do they add and why? (covered in part 2)
  - the consequences – describing the consequences of the assessment, and how decisions made using assessments are defensible. Decisions should be consistent, defensible and fair to doctors in training and provide appropriate assurance about the safety and quality of their practice (HPAC 2016). The consequences of a decision will affect the evidence needed to support it; more impactful decisions will need more robust evidence (Kane 2013). (covered in part 3)
- Argument: bringing the evidence together to argue that assessments are valid for their intended purpose.

19 This approach should form the basis of the planning, conduct and management of assessment, and be used to carry out quality review and improvement of the assessment. HPAC (2016:12) note that this includes the information provided to learners and the information and training provided for those assessing.

Outcomes-based curricula

20 *Excellence by design*, our standards for curricula, requires all postgraduate curricula to describe appropriate high level outcomes as generic, shared and specialty-specific professional capabilities. Outcomes-based curricula focus on what kind of capabilities doctors will have upon completion of the programme rather than the process by

which these capabilities are achieved (Harden et al 1999). Doctors are required to demonstrate complex knowledge and skills, but (good) doctors are defined by much more than this. Training programmes should ultimately aspire to assess and evidence a learner's overall performance and professional capabilities.

Incorporating *Good medical practice* and the *Generic professional capabilities framework* as generic outcomes in the programmes of assessment

21 In the standards, we require organisations to develop outcomes-based curricula containing high level generic, shared and specialty-specific outcomes. The expectations of doctors outlined in *Good medical practice* and the *Generic professional capabilities framework* must be included in all postgraduate medical curricula as minimum regulatory requirements of training programmes.

The importance of professional judgement in all assessments

22 The guidance emphasises the importance and centrality of professional judgment in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors must use their professional expertise and experience. Through their understanding of the expected levels of performance, they must make accountable, professional judgements as part of a valid programme of assessment. A coherent and integrated *programme of assessment* will include how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

College and faculty responsibilities for administration and conduct of assessments

23 The quality of administration and governance is part of an assessment's validity. We describe colleges' responsibilities for:

- quality managing the assessments they carry out themselves; they will also have a role in
- supporting and enabling the quality of assessments carried out locally by issuing appropriate guidance about assessment methods, decision aids and specialty-specific expected levels of performance at different stages or critical progression points in training.

Flexibility

24 Our curriculum standards allow for greater flexibility in the way assessments are designed. Those designing a programme of assessment will need to describe what informed their choices and how these considerations support the overall validity of the programme of assessment.

Part 1: Designing programmes of assessment

Setting out the purpose of the programme of assessment

Excellence by design: Theme 1, CR4.1a, CR4.1b, CR4.2, CR4.3, CR4.4

This section relates to validity theory requirements that organisations need to set out the purpose of a programme of assessment as a whole and its individual components.

Key issues in this section

Ref	Key issues for consideration
CR4.1a **CR4.1b**	What capabilities and kind of doctors are you aiming to produce? What is their scope of practice and level of performance? How does the programme of assessment help to achieve or confirm these objectives? Where is this written down? What are the underlying principles and purpose of the programme of assessment? Does each assessment within the programme of assessment have a clear purpose in relation to the curricular outcomes? Is it clear what methods will be used to assess and when? How do they relate to critical progression points? Is the choice of methods and timing supported by a clear rationale, support, research or informed practice?
CR4.3	How does the programme of assessment aim to capture the doctor's professional development towards achieving curricular learning outcomes over time? How is longitudinal development intended to be captured in assessment? Where and how is global judgement of a learner's overall performance made? What is the format of the test (numbers/length/scoring)? How was this decided?
CR4.2	How is underperformance by learners identified, and what is the approach to its management? Are their decision aids or guidance frameworks? Can learners who aren't making progress be identified? What happens to them then?
CR4.4	What are the equality considerations of your choices?

Ref	Considerations for approvals or quality assurance
CR4.1a	■ Clear articulation of desired purpose of each element of an assessment, and indication that this has informed choice of format to ensure validity
CR4.1b	■ Assessment strategy document clearly presenting the identified purpose of each assessment element in relation to one another and in the context of the wider curricular learning outcomes. Identification of the role each summative assessment plays in progression decisions and satisfactory completion of training
CR4.3	■ Systematic approach to identifying each area or level of attainment required prior to critical progression points or for satisfactory completion of the training programme (documented and highlighted in a matrix/overarching blueprint) ■ Systematic approach to consistently identifying discrepancies between learners' performance, behaviour and attainment of expected levels of performance across different components of the programme of assessment

Guidance

Assessing outcomes using a programmatic approach (CR4.1b)

25 A programme of assessment is designed to demonstrate that a learner has met the learning outcomes of the approved curriculum. Since most outcomes are not confined to one-off assessments (Schuwirth and van der Vleuten 2011), assessments should be part of an integrated programme of assessment that gives learners multiple opportunities for feedback and development, and to demonstrate the required outcomes over the course of their training.

26 A programme of assessment must have a clearly stated overall purpose in relation to the curriculum and must clearly state the purpose of its individual assessment components, setting out the range of different assessments that can contribute different evidence to support overall judgements about performance and decisions about progression and satisfactory completion of training.

27 This means organisations will need to plan their programme of assessment (not just examinations) as an integrated, interdependent, programme to show doctors have achieved the relevant learning outcomes at appropriate stages of training. Programmes of assessment should be synoptic in design, asking learners to integrate learning from across the programme, applying 'their skills, knowledge and understanding with breadth and depth' (Plymouth University, undated).

Designing a strategy as a basis for a programme of assessment (CR4.1b)

28 An organisation should take a structured, coordinated approach to the design and development of its programme of assessment and communicate these in the form of an assessment strategy. This will be required to demonstrate that the programme of assessment meets the standards set out in *Excellence by design.* The fundamental principles and practical considerations must be assembled into a coherent strategy that demonstrates how judgements made throughout the programme of assessment can be used to justify that learners can be deemed to have safely and competently completed the approved programme of training.

29 Specifically, the overall assessment strategy should set out how organisations have made sure:

- assessments contribute to enabling safe, high quality care for patients
- all learners have opportunities to develop and improve their performance from feedback to achieve the approved learning outcomes
- the assessment approaches adopted afford all groups of learners a fair opportunity to develop or demonstrate they have achieved the required learning outcomes (subject to patient safety considerations)
- learners who have not met curricular outcomes are identified and there is a clear approach as to how they should be managed.

30 In adhering to these high-level principles, the assessment strategy document should clearly articulate:

- the purpose of each assessment and how this is ensured in the selection, development and validation of the format chosen
- the combination of assessment methods that are to be used to test each part of the curriculum, and why they are appropriate and proportionate to what is being tested
- standard setting principles and approaches in the context of expected levels of performance
- the way assessments provide, in conjunction with one another, the required information to contribute appropriately to important decisions regarding progression within, and completion of, training.

31 The assessment strategy document does not require exacting detail for each assessment, but should give an overview of the programme as a whole and where and how critical progression point decisions should be made, highlighting key principles such as safety, expected levels of performance and scope of practice and

responsibility. We anticipate a wide range of approaches will be acceptable if supported by appropriate evidence, and a clear compelling narrative.

Making decisions at critical progression points within the programme of assessment (CR4.3)

32 The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time (see also AoMRC 2016).

33 Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. Current annual reviews of progression (ARCP) processes can support the collation and integration of evidence to make decisions about the achievement of expected outcomes.

34 Assessments such as entrustable professional activities-type formats also involve looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of modules or defined areas of practice within curricula.

35 To put this into practice, organisations will need to:

- provide clear performance criteria and acceptable evidence at each critical progression point against which summative decisions and judgements can be made. Decision aids or flow diagrams may assist this process as will guidance describing expected or inadequate levels of performance

- match assessments to appropriate points in the curriculum. In structuring programmes of assessment organisations should consider:

  - identifying how learners are expected to progress through the curriculum; we anticipate the latter stages of the programme of learning will include assessments that integrate complex evidence to reflect the increasing complexity and capability of those in training. The importance of making global judgements about overall performance and safe progression should be the guiding principle

  - describing what outcomes learners should have already demonstrated and to what level, and with what degree of confidence or reliability

- the overall balance and assessment load placed on learners, faculty, organisations and patients.

36 Some examples of approaches to structuring assessments organisations may find helpful to use, adapt or combine are:

- HPAC's programmatic assessment case study (2016)
- the portfolio approach to a curriculum module described in Roberts et al (2014)
- the approach developed by the Association of American Medical Colleges (2014) which is concerned with a learner's trustworthiness to complete clinical tasks that integrate different skills and knowledge independently (ten Cate 2013).

37 The choice is not limited to these approaches but decisions and choices should be set out and clearly justified in the assessment strategy and supporting documentation.

Linking curriculum content and assessment

Excellence by design: CR4.1d-e

This section discusses elements of the first domain of evidence set out in validity theory, which looks at evidence in relation to content and format decisions about assessments.

Key issues in this section

Ref	Key issues for consideration
CR4.1d	How do you make sure those completing training meet our regulatory requirements in relation to demonstrating the generic outcomes? How do you embed *Good medical practice* and the generic professional capabilities throughout your curriculum or assessment programme? Can the college or faculty demonstrate that the learning outcomes and assessments have been clearly linked through blueprinting to the approved curriculum, and is the blueprint used as a basis for the programme of assessment? How are the expected levels of performance determined and what should they be at critical progression points in and for satisfactory completion of training? Examinations ■ How do you map the programme of assessment to the learning outcomes? ■ How do you choose and develop items relevant to assessment blueprint domains? (HPAC 2A.1-3) Assessments at work ■ How do you map the skills required by the assessment task to learning outcomes? (HPAC 2B.1) ■ How are the results intended to be used?
CR4.1e	With respect to the curricular outcomes, how are the assessments of skills, knowledge and capabilities balanced and demonstrated at the appropriate level throughout the programme of training? What are the critical progression points in training? What will ARCPs be required to demonstrate?

Ref	Key issues for consideration
CR4.1d **CR4.1e**	How do you make sure the programme of assessment continues to reflect the curricular purpose and outcomes? How are decisions about assessment made with appropriate oversight and input from those responsible for the curriculum? What structures make sure that those responsible for curriculum design and development have appropriate oversight and input into all aspects of the programme of assessment?

Ref	Considerations for approvals or quality assurance
CR4.1d	■ Blueprinting grid for each assessment element reflecting the organisation of the relevant syllabus (informed by the organisation of the curriculum), with sample population showing the division of labour between different formats used where applicable ■ Multi-dimensional approach to blueprinting, demonstrating how different domains within each area or module of the curriculum are covered by a given assessment (single clinical topic assessed with regard to basic science, management, investigations, communication etc) ■ Overarching assessment blueprint identifying what is assessed by which method in the context of the curriculum modules; clear identification of what is required by way of attainment in such a context for satisfactory progression or completion of training
CR4.1e	■ Syllabus for each assessment clearly organised with reference to the organisation of the curriculum and linked to learning outcomes at each critical progression point so expected content or performance and standard is clear and progress can be monitored

Guidance

38 Our standards require programmes of assessment to be based on the curriculum, and must reflect the themes, duties and responsibilities described in *Good medical practice* and the *Generic professional capabilities framework*. As such organisations need to make sure that:

- curricula describe the generic, shared and specialty-specific learning outcomes required for satisfactory completion of the programme of training and that must be demonstrated at critical progression points within that training

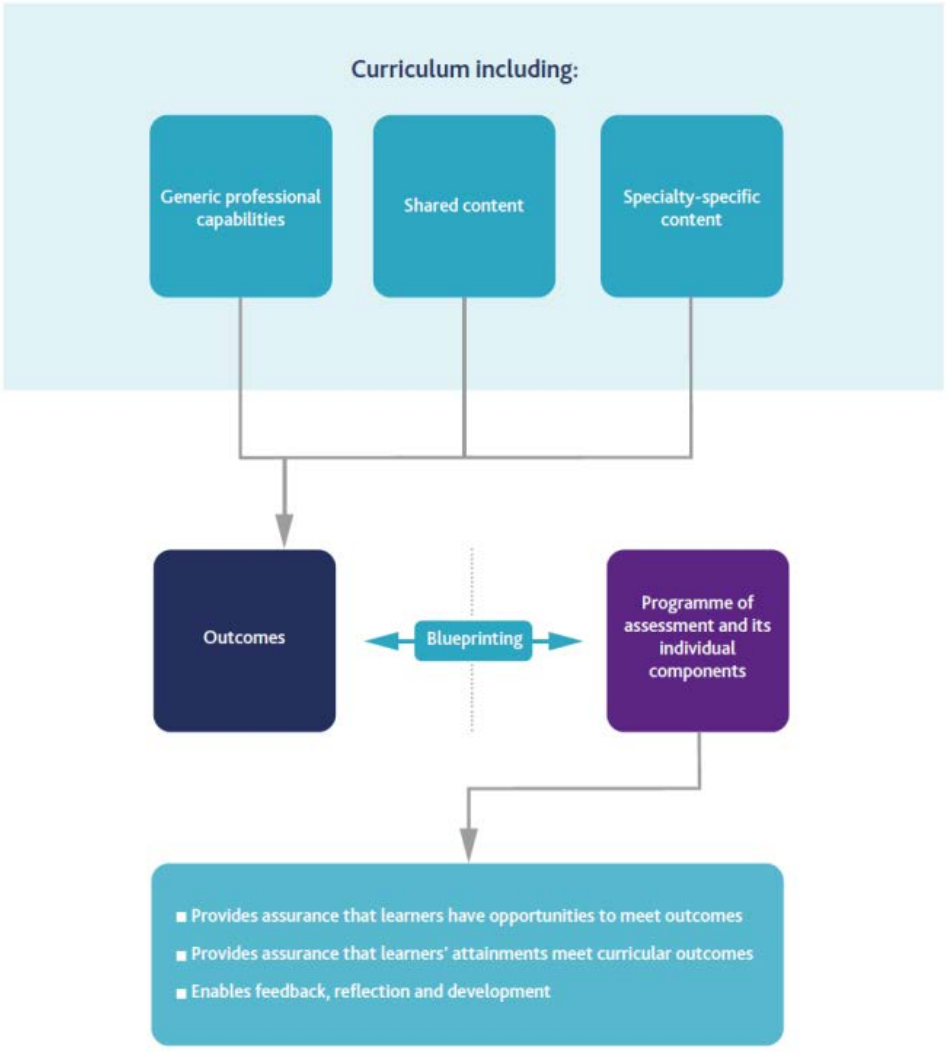
- generic, shared and specialty-specific learning outcomes are linked to and demonstrated through evidence gathered throughout the approved programme of assessment

- the programme of assessments, the individual items within it and the content and format are derived exclusively from the content of the approved curriculum.

39 To make sure this is the case, those that are responsible for the curriculum should be closely involved in the development of the programme of assessment and those involved in assessment should be familiar with the curriculum; assessment developments should not be carried out independently of the curriculum requirements.

40 A blueprint is a template, table or matrix that provides the evidence that learners are judged against the stated learning outcomes of the approved curriculum. The generic, shared and specialty-specific outcomes of the curriculum provide the framework for the design, planning and evaluation of the programme of assessment.

Assessment should link to curriculum through a coherent strategy and blueprint



41 Blueprinting is a key exercise for developing the evidence to support the validity of an assessment (Coderre et al 2009). A blueprint specifies which assessment method is used to assess each learning outcome; it is also used to describe how the content of an exam should be chosen. It may also show the stage of training or critical progression points at which outcomes are assessed, and how content may be sampled across different assessments over time. Blueprinting of assessments against the curricular learning outcomes is essential in taking a systematic approach to the design of the programme of assessment; this is sometimes referred to as mapping.

42 As well as this overarching blueprint for the programme of assessment, individual tests should also have a blueprint showing how curricular content will be covered and sampled in the individual assessment.

43 Organisations may also design systems to collate and aggregate various low stakes assessment (including assessments at work) and provide evidence of coverage of outcomes (for example, see Maastricht case study in HPAC 2016). To do this, organisations need to provide a range of assessments mapped to curricular outcomes which can be completed, captured and used to demonstrate the spread of assessments completed by the learner, and provide a process by which the spread of assessments completed is reviewed against the criteria required for progression or satisfactory completion.

44 Failing to reflect changes in the curriculum within the programme of assessment will compromise the purpose and validity of the assessment system. For this reason, changes to the format, content, rules, standard or structure of assessments should not be made without appropriate oversight, involvement and agreement of those responsible for the curricula and vice versa. Similarly, blueprints must be kept up to date and reflect the approved curricular content and learning outcomes. Organisations should be able to describe why any standalone changes to the assessment system are required and be able to describe how the programme of assessment continues to meet the needs of the curriculum (or why it will be unaffected by the change, if the change is purely a technical assessment issue).

Content decisions: formative and summative

Excellence by design: CR2.4, CR4.1h, CR4.2, CR4.8

This section discusses elements of the first domain of evidence set out in validity theory, which looks at evidence in relation to content and format decisions about assessments.

Key issues in this section

Ref	Key issues for consideration
CR4.1h	Where are summative decisions made about whether learners have achieved the stated outcomes? How are the different kinds of assessment reflected in blueprints and assessment strategies? What are the formative or developmental assessments?
CR4.2 **CR4.8**	How are feedback, improvement and remediation incorporated into your programme of assessments? What are the expectations regarding feedback for those conducting assessments locally?

Ref	Considerations for approvals or quality assurance
CR4.8	■ Feedback integrated into assessments at work, with sufficient prominence afforded to this in the case of formative assessments ■ Routine feedback provision with summative assessment results to enable unsuccessful candidates to identify and target specific areas of development prior to their next attempt at that examination or assessment ■ Routine feedback provision with summative assessment results to enable successful candidates to improve their performance ■ Routine feedback provision with summative assessment results to enable successful candidates to improve their performance
CR4.1h	■ Assessment clearly framed as summative by explicit contextualisation with regard to a critical progression point or stage of training and inability to progress without successful completion; role of such decisions in relevant ARCP processes identified. Mandatory nature of expected levels of performance to progress and relevant limits on number of attempts clearly identified ■ Clear identification of formative and summative elements, along with how each part of the programme of assessment contributes to decisions regarding progression with training

Ref	Considerations for approvals or quality assurance
CR4.2	■ Routine feedback provision to enable unsuccessful candidates to identify and target specific areas of weakness prior to their next attempt at the examination ■ Clear information for trainees regarding sources of guidance and support where difficulties are encountered in passing relevant assessments ■ Clear information regarding rationale and detail of the relevant attempts limit and any requirements or conditions for extra attempt(s) beyond this
CR4.2	■ Process in place for examiners to identify potentially dangerous practice demonstrated by candidates within the context of an assessment ■ Feedback sufficiently instructive to identify occasions on which an unsuccessful candidate is some way below the minimum standard required, either in specific domains/syllabus areas, or in the assessment overall to ensure appropriate and timely remediation
CR2.4	■ Clear information regarding the overall assessment system and its constituent parts available in the public domain

Guidance

45 Programmes of assessment combine several functions (see paragraph 26 above). Individual types of assessments within the programme may have a range of purposes, such as:

- identifying or developing an individual's strengths and weaknesses (CS4.6, CR4.3) to plan future learning, career guidance, remediation and professional development
- providing opportunities for reflection
- enabling key capabilities to be developed further through formative or developmental assessments particularly when outlining expected levels of performance or in the promotion of excellence
- demonstrating (partly or wholly) the achievement of curricular outcomes at critical progression points and preventing the progression of those who have not achieved them
- demonstrating achievement of the expected level of performance and in determining satisfactory completion of training.

46 The purpose of an assessment in relation to both its immediate objective and the role it plays more generally within the programme of assessment must be clear to learners and assessors. A lack of clarity regarding the purpose of an assessment can serve to undermine its validity by compromising the extent to which this purpose is understood and achieved.

47 All assessments should, as far as possible:

- generate effective feedback, from assessors with the right expertise and/or experience, and with appropriate training where required
- prompt the learner to consider their own performance and development needs
- result in the learner taking action and provide evidence of that action (eg through a further formative assessment or in the course of supervision).

48 As part of the requirement for curricula to make sure learners get appropriate developmental feedback, organisations should provide assessments at work that are primarily formative in nature. Dedicated advice on improving the quality of feedback is given by AoMRC (2017).

49 Formative assessments should:

- require and enable interaction between learners, assessors, teams and patients
- be chosen or led by the learner or a trainer to gain experience of, feedback about or insight into one or more areas of the learner's performance.

50 Feedback from these formative assessments can be used to identify issues of engagement, professional development or serious underperformance, which can be communicated to those responsible for training programmes. In prioritising learning and feedback, such assessments should not require learners to demonstrate that they can progress; rather, the standard required to progress may be used as a benchmark to guide discussions, comment upon attainment and plan future learning and development.

51 Feedback from numerous small formative assessments can be monitored, collated and reviewed periodically to give a rounded view of the learner's performance and improvement over time. This can in turn enable reliable holistic judgement to be made about suitability for progression, eg at annual review (ARCP) (see HPAC 2016 case study, van der Vleuten et al 2012).

52 Organisations should also provide summative assessments and processes which:

- demonstrates that the learner has acquired (and maintained) knowledge and skills as required by the approved curriculum (eg knowledge or clinical exams, logbooks, assessments of practice)

- enables management of learners who do not demonstrate expected levels of performance, including providing further assessments to gain further evidence (for more information, see the AoMRC's guidance on implementing generic professional capabilities)

- give information on a learner's ability to practice safely within a defined area or aspects of it with progressive levels of supervision and accountability (multi-source feedback (MSF), supervision reports, portfolios, entrustable professional activities (EPAs), some assessments of practice)

- synthesises the range of assessment data at critical progression points to consider the overall performance of the learner and to make summative decisions and judgements about whether they are performing to the level expected/whether they are making acceptable progress towards achieving curricular outcomes. This is consistent with the approach in which assessments are neither formative nor summative but have different stakes attached (see Maastricht case study in HPAC 2016). Underpinning this should be:

    - clear information on the use of assessments for learners and assessors

    - a defensible process for collation and synthesis of this evidence, supported by guidance and decision aids to enable synthesis and decision making; currently this is provided through ARCP.

Evidencing format decisions: acceptability, feasibility, cost effectiveness

Excellence by design: CR2.5a-f, CR4.1b-c, CR4.4

This section discusses elements of the first domain of evidence set out in validity theory, which looks at evidence in relation to content and format decisions about assessments.

Key issues in this section

Ref	Key issues for consideration
CR2.5 a-f **CR4.4**	How are the stakeholders of an assessment included or represented in the design process? What do you know about the experiences of different stakeholders, and especially different groups of learners? How were learners, supervisors, deaneries/Health Education England (HEE) local offices and local education providers, patients and the public involved in the development of, or change to, assessments (where appropriate)? What equality and diversity considerations were identified? How did they influence the outcome?
CR4.1b **CR4.1c**	How are you assured that assessments will function as intended in practice? Do new or modified assessments require piloting to determine their feasibility or reliability in practice? If so, what does piloting show? What other information did you gather about putting assessments into practice? What resources and guidance are required to implement the programme of assessment? How are patient safety and quality of care prioritised in assessment design? How do you decide that an assessment is safe to use? What rules or processes ensure safety?

Ref	Considerations for approvals or quality assurance
CR4.1b	■ Assessment strategy document clearly presents the identified purpose of each element in relation to one another and in the context of the assessment's outcome. Identification of the role each summative assessment plays in progression decisions within the broader training programme
CR4.1c	■ Details of pilot structure and outcomes (include metrics where appropriate) for proposed new assessments ■ Details of pilot participants (prospective candidates or past candidates of the live assessment) ■ Evidence of routine monitoring in the inclusion of new questions whilst ensuring that reliability of the assessment is not compromised
CR4.4	■ Equality and diversity considerations in assessment material development

Guidance

53 Assessments should be developed with input from those responsible for carrying them out and subject to them (R2.1–3). Ensuring feasibility and acceptability to assessors and doctors in training is a priority in assessments at work (AoMRC 2009, 2016), as is ensuring the environment has the capacity to deliver the assessment. Organisations could demonstrate this in a number of ways:

- Using (or establishing) groups which involve trainers, employers, learners and patients to understand what is likely to work in practice or not. This should be proportionate, and many organisations will already have structures for this.
    - We recommend including the service in the development of the assessment to ensure feasibility in the learning and working environment.
    - It is desirable to include a diverse range of stakeholders who share protected characteristics in such groups; different groups of learners are likely to have different experiences of undertaking assessments, which can affect the outcome. Taking steps to understand these experiences and include them in the process of producing these assessments may help organisations to understand and address the possible impacts of assessments.
- Identifying the resource required and the capacity of the environment to deliver them.
- Planning the programme to be cost effective and efficient in sampling and evidencing the approved curricular learning outcomes.

- Piloting or trialling new developments if feasibility is questionable or if practical experience of delivery is required.

54 Organisations should gather evidence that equality and diversity issues have been properly considered and have influenced the outcome. Organisations and institutions need to be able to demonstrate that, wherever it was relevant to do so, they considered equality and diversity issues pertinent to the work they undertook (eg through data collection, impact assessments and equality analyses).

Part 2: Managing programmes of assessment

Evidencing content quality: setting up structures to ensure the quality of assessment

Excellence by design: CR2.5a–f, CR4.1g, CR4.5, CR4.6

This section discusses establishing quality management and improvement structures and processes to collect and analyse performance data against all the evidence domains described in the model of validity theory. Specifically it discusses in detail:

- elements of the second domain of evidence in validity theory, which is concerned with the conduct and administration of assessments, including supporting information to all those involved
- elements of the fourth domain of evidence in validity theory, which is concerned with the relationships between assessments testing similar things.

Key issues in this section

Ref	Key issues for consideration
Quality structures	
CR2.5 a-f **CR4.5**	How are stakeholders, including learners, patients and the public, involved in the oversight of assessment? How is the programme of assessment reviewed and continuously improved? How do structures make sure the review and management of assessment is carried out with appropriate input from or links to the curriculum? How do structures make sure curricula changes are reflected in assessment approaches and the wider programme of assessment? How do you make sure the quality of assessments and items produced? What checks and review of assessments are made?
CR4.6	Does comparing assessments with other assessments that purport to measure similar things assure you that assessments are measuring what they intend to measure? What does this tell you about the validity and balance of assessments within the programme of assessment?

Ref	Key issues for consideration
Managing exams and assessments in the learning environment	
CR4.1g **CR4.5**	How do you quality control all stages of the production of assessments and assessment items, and review and manage the quality of exams? How do you check the marking or moderation of the exam for accuracy and quality? What safeguards make sure responses are accurate? How do you systematically analyse learner responses to review and check assessment question phrasing and brief to learners?
CR4.1g **CR4.5**	How do you support the local conduct of assessments or organisations that carry out assessments locally? What training, guidance, rules, decision aids or other resources do you give to support deaneries/HEE local offices and assessors to conduct assessments, understand the expected level of performance or make decisions? What information or processes can you use to support the identification of issues and improvement of local practice? How do you identify where design changes and additional support or information are necessary?

Ref	Considerations for approvals or quality assurance
CR4.1g	■ Evidence of quality assurance infrastructure, with processes drawing on appropriate expertise to identify and manage issues and resolve these appropriately
CR4.5	■ Systematic monitoring of assessment performance metrics including: reliability coefficients, standard errors of measurement (SEMs); pass rates; examiner marking behaviour; ARCP outcomes with regard to assessment outcomes ■ Periodic review of guidance material in the public domain; feedback from relevant stakeholder groups regarding need for necessary updates
CR4.6	■ Regular reporting through annual specialty return and the GMC quality assurance framework

Guidance

Quality structures

55 Organisations must subject their programme of assessment to systems and processes that continually monitor and improve the validity (including reliability) if their assessments. Organisations must have processes to quality control all stages of assessments they deliver themselves (such as national knowledge based exams) and specific guidance and expectations to support those conducted by others.

56 A common issue across medical education is difficulty collecting equality and diversity data about learners. Given the importance of collecting equality data as part of the management of assessment, organisations may wish to consider what information they can provide (in addition to legal notices) to explain to learners the importance of equality and diversity data in manging the programme of assessment, citing examples of its use where appropriate.

Managing the ongoing quality of assessment designed and delivered by organisations (usually exams)

57 The validity of assessments depends on their practical conduct and management as well as their design. Assessments designed and delivered entirely by organisations, such as national exams, require appropriate quality management at all stages. Organisations:

- are obliged to carry out quality control of the scoring and judgements of examiners
- must make sure assessments have been scored and reported accurately and fairly
- must have processes to check for and identify errors in administration
- should take steps to prevent and detect instances of potential or actual malpractice.

58 Software packages to process assessment data are widely available and can help to minimise clerical and processing errors; we encourage organisations to use technology to manage assessment data for this reason. Staff should have sufficient expertise to use this software appropriately and be able to identify where errors in the use of, or calculations made by, this software have occurred.

59 Organisations should also:

- publish information about the performance of their exams (see appendix 1 for a suggested publication scheme) (CR4.8)

- routinely analyse (and publish) them for trends related to protected (and other relevant characteristics) (see appendix 1 for suggested analysis)
- use information from routine analysis to continuously improve their assessments; an example may include conducting item analysis to improve reliability of exams (eg Auewarakul et al 2005)
- investigate anomalies and act to address risks to fairness or safety identified
- report any such concerns to the regulator if they are serious or systemic.

60 Bodies within the organisations should routinely review and report on the overall patterns shown in assessment and consider what issues these raise. This should include analysis of results for equality and diversity issues (Coombes et al 2016), and the identification of performance differentials between different groups.

Managing the ongoing quality of assessment – conducted in the learning environment

61 Assessments conducted in the learning environment, particularly formative or developmental assessments, need an environment and culture that values and supports education and training. The quality and conduct of these assessments are the responsibility of organisations providing training. These organisations are subject to our *Promoting excellence* standards. Monitoring and maintaining the quality of these assessments, when conducted, should be an explicit consideration in their design and development (see *Promoting excellence* standard 1.2). Organisations and deaneries and HEE local offices need to work together to make sure curricular and professional standards are maintained. This may include gathering information to:

- take steps to provide or improve guidance for those using and providing assessments
- engage with those using and providing assessments
- improve the design of assessments conducted in the workplace
- support deaneries' and HEE local offices' quality management, helping them in continuously improving their conduct of assessment (where appropriate and possible).

Managing the programme of assessment as a whole

62 Collating the results of different assessments together enables integrated judgements about a trainee's overall performance. Organisations should:

- where possible, provide evidence that assessments are valid by reference to other assessments that assess similar things

- optimise and minimise the assessment load by establishing the relationships between assessments and eliminating unnecessary repetition of testing, balancing this with the need to triangulate judgements

- where possible, make this information available to learners and supervisors so that a longitudinal view of an individual's strengths and weaknesses can be formed.

63 A benefit of using a programme of assessment is that a balanced view can be taken of the need for testing across the length of training. Evidence of validity of individual assessments can also be collected through looking at the relationships between results of different assessments that aim to test similar things (HPAC 2016); for example showing 'a strong positive correlation with some other measure of the same achievement or ability' and no/negative correlation with assessments of different outcomes (Downing 2003:835). High level outcomes are likely to be demonstrated by a range of assessments over time, so some degree of congruence between different assessments of similar or the same outcomes may be useful to show that the outcome has been demonstrated by the trainee.

Setting out expectations: learners

Excellence by design: CR2.4, CR4.1g, CR4.2, CR4.4

This section discusses elements of the second domain of evidence in validity theory, which is concerned with the conduct and administration of assessments, including supporting information to all those involved.

Key issues in this section

Ref	Key issues for consideration
CR4.1g **CR4.2**	How do you make sure educators and learners have enough information about assessment to respond to it in the way intended in the design? How are learners informed about the role of formative or developmental assessments in the programme of assessment? What information is given to learners about the intended purpose of specific assessments? How can communication to learners around what is expected be improved? How are learners familiarised with assessment formats? Is the grading or mark sheet (or a variation of it) or expected level of performance shared with learners prior to the completion of the assessment? If not, why not? How are learners informed about the feedback and development they can expect to receive from all parts of the programme of assessment?
CR4.4	What kind of support do you offer to different groups of learners (eg international graduates, those in need of reasonable adjustments)? Do you mandate, support or suggest particular actions for those delivering assessments on your behalf? Do you provide clear guidance material for assessors? How are reasonable adjustments and appeals dealt with? What is the process for handling complaints? How is this information communicated to learners?

Ref	Considerations for approvals or quality assurance
CR4.1g	■ Evidence of quality assurance infrastructure, with structures and processes drawing on appropriate expertise to identify and manage issues and resolve these appropriately. Presentation of this infrastructure to all stakeholders to offer appropriate transparency of processes, including the ability to appeal outcomes ■ Clear identification of assessment context, content (syllabus) and standard against which candidates will be assessed, with reference to the relevant critical progression point where applicable ■ Sample questions for each format available in the public domain
CR4.2	■ Clear information for trainees regarding sources of guidance and support where difficulties are encountered in passing relevant assessments
CR2.4	■ Clear information regarding the overall assessment system and its constituent parts available in the public domain
CR4.4	■ Reasonable adjustments policy in the public domain

Guidance

64 An effective programme of assessment depends on learners being aware of what is expected from them. Learners should have information to help them understand:

- how they can use the programme of assessment to drive and plan their own learning and development
- what feedback they can expect to receive from their assessments
- why they are being assessed
- what skills, knowledge, behaviours and capabilities they are expected to develop and demonstrate to satisfactorily complete training
- the relationship between assessments
- what are the critical progression points and expected levels of performance at different phases of training
- what assessments are summative or enable progression and which are formative or developmental, and how critical progression decisions are made

- the processes for appeals in summative exams, reasonable adjustments and similar should be clear and transparent.

65 The responsibility for communicating about these issues with learners is shared with deaneries/HEE local offices, as part of their responsibility under *Promoting excellence*. Organisations will need to make resources available to communicate the purpose, format, rules and decision making process to learners depending on the individual assessment and how it impacts upon the programme of assessment. Organisations designing assessments at work should work with those putting them into practice to give all relevant information to learners.

Setting out expectations: examiners and assessors

Excellence by design: CR4.1g, CR4.4, CR4.9, CR4.10, CR4.11, CR4.12, CR4.13

This section discusses elements of the second domain of evidence in validity theory, which is concerned with the conduct and administration of assessments, including supporting information to all those involved.

Key issues in this section

Ref	Key issues for consideration
CR4.1g **CR4.9**	What are the organisation's expectations for assessors and examiners in each assessment? What information is given to assessors and examiners about assessments they work within? How can communication with assessors and examiners around what is expected be improved? How is understanding of the standards required developed across all assessors and examiners involved? (HPAC 2B.5)
	Who can act as an assessor or examiner in what circumstances? What are the particular requirements for particular roles? Where is this set out? Which of these roles requires formal selection and how is this done?
	Which roles require particular training or experience, and why? What is the content of the training? How is this training managed, organised and delivered?
CR4.4 **CR4.10** **CR4.11** **CR4.12** **CR4.13**	How are assessors or examiners able to use their judgement and experience in decision making and providing feedback? Do they understand their equality and diversity responsibilities? What monitoring, appraisal, feedback and support do your assessors receive?

Ref	Considerations for approvals or quality assurance
CR4.1g	■ Appropriate guidance provided to examiners about their role within assessment material in addition to provision through briefing and subsequent calibration processes
CR4.13	■ Equality and diversity training requirement for examiners, and, where appropriate, other assessors, outline content of training
CR4.10	■ Role description and person specification for assessors and examiners respectively ■ Selection policy available for the appointment of new examiners ■ Outline content of examiner training programme ■ Clear communication of annual time commitment expected of examiners
CR4.11	■ Calibration of examiners integrated into routine examination schedule ■ Calibration includes material-specific discussion where a station is marked by more than one examiner, in addition to overview of expected standard, with reference to the role played by summative assessment within the training programme, undertaken with all examiners prior to each examination diet ■ Feedback provided to examiners in the form of peer observation or marking data
CR4.12	■ Guidance for examiners included in marking scheme or, where global judgements are applied to generic domains, station-specific guidance included in the assessment material to inform judgements
CR4.13	■ The need for initial training (and subsequent training, where applicable) stipulated and includes equality and diversity training

Guidance

66 Organisations are already required to set out requirements for those who work directly for them in their exams (examiners), and should take steps to support the conduct of assessment in the workplace through setting out clear requirements and providing support, guidance, training and resources as appropriate. These should be provided for every stage in which assessors or examiners are involved, including in item writing, standard setting and the conduct of specific assessments.

Professional judgements

67 Assessment literature sees professional judgement of appropriately trained, expert assessors as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance (HPAC 2016, Street 2015). Assessment tools are available that can capture and integrate a range of professional judgements from different groups including colleagues, supervisors and non-medical staff. HPAC (2016) advises that expert judgement can be applied to decisions about levels of supervision or entrustment and that the concept of trust can be helpful in supporting assessor decisions and feedback. Methods that can give this evidence include:

- multi-source feedback
- entrustable professional activities and other assessments at work
- supervision reports.

Supporting professional judgement in examinations and assessments at work

68 Research on differential attainment has found that interpersonal interactions and local context can potentially put some groups at a disadvantage (Regan de Beere et al 2015, Woolf et al 2016). Professional judgements are made in this context so it is important that assessments take place fairly and reliably. Organisations can support this by:

- the design of assessments, specifically:
  - designing assessment programmes that collate multiple judgements and assessors when using professional judgements
  - setting out clearly what criteria professionals should judge against
  - using formats that require or encourage assessors to record evidence and provide reasons for their judgements where appropriate.
- the choice of assessors, specifically:
  - defining what professional expertise is needed for in each assessment and when or if particular training is required. This should not unduly restrict the range of assessors that can be used, but where particular professional qualifications, experience, credibility or training is necessary, this should be clear
  - encouraging diversity amongst decision makers (Woolf et al 2016); for example attempting to recruit a diverse cohort of examiners and standard setters

- considering how patient feedback can be used eg:
    - giving opportunities for learners to obtain formative feedback from patients
    - considering the evidence base for using (simulated) patients in summative assessments practical examinations.

- training and supporting assessors, including:
    - providing information and training for assessors where appropriate, including their responsibilities in safeguarding patients and the public, and refreshing training periodically
    - providing resources such as decision aids to those who make such judgements (eg considering when and what training or guidance is needed) to make sure they understand their role and how to keep their judgements fair
    - increasing trainers' and assessors' understanding of the barriers faced by specific groups of doctors: for example, Woolf et al (2016) found that, while all doctors in training faced challenges, those from UK minority backgrounds or who trained overseas were vulnerable in particular ways that could result in poorer outcomes for these groups – such as in poorer perceptions by trainers and lack of opportunities to demonstrate outcomes
    - providing, where possible and appropriate, training in the consistent application of the mark criteria and standards, and providing regular calibration opportunities for high stakes tests.

- monitoring and appraising their performance, including:
    - producing information about their examiners' performance (eg leniency vs harshness)
    - acting to remediate or remove their assessors who consistently fail to assess candidates in line with assessment rules.

69 For assessors they manage directly (usually their examiners), guidance on the recruitment and management of these assessors is already set out by the AoMRC.

Assessors working within deaneries/HEE local offices/delivering assessments at work

70 Postgraduate deaneries and HEE local offices make sure that educators have the necessary knowledge and skills, support and resources they need for their role. Organisations do not have any specific obligations for the quality or appraisal of these assessors. But they should:

- set out clear expectations for assessors, including who is an appropriate assessor in a particular task and what professional expertise, experience, credibility or training (if any) is required
- provide resources to support deaneries and HEE local teams to fulfil their role in ensuring the fair and correct conduct of assessment – this may include providing guidance or training
- use local networks, where possible, to support assessors (eg college tutors)
- support local quality management of assessors. Examples of this support might include feeding the results of portfolio audits to deaneries/HEE local teams or providing targeted training to support the conduct of a particular assessment
- gather and use information on supervisor and assessor engagement with appropriate quality management and feedback processes where possible
- consider providing information to support the educational aspects of appraisal by the deanery/HEE local team where possible and appropriate; eg enabling supervisors to review the feedback they have given to learners in their appraisal where possible.

Evidencing decisions about assessment structure: standard setting

Excellence by design: CR4.1f, CR4.11, CR4.12

This section discusses elements of the third domain of evidence in validity theory, which is concerned with the internal structure of assessments.

Key issues in this section

Ref	Key issues for consideration
CR4.1f	How do you use standard setting to ensure safety, fairness to learners and promote excellent patient care? How does this provide assurance to stakeholders? What standard setting method do you use to determine the passing standard? Why do you use this method? What do you do to manage uncertainty around borderline candidates? Why? How do you ensure consistency in the standard between diets? What arrangements exist for review of the standard itself and the standard setting process? How are the range of stakeholders, including patients and the public and learners themselves, involved in this?
CR4.11 **CR4.12**	What experience do you need to set standards? How are standard setters recruited, trained and managed?

Ref	Considerations for approvals or quality assurance
CR4.1f	■ Clear identification of standard against which trainees are being assessment, evident in syllabus and with reference to relevant critical progression point within training programme ■ Criterion-referenced approach in the standard setting of assessments; compromise methods used in addition to this by way of triangulation but not as principal method to identify pass marks ■ Details of standard setting approach used for each individual component of an assessment. If test equating is applied to standard set assessments, indication of review process and frequency of periodical revisiting of question material ■ Details of training for standard setters and calibration measures prior to each exercise ■ Details of whether a compensatory or conjunctive approach is taken for each element of the assessment to inform the overall pass/fail status ■ Details of application of SEM in deciding upon the final pass mark of an assessment
CR4.11	■ Role description and person specification (standard setters)
CR4.12	■ The need for initial training (and subsequent training, where applicable) stipulated and includes equality and diversity training (standard setters)

Guidance

71 Standard setting should reference the purpose of the assessment in explicitly considering what the consequence of passing the assessment will be in providing assurance about the safety of training, professional practice, patients and the public.

72 Decisions with significant consequences (eg GMC specialist registration) must not use norm-referenced standards, by which passing or failing learners are defined relative to the performance of other learners. Aside from this, organisations should select the most appropriate method to ensure professional standards and fairness to learners are maintained. The AoMRC notes the importance of considering the purpose of an assessment in deciding the standard setting method.

73 Organisations should attempt to make sure the identified standard is maintained with each diet of a summative exam (unless there is a reason to modify the standard). This means making sure that, through a criterion-referenced approach, the chosen standard setting technique enables the identified standard to be applied consistently to assessment material in each examination diet. Fluctuations in pass marks or pass

rates and data gathered from statistical analysis might for example prompt consideration of examiner behaviour, standard setting or item quality.

74 Organisations need to show that an appropriate standard has been set to pass a summative assessment. They also need to:

- make sure the chosen approach to standard setting is suitable for the format of the examination and put into practice in a way that follows evidence and best practice. A typology and explanation of methods is set out in guidance from the AoMRC (2015:3,11–18)
- make sure the standard setting process is informed by the expected scope of practice and level of performance of doctors training in programmes leading to the award of a UK CCT only
- establish how borderline candidates are to be treated*
- consider guidance from the AoMRC (2015).

75 Where pass rates are unstable, low or otherwise of cause for concern, organisations should investigate to determine whether this is caused by defects in the assessment itself, or whether this stems from other causes (eg changes in the performance of the learners taking the test). They should take action where this analysis shows the quality of the assessment is an issue. Organisations should consider:

- comparison of each assessment diet with others
- reviewing assessment material
- reviewing standard setting approaches
- looking over a period of years to identify pass rate trends and investigating possible factors accordingly
- reviewing the curriculum and the linking of the curriculum and learning to assessment.

76 Organisations should periodically review both the standard and the standard setting process to ensure the standard set and methodology around it continues to be appropriate.

* Advice on the choices available about the calculation of SEM when it is used to adjust pass-marks can be found in McManus (2012).

Evidence about assessment structure: statistical analysis

Excellence by design: CR4.1a, CR4.5, CR4.6, CR4.7

This section discusses elements of the third domain of evidence in validity theory, which is concerned with the internal structure of assessments.

Key issues in this section

Ref	Key issues for consideration
CR4.1a **CR4.5** **CR4.6** **CR4.7**	How do statistics show your exams or assessments are of good quality and set appropriately to consistent standards? How can/do you use this information to strengthen the validity (including the reliability) of your assessments? What psychometric analyses do you perform on your test or test response data? ■ Item level data (eg discrimination) ■ Test level data (eg reliability, SEM, generalisability) How does this show the test is valid? What's your approach to ensuring reliability in exams where cohorts are too small to calculate reliability or SEM? If an assessment is too small to make reliability calculations, what steps have you followed to ensure reliability?
CR4.6	What does assessment data say about the performance of different groups of learners? What is your review process for checking quality of items using the data from the test? How are poorly performing items managed? How is data used to set standards for, or trigger review of items or whole assessments? Can you identify or quantify the main sources of error in assessments? Who reviews and interprets this data, and what actions are taken as a result? Which correlations with other relevant variables such as other in-course assessments or other summative assessment do you investigate? Is the correlation with similar tests, or dissimilar tests?

Ref	Considerations for approvals or quality assurance
CR4.1a	■ Clear articulation of how the question sampling (number of questions included in each element of an assessment) fulfils requirements of appropriate syllabus coverage and reliability (internal consistency)
CR4.5	■ Systematic monitoring of assessment performance metrics including: reliability coefficients, SEMs, pass rates, examiner marking behaviour, ARCP outcomes with regard to assessment outcomes
CR4.6 (CR4.7)	■ Report of examination quality, considering and explaining key sources of validity evidence including psychometric properties of individual elements of assessments (item and test level metrics, especially reliability and SEM) and contribution to the programme as a whole including (eg through congruence with similar or related tests)

Guidance

77 An important source of evidence about the validity of an assessment (or set of assessments) is its internal structure, ie psychometric properties (Sullivan 2011:119). These properties can help to understand the quality of the pre-test planning, design and the quality of the assessment's conduct. It can help to identify key quality concerns and provide evidence about whether decisions are fair and defensible, and provide information that enables the validity of assessment approaches to be strengthened. Psychometric evidence can also help to identify and investigate questions about fairness and variations between different groups.

78 This information cannot be produced or used without a critical understanding of the different measures. Organisations need to:

- make sure they have secured sufficient access to expertise to analyse and understand the data, and to act where it shows action is required
- carry out psychometric review and investigation into assessments at the level of:
  - items within exams. Examples of metrics that are likely to be appropriate for this purpose and which organisations should consider using as appropriate include:
    - item/test characteristic curves (ICCs/TCCs)
    - inter-item correlations
    - item-total correlations.

- the properties of tests as a whole. In particular, reliability is an important part of the demonstration of overall validity (Downing 2004). Examples of metrics likely to be appropriate for this purpose and which organisations should consider using as appropriate include:
  - the reliability
  - generalisability
  - SEM
  - item factor analysis
  - differential item functioning.
- the programme as a whole (eg through the congruence of similar tests or analysis of the outcomes of those completing training).

79 Psychometric analysis should take a broad view of the quality of assessments and aim to produce information that enables the quality of all aspects of assessment to be understood and continuously improved. The exact choice of metrics may vary with the test in question but the range of metrics should be justified in reporting about tests.

Assessments at work and reliability

80 The purpose of assessments at work will generally be formative supervised learning events, where feedback and engagement in the learning process is key; we do not require these assessments to meet reliability criteria and caution it may be undesirable to try and reduce the rich information these formats can give to something that can be demonstrably reliable (see HPAC 2016:37,44).

81 If the purpose of assessment in the workplace is summative, then judgements about knowledge, skills or performance need to be made reliably. Organisations may wish to consider:

- using tools or formats shown to be reliable elsewhere (provided they are transferable)
- making use of expert judgement, and doing so over multiple assessors and occasions (AoMRC 2016:4). This can be:
  - within the individual assessment (with some research supporting the psychometric reliability of an MSF (Moonen-van Loon et al 2015)) or
  - as part of a programmatic approach in which a summative process collates and synthesises formative elements (see examples cited above).

- training assessors in their roles and declaring expected standards.

82 HPAC (2016:44) also suggest that entrustment formats may have advantages in terms of authenticity and rigour. Furthermore asking assessors to entrust responsibilities for patient care may link the assessor's judgement more closely to their own duties to uphold standards. This is important because research indicates such considerations can enable assessors, who might otherwise feel unwilling or unable, to fail underperforming or unsafe learners (Yepes-Rios et al 2016).

83 We do not mandate a particular approach but organisations should show that, where assessments at work are used for summative purposes, the judgement produced will be defensible, and supported by consideration of reliability and fairness issues.

Small cohorts

84 Some cohorts of learners may be too small to produce meaningful statistics about reliability in summative assessments. Organisations still need to design and deliver assessments that have overall validity for their intended purpose, including appropriate reliability, even if this cannot be demonstrated as a coefficient. Organisations can address some of these difficulties by:

- using tools or formats shown to be reliable elsewhere (provided they are transferable)
- carrying out assessment design, conduct and quality management to a high standard
- trying to achieve reliable overall results by appropriate combinations and correlations of numerous assessments taken over time with different assessors
- comparing or correlating results with tests assessing similar things and which are known to be reliable (concurrent or predictive validity).

85 Approaches that use assessments at work in combination to make judgements are acceptable, as long as a programme of assessment was appropriately designed.

Part 3: The impact of a decision

Evidencing the impact of assessments

Excellence by design: CR4.2, CR4.3, CR4.4, CR4.5, CR4.6

This section discusses elements of the fifth domain of evidence in validity theory, which is concerned with the consequences of assessment decisions for all those involved.

Key issues in this section

Ref	Key issues for consideration
CR4.3 **CR4.5**	How can the evidence about the design, delivery and analysis of assessment be summarised to justify why the assessment has strong validity? How can it be improved against all the domains of validity theory? Where is this reported and set out? How do you manage the impact of failing on learners and feed back to employers and training providers? What arrangements are there for remediation and support? How is potential or actual malpractice by learners managed?
CR4.2 **CR4.4**	How do decisions ensure fairness to learners, patient safety and support learners to achieve excellence? What kind of feedback (score reporting and qualitative information) is given on the assessment? How does the programme of assessment enable the identification and management of learners who are not (yet) safe to practice at critical progressions points or at the point of completion of training?
CR4.5 **CR4.6**	What monitoring of assessment outcomes do you carry out? What impact do the results of the assessment have on: ■ curricular outcomes ■ the programme of learning ■ the future design and conduct of assessments? What external review is undertaken of the programme of assessment? What impact do the results of the assessment have on the design and development of the curriculum and assessments and the programme of assessment in general? How can data about assessments help you improve quality?

Ref	Considerations for approvals or quality assurance
CR4.2	■ Process in place for assessors to identify (and manage) potentially dangerous learners
CR4.3	■ Systematic approach to identifying each area required prior to progression at critical progression points of the training programme (documented and highlighted in a matrix or overarching blueprint for the programme of assessment as a whole)
CR4.4	■ Conscious action to make sure assessment decisions and decision aids are made without bias
CR4.5	■ Systematic monitoring of assessment performance metrics including: reliability coefficients, SEMs, pass rates, examiner marking behaviour, ARCP outcomes with regard to assessment outcomes ■ Periodic review of guidance material in the public domain; feedback from relevant stakeholder groups regarding need for necessary updates
CR4.6	■ Regular reporting through annual specialty return on assessment quality

Guidance

86 The successful completion of many postgraduate training programmes is linked to the ability to practise as a consultant or GP in the NHS – so concerns about validity of assessment have their roots in the concerns of the wider public (Kane 2013:2). Organisations need to make sure decisions about progression and actions in respect of learners who do not (yet) meet standards reflect this. Guidance on the maximum number of attempts at examinations is provided in our position statement on this issue.

87 Organisations should recognise that assessments support processes in the wider healthcare and training system. Organisations and deaneries or HEE local offices should work collaboratively to ensure and provide assurance about the quality of learners completing the programme by providing evidence against the domains of validity (see above 4). Organisations should consider how deaneries or HEE local offices would need to use assessment data, eg in the planning and management of service and training. They should make sure they provide data in a sufficiently timely way to enable deaneries/HEE local offices to use the information to plan learners' progression.

Assuring patients, learners and others

88 Groups who have an interest in assessment decisions include:

- patients and the public, employers and colleagues, all of whom can expect a certain standard of performance from a doctor; patient safety is the first priority
- the doctor, who can expect to be treated fairly, assessed objectively and to have reasonable opportunities to remediate and develop in areas of weakness
- the organisation, along with relevant local training organisation, who are accountable for conducting assessments and making key decisions in the form of critical progression and satisfactory completion. They are also responsible for deciding what is taught and, to some extent, how. Organisations should:
  - use data to continuously improve the quality and performance of their assessments
  - use data to support curricula and outcomes review.

89 Organisations should report on how the programme of assessment has provided appropriate assurance about those successfully completing training, and how its validity can be strengthened against across all the areas of evidence identified by validity theory:

- the content and design or format of the assessment
- the conduct of the assessment, including the information and training provided to all stakeholders about the assessment
- psychometric evidence and other aspects of the internal structure of individual assessments
- the relationships between the different assessments within the programme
- whether decisions made about progression in and completion of training are supported by satisfactory evidence to protect patients and ensure fairness to learners.

90 Establishing formal mechanisms with external organisations and peers to carry out periodic reviews of their programmes of assessment may help to improve quality and share practice.

Appendix 1: Annual publication of exam data

CR4.7 of our standards requires organisations to publish the quality performance metrics of high-stakes summative or progression assessments to promote transparency and openness.

We suggest the following as a minimum set of information or a template for publication about individual major national exams which provide assessment against approved curricula.

Exam name	
Exam format	Please describe the type of assessment, type and number of items
Number of candidates* and pass rates	Please state the number attempting the exam in year or each diet within year. We recommend reporting those in UK training as a distinct group (see footnote).
Breakdown of candidates and passing candidates by: ■ **demographic groups/ protected characteristics** ■ **place of qualification** ■ **attempt number**	

* We recommend colleges report data on the basis of those candidates to whom the whole programme of assessment to which a test is part of applies; for example where an examination forms part of a programme leading (eventually) to specialist/GP registration, we recommend reporting explicitly on those candidates who are in UK training and might be expected to eventually achieve entry to the specialist/GP registers (and not those pursing the exam as an independent qualification or for purposes overseas).

Standard setting method	Please describe: ■ the standard setting method and reasons for the choice or reference to where this is set out in other documents eg approvals documentation ■ the frequency with which standard setting is carried out ■ additional measures to ensure the safety of the standard set, eg minimum numbers of stations to pass or adjustments for error.
Most recent report to oversight body	A report describing in a comprehensive and holistic manner: ■ the quality of the assessment using a range of metrics supported by appropriate explanation and interpretation ■ this should include discussion of the reliability/internal consistency of the assessment for those in UK training using an appropriate choice of metrics ■ interpretations of this information including discussion of quality management activity which is required or desirable in respect of the assessment ■ any other action appropriate action in respect of the wider functions of the organisation setting the assessment ■ the quality activity undertaken in respect of the examination since the last report. We suggest reporting on a regular (annual) basis, to considering the diets of the assessment carried out that year.

Key terms used in this guidance

Term	Meaning
Assessment	We define assessment as all activity aimed at judging a learner's attainment of curriculum outcomes, whether for summative purposes (determining progress or completion) or formative purposes (giving feedback). An examination is an example of an individual assessment test.
Assessor	An assessor provides an assessment and is responsible for interpreting the learner's performance in that assessment. Assessors should be appropriately trained and should normally be competent (preferably expert) in the area that is being assessed. It includes examiners as a specific type of assessor.
Critical progression point	A point in a curriculum where a learner transitions to higher levels of professional responsibility or enters a new or specialist area of practice or experiences significant changes in the level of supervision or trust. Satisfactory completion of training is a critical progression point.
Examiner	An examiner is a category of assessor working within the context of a formal, summative exam.
Learners	Learners are medical students receiving education leading to a primary medical qualification and doctors in postgraduate training leading to a certificate of completion of training (CCT) or doctors completing a regulated credential.
Learning outcomes	An outcome can be defined as a level of performance or behaviour that a trainee is expected to achieve as part of their development according to their stage of training within their specialty curriculum. This can include an area of professional practice that may be trusted to a learner to execute unsupervised, once he or she has demonstrated the required competence.
Organisation	In this guidance, organisation refers to a body, expected to be a college or faculty (or a combination of colleges and faculties), with responsibility for design and maintenance of an approved curriculum and programme of assessment or a part of it. It does not include HEE local offices or deaneries which may have responsibilities for the quality of the conduct of some assessments locally.

Bibliography

Academy of Medical Royal Colleges (AOMRC) (2016), *Improving Assessment: Further Guidance and Recommendations*, http://www.aomrc.org.uk/publications/reports-guidance/improving-assessment-guidance-recommendations/

AoMRC (2015), *Guidance for standard setting: A framework for high stakes postgraduate competency-based examinations*, http://www.aomrc.org.uk/wp-content/uploads/2016/05/Standard_setting_framework_postgrad_exams_1015.pdf

AoMRC (Forthcoming 2017), *Improving Feedback and Reflection to Improve Learning: a practical guide for trainees and trainers*, http://www.aomrc.org.uk/all-publications/reports-guidance/

Auewarakul C, Downing SM, Praditsuwan R, Jaturatamrong U (2005) Item Analysis to Improve Reliability for an Internal Medicine Undergraduate OSCE. *Advances in Health Sciences Education*. 10(2), 105–113

Coderre S, Woloschuk W, McLaughlin K (2009) Twelve tips for blueprinting. *Medical Teacher.* 31(4), 322–324

Coombes, L, Roberts M, Zahra D, Burr S (2016) Twelve tips for assessment psychometrics. *Medical Teacher*, 38(3), 250–254

Downing, SM (2003) 'Validity: on the meaningful interpretation of assessment data' *Medical Education* 2003;37:830–837

Downing, SM (2004) 'Reliability: on the reproducibility of assessment data' *Medical Education*, Vol. 38 Issue 9, September 2004 Pages 915–1018

GMC (2011) *Assessment in undergraduate medical education Advice supplementary to Tomorrow's Doctors (2009)*, GMC, London http://www.gmc-uk.org/Assessment_in_undergraduate_medical_education___guidance_0815.pdf_56439668.pdf

Harden, RM , Crosby, JR, Davis, MH (1999) 'An introduction to outcome-based education' in ed Lilley, P, *Outcome-based education AMEE Medical Education Guide No 14*, Dundee, 1999 https://amee.org/getattachment/AMEE-Initiatives/ESME-Courses/AMEE-ESME-Face-to-Face-Courses/ESME/ESME-Online-Resources-China-Dec-2015-(1)/Session-1-Guide-14-Outcome-based-education.pdf

Health Professional Assessment Consultancy (HPAC), (2016), Final Report for the provision of identifying key principles for consistency and reliability in curricula and assessment frameworks Prepared for the General Medical Council (GMC331), http://www.gmc-uk.org/Key_principles_for_curricula_and_assessment___HPAC_final_report___Nov_2016.pdf_69345344.pdf

Kane, MT (2013) 'Validating the Interpretations and Uses of Test Scores', *Journal of Educational Measurement*, Special Issue: Validity Volume 50, Issue 1, pages 1–73, Spring 2013

McManus, IC (2012), 'The misinterpretation of the standard error of measurement in medical education: a primer on the problems, pitfalls and peculiarities of the three different standard errors of measurement.' *Med Teach*. 2012; 34(7):569–76.

Moonen-van Loon JM, Overeem K, Govaerts MJ, Verhoeven BH, van der Vleuten CP, Driessen EW (2015) The reliability of multisource feedback in competency-based assessment programs: the effects of multiple occasions and assessor groups, Acad Med. 2015 Aug; 90(8):1093-9.

Plymouth University (Undated), *Glossary of assessment terms*, www.plymouth.ac.uk/your-university/teaching-and-learning/guidance-and-resources/glossary-of-assessment-terms accessed 21 April 2017

Regan de Bere, S, Suzanne Nunn, Mona Nasser (2015), *Understanding differential attainment across medical training pathways: A rapid review of the literature Final report prepared for The General Medical Council*, GMC commissioned literature review www.gmc-uk.org/GMC_Understanding_Differential_Attainment.pdf_63533431.pdf

Roberts, C, N Shadbolt, T Clark and P Simpson (2014), 'The reliability and validity of a portfolio designed as a programmatic assessment of performance in an integrated clinical placement' BMC Medical Education 2014, 14:197

Schuwirth LWT & CPM Van der Vleuten (2011), Programmatic assessment: from assessment of learning to assessment for learning, Medical Teacher, 33:6, 478–485

Sullivan, GM (2011) 'A Primer on the Validity of Assessment Instruments' Journal of Graduate Medical Education, June 2011, pp119–120

Street, S (2015) 'The progressive challenge of assessing a GP trainee's skills in the workplace: a UK update' Education for Primary care (2015) 26 60:2

ten Cate, O, (2013), 'Nuts and Bolts of Entrustable Professional Activities' J Grad Med Educ. 2013 Mar; 5(1): 157–158. doi: 10.4300/JGME-D-12-00380.1

Tighe, J, IC McManus, NG Dewhurst, L Chis, J Mucklow (2010) 'The standard error of measurement is a more appropriate measure of quality for postgraduate medical assessments than is reliability: an analysis of MRCP(UK) examinations', *BMC Medical Education* 10:40

van der Vleuten, CPM (1996) 'The Assessment of Professional Competence: Developments, Research and Practical Implications' Advances in Health Sciences Education 1: 41-67, 1996

Woolf, C, Rich, A, Viney, R, Rigby, M, Needleman, S, Griffin, A (2016) *Fair Training Pathways for All: Understanding Experiences of Progression Final Report*, www.gmc-uk.org/2016_04_28_FairPathwaysFinalReport.pdf_66939685.pdf

Yepes-Rios, M, Dudek, N, Duboyce, R, Curtis, J,Allard, RJ & Varpio L (2016): The failure to fail underperforming trainees in health professions education: A BEME systematic review: BEME Guide No. 42, Medical Teacher, DOI: 10.1080/0142159X.2016.1215414

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General Medical Council

Generic professional capabilities framework

Working with doctors Working for patients

General Medical Council

Contents

Introduction

There are 66 medical specialties and 32 sub-specialties in the UK. For postgraduate medical training, each discipline has its own distinct curriculum set by the medical colleges or faculties, which we approve. There is significant variability of core professional content across many of these postgraduate curricula.

Our fitness to practise data shows that most concerns about doctors' performance fall into one or more of the nine domains identified in this *Generic professional capabilities framework*. And several high profile patient safety inquiries have identified major deficits in these basic areas of professional practice. Reports from these inquiries recommend the importance of and need for specific training to address individual, team and organisational deficiencies, as well as addressing wider systemic failures.

The Shape of Training review[*] in 2013 recognised the importance of developing a *Generic professional capabilities framework*. Many of these educational or training requirements are now specifically addressed for the first time in this framework.

A consistent approach to outcomes

We concluded there is a clear need to develop a consistent approach that embeds common generic outcomes and content across all postgraduate medical curricula. We therefore developed this framework, in close partnership with the Academy of Medical Royal Colleges. It prioritises themes, such as patient safety, quality improvement, safeguarding vulnerable groups, health promotion, leadership, team working, and other fundamental aspects of professional behaviour and practice.

While developing this framework, we were informed by national initiatives, for example those focusing on patient safety and end of life care. We have drawn upon expert advice, consulted widely across the service, profession and the public and received overwhelming support and validation for the content of the *Generic professional capabilities framework*.

For doctors in training to achieve a UK certificate of completion of training (CCT), the framework requires that they demonstrate an appropriate and mature professional identity applicable to their level of seniority. Satisfactory achievement of these generic outcomes will demonstrate that they have the necessary generic professional capabilities needed to provide safe, effective and high quality medical care in the UK.

The *Generic professional capabilities framework* gives a detailed description of the interdependent essential capabilities that underpin professional medical practice in the UK and are therefore a fundamental and integral part of all postgraduate training programmes.

[*] Shape of Training review available at www.shapeoftraining.co.uk/

At the heart of the *Generic professional capabilities framework* are the principles and professional responsibilities of doctors as set out in *Good medical practice* and our associated professional guidance, along with other statutory and legal requirements placed upon doctors. These professional responsibilities have been converted into educational outcomes with associated descriptors, so they can be incorporated into curricula. Although this framework relates to postgraduate medical education and training, we expect that it will support all phases of medical education and continuing professional development in the UK.

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- Forum of key interest groups
- Informal discussion group.

How the framework is organised

The *Generic professional capabilities framework* has three fundamental domains:

- professional values and behaviours
- professional skills
- professional knowledge.

There are six further themed or targeted domains. These domain headings were selected to prioritise particular areas of clinical or professional practice and to give clarity and structure for curriculum development. Under each of the domains, there are detailed descriptors – these outline the particular capabilities and expected levels of performance and behaviour needed to meet our regulatory requirements for minimum common core content across all curricula.

This diagram shows the interdependence of the domains of the *Generic professional capabilities framework*.

Full list of expected educational outcomes from the framework

Those completing training for the award of a CCT or equivalent should demonstrate appropriate:

- professional values and behaviours (Domain 1)
- professional skills (Domain 2):
  - practical skills
  - communication and interpersonal skills
  - dealing with complexity and uncertainty
  - clinical skills
    - *history taking, diagnosis and medical management*
    - *consent*
    - *humane interventions*
    - *prescribing medicines safely*
    - *using medical devices safely*
    - *infection control and communicable disease*
- professional knowledge (Domain 3):
  - professional requirements
  - national legislative requirements
  - the health service and healthcare system in the four countries
- capabilities in health promotion and illness prevention (Domain 4)
- capabilities in leadership and team working (Domain 5)
- capabilities in patient safety and quality improvement (Domain 6)
- capabilities in safeguarding vulnerable groups (Domain 7)
- capabilities in education and training (Domain 8)
- capabilities in research and scholarship (Domain 9).

How the framework relates to education standards

The curricula and assessment standards *Excellence by design: standards for postgraduate curricula*[*] set out the requirements for postgraduate medical curricula in the UK. We use these standards to approve the curricula developed by colleges and faculties.

Colleges and faculties are required to include *Good medical practice* and the *Generic professional capabilities framework* within their specialty curricula as minimum GMC regulatory requirements.

Our separate education standards *Promoting excellence: standards for medical education and training*[†] set out requirements for managing and providing undergraduate and postgraduate medical education and training in the UK. We also use them in our quality assurance processes.

[*] General Medical Council. *Excellence by design: standards for postgraduate curricula* available at: www.gmc-uk.org/education/postgraduate/standards_for_curricula.asp

[†] General Medical Council. *Promoting excellence: standards for medical education and training* available at: www.gmc-uk.org/education/standards.asp

Domain 1: Professional values and behaviours

We expect all doctors to demonstrate appropriate personal and professional values and behaviours. These requirements are set out in *Good medical practice* and related professional guidance.*

Our guidance outlines the expectations for doctors' professional responsibilities, including their duty of care to their patients. Doctors have a wide range of other professional responsibilities, relating to their roles as an employee, clinician, educator, scientist, scholar, advocate and health champion. These responsibilities include demonstrating the following expected professional values and behaviours:

- acting with honesty and integrity
- maintaining trust by showing respect, courtesy, honesty, compassion and empathy for others, including patients, carers, guardians and colleagues
- treating patients as individuals, respecting their dignity and ensuring patient confidentiality
- taking prompt action where there is an issue with the safety or quality of patient care, raising and escalating concerns where necessary†‡
- demonstrating openness and honesty in their interactions with patients and employers – known as the professional duty of candour
- being accountable as an employee to their employer and working within an appropriate clinical governance framework
- managing time and resources effectively
- being able to self-monitor and seek appropriate advice and support to maintain their own physical and mental health
- demonstrating emotional resilience
- demonstrating situational awareness
- reflecting on their personal behaviour and its impact on others
- demonstrating awareness of their own behaviour, particularly where this might put patients or others at risk

* General Medical Council. *Good medical practice: explanatory guidance* available at: www.gmc-uk.org/guidance/ethical_guidance.asp

† General Medical Council. *Raising and acting on concerns about patient safety* available at: www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp

‡ NHS Improvement. *Serious incident framework* available at: improvement.nhs.uk/resources/serious-incident-framework/

- demonstrating awareness of their own limitations and understanding when and who to refer on to or seek professional advice from
- demonstrating awareness of the behaviour, conduct or health of others, particularly where this might put patients or others at risk
- interacting with colleagues in a way that demonstrates appropriate professional values and behaviours, in terms of supporting colleagues, respecting difference of opinion, and working as a collaborative member of a team
- being able to identify and create safe and supportive working and learning environments
- listening to patients, carers and guardians, and accepting that they have insight into, preferences for and expertise about the patient's own condition and context
- working within appropriate equality and diversity legislation
- working within appropriate health and safety legislation
- demonstrating a commitment to learn from patient safety investigations and complaints
- maintaining their continuing professional development and completing relevant statutory and mandatory training
- demonstrating an ability to learn from and reflect on their professional practice and clinical outcomes
- being able to accept constructive and appropriately framed criticism
- being a professional role model.

Domain 2: Professional skills

Practical skills

We have set out below basic practical skills and capabilities that are fundamentally important to safe and effective patient care in the UK. Doctors in training must be:

- literate
- numerate
- articulate and be able to give clear, accurate and legible written instructions in English
- able to give clear, accurate and comprehensible verbal instructions in English
- able to make clear, accurate and contemporaneous records of their observations or findings in English
- able to demonstrate a clear and appropriate knowledge of the legal aspects of digital and written records
- able to accurately complete legal medical forms or certifications, eg cremation, sickness, insurance
- able to demonstrate an appropriate knowledge of information governance, data protection and storage
- able to demonstrate appropriate IT skills, including word processing and data collection.

Communication and interpersonal skills

Due to the complex nature of medical practice, doctors in training must develop high levels of communication and interpersonal skills. Doctors in training must demonstrate that they can communicate effectively and be able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement. They must do this:

- with patients, relatives, carers, guardians and others by:
  - establishing an effective and respectful doctor-patient partnership with the ability to demonstrate empathy and compassion
  - demonstrating effective consultation skills including effective verbal and non-verbal interpersonal skills
  - sharing decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's concerns and expectations
  - sharing decision making with children and young people
  - supporting patients in caring for themselves
  - demonstrating active listening skills
  - demonstrating cultural and social awareness
  - communicating effectively and sensitively when breaking bad news, and being well prepared to give clear information
  - effectively managing challenging conversations or consultations
  - using an interpreter or translation services where appropriate
  - making arrangements to communicate effectively with someone who:
    - has impaired hearing, speech or sight
    - lacks mental capacity or has a learning disability
  - making appropriate arrangements where patients request to see a doctor of the same gender as themselves
  - delivering an honest apology* and offering an effective explanation where appropriate
  - communicating, consulting and sharing information appropriately with carers†

* General Medical Council. *Openness and honesty when things go wrong: the professional duty of candour* available at: www.gmc-uk.org/guidance/ethical_guidance/27233.asp

† General Medical Council. *Confidentiality: good practice in handling patient information* available at: www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

- understanding the risks, professional responsibilities and appropriate safeguards of remote consultations such as telephone or online consultations.

- with colleagues in the multidisciplinary team by:
  - exploring and resolving diagnostic and management challenges or differences
  - applying management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations
  - ensuring continuity and coordination of patient care through the appropriate transfer of information
  - demonstrating safe and effective handover, both verbally and in writing.
- individually by:
  - maintaining appropriate situational awareness and sensitivity to the impact of their comments and behaviours on others.

Dealing with complexity and uncertainty

Doctors in training must demonstrate that they can:

- show appropriate professional behaviour and judgement in a wide range of clinical and non-clinical contexts and circumstances
- manage the uncertainty of achieving specific outcomes in clinical practice
- manage the uncertainty of treatment success or failure
- adapt management proposals and strategies of medical problems to take account of patients' informed preferences, co-morbidities and long-term conditions
- make reasonable adjustments for patients, students and colleagues as appropriate
- support and empower patient self-care*
- respect patient autonomy
- explain that wellbeing is a complex physical, mental and social interaction
- describe the factors impacting on health and wellbeing
- explain the complex relationship between mind and body in illness presentation and management
- adapt management proposals and strategies to patients at extremes of age, which includes neonates, children and older people with frailty
- formulate management plans beyond guidelines and produce patient-centred management plans
- manage the personal challenges of coping with uncertainty
- be resilient, diligent and thorough
- explain critical objectives and requirements for successful recovery and rehabilitation
- recognise patients with common mental health conditions (eg depression, dementia or delirium), manage them and, if appropriate, refer them to colleagues with relevant expertise
- recognise limits of own competence and refer patients to colleagues with appropriate expertise.

* General Medical Council. *Good medical practice* available at: www.gmc-uk.org/guidance/good_medical_practice/partnerships.asp

Clinical skills

For the many clinical specialties that involve direct patient contact, doctors should demonstrate the following key generic clinical skills.

History taking, diagnosis and medical management

Doctors in training must demonstrate that they can:

- take a relevant patient history accommodating patient ideas, concerns and expectations
- perform accurate clinical examinations
- show appropriate clinical reasoning by analysing physical and psychological findings
- formulate an appropriate and prioritised differential diagnosis
- formulate an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
- explain clinical reasoning behind diagnostic and clinical management decisions to patients, carers, guardians and other colleagues
- appropriately select, manage and interpret investigations (eg reviewing results)
- understand the role of the chaperone when carrying out clinical examinations, particularly those of a sensitive or intimate nature.

Consent

Doctors in training must demonstrate and understand the professional requirements and legal processes associated with consent,* including:

- making sure patients are accurately identified
- considering and addressing mental capacity issues
- getting informed consent from the patient, or other valid authority, before carrying out any examination, investigation or treatment
- safeguarding children and vulnerable adults
- protecting and ensuring patient confidentiality

* General Medical Council. *Consent: patients and doctors making decisions together* available at: www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp. This guidance is being reviewed in 2017.

- considering humane interventions (see section below), and making sure that treatment needs, wherever possible, are in line with patient preferences
- the principles of requesting and coordinating organ donation and the factors which determine suitability of patients and successful organ donation.

Humane interventions

Doctors in training must demonstrate compassionate professional behaviour, clinical judgement and intervene appropriately to make sure patients have adequate:

- nutrition
- hydration and rehydration
- symptom control
- pain management
- end of life care
- cardiopulmonary resuscitation when and if appropriate[*].

Prescribing medicines safely

Doctors in training must be able to:

- prescribe safely and use appropriate therapeutic approaches and strategies to make sure medicines are managed effectively and used safely[†]
- review and monitor therapeutic interventions appropriate to their scope of clinical practice
- prescribe antimicrobial drugs appropriately
- prescribe medications and use other therapies in line with the latest evidence
- comply with safety checks, contributing to medication reporting systems, and following other monitoring processes as necessary
- understand the challenges of safe prescribing in people at extremes of age, which includes neonates, children and older people with frailty
- assess a clinical situation to recognise a drug reaction
- manage adverse incidents,[*] therapeutic interactions and report adverse drug reactions appropriately

[*] General Medical Council. *Treatment and care towards the end of life* available at:www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

[†] General Medical Council. *Good practice in prescribing and managing medicines and devices* available at: www.gmc-uk.org/guidance/ethical_guidance/14316.asp

- access the current product literature to make sure medicines are prescribed and monitored according to most up to date criteria
- make an appropriate risk benefit assessment with regard to the patient's preferences and circumstances
- fully recognise if they are prescribing an unlicensed medicine
- correctly counsel a patient on what a medicine is for and share any important safety information.

Using medical devices safely

Doctors in training must:

- understand the importance of being trained in the use of specialist medical equipment and devices
- demonstrate they can safely operate medical devices after appropriate training
- make sure medical devices are used safely by complying with safety checks, contributing to reporting systems, and following other appropriate maintenance, monitoring and reporting processes
- understand the design features and demonstrate the safety aspects associated with the safe use of medical devices.

Infection control and communicable disease

Doctors in training must demonstrate that they can:

- appropriately prevent, manage and treat infection, including controlling the risk of cross-infection
- work appropriately within the wider community to manage the risk posed by communicable diseases.

* MHRA. *Yellow Card Scheme* available at https://yellowcard.mhra.gov.uk/

Domain 3: Professional knowledge

Professional requirements

Doctors in training must be aware of and adhere to our professional requirements, including:

- meeting the standards expected of all doctors, set out in *Good medical practice*
- keeping up to date with GMC guidance*
- participating in annual reviews of performance or progression
- working within appropriate quality management and clinical governance frameworks
- understanding risk, risk identification, management or mitigation
- participating in reflective annual appraisal, job planning and performance management including audit of and responsibility for their own clinical outcomes
- recognising the need for all doctors to take part in revalidation, which involves demonstrating their scope of practice, and the role and responsibility of the responsible officer
- participating in continuing professional development to keep their knowledge, skills and capabilities up to date.†

National legislative requirements

Doctors in training must be aware of their legal responsibilities and be able to apply in practice any legislative requirements relevant to their jurisdiction of practice, for example:

- employment law, particularly as it relates to them as an employee, including working time regulations
- mental capacity and deprivation of liberty safeguards
- mental health
- the legal requirements about patient and carer involvement in shared decision making
- safeguarding of vulnerable children and adults

* General Medical Council. *Good medical practice: explanatory guidance* available at: www.gmc-uk.org/guidance/ethical_guidance.asp

† General Medical Council. *Continuing professional development - Guidance for all doctors* available at: www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp

- female genital mutilation
- equality and diversity, including legally protected characteristics
- data protection and confidentiality
- health and safety legislation, including the management of radiation and hazardous substances
- transportation legislation including fitness to drive and DVLA or DVA notification processes
- confirming and completing medical certificates of cause of death
- cremation authorisation
- referral to the coroner or procurator fiscal
- any other legislation relevant to medical practice.

The health service and healthcare systems in the four countries

Doctors in training must be aware of and understand:

- the structure and organisation of the health service and system, including the independent sector and the wider health and social care landscape
- the local healthcare system and its relationship to and interaction with social care
- how services are commissioned, funded and audited
- how services are deemed to be clinically effective, cost effective or restricted such as on a named patient basis
- how resources are managed, being aware of competing demands and the importance of avoiding waste
- how services are held publically accountable through political and governance systems, public scrutiny and judicial review.

Domain 4: Capabilities in health promotion and illness prevention

Doctors in training must be aware of and demonstrate:

- the factors affecting health inequalities and the social determinants of health
- the relationship of the physical, economic and cultural environment to health
- basic principles of public health, including population health, promoting health and wellbeing, work, nutrition, exercise, vaccination and illness prevention
- applying the principles of promoting:
    - public health interventions* such as targeting smoking cessation, reducing obesity and the harm caused by alcohol abuse
    - mental health and wellbeing
- basic principles of person-centred care, including effective self-management, self-care and expert patient support
- the influence of ageing, dependency, multiple co-morbidities and frailty upon individual and population-level healthcare needs
- the potential harms and population risks of health care interventions
- how to assess mental health and wellbeing
- how to identify and assess suicide risk and refer and coordinate care
- basic principles of global health† including governance, health systems and global health risks
- the responsibilities and needs of carers as they play an increasing role in healthcare provision
- how to manage, support and develop the health and social care of local populations through:
    - community engagement
    - family and community-based interventions
    - global and multicultural aspects of delivering evidence-based, sustainable healthcare.

* Health Education England. *Making Every Contact Count* available at www.makingeverycontactcount.co.uk/

† Academy of Medical Royal Colleges. *Global Health Capabilities for UK Health Professionals* available at: www.aomrc.org.uk/publications/reports-guidance/global-health-capabilities-uk-health-professionals/

Domain 5: Capabilities in leadership and team working

Doctors in training must demonstrate that they can lead and work effectively in teams by:

- demonstrating an understanding of why leadership and team working is important in their role as a clinician
- showing awareness of their leadership responsibilities as a clinician and why effective clinical leadership is central to safe and effective care
- demonstrating an understanding of a range of leadership principles, approaches and techniques and applying them in practice
- demonstrating appropriate leadership behaviour and an ability to adapt their leadership behaviour to improve engagement and outcomes
- appreciating their leadership style and its impact on others
- actively participating and contributing to the work and success of a team (appropriate followership)
- thinking critically about decision making, reflecting on decision-making processes and explaining those decisions to others in an honest and transparent way
- supervising, challenging, influencing, appraising and mentoring colleagues and peers to enhance performance and to support development
- critically appraising performance of colleagues, peers and systems and escalating concerns
- promoting and effectively participating in multidisciplinary and interprofessional team working
- appreciating the roles of all members of the multidisciplinary team
- promoting a just, open and transparent culture
- promoting a culture of learning and academic and professional critical enquiry.

Domain 6: Capabilities in patient safety and quality improvement

Patient safety

Doctors in training must demonstrate that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes. To do this, they must:

- raise safety concerns appropriately through clinical governance systems*
- understand the importance of raising and acting on concerns
- understand the importance of sharing good practice
- demonstrate and apply basic Human Factors principles and practice at individual, team, organisational and system levels
- demonstrate and apply non-technical skills and crisis resource management techniques in practice
- demonstrate effective multidisciplinary and interprofessional team working
- demonstrate respect for and recognition of the roles of other health professionals in the effective delivery of patient care
- promote and participate in interprofessional learning
- promote patient involvement in safety and quality improvement reviews
- understand risk, including risk identification (clinical, suicide and system), management or mitigation
- understand fixation error, unconscious and cognitive biases
- reflect on their personal behaviour and practice
- effectively pre-brief, debrief and learn from their own performance and that of others
- make changes to their practice in response to learning opportunities
- be able to keep accurate, structured and where appropriate standardised records.†

* NHS Improvement. *Learning from patient safety incidents* available at: improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

† Academy of Medical Royal Colleges: *Standards for the Clinical Structure and Content of Patient Records* available at: www.aomrc.org.uk/publications/reports-guidance/standards-for-the-clinical-structure-and-content-of-patient-records-0713/

Quality improvement

- design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience by:
  - using data to identify areas for improvement
  - critically appraising information from audit, inquiries, critical incidents or complaints, and implementing appropriate changes
  - deploying quality improvement methods (eg plan, do, study, act or action research) and repeat quality improvement cycles to refine practice
  - involving patients and public in decision making at group or community level
  - engaging with stakeholders, including patients, doctors and managers, to plan and implement service change
  - effectively evaluating the impact of quality improvement interventions.

Domain 7: Capabilities in safeguarding vulnerable groups

Doctors in training must demonstrate that they can:

- recognise and take responsibility for safeguarding children, young people and adults, using appropriate systems for identifying, sharing information, recording and raising concerns, obtaining advice and taking action
- understand the professional responsibilities in relation to procedures performed on minors for non-medical reasons
- apply the mental capacity legislation in clinical practice, to protect the safety of individuals and society
- identify, assess and manage suicide risk
- understand the needs and support required for people with learning disabilities
- understand positive behavioural support and determine when and how to safely restrain and safeguard vulnerable adults in distress
- recognise where addiction (to drugs, alcohol or smoking), obesity, environmental exposure or social deprivation issues are contributing to ill health and act on this information
- apply appropriate equality and diversity legislation, including disability discrimination requirements, in the context of patient care
- identify and escalate concerns about modern slavery and human trafficking to appropriate authorities.

Domain 8: Capabilities in education and training

Doctors in training must demonstrate that they can:

- understand that the safety of patients must come first and that the needs of education must be considered in this context
- provide safe clinical supervision of learners and other doctors in training in the workplace at all times
- plan and provide effective education and training activities
- use simulation or technology-enhanced learning appropriately in protecting patients from harm
- take part in their own induction and orientation, and that of new staff
- take part in patient education
- respect patients' wishes about whether they wish to participate in the education of learners and doctors in training
- provide supportive developmental feedback, both verbally and in writing, to learners and doctors in training
- create effective learning opportunities for learners and doctors in training
- evaluate and reflect on the effectiveness of their educational activities
- promote and participate in interprofessional learning
- assess objectively and fairly the performance of learners and other doctors in training
- give timely and constructive feedback on learning activities and opportunities
- understand how to raise concerns about the performance or behaviour of a learner or other doctor in training who is under their clinical supervision
- participate in national surveys and other quality control, quality management and quality assurance processes as required by the regulator
- carry out the roles and responsibilities of a clinical trainer
- meet any regulatory or statutory requirements as a clinical trainer or educator.

Domain 9: Capabilities in research and scholarship

Doctors in training must demonstrate that they can:

- keep up to date with current research and best practice in the individual's specific area of practice, through appropriate continuing professional development activities and their own independent study and reflection
- practise in line with the latest evidence
- conduct literature searches and reviews to inform their professional practise
- critically appraise academic literature
- understand the role of evidence in clinical practice and demonstrate shared decision making with patients
- locate and use clinical guidelines appropriately
- demonstrate appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry
- demonstrate appropriate knowledge of research principles and concepts and the translation of research into practice, including:
  - recruitment into trials and research programmes
  - ethical implications of research governance
- understand and promote innovation in healthcare
- understand and apply:
  - informatics
  - genomics
  - stratified risk and personalised medicine
- draw from public health epidemiology and other data sources and large scale reviews
- communicate and interpret research evidence in a meaningful way for patients to support them making informed decisions about treatment and management.

Glossary

Term	Meaning
Capabilities	High level, complex professional capabilities are flexible and adaptive in a wide range of contexts. Many of the qualities of effective professionals, such as clinicians, leaders and educators, can be characterised by such professional capabilities. This includes the kinds of outcomes and descriptors outlined in this framework that are integral to their professional practice.
Clinical governance framework	The system through which National Health Service (NHS) organisations are accountable for continuously monitoring and improving the quality of their care and services, and for safeguarding the high standard of care and services.
Clinical reasoning	The cognitive process that is necessary to evaluate and manage a patient's medical problem.
Cognitive bias	A mistake in reasoning, evaluating, remembering, or other cognitive process, often occurring as a result of holding onto one's preferences and beliefs regardless of contrary information or evidence.
Deprivation of Liberty Safeguards (DoLS)	A set of checks within mental capacity legislation that makes sure any care that restricts a person's liberty is both appropriate and for their overall benefit.
Differential diagnosis	A systematic method of reaching a diagnosis that consists of creating a broad list of possible conditions. This list would include possible diseases underlying the signs and symptoms that are present. Through clinical reasoning, the options are refined by eliminating the possible conditions through further tests, investigations, pattern recognition and hypothesis testing.
Duty of candour	All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients when things go wrong. This is described in our explanatory guidance *Openness and honesty when things go wrong*.
Emotional resilience	The ability to adapt and be resourceful, mindful and effective in complex, uncertain or stressful situations or crises.
Fixation error	Occur when the practitioner concentrates solely upon a single aspect or feature of a case or circumstance to

Term	Meaning
	the detriment of all other relevant aspects. This is discussed in detail in relation to Human Factors.
Followership	The active and positive characteristics, behaviours and processes of individuals acting in relation to leaders.
Human Factors	The environmental, organisational and occupational factors, and human and individual characteristics, which influence behaviour at work in a way that can affect health and safety. Human Factors approaches aim to reduce error and influence behaviour through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and capabilities, and the application of that knowledge to clinical practice and clinical settings.
Information governance	Processes, roles, controls and metrics that ensure necessary safeguards for, and appropriate use of, patient and personal information.
Interprofessional learning	Occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.
Interprofessional team working	A collaborative interaction among interprofessional team members to provide quality, individualised care for patients.
Person-centred care	Through shared decision making, sees patients as equal partners in planning, developing and assessing care to make sure it is most appropriate for their needs. It involves putting patients at the heart of all decisions.
Positive behavioural support and restraint	Techniques used to safely manage and contain distressed individuals who pose a risk to themselves or others. Safe and proportionate physical restraint is a last resort and other cognitive or behavioural techniques to de-escalate are preferred management options.
Public health epidemiology	The study of the distribution and determinants of diseases in populations. It is the key quantitative discipline that underpins public health, which is often defined as the organised efforts of society to prevent disease and to promote health. Further information is available from the University of

Term	Meaning
	Cambridge School of Clinical Medicine.
Safeguarding	Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. We have guidance on protecting children and young people, and resources on better care for older people and those with learning disabilities.
Situational awareness	The ability to identify, process and comprehend the critical elements of information in a dynamic situation, and be able to adapt, manage and mitigate emergent risk.
Unconscious bias	Refers to a bias that we are unaware of, and which happens outside our cognitive control. It happens automatically and is triggered by our brain making quick judgements, assumptions and unconscious assessments of people and situations.

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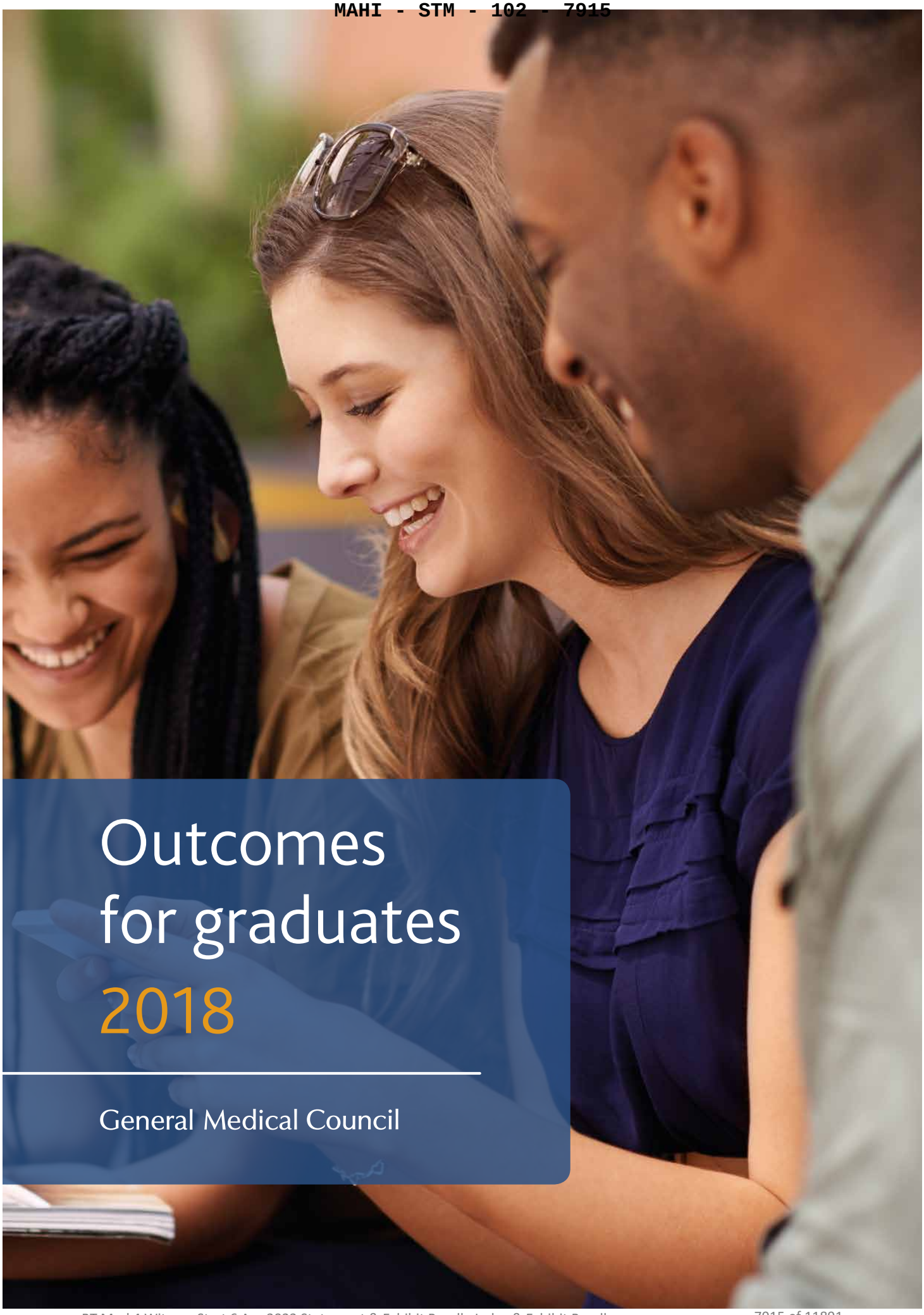
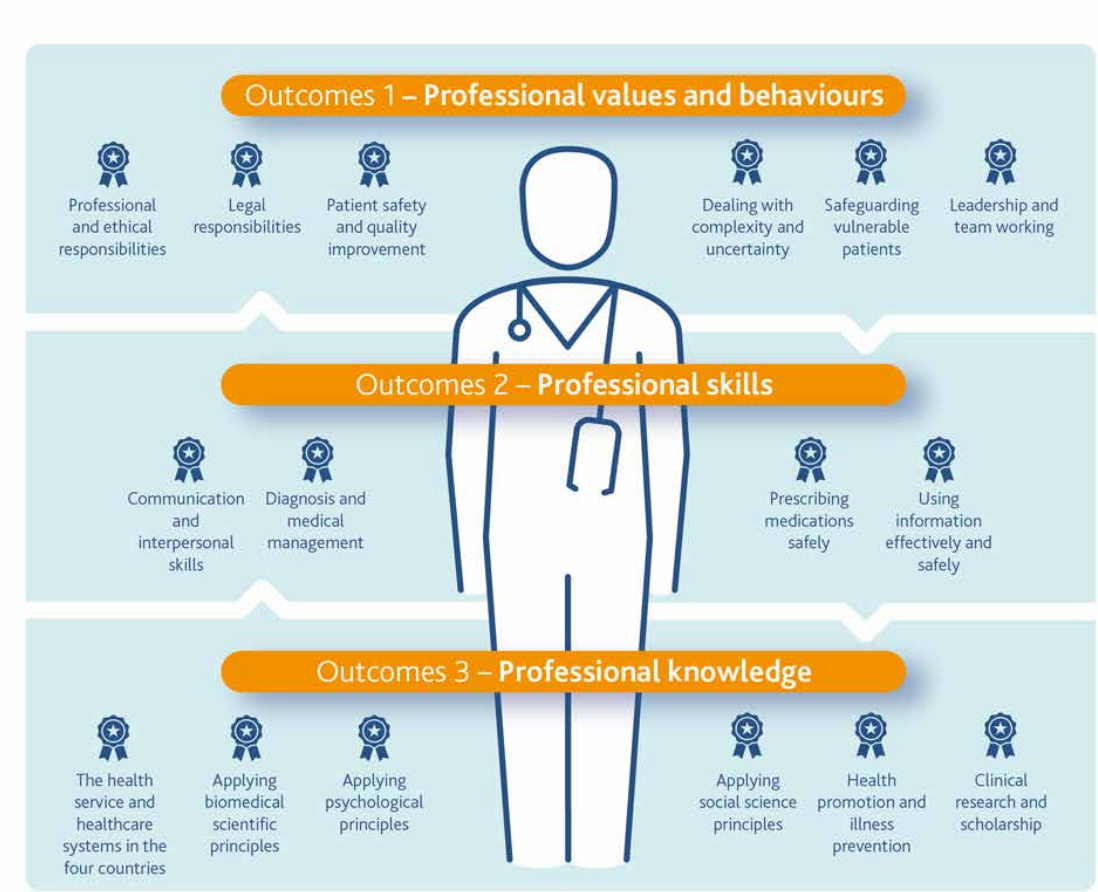


Outcomes for graduates 2018

General Medical Council

Contents

Structure of the outcomes



Each section includes outcomes in a number of areas.

This document will be supplemented by a list of practical procedures – a minimum set of practical skills that newly qualified doctors must have when they start work for the first time so they can practise safely. The list will be published in spring 2019.

Introduction

Purpose of the outcomes

We set the standards and requirements for all stages of medical education and training in *Promoting excellence: standards for medical education and training* (pdf). And we hold a list of universities entitled to issue medical degrees (also known as UK primary medical qualifications).

This document sets out what newly qualified doctors from all medical schools who award UK primary medical qualifications must know and be able to do and it is:

- a guide for students on what they need to learn during their time at medical school
- a basis for medical schools to develop their curricula and programmes of learning
- a blueprint or plan for assessments at medical schools
- a framework we use to regulate medical schools
- a summary of what newly qualified doctors will know and be able to do for those designing postgraduate training.

We recognise and expect that newly qualified doctors will have achieved the capabilities described in the *Outcomes for graduates*. But we acknowledge that they will need ongoing practical experience to develop and consolidate their skills and capabilities during foundation training.

It's important to remember that newly qualified doctors who enter the Foundation Programme will work under educational and clinical supervision and in a multidisciplinary team. In accordance with the Foundation Programme Curriculum, they will need to demonstrate that they are refining their skills and that they are able to take responsibility appropriately whilst recognising and working within the limits of their competence.[1]

Why we've updated the outcomes

Developments in the organisation of care and patterns of disease since Outcomes for graduates was first published in 2009 mean that there is an increased need for newly qualified doctors to:

- be able to care for patients in a variety of settings, including the patient's home and community settings as well as general practices and hospitals
- be able to care for growing numbers of patients with multiple morbidities and long term physical and mental health conditions

- be able to provide integrated care, including mental health care, with social care
- be able to apply principles of health promotion and disease prevention at population level to the care of individual patients
- commit to lifelong learning to keep up to date with developments in medical practice and trends in disease at population level.

How the outcomes relate to our other standards and guidance

Promoting excellence sets out the standards and requirements for the management and delivery of undergraduate and postgraduate medical education and training. The *Outcomes for graduates* set out what we expect newly qualified doctors to be able to know and do and should be read alongside *Promoting excellence*.

We expect all newly qualified doctors to practise in accordance with the professional requirements set out in *Good medical practice* and related guidance. The outcomes have been aligned to *Good medical practice*.

How the outcomes relate to our Generic professional capabilities framework

The *Generic professional capabilities framework*, published in May 2017, describes the interdependent essential capabilities that underpin professional medical practice in the UK and sets these out as educational outcomes. We expect the generic professional capabilities to be integrated into the Foundation Programme Curriculum and all postgraduate specialty training curricula.

We have reflected the capabilities and educational outcomes in this document so there is a recognisable progression through undergraduate and postgraduate medical education and training.

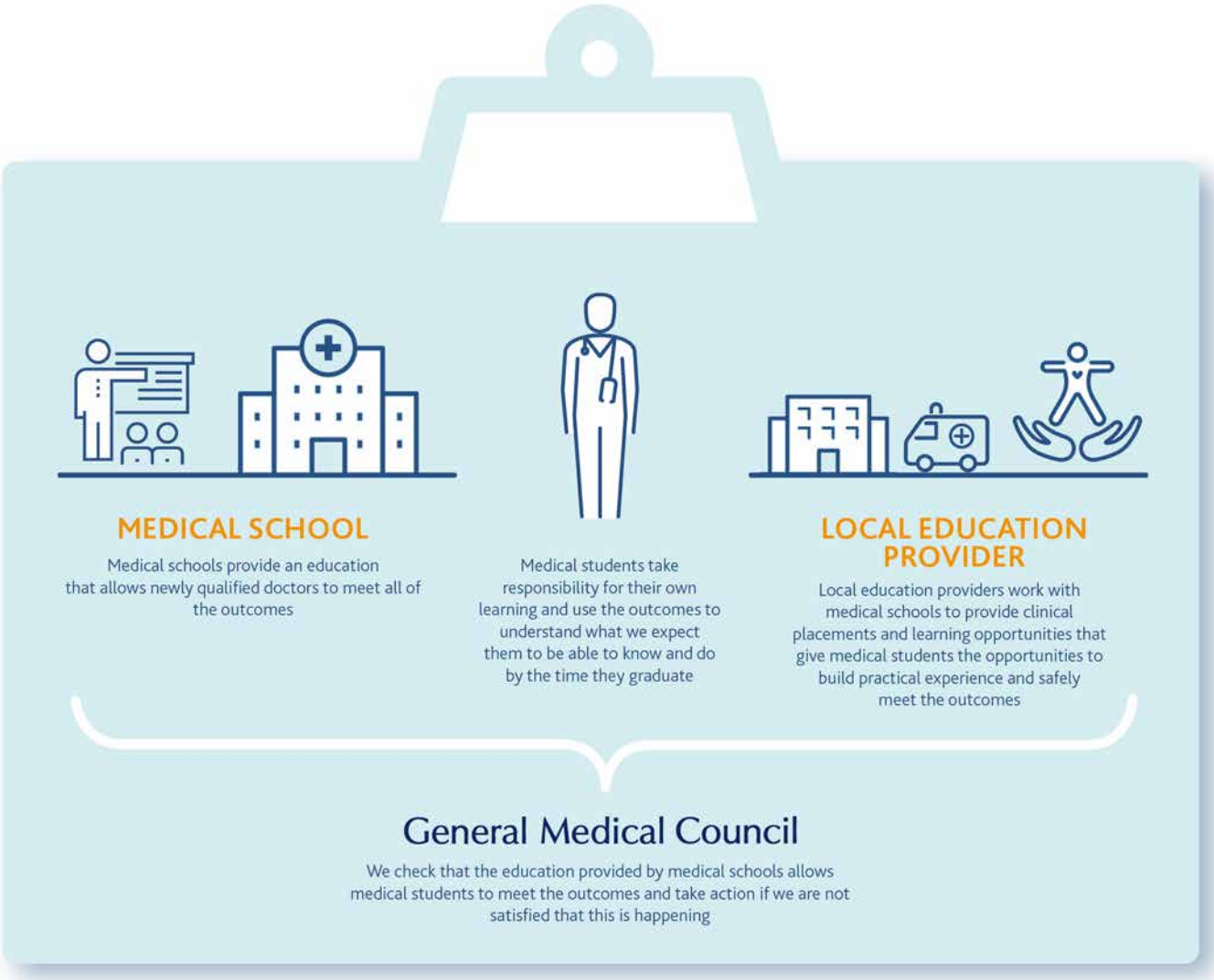
The structure of the outcomes reflects the *Generic professional capabilities framework*. The three sections of the outcomes match the three fundamental domains of the Generic professional capabilities framework. The outcomes also include sections that map to the targeted domains in the *Generic professional capabilities framework*.

Some outcomes in this document are similar to those in the Generic professional capabilities framework. This is because we expect newly qualified doctors and doctors in postgraduate training to demonstrate knowledge and capability in the same areas, but at the level appropriate for the stage of their training.

Newly qualified doctors will build on and develop their knowledge and capabilities as they move through the Foundation Programme and speciality training. These postgraduate curricula will be underpinned by the educational outcomes set out in the *Generic professional capabilities framework*, some of which are common to the outcomes in this document and some of which are necessarily pitched at a higher level.

Responsibility for delivering the outcomes

- **Medical schools** must provide an education that allows newly qualified doctors to meet all the outcomes, including the practical procedures specified in the supplementary list, and therefore to be fit to practise safely as a doctor when they graduate.
- **Local education provider**s working with medical schools must provide and quality manage clinical placements and learning opportunities that give medical students the opportunities to build knowledge, skills and practical experience to meet the outcomes and to safely and effectively carry out practical procedures by the time they qualify.
- **Medical students** are responsible for their own learning. They should refer to *Outcomes for graduates* during their undergraduate education to understand what we expect them to be able to know and do by the time they graduate.



Making sure the *outcomes for graduates* are met

Medical schools must provide us with evidence to show that medical students' learning is directed towards the outcomes and that students' progress towards meeting the outcomes at graduation is assessed.

This evidence must include medical schools' curricula – which we expect to be mapped to the outcomes – and assessment blueprints – which we expect to show when and how students are assessed on their learning against the outcomes.

Assessment could include formal written and clinical examinations, workplace based assessments, evidence of their development as reflective practitioners, essays, research projects, presentations, self assessment or coursework.

We will take action if we are not satisfied that the curriculum and assessments at a medical school are resulting in graduates being able to meet the outcomes. We'll do this in accordance with our Quality Assurance Framework, by requiring the medical school to make changes so the outcomes are met. We will monitor the medical school until we have satisfactory evidence. We may also make regulatory visits to medical schools.

Keeping the outcomes up to date

Medical education responds continually to changes in the health of the population and healthcare systems. And it has to keep up with developments in the technologies used to diagnose, treat and manage illness. Medical education must also adapt to the needs of society and be appropriately responsive to patients and the public.

We'll keep these outcomes up to date with timely revisions to make sure they reflect contemporary medical practice and science.

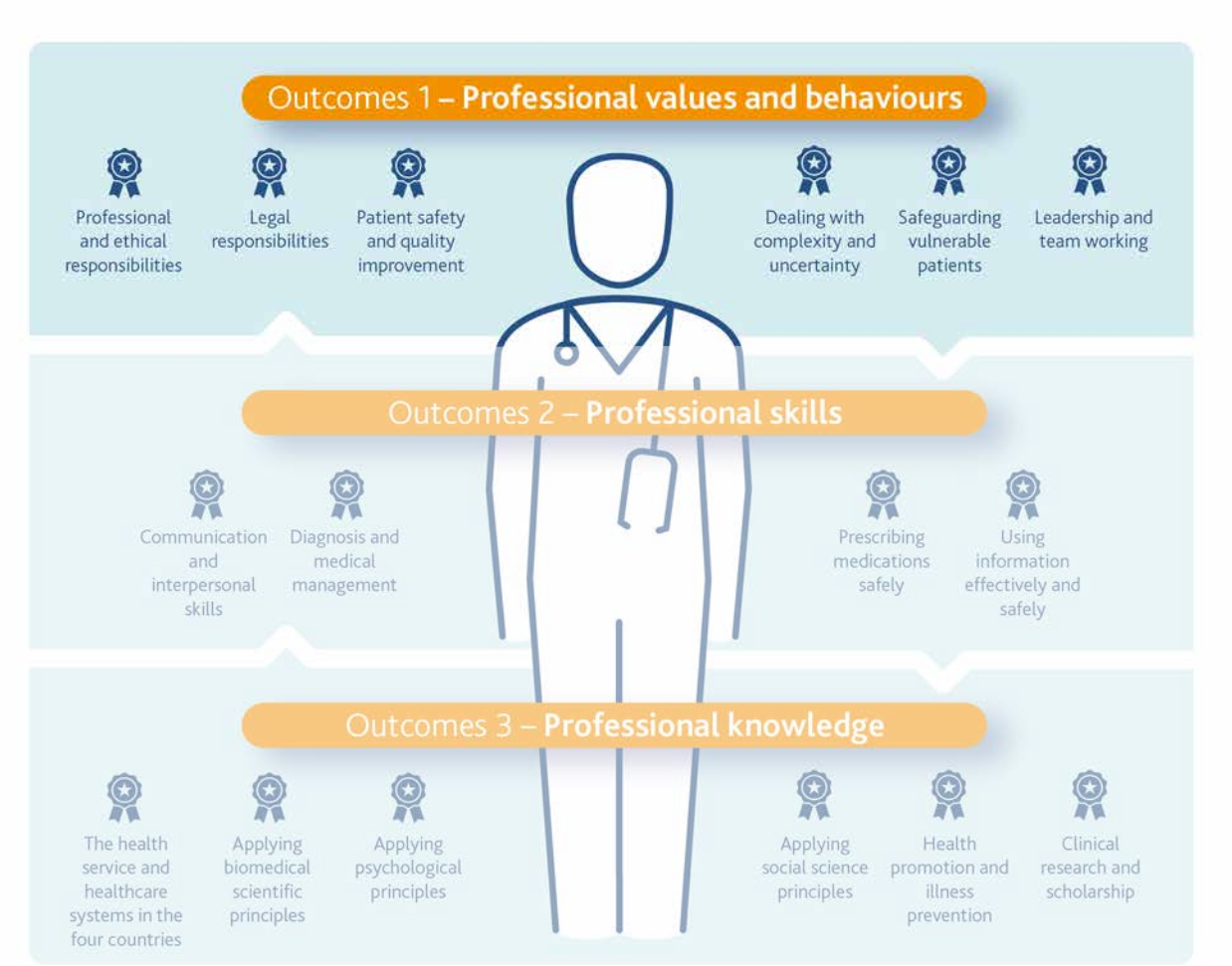
Outcomes for graduates

Overarching outcome for graduates

1 Medical students are tomorrow's doctors. In accordance with Good medical practice, newly qualified doctors must make the care of patients their first concern, applying their knowledge and skills in a competent, ethical and professional manner and taking responsibility for their own actions in complex and uncertain situations.

Outcomes 1 – Professional values and behaviours

We expect newly qualified doctors to demonstrate appropriate generic personal and professional values and behaviours. They must keep to our ethical guidance and standards, *Good medical practice* and the explanatory guidance, which together describe what is expected of all doctors who are registered with us.[2, 3]



Professional and ethical responsibilities

2 Newly qualified doctors must behave according to ethical and professional principles. They must be able to:

a demonstrate the clinical responsibilities and role of the doctor

b demonstrate compassionate professional behaviour and their professional responsibilities in making sure the fundamental needs of patients are addressed

c summarise the current ethical dilemmas in medical science and healthcare practice; the ethical issues that can arise in everyday clinical decision-making; and apply ethical reasoning to situations which may be encountered in the first years after graduation

d maintain confidentiality and respect patients' dignity and privacy

e act with integrity, be polite, considerate, trustworthy and honest

f take personal and professional responsibility for their actions

g manage their time and prioritise effectively

h recognise and acknowledge their own personal and professional limits and seek help from colleagues and supervisors when necessary, including when they feel that patient safety may be compromised

i Protect patients from any risk posed by their own health including:

- the risks to their health and to patient safety posed by self-prescribing medication and substance misuse
- the risks to their health and to patient safety posed by fatigue – they must apply strategies to limit the impact of fatigue on their health.

j recognise the potential impact of their attitudes, values, beliefs, perceptions and personal biases (which may be unconscious) on individuals and groups and identify personal strategies to address this

k demonstrate the principles of person-centred care and include patients and, where appropriate, their relatives, carers or other advocates in decisions about their healthcare needs

l explain and demonstrate the importance of:

- seeking patient consent, or the consent of the person who has parental responsibility in the case of children and young people, or the consent of those with lasting power of attorney or independent mental capacity advocates if appropriate
- providing information about options for investigations, treatment and care in a way that enables patients to make decisions about their own care
- assessing the mental capacity of a patient to make a particular decision, including when the lack of capacity is temporary, and knowing when and how to take action.

m act appropriately, with an inclusive approach, towards patients and colleagues

n be open and honest in their interactions with patients, colleagues and employers when things go wrong – known as the professional duty of candour [4]

- **o** raise and escalate concerns through informal communication with colleagues and through formal clinical governance and monitoring systems [5] about:
  - patient safety and quality of care
  - bullying, harassment and undermining
- **p** explain and demonstrate the importance of professional development and lifelong learning and demonstrate commitment to this
- **q** work effectively and appropriately as a mentor and teacher for other learners in the multi-professional team
- **r** respect patients' wishes about whether they wish to participate in the education of learners
- **s** access and analyse reliable sources of current clinical evidence and guidance and have established methods for making sure their practice is consistent with these
- **t** explain and demonstrate the importance of engagement with revalidation,[6] including maintaining a professional development portfolio which includes evidence of reflection, achievements, learning needs and feedback from patients and colleagues
- **u** engage in their induction and orientation activities, learn from experience and feedback, and respond constructively to the outcomes of appraisals, performance reviews and assessments.

3 Newly qualified doctors must demonstrate awareness of the importance of their personal physical and mental wellbeing and incorporate compassionate self-care into their personal and professional life.[7]

They must demonstrate awareness of the need to:

- **a** self-monitor, self-care and seek appropriate advice and support, including by being registered with a GP and engaging with them to maintain their own physical and mental health
- **b** manage the personal and emotional challenges of coping with work and workload, uncertainty and change
- **c** develop a range of coping strategies, such as reflection, debriefing, handing over to another colleague, peer support and asking for help, to recover from challenges and set-backs.

Legal responsibilities

4 Newly qualified doctors must demonstrate knowledge of the principles of the legal framework in which medicine is practised in the jurisdiction in which they are practising, and have awareness of where further information on relevant legislation can be found.[8]

Patient safety and quality improvement

5 Newly qualified doctors must demonstrate that they can practise safely. They must participate in and promote activity to improve the quality and safety of patient care and clinical outcomes.

They must be able to:

a place patients' needs and safety at the centre of the care process

b promote and maintain health and safety in all care settings and escalate concerns to colleagues where appropriate, including when providing treatment and advice remotely

c recognise how errors can happen in practice and that errors should be shared openly and be able to learn from their own and others' errors to promote a culture of safety

d apply measures to prevent the spread of infection, and apply the principles of infection prevention and control

e describe the principles of quality assurance, quality improvement, quality planning and quality control, and in which contexts these approaches should be used to maintain and improve quality and safety

f describe basic human factors principles and practice at individual, team, organisational and system levels and recognise and respond to opportunities for improvement to manage or mitigate risks

g apply the principles and methods of quality improvement to improve practice (for example, plan, do, study, act or action research), including seeking ways to continually improve the use and prioritisation of resources

h describe the value of national surveys and audits for measuring the quality of care.

Dealing with complexity and uncertainty

6 The nature of illness is complex and therefore the health and care of many patients is complicated and uncertain. Newly qualified doctors must be able to recognise complexity and uncertainty. And, through the process of seeking support and help from colleagues, learn to develop confidence in managing these situations and responding to change.

They must be able to:

a recognise the complex medical needs, goals and priorities of patients, the factors that can affect a patient's health and wellbeing and how these interact. These include psychological and sociological considerations that can also affect patients' health

b identify the need to adapt management proposals and strategies for dealing with health problems to take into consideration patients' preferences, social needs, multiple morbidities, frailty and long term physical and mental conditions

c demonstrate working collaboratively with patients, their relatives, carers or other advocates, in planning their care, negotiating and sharing information appropriately and supporting patient self-care

d demonstrate working collaboratively with other health and care professionals and organisations when working with patients, particularly those with multiple morbidities, frailty and long term physical and mental conditions

e recognise how treatment and care can place an additional burden on patients and make decisions to reduce this burden where appropriate, particularly where patients have multiple conditions or are approaching the end of life

f manage the uncertainty of diagnosis and treatment success or failure and communicate this openly and sensitively with patients, their relatives, carers or other advocates

g evaluate the clinical complexities, uncertainties and emotional challenges involved in caring for patients who are approaching the end of their lives and demonstrate the relevant communication techniques and strategies that can be used with the patient, their relatives, carers or other advocates.

Safeguarding vulnerable patients

7 Newly qualified doctors must be able to recognise and identify factors that suggest patient vulnerability and take action in response.

They must be able to:

a identify signs and symptoms of abuse or neglect and be able to safeguard children, young people, adults and older people, using appropriate systems for sharing information, recording and raising concerns, obtaining advice, making referrals and taking action

b take a history that includes consideration of the patient's autonomy, views and any associated vulnerability, and reflect this in the care plan and referrals

c assess the needs of and support required for children, young people and adults and older people who are the victims of domestic, sexual or other abuse

d assess the needs of, and support required, for people with a learning disability

e assess the needs of, and support required, for people with mental health conditions

f adhere to the professional responsibilities in relation to procedures performed for non-medical reasons, such as female genital mutilation[9] and cosmetic interventions[10]

g explain the application of health legislation that may result in the deprivation of liberty to protect the safety of individuals and society

h recognise where addiction (to drugs, alcohol, smoking or other substances), poor nutrition, self-neglect, environmental exposure, or financial or social deprivation are contributing to ill health. And take action by seeking advice from colleagues and making appropriate referrals

i describe the principles of equality legislation in the context of patient care.

Leadership and team working

8 Newly qualified doctors must recognise the role of doctors in contributing to the management and leadership of the health service.

They must be able to:

a describe the principles of how to build teams and maintain effective team work and interpersonal relationships with a clear shared purpose

b undertake various team roles including, where appropriate, demonstrating leadership and the ability to accept and support leadership by others

c identify the impact of their behaviour on others

d describe theoretical models of leadership and management that may be applied to practice.

9 Newly qualified doctors must learn and work effectively within a multi-professional and multi-disciplinary team and across multiple care settings. This includes working face to face and through written and electronic means, and in a range of settings where patients receive care, including community, primary, secondary, mental health, specialist tertiary and social care settings and in patients' homes.

They must be able to:

a demonstrate their contribution to effective interdisciplinary team working with doctors from all care settings and specialties, and with other health and social care professionals for the provision of safe and high-quality care

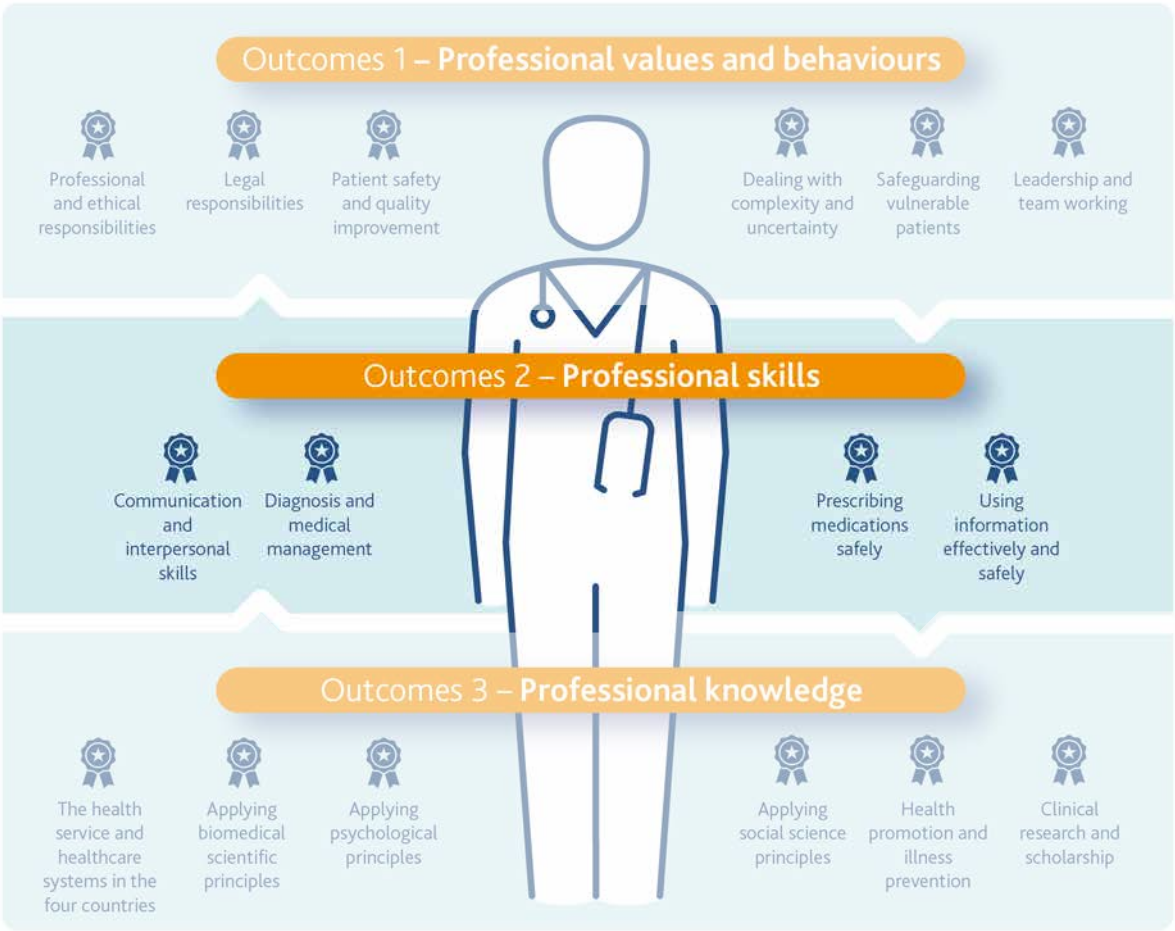
b work effectively with colleagues in ways that best serve the interests of patients. This includes:

- safely passing on information using clear and appropriate spoken, written and electronic communication:
  - at handover in a hospital setting and when handing over and maintaining continuity of care in primary, community and social care settings
  - when referring to colleagues for investigations or advice
  - when things go wrong, for example when errors happen
  - questioning colleagues during handover where appropriate
  - working collaboratively and supportively with colleagues to share experiences and challenges that encourage learning
  - responding appropriately to requests from colleagues to attend patients
  - applying flexibility, adaptability and a problem-solving approach to shared decision making with colleagues.

c recognise and show respect for the roles and expertise of other health and social care professionals and doctors from all specialties and care settings in the context of working and learning as a multi-professional team.

Outcomes 2 – Professional skills

We expect doctors to demonstrate appropriate skills in clinical practice.



Communication and interpersonal skills

10 Newly qualified doctors must be able to communicate effectively, openly and honestly with patients, their relatives, carers or other advocates, and with colleagues, applying patient confidentiality appropriately.

They must be able to:

a communicate clearly, sensitively and effectively with patients, their relatives, carers or other advocates, and colleagues from medical and other professions, by:

- listening, sharing and responding

- demonstrating empathy and compassion
- demonstrating effective verbal and non-verbal interpersonal skills
- making adjustments to their communication approach if needed, for example for people who communicate differently due to a disability or who speak a different first language
- seeking support from colleagues for assistance with communication if needed.

b communicate by spoken, written and electronic methods (including in medical records) clearly, sensitively and effectively with patients, their relatives, carers or other advocates, and colleagues from medical and other professions. This includes, but is not limited to, the following situations:

- where there is conflict or disagreement
- when sharing news about a patient's condition that may be emotionally challenging for the patient and those close to them
- when sharing news about a patient's death with relatives and carers or other advocates
- when discussing issues that may be sensitive for the patient, such as alcohol consumption, smoking, diet and weight management or sexual behaviour
- when communicating with people who lack insight into their illness or are ambivalent about treatment
- when communicating with children and young people
- when communicating with people who have impaired hearing, language, speech or sight
- when communicating with people who have cognitive impairment
- when communicating with people who have learning disabilities
- when English is not the patient's first language - by using an interpreter, translation service or other online methods of translation[11]
- when the patient lacks capacity to reach or communicate a decision on their care needs
- when advocating for patients' needs
- when making referrals to colleagues from medical and other professions
- when providing care remotely, such as carrying out consultations using telecommunications.

c use methods of communication used by patients and colleagues such as technology-enabled communication platforms, respecting confidentiality and maintaining professional standards of behaviour.

11 Newly qualified doctors must be able to carry out an effective consultation with a patient. They must be able to:

a elicit and accurately record a patient's medical history, including family and social history, working with parents and carers or other advocates when the patient is a child or young person or an adult who requires the support of a carer or other advocate

b encourage patients' questions, discuss their understanding of their condition and treatment options, and take into account their ideas concerns, expectations, values and preferences

c acknowledge and discuss information patients have gathered about their conditions and symptoms, taking a collaborative approach

d provide explanation, advice and support that matches patients' level of understanding and needs, making reasonable adjustments to facilitate patients' understanding if necessary

e assess a patient's capacity to understand and retain information and to make a particular decision, making reasonable adjustments to support their decision making if necessary, in accordance with legal requirements in the relevant jurisdiction and the GMC's ethical guidance as appropriate

f work with patients, or their legal advocates, to agree how they want to be involved in decision making about their care and treatment

g describe the principles of holding a fitness for work conversation with patients, including assessing social, physical, psychological and biological factors supporting the functional capacity of the patient, and how to make referrals to colleagues and other agencies.

Diagnosis and medical management

12 Newly qualified doctors must work collaboratively with patients and colleagues to diagnose and manage clinical presentations safely in community, primary and secondary care settings and in patients' homes. Newly qualified doctors must, wherever possible, support and facilitate patients to make decisions about their care and management.

13 Newly qualified doctors must be able to perform a range of diagnostic, therapeutic and practical procedures safely and effectively, and identify, according to their level of skill and experience, the procedures for which they need supervision to ensure patient safety.[12]

14 Newly qualified doctors must be able to work collaboratively with patients, their relatives, carers or other advocates to make clinical judgements and decisions based on a holistic assessment of the patient and their needs, priorities and concerns, and appreciating the importance of the links between pathophysiological, psychological, spiritual, religious, social and cultural factors for each individual.

They must be able to:

a propose an assessment of a patient's clinical presentation, integrating biological, psychological and social factors, agree this with colleagues and use it to direct and prioritise investigations and care

b safely and sensitively undertake:

- an appropriate physical examination (with a chaperone present if appropriate)
- a mental and cognitive state examination, including establishing if the patient is a risk to themselves or others, seeking support and making referrals if necessary
- a developmental examination for children and young people.

c interpret findings from history, physical and mental state examinations

d propose a holistic clinical summary, including a prioritised differential diagnosis/diagnoses and problem list

e propose options for investigation, taking into account potential risks, benefits, cost effectiveness and possible side effects and agree in collaboration with colleagues if necessary, which investigations to select

f interpret the results of investigations and diagnostic procedures, in collaboration with colleagues if necessary

g synthesise findings from the history, physical and mental state examinations and investigations, in collaboration with colleagues if necessary, and make proposals about underlying causes or pathology

h understand the processes by which doctors make and test a differential diagnosis and be prepared to explain their clinical reasoning to others

i make clinical judgements and decisions with a patient, based on the available evidence, in collaboration with colleagues and as appropriate for their level of training and experience, and understand that this may include situations of uncertainty

j take account of patients' concerns, beliefs, choices and preferences, and respect the rights of patients to reach decisions with their doctor about their treatment and care and to refuse or limit treatment

k seek informed consent for any recommended or preferred options for treatment and care

l propose a plan of management including prevention, treatment, management and discharge or continuing community care, according to established principles and best evidence, in collaboration with other health professionals if necessary

m support and motivate the patient's self-care by helping them to recognise the benefits of a healthy lifestyle and motivating behaviour change to improve health and include prevention in the patient's management plan

n recognise the potential consequences of over-diagnosis and over-treatment.

15 Newly qualified doctors must demonstrate that they can make appropriate clinical judgements when considering or providing compassionate interventions or support for patients who are nearing or at the end of life. They must understand the need to involve patients, their relatives, carers or other advocates in management decisions, making referrals and seeking advice from colleagues as appropriate.

16 Newly qualified doctors must be able to give immediate care to adults, children and young people in medical and psychiatric emergencies and seek support from colleagues if necessary.

17 Newly qualified doctors must be able to recognise when a patient is deteriorating and take appropriate action.

They must be able to:

a assess and determine the severity of a clinical presentation and the need for immediate emergency care

b diagnose and manage acute medical and psychiatric emergencies, escalating appropriately to colleagues for assistance and advice

c provide immediate life support

d perform cardiopulmonary resuscitation.

Prescribing medications safely

18 Newly qualified doctors must be able to prescribe medications safely, appropriately, effectively and economically and be aware of the common causes and consequences of prescribing errors.

They must be able to:

a establish an accurate medication history, covering both prescribed medication and other drugs or supplements, and establish medication allergies and the types of medication interactions that patients experience

b carry out an assessment of benefit and risk for the patient of starting a new medication taking into account the medication history and potential medication interactions in collaboration with the patient and, if appropriate, their relatives, carers or other advocates

c provide patients, their relatives, carers or other advocates, with appropriate information about their medications in a way that enables patients to make decisions about the medications they take

d agree a medication plan with the patient that they are willing and able to follow

e access reliable information about medications and be able to use the different technologies used to support prescribing

f calculate safe and appropriate medication doses and record the outcome accurately

g write a safe and legal prescription, tailored to the specific needs of individual patients, using either paper or electronic systems and using decision support tools where necessary

h describe the role of clinical pharmacologists and pharmacists in making decisions about medications and prescribe in consultation with these and other colleagues as appropriate

i communicate appropriate information to patients about what their medication is for, when and for how long to take it, what benefits to expect, any important adverse effects that may occur and what follow-up will be required

j detect and report adverse medication reactions and therapeutic interactions and react appropriately by stopping or changing medication

k monitor the efficacy and effects of medication and with appropriate advice from colleagues, reacting appropriately by adjusting medication, including stopping medication with due support, care and attention if it proves ineffective, is no longer needed or the patient wishes to stop taking it

l recognise the challenges of safe prescribing for patients with long term physical and mental conditions or multiple morbidities and medications, in pregnancy, at extremes of age and at the end of life

m respect patient choices about the use of complementary therapies, and have a working knowledge of the existence and range of these therapies, why patients use them, and how this might affect the safety of other types of treatment that patients receive

n recognise the challenges of delivering these standards of care when prescribing and providing treatment and advice remotely, for example via online services

o recognise the risks of over-prescribing and excessive use of medications and apply these principles to prescribing practice.

Using information effectively and safely

19 Newly qualified doctors must be able to use information effectively and safely in a medical context, and maintain accurate, legible, contemporaneous and comprehensive medical records.

They must be able to:

a make effective use of decision making and diagnostic technologies

b apply the requirements of confidentiality and data protection legislation and comply with local information governance and storage procedures when recording and coding patient information

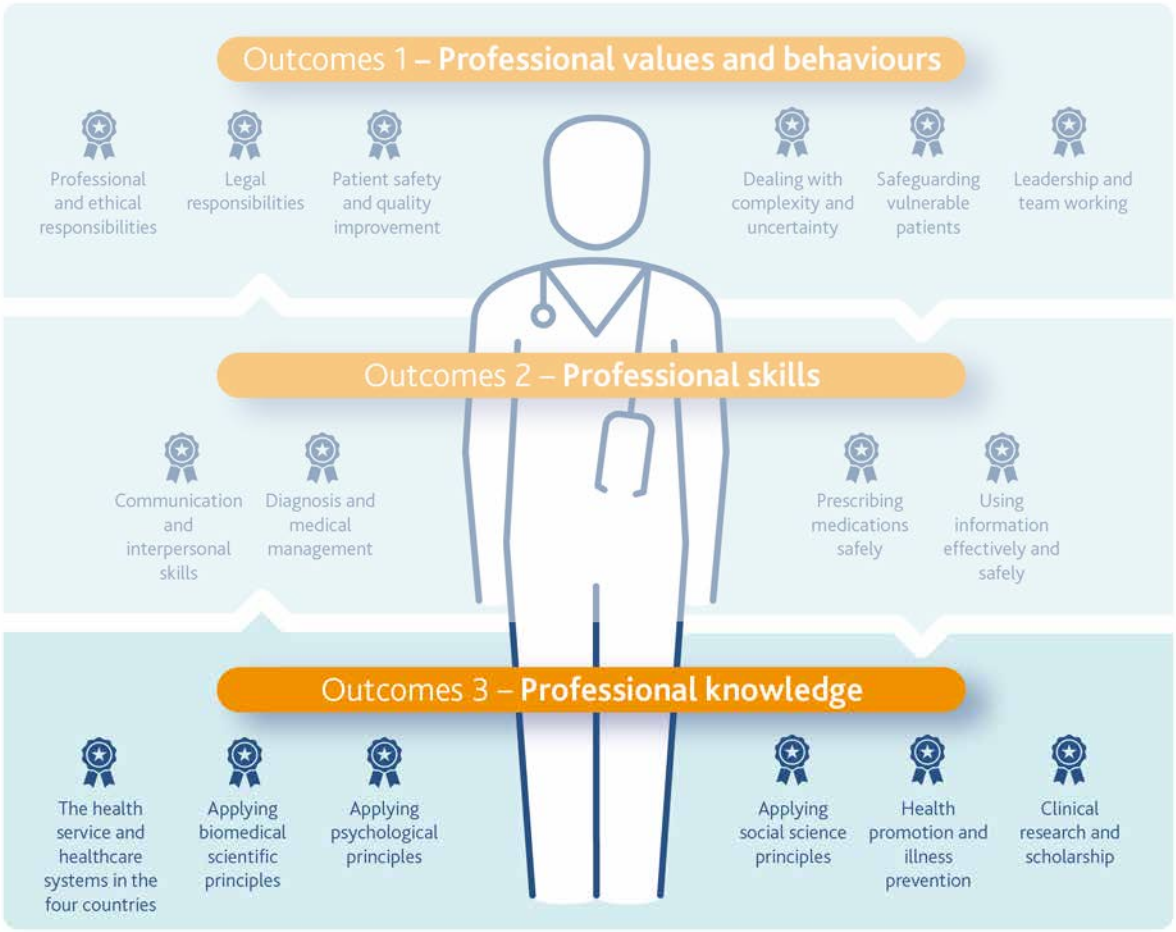
c explain their professional and legal responsibilities when accessing information sources in relation to patient care, health promotion, giving advice and information to patients, and research and education

d discuss the role of doctors in contributing to the collection and analysis of patient data at a population level to identify trends in wellbeing, disease and treatment, and to improve healthcare and healthcare system

e apply the principles of health informatics to medical practice.

Outcomes 3 – Professional knowledge

We expect newly qualified doctors to demonstrate their knowledge through scholarly application to the care of patients in practice. Newly qualified doctors must recognise biomedical, psychological and social science principles of health and disease, and integrate and apply scholarly principles to the care of patients. Newly qualified doctors must understand the patient journey through the full range of health and social care settings.



The health service and healthcare systems in the four countries

20 Newly qualified doctors must demonstrate how patient care is delivered in the health service. They must be able to:

a describe and illustrate from their own professional experience the range of settings in which patients receive care, including in the community, in patients' homes and in primary and secondary care provider settings

b explain and illustrate from their own professional experience the importance of integrating patients' care across different settings to ensure person-centred care

c describe emerging trends in settings where care is provided, for example the shift for more care to be delivered in the community rather than in secondary care settings

d describe the relationship between healthcare and social care and how they interact.

21 Newly qualified doctors must recognise that there are differences in healthcare systems across the four nations of the UK and know how to access information about the different systems, including the role of private medical services in the UK.

Applying biomedical scientific principles

22 Newly qualified doctors must be able to apply biomedical scientific principles, methods and knowledge to medical practice and integrate these into patient care. This must include principles and knowledge relating to anatomy, biochemistry, cell biology, genetics, genomics and personalised medicine, immunology, microbiology, molecular biology, nutrition, pathology, pharmacology and clinical pharmacology, and physiology.

They must be able to:

a explain how normal human structure and function and physiological processes applies, including at the extremes of age, in children and young people and during pregnancy and childbirth

b explain the relevant scientific processes underlying common and important disease processes

c justify, through an explanation of the underlying fundamental principles and clinical reasoning, the selection of appropriate investigations for common clinical conditions and diseases

d select appropriate forms of management for common diseases, and ways of preventing common diseases, and explain their modes of action and their risks from first principles

e describe medications and medication actions: therapeutics and pharmacokinetics; medication side effects and interactions, including for multiple treatments, long term physical and mental conditions and non-prescribed drugs; the role of pharmacogenomics and antimicrobial stewardship

f analyse clinical phenomena and conduct appropriate critical appraisal and analysis of clinical data, and explain clinical reasoning in action and how they formulate a differential diagnosis and management plan.

Applying psychological principles

23 Newly qualified doctors must explain and illustrate by professional experience the principles for the identification, safe management and referral of patients with mental health conditions.

They must be able to:

a describe and illustrate from examples the spectrum of normal human behaviour at an individual level

b integrate psychological concepts of health, illness and disease into patient care and apply theoretical frameworks of psychology to explain the varied responses of individuals, groups and societies to disease

c explain the relationship between psychological and medical conditions and how psychological factors impact on risk and treatment outcome

d describe the impact of patients' behaviours on treatment and care and how these are influenced by psychological factors

e describe how patients adapt to major life changes, such as bereavement, and the adjustments that might occur in these situations

f identify appropriate strategies for managing patients with substance misuse or risk of self-harm or suicide

g explain how psychological aspects of behaviour, such as response to error, can influence behaviour in the workplace in a way that can affect health and safety and apply this understanding to their personal behaviours and those of colleagues.

Applying social science principles

24 Newly qualified doctors must be able to apply social science principles, methods and knowledge to medical practice and integrate these into patient care. They must be able to:

a recognise how society influences and determines the behaviour of individuals and groups and apply this to the care of patients

b review the sociological concepts of health, illness and disease and apply these to the care of patients

c apply theoretical frameworks of sociology to explain the varied responses of individuals, groups and societies to disease

d recognise sociological factors that contribute to illness, the course of the disease and the success of treatment and apply these to the care of patients – including issues relating to health inequalities and the social determinants of health, the links between occupation and health, and the effects of poverty and affluence

e explain the sociological aspects of behavioural change and treatment concordance and compliance, and apply these models to the care of patients as part of person-centred decision making.

Health promotion and illness prevention

25 Newly qualified doctors must be able to apply the principles, methods and knowledge of population health and the improvement of health and sustainable healthcare to medical practice.

They must be able to:

a explain the concept of wellness or wellbeing as well as illness, and be able to help and empower people to achieve the best health possible, including promoting lifestyle changes such as smoking cessation, avoiding substance misuse and maintaining a healthy weight through physical activity and diet

b describe the health of a population using basic epidemiological techniques and measurements

c evaluate the environmental, social, behavioural and cultural factors which influence health and disease in different populations

d assess, by taking a history, the environmental, social, psychological, behavioural and cultural factors influencing a patient's presentation, and identify options to address these, including advocacy for those who are disempowered

e apply epidemiological data to manage healthcare for the individual and the community and evaluate the clinical and cost effectiveness of interventions

f outline the principles underlying the development of health, health service policy, and clinical guidelines, including principles of health economics, equity, and sustainable healthcare

g apply the principles of primary, secondary and tertiary prevention of disease, including immunisation and screening

h evaluate the role of ecological, environmental and occupational hazards in ill-health and discuss ways to mitigate their effects

i apply the basic principles of communicable disease control in hospital and community settings, including disease surveillance

j discuss the role and impact of nutrition to the health of individual patients and societies

k evaluate the determinants of health and disease and variations in healthcare delivery and medical practice from a global perspective and explain the impact that global changes may have on local health and wellbeing.

Clinical research and scholarship

26 Newly qualified doctors must be able to apply scientific method and approaches to medical research and integrate these with a range of sources of information used to make decisions for care.

They must be able to:

a explain the role and hierarchy of evidence in clinical practice and decision making with patients

b interpret and communicate research evidence in a meaningful way for patients to support them in making informed decisions about treatment and management

c describe the role and value of qualitative and quantitative methodological approaches to scientific enquiry

d interpret common statistical tests used in medical research publications

e critically appraise a range of research information including study design, the results of relevant diagnostic, prognostic and treatment trials, and other qualitative and quantitative studies as reported in the medical and scientific literature.

f formulate simple relevant research questions in biomedical science, psychosocial science or population science, and design appropriate studies or experiments to address the questions

g describe basic principles and ethical implications of research governance including recruitment into trials and research programmes

h describe stratified risk

i describe the concept of personalised medicine to deliver care tailored to the needs of individual patients

j use evidence from large scale public health reviews and other sources of public health data to inform decisions about the care of individual patients.

References

1 Find out more about the Foundation Programme curriculum on the Foundation Programme website.

2 General Medical Council. *Good medical practice* and explanatory guidance available at: https://www.gmc-uk.org/guidance/ethical_guidance.asp

3 See our supplementary guidance on Good medical practice and explanatory guidance for specific areas of Good medical practice and explanatory guidance that we expect newly qualified doctors to be familiar with.

4 For more information, see our ethical guidance on the professional duty of candour and also, the revalidation pages of our website.

5 This could include whistleblowing, see UK government guidance on whistleblowing for employees.

6 For more information, see our revalidation home page: https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation

7 We require medical schools and postgraduate training organisations and local education providers to give learners resources to support their health and wellbeing. Theme 3: Supporting learners, Requirement R3.2.

8 See our supplementary guidance on legislation for specific areas of legislation that we expect newly qualified doctors to be able to understand the principles of.

9 See UK guidance on Mandatory reporting of female genital mutilation.

10 See our Guidance for doctors who offer cosmetic interventions.

11 Newly qualified doctors working in Wales need to be aware of provisions for Welsh language services in health, social services and social care in Wales. NHS Wales Welsh Language Policy Unit.

12 This document will be supplemented by a list of practical procedures – a minimum set of practical skills that newly qualified doctors must have when they start work for the first time so they can practise safely. The list will be published in spring 2019.

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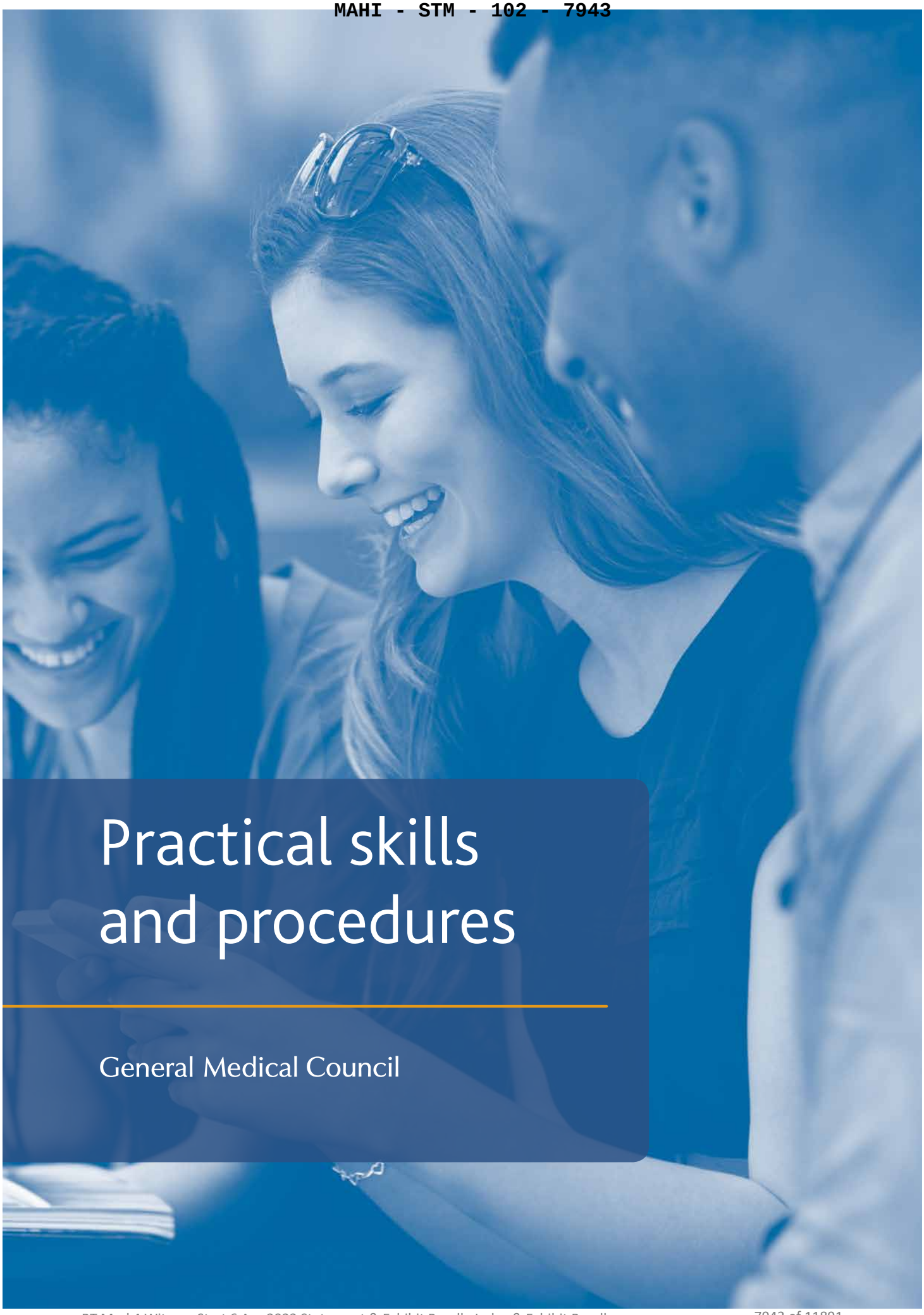

Practical skills and procedures

General Medical Council

Practical skills and procedures

Purpose of the practical skills and procedures

We set the standards and requirements for all stages of medical education and training in *Promoting excellence: standards for medical education and training* (2016, pdf) and hold a list of universities entitled to award a medical degree recognised as a UK primary medical qualification.

Our *Outcomes for graduates* (2018) set out what newly qualified doctors from all medical schools must know and be able to do.

The *Practical skills and procedures* outline the core set of practical skills and procedures, and minimum level of performance that newly qualified doctors must have when they start work for the first time so they can practise safely.

Provisions for encouraging diversity in medicine

We believe that equality, diversity and inclusion are integral to our work as a regulator. We are committed to supporting diversity in medicine.

We expect organisations to make supportive and pragmatic adjustments for learners to enable achievement of the practical skills and procedures, including where learners have long-term health conditions and disabilities, while also abiding by the Equality Act 2010 and the Disability Discrimination Act 1995.

Students need to be able to perform the practical skill or procedure using the specified method, but reasonable adjustments could be made to other aspects. For example, an adapted chair if the student needs to sit down while carrying out the procedure. Further detailed information can be found in our publications *Welcomed and valued* (2019, pdf), *Promoting Excellence* (2016, pdf) and *Promoting excellence - equality and diversity considerations* (2017, pdf).

How the procedures relate to our other standards and guidance

Our *Outcomes for graduates* (the outcomes) set out what newly qualified doctors from all medical schools who award UK primary medical qualifications must know and be able to do. The *Practical skills and procedures* supplements the outcomes by defining the core diagnostic, therapeutic and practical skills and procedures newly qualified doctors must be able to perform safely and effectively, and identifying the level of supervision needed to ensure patient safety.

Promoting excellence sets out the standards and requirements for the management and delivery of undergraduate and postgraduate medical education and training. The outcomes and the *Practical skills and procedures* set out what we expect newly qualified doctors to be able to know and do and should be read alongside *Promoting excellence*.

We expect all newly qualified doctors to practise in accordance with the professional requirements set out in *Good medical practice* and related guidance.

Responsibility for delivering the procedures

- **Medical schools** must provide an education that allows newly qualified doctors to meet all the outcomes, including the practical skills and procedures specified in this list, and therefore to be fit to practise safely as a doctor when they graduate.

- **Local education providers**, working with medical schools, must provide and quality manage clinical placements and learning opportunities that give medical students the opportunities to build knowledge, skills and practical experience to meet the outcomes and to safely and effectively carry out the practical skills and procedures by the time they qualify.
- **Medical students** are responsible for their own learning. They should refer to the outcomes and the practical skills and procedures specified in this list during their undergraduate education to understand what we expect them to be able to know and do by the time they graduate.

What must newly qualified doctors demonstrate for satisfactory completion?

Three levels of competence

Safe to practise in simulation

The newly qualified doctor is safe to practise in a simulated setting and is ready to move to direct supervision. This means that the newly qualified doctor will not have performed the procedure on a real patient during medical school, but on a simulated patient or manikin. This means that they will have some knowledge and skill in the procedure but will require direct supervision when performing the procedure on patients.

Safe to practise under direct supervision

The newly qualified doctor is ready to perform the procedure on a patient under direct supervision. This means that the newly qualified doctor will have performed the procedure on real patients during medical school under direct supervision. By direct supervision, we mean that the medical student or newly qualified doctor will have a supervisor with them observing their practice as they perform the procedure. As the newly qualified doctor's experience and skill becomes sufficient to allow them to perform the procedure safely they will move to performing the procedure under indirect supervision.

Safe to practise under indirect supervision

The newly qualified doctor is ready to perform the procedure on a patient under indirect supervision. This means that the newly qualified doctor will have performed the procedure on real patients during medical school under direct supervision at first and, as their experience and skill became sufficient to allow them to perform the procedure safely, with indirect supervision. By indirect supervision, we mean that the newly qualified doctor is able to access support to perform the procedure if they need to – for example by locating a colleague and asking for help.

Generic requirements

There are both generic requirements and specific procedure requirements for each procedure. Newly qualified doctors should comply with local and national guidelines, and employers will also typically have protocols for the safe performance of each procedure which should be followed.

Generic requirements for each procedure

The following generic requirements apply to each procedure:

- introduce themselves
- check the patient's identity
- confirm that the procedure is required
- explain the procedure to the patient (including possible complications and risks) and gain informed consent for the procedure (under direct supervision where appropriate)
- follow universal precautions to reduce the risk of infections, including:
  - control the risk of cross infection, and take appropriate steps for personal safety
  - follow approved processes for cleaning hands before procedures or surgical operations
  - correctly use personal protective equipment (for example gloves, gowns and masks)
  - employ safe disposal of clinical waste, needles and other sharps
  - dispose of all equipment in the appropriate receptacles

- label samples appropriately according to local guidelines
- accurately document the procedure according to local guidelines
- ensure confidentiality
- interpret any results and act appropriately on them;* and
- arrange appropriate aftercare/monitoring.

It's important to remember that newly qualified doctors who enter the Foundation Programme will work under educational and clinical supervision and in a multidisciplinary team. In accordance with the Foundation Programme Curriculum, they will need to demonstrate that they are refining their skills and that they are able to take responsibility appropriately whilst recognising and working within the limits of their competence.

Assessment of patient needs

No	Procedure	Description	Level of competence
1	Take baseline physiological observations and record appropriately	Measure temperature, respiratory rate, pulse rate, blood pressure, oxygen saturations and urine output.	Safe to practise under indirect supervision
2	Carry out peak expiratory flow respiratory function test	Explain to a patient how to perform a peak expiratory flow, assess that it is performed adequately and interpret results.	Safe to practise under indirect supervision
3	Perform direct ophthalmoscopy	Perform basic ophthalmoscopy and identify common abnormalities.	Safe to practise under indirect supervision
4	Perform otoscopy	Perform basic otoscopy and identify common abnormalities.	Safe to practise under indirect supervision

Diagnostic procedures

No	Procedure	Description	Level of competence
5	Take blood cultures	Take samples of venous blood to test for the growth of infectious organisms.	Safe to practise under direct supervision
6	Carry out arterial blood gas and acid base sampling from the radial artery in adults	Insert a needle into a patient's radial artery (in the wrist) to take a sample of arterial blood and interpret the results.	Safe to practise under direct supervision

* The newly qualified doctor must recognise the need to seek advice on unexpected or unusual results.

7	Carry out venepuncture	Insert a needle into a patient's vein to take a sample of blood for testing. Make sure that blood samples are taken in the correct order, placed in the correct containers, that these are labelled correctly and sent to the laboratory promptly.	Safe to practise under indirect supervision
8	Measure capillary blood glucose	Measure the concentration of glucose in the patient's blood at the bedside using appropriate equipment. Record and interpret the results.	Safe to practise under indirect supervision
9	Carry out a urine multi dipstick test	Explain to patient how to collect a midstream urine sample. Test a sample of urine to detect abnormalities. Perform a pregnancy test where appropriate.	Safe to practise under indirect supervision
10	Carry out a 3- and 12-lead electrocardiogram	Set up a continuous recording of the electrical activity of the heart, ensuring that all leads are correctly placed.	Safe to practise under indirect supervision
11	Take and/or instruct patients how to take a swab	Use the correct technique to apply sterile swabs to the nose, throat, skin and wounds. Make sure that samples are placed in the correct containers, that these are labelled correctly and sent to the laboratory promptly and in the correct way.	Safe to practise under indirect supervision for nose, throat, skin or wound swabs

Patient care

No	Procedure	Description	Level of competence
12	Perform surgical scrubbing up	Follow approved processes for cleaning hands and wearing appropriate personal protective equipment before procedures or surgical operations.	Safe to practise under direct supervision
13	Set up an infusion	Set up and run through an intravenous infusion. Have awareness of the different equipment and devices used.	Safe to practise under direct supervision
14	Use correct techniques for moving and handling, including patients who are frail	Use, and/or direct other team members to use, approved methods for moving, lifting and handling people or objects, in the context of clinical care, using methods that avoid injury to patients, colleagues, or oneself.	Safe to practise under indirect supervision

Prescribing

No	Procedure	Description	Level of competence
15	Instruct patients in the use of devices for inhaled medication	Explain to a patient how to use an inhaler correctly, including spacers, and check that their technique is correct.	Safe to practise under indirect supervision
16	Prescribe and administer oxygen	Prescribe and administer oxygen safely using a delivery method appropriate for the patient's needs and monitor and adjust oxygen as needed.	Safe to practise under indirect supervision
17	Prepare and administer injectable (intramuscular, subcutaneous, intravenous) drugs	Prepare and administer injectable drugs and prefilled syringes.	Safe to practise under direct supervision

Therapeutic procedures

No	Procedure	Description	Level of competence
18	Carry out intravenous cannulation	Insert a cannula into a patient's vein and apply an appropriate dressing.	Safe to practise under direct supervision
19	Carry out safe and appropriate blood transfusion	Following the correct procedures, give a transfusion of blood (including correct identification of the patient and checking blood groups). Observe the patient for possible reactions to the transfusion, and take action if they occur.	Experienced in a simulated setting; further training required before direct supervision
20	Carry out male and female urinary catheterisation	Insert a urethral catheter in both male and female patients.	Safe to practise under direct supervision
21	Carry out wound care and basic wound closure and dressing	Provide basic care of surgical or traumatic wounds and apply dressings appropriately.	Safe to practise under direct supervision
22	Carry out nasogastric tube placement	Pass a tube into the stomach through the nose and throat for feeding and administering drugs or draining the stomach's contents. Know how to ensure correct placement.	Safe to practise in simulation
23	Use local anaesthetics	Inject or topically apply a local anaesthetic. Understand maximum doses of local anaesthetic agents.	Safe to practise under direct supervision

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Good Psychiatric Practice

3rd edition

Contents

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College Report CR154

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Contents

Introduction

Good Psychiatric Practice sets out standards of practice for psychiatrists. It is aligned to the General Medical Council's (GMC's) *Good Medical Practice* (2006), the standards for all medical practitioners. In this edition, the GMC standards for *Good Medical Practice* (2006) are followed by the additional standards required for good psychiatric practice. Repetition of standards is avoided where possible. *Good Medical Practice* (2006) is not reproduced in full in this document and is available at www.gmc-uk.org/guidance/good_medical_practice/index.asp.

CR154 replaces the second edition of *Good Psychiatric Practice* (CR125). The document has been revised with the GMC's approach to revalidation in mind. The standards set out in *Good Psychiatric Practice* are those psychiatrists will need to meet for recertification in the UK. Reference is also made to legal principles relevant to the UK. The standards of practice do, however, apply to members of the Royal College of Psychiatrists, or other psychiatrists, whatever their grade, whatever the clinical setting and wherever they are practising.

Good Psychiatric Practice does not set out the competencies of psychiatric practice, nor those of the practice of subspecialties. Competencies are detailed in the competency based curriculum available on the College website (www.rcpsych.ac.uk/training/curriculum.aspx)

For ease of reference and continuity, the framework of the document has been revised to follow that of *Good Medical Practice* (2006).

Good Psychiatric Practice should be read in conjunction with the following guidance documents published by the College in the *Good Psychiatric Practice* series. The dates and references of these documents will change over time.

- *Good Psychiatric Practice: Confidentiality and Information Sharing* (CR133) (2006)
- *Vulnerable Patients, Safe Doctors: Good Practice in our Clinical Relationships* (CR146) (2007)
- *Sexual Boundary Issues in Psychiatric Settings* (CR145) (2007)
- *Good Psychiatric Practice: Continuing Professional Development* (CR90) (2001)
- *Good Psychiatric Practice: Relationships with Pharmaceutical and Other Commercial Organisations* (CR148) (2008)
- *Court Work* (CR147) (2008)

The above reports, and many others, are available in PDF format on the College's website at www.rcpsych.ac.uk/publications/collegereports/collegereports.aspx. Some reports have been printed, and hard copies of these are available for purchase from the College's Book Sales Office.

The duties of a doctor registered with the GMC

Patients must be able to trust doctors with their lives and health. To justify that trust, you must show respect for human life and you must:

- make the care of the patient your first concern
- protect and promote the health of patients and the public
- provide a good standard of practice and care
  - keep your professional knowledge and skills up to date
  - recognise and work within the limits of your competence
  - work with colleagues in the ways that best serve patients' interests
- treat patients as individuals and respect their dignity
  - treat patients politely and considerately
  - respect patients' right to confidentiality
- work in partnership with patients
  - listen to patients and respond to their concerns and preferences
  - give patients the information they want or need in a way they can understand
  - respect patients' right to reach decisions with you about their treatment and care
  - support patients in caring for themselves to improve and maintain their health
- be honest and open and act with integrity
  - act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
  - never discriminate unfairly against patients or colleagues
  - never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good doctors

1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity.

Core attributes – good psychiatrists

Patients, their carers, their families and the public need good psychiatrists. Good psychiatrists make the care of their patients their first concern: they are competent; keep their knowledge up to date; are able and willing to use new research evidence to inform practice; establish and maintain good relationships with patients, carers, families and colleagues; are honest and trustworthy, and act with integrity. Good psychiatrists have good communication skills, respect for others and are sensitive to the views of their patients, carers and families.

A good psychiatrist must be able to consider the ethical implications of treatment and clinical management regimes. The principles of fairness, respect, equality, dignity and autonomy are considered fundamental to good ethical psychiatric practice. A good psychiatrist will take these issues into account when making decisions, and will need to pay particular attention to issues concerning boundaries and the vulnerability of individual patients. A good psychiatrist will not enter into a relationship with a patient or with someone who has been a patient.

Unacceptable psychiatric practice will include failure to adhere to the standards set in this document.

Good clinical care

Providing good clinical care

2 Good clinical care must include:

(a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views and where necessary examining the patient

(b) providing or arranging advice, investigations or treatment where necessary

(c) referring a patient to another practitioner, when this is in the patient's best interests.

3 In providing care you must:

(a) recognise and work within the limits of your competence

(b) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs

(c) provide effective treatments based on the best available evidence

(d) take steps to alleviate pain and distress, whether or not a cure may be possible

(e) respect the patient's right to seek a second opinion

(f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigations or treatment

(g) make records at the same time as the events you are recording or as soon as possible afterwards

(h) be readily accessible when you are on duty

(i) consult and take advice from colleagues, when appropriate

(j) make good use of the resources available to you.

Supporting self-care

4 You should encourage patients and the public to take an interest in their health and to take action to improve and maintain it. This may include advising patients on the effects of their life choices on their health and well-being and the possible outcomes of their treatments.

Avoid treating those close to you

5 Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship.

Raising concerns about patients' safety

6 If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps taken to try to resolve them.

Decisions about access to medical care

7 The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance.

8 If carrying out a procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.

9 You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are in your power. If inadequate resources, policies or systems prevent you from doing this, and patient safety is or may be seriously compromised, you must follow the guidance in paragraph 6.

10 All patients are entitled to care and treatment to meet their clinical needs. You must not refuse to treat a patient because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making suitable alternative arrangements for treatment.

Treatment in emergencies

11 In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence and the availability of other options for care.

Good clinical care

Good psychiatric practice involves providing the best level of clinical care that is commensurate with training, experience and the resources available. It involves the ability to formulate a diagnosis and management plan based on often complex evidence from a variety of sources. Good psychiatric practice involves the particular skills of being a good listener and good communicator.

Ensuring good clinical care

1 A psychiatrist must undertake competent assessments of patients with mental health problems and must:

(a) be competent in obtaining a full and relevant history that incorporates developmental, psychological, social, cultural and physical factors, and:

i be able to gather this information in difficult or complicated situations

ii in situations of urgency, prioritise what information is needed to achieve a safe and effective outcome for the patient

iii seek and listen to the views and knowledge of the patient, their carers and family members and other professionals involved in the care of the patient

(b) have knowledge of:

i human development and developmental psychopathology, and the influence of social factors and life experiences

ii gender and age differences in the presentation and management of psychiatric disorders

iii biological and organic factors present in many psychiatric disorders

iv the impact of alcohol and substance misuse on physical and mental health

(c) be competent in undertaking a comprehensive mental state examination

(d) be competent in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability

(e) be competent in determining the necessary physical examination and investigations required for a thorough assessment

(f) ensure that they are competent and trained, where appropriate, in the use of any assessment or rating tools used as part of the assessment.

2 A psychiatrist must demonstrate a consultation style that fosters a therapeutic alliance with the patient and, where appropriate, their carers and families, and must:

(a) endeavour to maximise patient participation in assessment and treatment planning

(b) communicate effectively with patients, carers and families using verbal, non-verbal and written skills as appropriate, taking into account whatever additional support may be required to meet any language or communication needs.

3 In making the diagnosis and differential diagnosis, a psychiatrist should use a widely accepted diagnostic system.

4 A psychiatrist must appropriately assess situations where the level of disturbance is severe and risk of adverse events, such as injury to self or others, or harm from others, may be high, and take appropriate clinical action.

5 A psychiatrist must work with patients, carers and the multidisciplinary team to make management decisions that balance risks to the patient or the public with the desire to facilitate patient independence. This should involve consideration of positive therapeutic risk-taking.

6 A psychiatrist must ensure that treatment is planned and delivered effectively, and must:

(a) formulate a care plan that relates to the patient's goals, symptoms, diagnosis, risk, outcome of investigations and psychosocial context; this should be carried out in conjunction with, and agreed with, the patient, unless this is not feasible

(b) if the treatment proposed is outside existing clinical guidelines or the product license of medication, discuss and obtain the patient's agreement, and where appropriate, the agreement of carers and family members

(c) involve detained patients in treatment decisions as much as possible, taking into account their mental health and the need to provide treatment in their best interests

(d) recognise the importance of family and carers in the care of patients, share information and seek to fully involve them in the planning and implementation of care and treatment, having discussed this with and considered the views of the patient.

7 A psychiatrist must have specialist knowledge of treatment options in the clinical areas within which they are working and, more generally, knowledge of treatment options within mental health. The psychiatrist must:

(a) ensure that treatments take account of clinical guidance available from relevant bodies/the College/scientific literature, and be able to justify clinical decisions outside accepted guidance

(b) have knowledge or, when needed, seek specialist advice in the prescribing of psychotropic medication; in so doing, the psychiatrist must have an understanding of the effects of prescription drugs, both beneficial and adverse

(c) have knowledge of the basic principles of the major models of psychological treatments, and only undertake psychological interventions within their competence

(d) understand the range of clinical interventions available within mental health services and arrange referrals where appropriate to the needs of the patient

(e) have sufficient knowledge and skills of psychiatric specialties other than their own in order to be able to provide emergency assessment, care and advice in situations where specialist cover is not immediately available.

8 A psychiatrist must refer patients to other services or colleagues as indicated by clinical need and local protocols:

(a) the psychiatrist should facilitate the smooth transfer of care between services, and provide a comprehensive summary of the clinical case to the receiving doctor/professional to enable them to take over the safe management and treatment of the patient

(b) when discharging from care, the psychiatrist should inform the patient, the referrer and the primary care team about the possible indications for future treatment and how to access help in future

(c) if there are disagreements or difficulties about transfer arrangements, the psychiatrist must ensure that the safety of the patient and others remains the first concern and must facilitate the swift resolution of any difficulties.

9 A psychiatrist must recognise the limits of their own competence, and value and utilise the contribution of peers, multidisciplinary colleagues and others as appropriate.

10 A psychiatrist should seek and carefully consider advice, assistance or a second opinion if there are uncertainties in diagnosis and management, or if there is conflict between the clinical team and the patient or their carer and family.

11 A psychiatrist should be readily accessible to patients and colleagues when on duty.

12 A psychiatrist must maintain knowledge of current mental health and other legislation as it applies to psychiatric practice, ensuring that it is applied appropriately in clinical practice.

13 A psychiatrist must provide care that does not discriminate and is sensitive to issues of gender, ethnicity, colour, culture, lifestyle, beliefs, sexual orientation, age and disability.

14 A psychiatrist must maintain a high standard of record-keeping:

(a) good psychiatric practice involves keeping complete and understandable records and adhering to the following:

i handwritten notes must be legible, dated and signed with the doctor's name and title printed

ii electronic records must be detailed, accurate and verified

iii a record must be kept of all assessments and significant clinical decisions

iv the reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded

v the record should include information shared with or received from carers, family members or other professionals

vi notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, and signing and dating them.

(b) the psychiatrist should ensure that a process is in place to obtain and record in the clinical record patients' consent to share clinical information, and that this is completed for patients with whom they have direct contact and for whom the have clinical responsibility

(c) if the psychiatrist has agreed to provide a report, this must be completed in a timely fashion so that the patient is not disadvantaged by delay

(d) letters with details of the treatment plan should be provided to patients following a consultation.

15 A psychiatrist must communicate treatment decisions, changes in treatment plans and other necessary information to all relevant professionals and agencies, with due regard to confidentiality.

Maintaining good medical practice

Keeping up to date

12 You must keep your knowledge and skills up to date throughout your working life. You should be familiar with relevant guidelines and developments that affect your work. You should regularly take part in educational activities that maintain and further develop your competence and performance.

13 You must keep up to date with, and adhere to, the laws and codes of practice relevant to your work.

Maintaining and improving your performance

14 You must work with colleagues and patients to maintain and improve the quality of your work and promote patient safety. In particular, you must:

(a) maintain a folder of information and evidence, drawn from your medical practice.

(b) reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation.

(c) take part in regular and systematic audit.

(d) take part in systems of quality assurance and quality improvement.

(e) respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary.

(f) help to resolve uncertainties about the effects of treatments.

(g) contribute to confidential inquiries and adverse event recognition and reporting, to help reduce risk to patients.

(h) report suspected adverse drug reactions in accordance with the relevant reporting scheme.

(i) Co-operate with legitimate requests for information from organisations monitoring public health – when doing so you must follow the guidance in *Confidentiality: Protecting and Providing Information.*

Maintaining good psychiatric practice

Lifelong learning is expected of all doctors. Patients rightly expect the knowledge and skills of a psychiatrist to be up to date. The process of remaining up to date is not only the demonstrable acquisition of information but also the establishment of a process of personal learning that enables a psychiatrist to maintain development, learning, competence and performance over the course of their professional career. As most psychiatrists work in teams, learning may be team based as well as individual. Psychiatrists should recognise that learning comes from a variety of methods. These include listening to the experiences of their patients and colleagues, reading journals, attending conferences, and learning from complaints and adverse incidents, from clinical audit and from the review of outcome measures.

Maintaining lifelong learning

16 A psychiatrist must ensure that their continuing professional development (CPD) activities are at least equivalent to those that will allow them to be in good standing for CPD within the College. In particular, the psychiatrist should:

- (a) undertake CPD activities that reflect the needs of their current and planned professional activities
- (b) keep up to date with clinical advances relevant to their practice
- (c) take advice from colleagues and from the appraisal process when determining their CPD activities
- (d) be able to provide evidence of learning from private study and meetings attended, for example by documented reflection on the key learning points, and demonstrate that new knowledge is incorporated into clinical practice.

17 A psychiatrist must take part in and, where appropriate, lead on processes that aim to monitor and maintain the quality of clinical care and patient safety. In particular, the psychiatrist:

- (a) should take part in quality monitoring programmes such as clinical audit, national audits, confidential inquiries, use of outcome measures, benchmarking and accreditation schemes
- (b) should be knowledgeable about audit methodology and participate in clinical audit to measure and improve clinical care provided by themselves and their team
- (c) should, where possible, work with colleagues to determine and monitor meaningful measures of clinical outcome

(d) must approach adverse incidents and complaints that involve both themselves and their team as learning opportunities, reflecting on lessons to be learned and lessons to be shared

(e) must respond to the results of audit, quality monitoring programmes and investigations to improve practise, undertaking further training or professional development as appropriate.

18 A psychiatrist must participate in regular appraisal of their work in an open manner, using the appraisal process to guide their professional development.

19 A psychiatrist must be up-to-date with the relevant law, codes of practice and statutory body regulations that govern medical practice, including Human Rights legislation, and legislation covering equality and diversity, and capacity.

20 A psychiatrist must accept and actively participate in appropriate supervision of their clinical and other work.

Teaching, training, appraising and assessing

15 Teaching, training, appraising and assessing doctors and students are important for the care of patients now and in the future. You should be willing to contribute to these activities.

16 If you are involved in teaching you must develop the skills, attitudes and practices of a competent teacher.

17 You must make sure that all staff for whom you are responsible, including locums and students, are properly supervised.

18 You must be honest and objective when appraising or assessing the performance of colleagues, including locums and students. Patients will be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

19 You must provide only honest, justifiable and accurate comments when giving references for, or writing reports about, colleagues. When providing references you must do so promptly and include all information that is relevant to your colleague's competence, performance or conduct.

Teaching, training, appraising and assessing

Teaching and training are an important aspect of the role of a psychiatrist. They involve teaching not only doctors and medical students but also other professionals and, where appropriate, members of the public.

Standards for psychiatrists involved in teaching, training, appraising and assessing

21 The content of teaching must provide an accurate representation of current knowledge in the area.

22 Information must be provided in a form suitable for the audience and be based on an understanding of the principles of education and learning.

23 Patients must be asked to consent before they are involved in teaching and training.

24 Written informed consent must be obtained before a patient's personal data are used for the purposes of public teaching, training or presentations.

25 Written informed consent must be obtained before the recording, including video recording, of patient interviews. Consent for any subsequent use or disclosure of the recording must be obtained.

26 Constructive criticism must be provided, when necessary, to improve performance and clinical skills.

27 As an appraiser, a psychiatrist must maintain high professional standards. In particular, the psychiatrist must ensure that:

(a) the appraisal is conducted in a way that facilitates the development of their colleague

(b) appropriate aspects of the appraisal process remain confidential, while at the same time raising concerns with others where this is necessary to ensure patient safety.

Relationships with patients

The doctor–patient partnership

20 Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs.

21 To fulfil your role in the doctor–patient partnership you must:

(a) be polite, considerate and honest

(b) treat patients with dignity

(c) treat each patient as an individual

(d) respect patient's privacy and right to confidentiality

(e) support patients in caring for themselves to improve and maintain their health

(f) encourage patients who have knowledge about their condition to use this when they are making decisions about their care.

Good communication

22 To communicate effectively you must:

(a) listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences

(b) share with patients, in a way they can understand, the information they want or need to know about their condition, its likely progression, and the treatment options available to them, including associated risks and uncertainties

(c) respond to patients' questions and keep them informed about the progress of their care

(d) make sure that patients are informed about how information is shared within teams and among those who will be providing their care.

23 You must make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

Children and young people

24 The guidance that follows in paragraphs 25–27 is relevant whether or not you routinely see children and young people as patients. You should be aware of the needs and welfare of children and young people when you see patients who are parents or carers, as well as any patients who may represent a danger to children or young people.

25 You must safeguard and protect the health and well-being of children and young people.

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26 You should offer assistance to children and young people if you have reason to think that their rights have been abused or denied.

27 When communicating with a child or young person you must:

(a) treat them with respect and listen to their views

(b) answer their questions to the best of your ability

(c) provide information in a way they can understand

The GMC gives further online ethical guidance in *0–18 years: Guidance for All Doctors*.

Relatives, carers and partners

29 You must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died. In doing this you must follow the guidance in *Confidentiality: Protecting and Providing Information*.

Being open and honest with patients if things go wrong

30 If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

31 Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient's complaint to affect adversely the care or treatment you provide or arrange.

Maintaining trust in the profession

32 You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.

33 You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.

34 You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests as well as your own.

35 You must be familiar with your GMC reference number. You must make sure you are identifiable to your patients and colleagues, for example by using your registered name when signing statutory documents, including prescriptions. You must make your registered name and GMC reference number available to anyone who asks for them.

Ending your professional relationship with a patient

38 In rare circumstances, the trust between you and a patient may break down, and you may find it necessary to end the professional relationship. For example, this may occur if a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderately or unreasonably. You should not end a relationship with a patient solely because of a complaint the patient has made about you or your team, or because of the resource implications of the patient's care or treatment.

39 Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and does not contravene the guidance in paragraph 7 [of *Good Medical Practice*]. You must be prepared to justify your decision. You should inform the patient of your decision and your reasons for ending the professional relationship, wherever practical in writing.

40 You must take steps to ensure that arrangements are made promptly for the continuing care of the patient, and you must pass on the patient's records without delay.

Relationships with patients

Good psychiatric practice and successful relationships between psychiatrists and patients depend on respect, openness, trust and good communication.

The need for psychiatrists to develop trusting relationships with patients may be more difficult where patients need to be detained against their wishes and/or treatments given without consent, or when concerns arise regarding the safeguarding of children and vulnerable adults.

It is also important for psychiatrists to develop trusting relationships with the carers and families of their patients when this is appropriate and with the agreement of the patient.

It may not be possible or appropriate for psychiatrists to provide, or refer on for, the treatment interventions requested by patients. The psychiatrist must at all times act in the best interests of the patient.

Particular attention must be paid to the vulnerability of some patients and to the need to maintain clear boundaries in professional relationships with all patients. The College has published detailed guidance on maintaining boundaries and on sexual boundary issues. Psychiatrists must be familiar with the following documents: *Vulnerable Patients, Safe Doctors: Good Practice in our Clinical Relationships* (CR146); *Sexual Boundary Issues in Psychiatric Settings* (CR145).

Establishing and maintaining trust and good communication

28 A psychiatrist must listen to the patient, ask for and respect their views, and must:

(a) respect the patient's right to seek a second opinion

(b) respect the patient's right to decline to take part in teaching or research and ensure that refusal does not adversely affect care and treatment

(c) respect the patient's right to lodge a complaint or appeal, and ensure that this does not adversely affect care and treatment

(d) consider and explain to the patient the risks and benefits of acting in accordance with or against the patient's expressed wishes.

29 A psychiatrist must provide information, both verbal and written, to support patients in maintaining their health. In particular, the psychiatrist must:

(a) provide information in understandable terms regarding diagnosis, treatment, prognosis and the support services available; this should recognise diversity of language, literacy and verbal skills

(b) if any medication is prescribed, provide information about side-effects and, where appropriate, dosage, as well as relevant information should an off-license drug be recommended.

30 A psychiatrist must respect a patient's right to be accompanied, supported or represented by their choice of carer, family, friend or advocate.

31 When negotiating the aims and outcomes of treatment plans, a psychiatrist must recognise and respect the diversity of patients' lifestyles, including cultural issues, religious and spiritual beliefs, ambitions and personal goals.

32 A psychiatrist must take a child-centred, developmentally appropriate approach to engaging, assessing and communicating with children that is at the same time respectful of their parents, family and carers.

33 Following an incident of harm to a patient, a psychiatrist must explain fully and promptly to the patient, and family and carers where appropriate, what has happened and the likely long- and short-term effects of such harm. The psychiatrist should act immediately to put matters right if possible and, where appropriate, offer an apology:

(a) in the case of an adult patient who lacks capacity, the explanation should be given to a person with responsibility for the care and welfare of the patient, or the patient's partner, close relative or a friend who has been involved in the care of the patient, unless there is reason to believe the patient would have objected to the disclosure

(b) in the case of children, the incident should be explained to those with parental responsibility and to the child if the child has the maturity to understand the issues.

GMC Good Medical Practice 2006

Consent

36 You must be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. Usually this will involve providing information to patients in a way they can understand, before asking for their consent. You must follow the guidance in *Seeking patients' consent: The ethical considerations*, which includes advice on children and patients who are not able to give consent.

Consent

Psychiatrists often decide on treatment options, and also on detention of patients, where the patient is either unwilling to consent or lacks capacity to make a judgement. Psychiatrists must ensure that the principle of fairness informs all their decisions concerning patients, irrespective of the patient's age or capacity.

Good psychiatric practice in relation to consent

34 A psychiatrist must participate in hearings and tribunals, and other similar activities that protect the rights of the patient, in a timely and appropriate manner, ensuring adherence to mental health legislation relating to consent to treatment and detention. The psychiatrist must provide written reports as required.

35 A psychiatrist must engage the patient and, where appropriate, carers, family members and patient advocates (particularly any person with the right to consent for the patient) in full and open discussions about treatment options.

36 Where patients have capacity to make a decision, a psychiatrist must ensure that the patient's valid consent to any proposed treatment is sought and their decision recorded.

37 A psychiatrist must demonstrate an awareness of the rights of children and the responsibilities of parents when deciding on treatment options.

38 Where the issues are complex, unclear or beyond their competence, a psychiatrist must seek legal advice and a second opinion.

GMC Good Medical Practice 2006

Confidentiality

37 Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died. If you are considering disclosing confidential information without a patient's consent, you must follow the guidance in with *Confidentiality: Protecting and providing information*.

Confidentiality

Patients have a right to expect that information about them will be held in confidence by psychiatrists. Information about patients must be treated as confidential. There will be circumstances when, in the best interest of the patient or the public, disclosure of confidential information without a patient's consent is considered. This includes disclosure of information to carers and families. In so doing, a psychiatrist must follow the GMC guidance *Confidentiality: Protecting and Providing Information* (in the ethical guidance series) and the detailed guidance in the College document *Good Psychiatric Practice: Confidentiality and Information Sharing* (CR133). A psychiatrist must have knowledge of and practise in accordance with the Data Protection Act, the policies and information-sharing protocols of employing and partner organisations, and seek the advice of the organisation's Caldicott Guardian as appropriate.

Good psychiatric practice in relation to confidentiality

39 A psychiatrist must maintain up-to-date knowledge on issues relating to confidentiality and ensure that their practice is in accordance with current GMC advice.

40 A psychiatrist must acknowledge and consider the views of carers and family members, recognising the right of the patient to confidentiality but also recognising the right of carers and family members to share and highlight their concerns:

(a) the psychiatrist must ensure that the patient understands the benefits of sharing, and the risks of not sharing, information with their carers and family, acknowledging the important role that carers and family have in the patient's care and treatment, and of their need for information to fulfil this role

(b) when treating children or adults lacking capacity, particular attention needs to be given to relationships with carers, parents, family members and other professionals involved. Consideration should be given to sharing information in the best interests of the patient.

41 A psychiatrist must be aware when dealing with children that there may be situations in which disclosure ensures that the psychiatrist is acting in the overall best interests of the child.

Working with colleagues

Working in teams

41 Most doctors work in teams with colleagues from other professions. Working in teams does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you should act as a positive role model and try to motivate and inspire your colleagues. You must:

(a) respect the skills and contributions of your colleagues

(b) communicate effectively with colleagues within and outside the team

(c) make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care

(d) participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies

(e) support colleagues who have problems with performance, conduct or health.

42 If you are responsible for leading a team, you must follow the guidance in *Management for doctors*.

Conduct and performance of colleagues

43 You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures.

44 If there are no appropriate local systems, or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation, or the GMC for advice.

45 If you have management responsibilities you should make sure that systems are in place through which colleagues can raise concerns about risks to patients, and you must follow the guidance in *Management for doctors.*

Respect for colleagues

46 You must treat your colleagues fairly and with respect. You must not bully or harass them, or unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them. You should challenge colleagues if their behaviour does not comply with this guidance.

47 You must not make malicious and unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them.

Arranging cover

48 You must be satisfied that, when you are off duty, suitable arrangements have been made for your patients' medical care. These arrangements should include effective hand-over procedures, involving clear communication with healthcare colleagues. If you are concerned that the arrangements are not suitable, you should take steps to safeguard patient care and you must follow the guidance in paragraph 6.

Taking up and ending appointments

49 Patient care may be compromised if there is not sufficient medical cover. Therefore, you must take up any post, including a locum post, you have formally accepted, and you must work your contractual notice period, unless the employer has reasonable time to make other arrangements.

Sharing information with colleagues

50 Sharing information with other healthcare professionals is important for safe and effective patient care.

51 When you refer a patient, you should provide all relevant information about the patient, including their medical history and current condition.

52 If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects.

53 If a patient has not been referred to you by a general practitioner, you should ask for the patient's consent to inform their general practitioner before starting treatment, except in emergencies or when it is impractical to do so. If you do not inform the patient's general practitioner, you will be responsible for providing or arranging all necessary after-care.

Delegation and referral

54 Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need.

GMC Good Medical Practice 2006

55 Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence. You must be satisfied that any healthcare professional to whom you refer a patient is accountable to a statutory regulatory body or employed within a managed environment. If they are not, the transfer of care will be regarded as delegation, not referral. This means you remain responsible for the overall management of the patient, and accountable for your decision to delegate.

Working with colleagues

Working as a member of a team

Most psychiatrists work as members of multidisciplinary teams. Psychiatrists should be aware of the key role that they often play in ensuring the success and good functioning of such teams. Whether or not psychiatrists have a formal leadership role within the team, they should use their skills and knowledge to ensure that the focus of the team is on the provision of high-quality care for patients. If a psychiatrist is responsible for leading a team, they must follow the GMC guidance in *Management for Doctors* (in the ethical guidance series).

Psychiatrists should recognise that although individual members of a team may have different roles, successful teams have shared goals. Psychiatrists should play a key role in formulating and delivering these shared goals by working collaboratively with their colleagues. Working in teams does not change personal accountability for professional conduct and the care provided. When working in a team, a psychiatrist should act as a positive role model to motivate and inspire colleagues.

The GMC has published guidance on delegation and referral as it applies to psychiatrists working within multidisciplinary or multi-agency teams in *Accountability in Multi-Disciplinary and Multi-Agency Mental Health Teams* (in the ethical guidance series). This is summarised in the following points.

- Psychiatrists should be competent in all aspects of their work, including: reviewing and auditing the standards of care they provide; training and supervising colleagues; and managing staff and the performance of the teams in which they work when they have management responsibility.
- Psychiatrists should ensure that the systems in which they are working provide a good standard of care to patients. If they cannot be satisfied that this is the case, they should draw the matter to the attention of their employing or contracting body.
- Psychiatrists should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are members. This is particularly important in circumstances in which responsibility for providing care is spread between a number of practitioners and/or different agencies.
- Doctors are not accountable for the decisions and actions of other clinicians. This means that when a psychiatrist delegates assessment,

treatment and care to a more junior doctor, the psychiatrist is not accountable to the GMC for the decision or actions of the junior doctor but is responsible for ensuring that the junior doctor is appropriately trained, experienced and supervised.

- Psychiatrists can delegate the care of patients for whom they have agreed to take responsibility. However, many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Referrals are often made to multidisciplinary teams and decisions about allocation are made according to the team's policies. The responsibility for the care of the patients is distributed between the clinical members of the team. Consultant psychiatrists retain oversight of the group of patients allocated to their care. They are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team. Nevertheless, they must do their best to ensure that arrangements are in place to monitor standards of care, and to identify potential or current problems. They should notify their employer about any unresolved concerns or problems.

42 A psychiatrist must work with colleagues in a collaborative way, having the best interests of the patient as a guiding principle, and must:

(a) have an understanding of the various professional roles within the team

(b) listen to, respect and take account of the opinions of colleagues in determining the care of patients

(c) work with colleagues to ensure that patients receive the best possible care within the resources available

(d) be willing to provide advice to colleagues when requested and where appropriate within their expertise.

43 A psychiatrist must develop collaborative working relationships with other professionals based on mutual professional respect, facilitating an atmosphere within the team in which individual opinions and the diversity of team members are valued.

44 A psychiatrist must treat colleagues fairly and with respect, seek to resolve professional difficulties and conflicts, and ensure that such difficulties do not impair patient care.

45 A psychiatrist must acknowledge and work within the lines of accountability established in their own and partner organisations.

46 A psychiatrist must set an example of good communication both within the team and with other agencies/professionals.

47 If a psychiatrist has concerns about a colleague or other professional, the concerns should be raised in a considered and measured way.

48 A psychiatrist must work flexibly with colleagues in other teams, and must not be constrained by rigid demarcations, to provide care that is in the best interests of the patient.

49 A psychiatrist must provide sufficient information when making a referral to ensure that the receiving team is able to provide safe and complete management.

GMC Good Medical Practice 2006

Working with management

For detailed guidance see *Management for Doctors*, in the GMC's ethical guidance series.

Working with management

All doctors are responsible for the use of resources. Psychiatrists who take on management roles assume a responsibility for resources provided to groups of patients and cannot simply advocate on behalf of a single patient. This role needs to be recognised, valued and supported by colleagues. Many psychiatrists also lead teams or are involved in the supervision of colleagues. Most work in managed systems. Psychiatrists have responsibilities to their patients, employers and those who contract for their services. This means that psychiatrists are both managers and managed.

Standards for psychiatrists as employees or working with managers in a managed system

50 A psychiatrist must demonstrate respect for and an understanding of the different roles and responsibilities of clinical and non-clinical management colleagues.

51 A psychiatrist must work collaboratively with colleagues who have management responsibilities for healthcare in order to plan and deliver patient-focused services and to develop a clear articulation of the values and working practices of the multidisciplinary team.

52 A psychiatrist must support management colleagues in resolving difficult clinical situations and demonstrate awareness of the balance between the needs of an individual patient and the needs of the wider clinical service.

53 A psychiatrist must alert managers if there are concerns about the provision of patient care.

54 A psychiatrist must collaborate with managers in improving patient services and in seeking appropriate remedies for identified areas of concern.

55 A psychiatrist must be open to challenge and to peer review, and be prepared to justify and/or adjust clinical decisions in light of discussion.

56 A psychiatrist must fully cooperate with complaint and adverse incident investigations that involve themselves or their team, including the development and implementation of appropriate action plans.

57 A psychiatrist must maintain professional standards when reviewing a colleague's or team's clinical management or performance.

Research

70 Research involving people directly or indirectly is vital in improving care and reducing uncertainty for patients now and in the future, and improving the health of the population as a whole.

71 If you are involved in designing, organising or carrying out research, you must:

(a) put the protection of the participants' interests first

(b) act with honesty and integrity

(c) follow the appropriate national research governance guidelines and the guidance in *Research: The role and responsibilities of doctors*.

Research

Research is important to improving the psychiatric care and treatment, and the mental well-being, of the population as a whole.

58 A psychiatrist must be aware of the importance of research in the understanding and treatment of mental illness.

59 A psychiatrist involved in designing, organising, supervising, conducting or publishing research must be aware of the associated issues regarding ethics, research and information governance, consent and publication, and probity.

Probity

Being honest and trustworthy

56 Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.

57 You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.

58 You must inform the GMC without delay if, anywhere in the world, you have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against your registration as a result of fitness to practise procedures.

59 If you are suspended by an organisation from a medical post, or have restrictions placed on your practice you must, without delay, inform any other organisations for which you undertake medical work and any patients you see independently.

Providing and publishing information about your services

60 If you publish information about your medical services, you must make sure the information is factual and verifiable.

61 You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

62 You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health.

Writing reports and CVs, giving evidence and signing documents

63 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.

64 You must always be honest about your experience, qualifications and position, particularly when applying for posts.

65 You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.

66 If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

67 If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.

68 You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to your work. You must disclose to anyone entitled to ask for it any information relevant to an investigation into your own or a colleague's conduct, performance or health. In doing so, you must follow the guidance in *Confidentiality: Protecting and providing information*.

69 You must assist the coroner or procurator fiscal in an inquest or inquiry into a patient's death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.

Financial and commercial dealings

72 You must be honest and open in any financial arrangements with patients. In particular:

(a) you must inform patients about your fees and charges, wherever possible before asking for their consent to treatment

(b) you must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services

(c) you must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you

(d) you must not put pressure on patients or their families to make donations to other people or organisations

(e) you must not put pressure on patients to accept private treatment

(f) if you charge fees, you must tell patients if any part of the fee goes to another healthcare professional.

73 You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

(a) before taking part in discussions about buying or selling goods or services, you must declare any relevant financial or commercial interest that you or your family might have in the transaction

(b) if you manage finances, you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.

Conflicts of interest

74 You must act in your patients' best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues.

75 If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.

76 If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser.

Health

77 You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78 You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79 If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

Probity

Probity is at the heart of medical and psychiatric professionalism. A psychiatrist must make sure that their conduct at all times justifies their patients' trust in them and the public's trust in the profession. It is of particular importance to maintain a high standard of practice and vigilance with regard to issues of probity when dealing with vulnerable children and adults.

A psychiatrist must be aware of and comply with equal opportunities legislation and work to ensure the ongoing development of antidiscriminatory practice, including challenge to stigma and cultural bias.

The College has published further guidance with regard to probity in relationships with pharmaceutical and other commercial organisation in *Good Psychiatric Practice: Relationships with Pharmaceutical and Other Commercial Organisations* (CR148).

Probity in good psychiatric practice

60 A psychiatrist must be aware of the risks of accepting gifts from patients, seek advice if necessary, and declare gifts that are other than small tokens.

61 A psychiatrist must not accept gifts or inducements that could be seen as affecting judgement in making clinical decisions, be they of prescribing, treatment or referral.

62 A psychiatrist must provide references for staff that are fair, factually correct and do not omit relevant information, in particular performance or conduct issues.

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A Competency Based Curriculum

for Specialist Training in Psychiatry

Specialists in the Psychiatry of Learning Disability

Royal College of Psychiatrists

***February 2010** (update approved 2 October 2014, revised March 2016 and May 2017)*

TABLE OF CONTENTS

This curriculum is divided into six Parts:

Specialists in the Psychiatry of Learning Disability work with others to assess, manage and treat people with mental health problems together with learning disabilities. They contribute to the development and delivery of effective services for people with these co-existing conditions.

1. Introduction

The advanced curriculum provides the framework to train Consultant Psychiatrists for practice in the UK to the level of CCT registration and beyond and is an add-on to the Core Curriculum. Those who are already consultants may find it a useful guide in developing new areas of skill or to demonstrate skills already acquired.

What is set out in this document is the generic knowledge, skills and attitudes, or more readily assessed behaviour, that we believe is common to all psychiatric specialties, together with those that are specific to specialists in Learning Disability Psychiatry. This document should be read in conjunction with *Good Medical Practice* and *Good Psychiatric Practice,* which describe what is expected of all doctors and psychiatrists. Failure to achieve satisfactory progress in meeting many of these objectives at the appropriate stage would constitute cause for concern about the doctor's ability to be adequately trained.

Achieving competency in core and generic skills is essential for all specialty and subspecialty training. Maintaining competency in these will be necessary for revalidation, linking closely to the details in *Good Medical Practice* and *Good Psychiatric Practice.* The Core competencies are those that should be acquired by all trainees during their training period starting within their undergraduate career and developed throughout their postgraduate career. The Core competencies need to be evidenced on an ongoing basis throughout training. It is expected that trainees will progressively acquire higher levels of competence during training.

2. Rationale

The purposes of the curriculum are to outline the competencies that trainees must demonstrate and the learning and assessment processes that must be undertaken:

for an award of a Certificate of Completion of Training (CCT) in Psychiatry of Learning Disability. The curriculum builds upon competencies gained in Foundation Programme training and Core Psychiatry Training and guides the doctor to continuing professional development based on *Good Psychiatric Practice* after they have gained their CCT.

3. Specific features of the curriculum

The curriculum is outcome-based and is learner-centred. Like the Foundation Programme Curriculum, it is a spiral curriculum in that learning experiences revisit learning outcomes. Each time a learning outcome is visited in the curriculum, the purpose is to support the trainee's progress by encouraging performance in situations the trainee may not have previously encountered, in more complex and demanding situations and with increasing levels of autonomy. The details of how the Curriculum supports progress is described in more detail in the Trainee and Trainer's Guide to ARCP panels that is set out later. The intended learning outcomes of the curriculum are structured under the Good Medical Practice (2013) headings that set out a framework of professional competencies. The curriculum is learner-centred in the sense that it seeks to allow trainees to explore their interests within the outcome framework, guided and supported by an educational supervisor. The Royal College of Psychiatrists has long recognised the importance of educational supervision in postgraduate training. For many years, the College recommended that all trainees should have an hour per week of protected time with their educational supervisor to set goals for training, develop individual learning plans, provide feedback and validate their learning.

The competencies in the curriculum are arranged under the Good Medical Practice headings as follows: -

1. Knowledge, Skills and Performance
2. Safety and Quality
3. Communication, Partnership and Teamwork
4. Maintaining Trust

They are, of course, not discrete and free-standing, but overlap and inter-relate to produce an overall picture of the Psychiatrist as a medical expert.

It is important to recognise that these headings are used for structural organization only. The complexity of medical education and practice means that a considerable number of the competencies set out below will cross the boundaries between different categories. Moreover, depending on circumstances, many competencies will have additional components or facets that are not defined here. This curriculum is based on meta-competencies and does not set out to define the psychiatrist's progress and attainment at a micro-competency level.

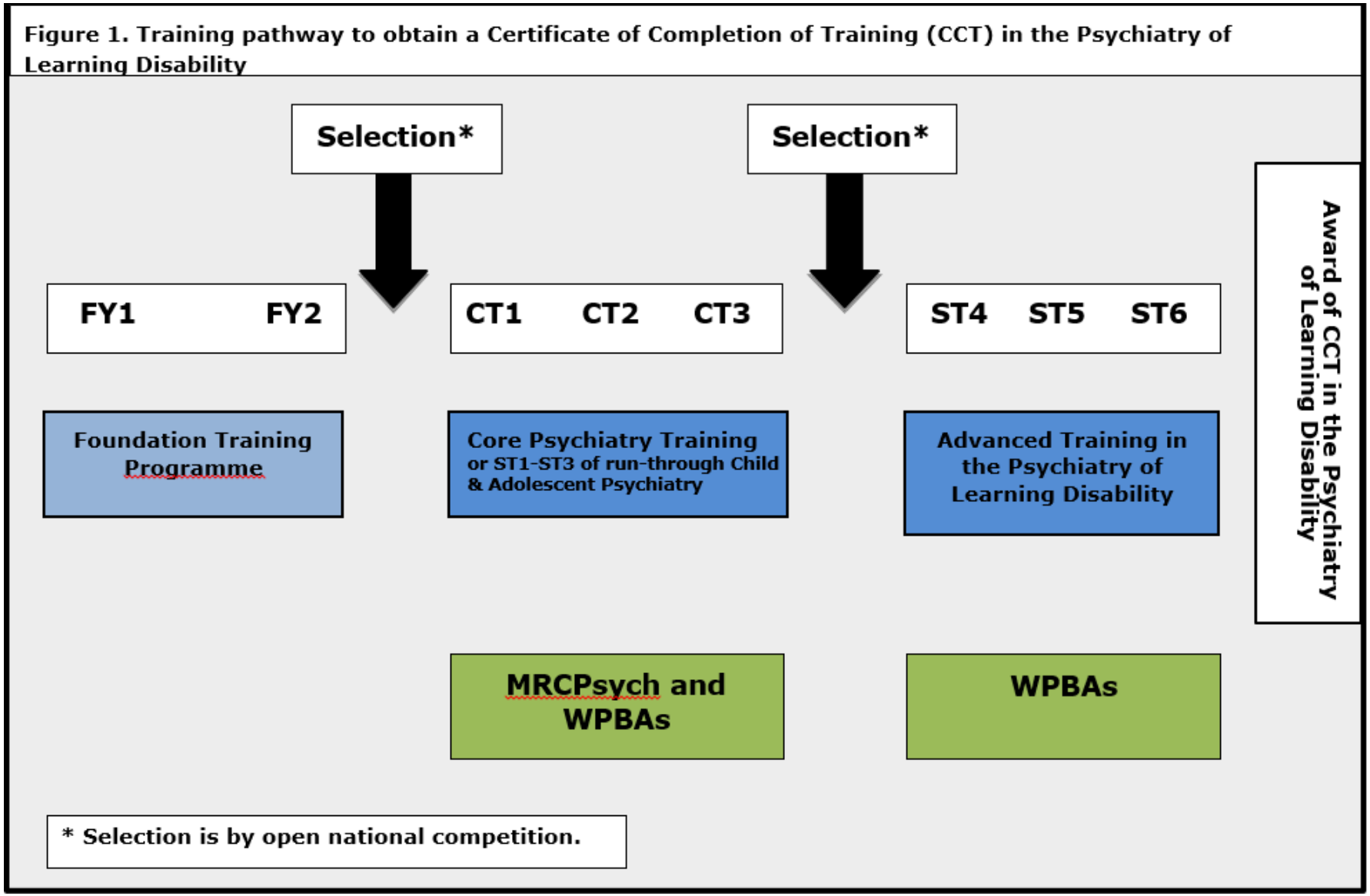
With these points in mind, this curriculum is based on a model of intended learning outcomes (which are summarised below) with specific competencies given to illustrate how these outcomes can be demonstrated. It is, therefore, a practical guide rather than an all-inclusive list of prescribed knowledge, skills and behaviours.

4. Training pathway

Trainees enter Psychiatry of Learning Disability Specialty Training after successfully completing both the Foundation Training Programme (or having evidence of equivalence) and either the Core Psychiatry Training programme or the early years (ST1-ST3) of the run-through Child and Adolescent Psychiatry Training programme. The progression is shown in Figure 1.

The six psychiatry specialties are Child and Adolescent Psychiatry, Forensic Psychiatry, General Psychiatry, Old Age Psychiatry, Psychiatry of Learning Disability and Medical Psychotherapy. In addition, there are three sub-specialties: Substance Misuse Psychiatry, Liaison Psychiatry and Rehabilitation Psychiatry. Specialty training in Psychiatry of Learning Disability is therefore one of the options that a trainee may apply to do after completing Core Psychiatry Training or the early years (ST1-ST3) of the run-through Child and Adolescent Psychiatry Training programme.

Figure 1. Training pathway to obtain a Certificate of Completion of Training (CCT) in the Psychiatry of Learning Disability



5. Acting Up

Up to a maximum of three months whole time equivalent (for LTFT trainee the timescale is also three months, Gold Guide 6.105) spent in an 'acting up' consultant post may count towards a trainees CCT as part of the GMC approved specialty training programme, provided the post meets the following criteria:

- The trainee follows local procedures by making contact with the Postgraduate Dean and their team who will advise trainees about obtaining prospective approval
- The trainee is in their final year of training (or possibly penultimate year if in dual training)
- 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 trainee's TPD
- The trainee still receives one hour per week education supervision either face to face or over the phone by an appropriately accredited trainer
- Trainees retain their NTN during the period of acting up
- Full time trainees 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 trainees 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 RA in its current form
- If a trainee is on call there must be consultant supervision
- If the period is sat 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 educational supervisor has been received and there is a satisfactory ARCP outcome

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.

6. Accreditation of Transferable Competences Framework (ATCF)

Many of the core competences are common across curricula. When moving from one approved training programme to another, a trainee doctor who has gained competences in core, specialty or general practice training should not have to repeat training already achieved. The Academy of Medical Royal Colleges (the Academy) has developed the Accreditation of Transferable Competences Framework (ATCF) to assist trainee doctors in transferring competences achieved in one core, specialty or general practice training programme, where appropriate and valid, to another training programme.

This will save time for trainee doctors (a maximum of two years) who decide to change career path after completing a part of one training programme, and transfer to a place in another training programme.

The ATCF applies only to those moving between periods of GMC approved training. It is aimed at the early years of training. The time to be recognised within the ATCF is subject to review at the first Annual Review of Competence Progression (ARCP) in the new training programme. All trainees achieving Certificate of Completion of Training (CCT) in general practice or a specialty will have gained all the required competences outlined in the relevant specialty curriculum. When using ATCF, the doctor may be accredited for relevant competences acquired during previous training.'

The Royal College of Psychiatrists accepts transferable competences from the following specialties core medical training, Paediatrics and Child Health and General Practice. For details of the maximum duration and a mapping of the transferable competences please refer to our guidance..

7. RESPONSIBILITIES FOR CURRICULUM DELIVERY

It is recognised that delivering the curriculum requires the coordinated efforts of a number of parties. Postgraduate Schools of Psychiatry, Training Programme Directors, Educational and Clinical Supervisors and trainees all have responsible for ensuring that the curriculum is delivered as intended.

Deanery Schools of Psychiatry

Schools of Psychiatry have been created to deliver postgraduate medical training in England, Wales and Northern Ireland. The Postgraduate Deanery manages the schools with advice from the Royal College. There are no Schools of Psychiatry in Scotland. Scotland has four Deanery Specialty Training Committees for mental health that fulfil a similar role.

The main roles of the schools are:

1. To ensure all education, training and assessment processes for the psychiatry specialties and sub-specialties meet General Medical Council (GMC) approved curricula requirements
2. To monitor the quality of training, ensuring it enhances the standard of patient care and produces competent and capable specialists
3. To ensure that each Core Psychiatry Training Programme has an appropriately qualified psychotherapy tutor who should be a consultant psychotherapist or a consultant psychiatrist with a special interest in psychotherapy.
4. To encourage and develop educational research
5. To promote diversity and equality of opportunity
6. To work with the Postgraduate Deanery to identify, assess and support trainees in difficulty
7. To ensure that clear, effective processes are in place for trainees to raise concerns regarding their training and personal development and that these processes are communicated to trainees

Training Programme Directors

The Coordinating/Programme Tutor or Programme Director is responsible for the overall strategic management and quality control of the Psychiatry of Learning Disability 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/Tutor must be recognized in their job plan, with time allocated to carry out the duties adequately. One programmed activity (PA) per week is generally recommended for 25 trainees. In a large scheme 2 PA's per week will be required. The Training Programme Director for Psychiatry of Learning Disability:

1. Should inform and support College and Specialty tutors to ensure that all aspects of clinical placements fulfil the specific programme requirements.
2. Oversees the progression of trainees through the programme and devises mechanisms for the delivery of co-ordinated educational supervision, pastoral support and career guidance.
3. Manages trainee performance issues in line with the policies of the Training School/Deanery and Trust and support trainers and tutors in dealing with any trainee in difficulty.
4. Ensures that those involved in supervision and assessment are familiar with programme requirements.
5. Will provide clear evidence of the delivery, uptake and effectiveness of learning for trainees in all aspects of the curriculum.

6. Should organise and ensure delivery of a teaching programme based on the curriculum covering clinical, specialty and generic topics.
7. Will attend local and deanery education meetings as appropriate.
8. Will be involved in recruitment of trainees.
9. Ensures that procedures for consideration and approval of LTFT (Less Than Full Time Trainees), OOPT (Out of Programme Training) and OOPR (Out of Programme Research) are fair, timely and efficient.
10. Records information required by local, regional and national quality control processes and provides necessary reports.
11. Takes a lead in all aspects of assessment and appraisal for trainees. This incorporates a lead role in organisation and delivery of ARCP. The Tutor/Training Programme Director will provide expert support, leadership and training for assessors (including in WPBA) and ARCP panel members.

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 Core Psychiatry Programme and in addition:

Will implement, monitor and improve the core training programmes in the Trust(s) in conjunction with the Directors of Medical Education and the Deanery and ensure that the programme meets the requirements of the curriculum and the Trust and complies with contemporary College Guidance & Standards (see College QA Matrix) and GMC Generic Standards for Training.

Will take responsibility with the Psychotherapy Tutor (where one is available) for the provision of appropriate psychotherapy training experiences for trainees. This will include:

1. Ensuring that educational supervisors are reminded about and supported in their task of developing the trainee's competencies in a psychotherapeutic approach to routine clinical practice.
2. Advising and supporting trainees in their learning by reviewing progress in psychotherapy
3. Ensuring that there are appropriate opportunities for supervised case work in psychotherapy.

Medical Psychotherapy Tutor

Where a scheme employs a Psychotherapy Tutor who is a Consultant Psychiatrist in Psychotherapy there is evidence that the Royal College of Psychiatrists' Psychotherapy Curriculum is more likely to be fulfilled than a scheme which does not have a trained Medical Psychotherapist overseeing the Core Psychiatry Psychotherapy training (Royal College of Psychiatrists' UK Medical Psychotherapy Survey 2012). This evidence has been used by the GMC in their quality assurance review of medical psychotherapy (2011-12).

It is therefore a GMC requirement that every core psychotherapy training scheme must be led by a Medical Psychotherapy Tutor who has undergone higher/advanced specialist training in medical psychotherapy with a CCT (Certificate of Completion of Training) in Psychotherapy. 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 in line with the GMC requirement of medical psychotherapy leadership in core psychotherapy training (GMC medical psychotherapy report and action plan, 2013).

Where there is no Medical Psychotherapy CCT holder in a deanery a period of derogation up to two years will be accepted by the GMC. Within this period a Medical Psychotherapy Tutor post will be required to be established in the deanery or LETB. The College will ask the Heads of School of Psychiatry what the interim arrangements are to develop the Medical Psychotherapy posts.

The Medical Psychotherapy Tutor:

1. Provides a clinical service in which their active and ongoing psychotherapy practice provides a clinical context for psychotherapy training in accordance with GMC requirements (2013)
2. Ensures that all core trainees have the opportunity to complete the psychotherapy requirements of the core curriculum
3. Advises and support core and higher trainees in their learning by reviewing progress in psychotherapy
4. Will be familiar with the ongoing psychotherapy training requirements for psychiatry trainees beyond core training and will lead on ensuring this learning and development continues for higher trainees in line with curriculum requirements
5. Oversees the establishment and running of the core trainee Balint/case based discussion group
6. Provides assessment and oversee the waiting list of therapy cases for core trainees and higher trainees
7. Monitors the selection of appropriate short and long therapy cases in accordance with the core curriculum
8. Selects and support appropriate therapy case supervisors to supervise and assess the trainees
9. Ensures the therapy 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)
10. Ensures the therapy case supervisors are trained in psychotherapy workplace based assessment
11. Ensures active participation of medical and non medical psychotherapy supervisors in the ARCP process
12. Maintains and builds on the curriculum standard of core psychotherapy training in the School of Psychiatry through the ARCP process.

Supervision

Supervision in postgraduate psychiatry training encompasses three core aspects:

- Clinical Supervision
- Educational Supervision
- Psychiatric 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

This guidance sets out the varied roles consultants inhabit within a supervisory capacity. Key principles underpinning all types of supervision include:

- Clarity
- Consistency
- Collaboration
- Challenge
- Compassion

Clinical Supervisors / Trainers

The clinical work of all trainees must be supervised by an appropriately qualified senior psychiatrist. All trainees must be made aware day-to-day of who the nominated 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 trainee 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 trainee**. No trainee should be expected to work to a level beyond their competence and experience;** no trainee should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise.

Trainees should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence; **both trainee and supervisor should at all times be aware of their direct responsibilities for the safety of patients in their care.**

The clinical supervisor:

1. Should be involved with teaching and training the trainee in the workplace.
2. Must support the trainee in various ways:
    a) direct supervision, in the ward, the community or the 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
3. May delegate some clinical supervision to other members of clinical team as long as the team member clearly understands the role and the trainee is informed. The trainee must know who is providing clinical supervision at all times.
4. Will perform workplace-based assessments for the trainee and will delegate performance of WPBA's to appropriate members of the multi-disciplinary team
5. Will provide regular review during the placement, both formally and informally to ensure that the trainee is obtaining the necessary experience. This will include ensuring that the trainee obtains the required supervised experience in practical procedures and receives regular constructive feedback on performance.

Time for providing clinical supervision must be incorporated into job planning, for example within teaching clinics.

Educational Supervisors/Tutors

An Educational Supervisor/tutor will usually be a Consultant, Senior Lecturer or Professor who has been appointed to a substantive consultant 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 will work with a small (no more than five) number of trainees. Sometimes the Educational Supervisor will also be the clinical supervisor/trainer, as determined by explicit local arrangements.

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

The educational supervisor/tutor:

1. Works with individual trainees 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 and attitudes.
2. Will act as a resource for trainees who seek specialty information and guidance.
3. Will liaise with the Specialty/Programme tutor and other members of the department to ensure that all are aware of the learning needs of the trainee.
4. Will oversee and on occasions, perform, the trainee's workplace-based assessments.
5. Will monitor the trainee's attendance at formal education sessions, their completion of audit projects and other requirements of the Programme.
6. Should contribute as appropriate to the formal education programme.
7. Will produce structured reports as required by the School/Deanery.
8. In order to support trainees, will: -
    a. Oversee the education of the trainee, act as their mentor and ensure that they are making the necessary clinical and educational progress.
    b. Meet the trainee at the earliest opportunity (preferably in the first week of the programme), to ensure that the trainee 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 trainee and the necessary paperwork signed and a copy kept by both parties.
    c. Ensure that the trainee receives appropriate career guidance and planning.
    d. Provide the trainee with opportunities to comment on their training and on the support provided and to discuss any problems they have identified.

Psychiatric Supervision

Psychiatrists in training require regular reflective 1:1 supervision with a nominated substantive consultant who is on the specialist register. This will usually be the nominated consultant who is also providing clinical, and often education, supervision.

Psychiatric supervision is required for all trainees throughout core and higher levels and must be for 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 competencies and is informed by psychodynamic, cognitive coaching models. It is imperative that consultants delivering psychiatric supervision have protected time within their job plans to deliver this. This aspect of supervision requires 0.25 PA per week.

The psychiatric supervisor is responsible for producing the supervisor report informing the ARCP process and will ensure contributions are received from key individuals involved in the local training programme including clinical supervisors. Often the psychiatric supervisor will also be the nominated educational supervisor.

Assessors

Assessors are members of the healthcare team, who need not be educational or clinical supervisors, who perform workplace-based assessments (WPBA's) for trainee psychiatrists. In order to perform this role, assessors must be competent 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 trainees.

Trainees

1. Must at all times act professionally and take appropriate responsibility for patients under their care and for their training and development.
2. Must ensure they attend the one hour of personal supervision per week, which is focused on discussion of individual training matters and not immediate clinical care. If this personal supervision is not occurring the trainee should discuss the matter with their educational supervisor/tutor or training programme director.
3. Must receive clinical supervision and support with their clinical caseload appropriate to their level of experience and training.
4. Should be aware of and ensure that they have access to a range of learning resources including:
   a. a local training course (e.g. MRCPsych course, for Core Psychiatry trainees)
   b. a local postgraduate academic programme
   c. the opportunity (and funding) to attend courses, conferences and meetings relevant to their level of training and experience

   d. appropriate library facilities
   e. the advice and support of an audit officer or similar
   f. supervision and practical support for research with protected research time appropriate to grade
5. Must make themselves familiar with all aspects of the curriculum and assessment programme and keep a portfolio of evidence of training.
6. Must ensure that they make it a priority to obtain and profit from relevant experience in psychotherapy.
7. Must collaborate with their personal clinical supervisor/trainer to:
   a. work to a signed educational contract
   b. maximize the educational benefit of weekly educational supervision sessions
   c. undertake workplace-based assessments, both assessed by their clinical supervisor and other members of the multidisciplinary team
   d. use constructive criticism to improve performance
   e. regularly review the placement to ensure that the necessary experience is being obtained
   f. discuss pastoral issues if necessary
8. Must have regular contact with their Educational Supervisor/tutor to:
   a. agree educational objectives for each post
   b. develop a personal learning and development plan with a signed educational contract
   c. ensure that workplace-based assessments and other means of demonstrating developing competence are appropriately undertaken
   d. review examination and assessment progress
   e. regularly refer to their portfolio to inform discussions about their achievements and training needs
   f. receive advice about wider training issues
   g. have access to long-term career guidance and support
9. Will participate in an Annual Review of Competence Progression (ARCP) to determine their achievement of competencies and progression to the next phase of training.
10. Should ensure adequate representation on management bodies and committees relevant to their training. This would include Trust clinical management forums, such as Clinical Governance Groups, as well as mainstream training management groups at Trust, Deanery and National (e.g. Royal College) levels.
11. On appointment to a specialty training programme the trainee must fully and accurately complete Form R and return it to the Deanery with a coloured passport size photograph. The return of Form R confirms that the trainee 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 trainee re-affirms his/her commitment to the training and thereby remains registered for their training programme.
12. 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.

13. Must inform the postgraduate dean and the Royal College of Psychiatrists of any changes to the information recorded.
14. Trainees must 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.
15. Must make themselves aware of local procedures for reporting concerns about their training and personal development and when such concerns arise, they should report them in a timely manner.

8. ADVANCED TRAINING IN LEARNING DISABILITY PSYCHIATRY

Having completed Core Training, the practitioner may enter Advanced Training in Psychiatry of Learning Disability Psychiatry. The outcome of this training will be an autonomous practitioner able to work at Consultant level. This Curriculum outlines the competencies the practitioner must develop and demonstrate before they may be certificated as a Specialist in Psychiatry of Learning Disability Psychiatry. Because this level of clinical practice often involves working in complex and ambiguous situations, we have deliberately written the relevant competencies as broad statements. We have also made reference to the need for psychiatrists in Advanced Training to develop skills of clinical supervision and for simplicity, rather than repeat them for each component in the Good Clinical Care Domain; we have stated them only once, although they apply to each domain.

This part of the curriculum in Psychiatry of Learning Disability psychiatry builds on Core Psychiatry training in two ways:

Firstly, Specialty Registrars in Psychiatry of Learning Disability Psychiatry continue to exercise the competencies set out in Core Psychiatry training throughout training. This involves acquiring new competencies, particularly in aspects such as leadership, management, teaching, appraising and developing core competencies such as examination and diagnosis to a high level and, as an expert, serving as a teacher and role model.

Secondly, the Psychiatry of Learning Disability Psychiatry curriculum sets out those competencies that are a particular feature of this specialty. These include competencies that are specific to the specialty, or that feature more prominently in the specialty than they do elsewhere, or that need to be developed to a particularly high level (mastery level) in specialty practice. **Overall a trainee is expected to progress through the three years gaining mastery in more independent management of complex LD cases, gaining a deeper understanding of the services and legal context with in which the Psychiatry of Learning Disability consultant operates, and the complexities of working in a multi-agency LD team.**

Some of the intended learning outcomes set out in the Core Curriculum are not included in this Advanced Curriculum. However, for consistency, the numbering system for the intended learning outcomes has been left unchanged here. Therefore, there are gaps in the sequence below.

9. THE INTENDED LEARNING OUTCOMES FOR SPECIALIST TRAINING IN THE PSYCHIATRY OF LEARNING DISABILITY PSYCHIATRY

Good Medical Practice, Domain 1: Knowledge, skills and performance

- *Develop and maintain professional performance*
- *Apply knowledge and experience to practice*
- *Record work clearly, accurately and legibly*

Intended learning outcome 1	
The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include: • **Presenting or main complaint** • **History of present illness** • **Past medical and psychiatric history** • **Systemic review** • **Family history** • **Socio-cultural history** • **Developmental history**	
Intended learning outcome 1	**Assessment methods**
Knowledge Demonstrate an understanding of the multidisciplinary and holistic approach to the psychiatric care of people with LD	CBD, CP, supervisor's reports
Understand the principles of life span issues that affect people with LD and how that influences the management of transitions	CBD, CP, DONCS, supervisor's reports
Demonstrate a knowledge of the principles of clinical supervision and their practical application (NB this competency applies across all the intended learning outcomes and subjects of this domain)	CBD, DONCS
Skills Competently make diagnoses of both organic and functional illnesses and the assessment of complex needs, leading to the formulation and implementation of appropriate management plans in LD	ACE, Mini-ACE, CBD, CP

Competently assess and manage: • patients with epilepsy • patients with ASD • patients needing secure care • patients with dementia associated with LD • challenging behaviours associated with LD	ACE, Mini-ACE, CBD, CP
Offer psychiatric expertise to other practitioners to enhance the value of clinical assessments (e.g. through clinical supervision) to which the psychiatrist has not directly contributed	CBD, DONCS, Mini-PAT
Elicit information required for each component of a psychiatric history; in situations of urgency, prioritise what is immediately needed; and gather this information in difficult or complicated situations	ACE, Mini-ACE, CBD
Attitudes demonstrated through behaviours Display willingness and availability to give clinical supervision to colleagues at all times (NB this competency applies across all the intended learning outcomes and subjects of this domain)	DONCS, Mini-PAT, supervisor's report
1b Patient examination, including mental state examination and physical examination	**Assessment methods**
Knowledge	
Skills By the completion of training, psychiatrists will be able to identify psychopathology in all clinical situations, including those that are urgent and/or complex	ACE, Mini-ACE, CBD, CP
Assess and diagnose patients with multiple and complicated pathologies	ACE, Mini-ACE, CBD, CP
Attitudes demonstrated through behaviours Display an awareness of complex needs	ACE, CBD, CP

Intended learning outcome 4	
Based on a comprehensive psychiatric assessment, the doctor will demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies	
Intended learning outcome 4	**Assessment methods**
Knowledge	
Skills Independently assess and manage patients with mental illnesses including uncommon conditions, in emergencies	CBD, CP, Mini-PAT, supervisor's report
Demonstrate expertise in applying the principles of crisis intervention in emergency situations	CBD, CP, Mini-PAT, supervisor's report
Make care plans in urgent situations where information may be incomplete	CBD, CP, Mini-PAT, supervisor's report
Make an assessment of risk, capacity to consent and the need for detention in complex cases in LD	CBD, CP, Mini-PAT, supervisor's report
Attitudes demonstrated through behaviours Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty	CBD, CP, Mini-PAT, supervisor's report
4c Mental health legislation	**Assessment methods**
Knowledge Demonstrate practical knowledge of the relevant mental health legislation. Including the use of emergency powers and compulsory treatment aspects.	CBD, CP, DONCS, supervisor's report
Skills Demonstrate the competent assessment of a patient using relevant mental health legislation both in emergency and routine practice	CBD, ACE, Mini-ACE,

Be able to give testimony at an appropriately convened tribunal to review the detention of a compulsory patient	CBD, DONCS
Be able to manage a detained patient within the relevant mental health legislation	CBD, DONCS, ACE, Mini-ACE, supervisor's report
Attitudes demonstrated through behaviours Always work within appropriate practice guidelines for the use of mental health legislation	CBD, CP, DONCS, Mini-PAT, supervisor's report
Be prepared to give advice to others on the use of mental health and allied legislation	CBD, CP, DONCS, Mini-PAT, supervisor's report
4d Broader legal framework	**Assessment methods**
Knowledge Demonstrate awareness of specialist aspects of the law	CBD, CP, DONCS, Mini-PAT, supervisor's report
Skills	
Attitudes demonstrated through behaviours	

Intended learning outcome 5	
Based on the full psychiatric assessment, the doctor will demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions	
5a Psychological therapies	**Assessment methods**
Knowledge Apply contemporary knowledge and principles in psychological therapies	CBD, CP, SAPE
Demonstrate the acquisition of more advanced treatment skills appropriate to LD settings	CBD, CP, Mini-PAT, SAPE

Skills Evaluate the outcome of psychological treatments on patients with LD, delivered either by self or others and organise subsequent management appropriately Explain, initiate, conduct and complete a range of psychological therapies in patients who have LD, with appropriate supervision Display the ability to provide expert advice to other health and social care professionals on psychological treatment and care in patients who have LD Assess and manage carers' needs and stress including the provision of psycho-education	CBD, CP, Mini-PAT, SAPE ACE, Mini-ACE, CBD, Mini-PAT, SAPE CBD, DONCS, Mini-PAT ACE, Mini-ACE, CBD, CP
Attitudes demonstrated through behaviours Continue to practice and develop a range of treatment skills	Supervisor's report, SAPE

Intended learning outcome 7	
Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states	
7a Management of severe and enduring mental illness	**Assessment methods**
Knowledge	
Skills Develop professional alliances with patients over the long-term Develop therapeutic optimism and hope Assist and guide trainees in assessing and managing patients with severe and enduring mental illness	CBD, Mini-PAT, SAPE CBD, Mini-PAT, SAPE CBD, DONCS
Attitudes demonstrated through behaviours	

Intended learning outcome 8	
To develop an understanding of research methodology and critical appraisal of the research literature	
8a Research techniques	**Assessment methods**
Knowledge	
Demonstrate an understanding of basic research methodology including both quantitative and qualitative techniques	Supervisor's report, JCP, DONCS
Demonstrates an understanding of the research governance framework including the implications for the local employer (NHS Trust or equivalent) of research.	Supervisor's report, DONCS
Demonstrates an understanding of the work of research ethics committees and is aware of any ethical implications of a proposed research study	Supervisor's report, DONCS
Demonstrate an understanding of how to design and conduct a research study	Supervisor's report, DONCS
Demonstrate an understanding of the use of appropriate statistical methods	Supervisor's report, DONCS
Describe how to write a scientific paper	Supervisor's report, DONCS
Demonstrate a knowledge of sources of research funding	Supervisor's report, DONCS
Use research methods to enrich learning about aetiology and outcomes within general psychiatry	Supervisor's report, DONCS
Skills	
Frame appropriate research questions	Supervisor's report, DONCS
Able to write a research protocol and draw up a realistic time line for the proposed study	Supervisor's report, DONCS

Able to apply successfully for R & D approval (if relevant)	Supervisor's report, DONCS
Able to apply successfully to an ethics committee (if relevant)	Supervisor's report, DONCS
Carry out a research project and able to modify protocol to overcome difficulties. Can adhere to time lines. Enters data onto standard computer software, eg EXCEL, STATA, SPSS etc	Supervisor's report, DONCS
Able to compare own findings with others	Supervisor's report, DONCS
Able to prepare research for written publication and follow submission instructions for most appropriate journal	Supervisor's report, DONCS
Able to present own research at meetings and conferences	Supervisor's report, DONCS
Apply research methods, including critical appraisal, in general psychiatry	Supervisor's report, DONCS
Attitudes demonstrated through behaviours	
Demonstrate a critical spirit of enquiry	Supervisor's report, DONCS
Ensure subject confidentiality	Supervisor's report, DONCS
Work collaboratively in research supervision	Supervisor's report, DONCS
Demonstrate consistent compliance with the highest standards of ethical behaviour in research practice	Supervisor's report, DONCS

8b Evaluation and critical appraisal of research	Assessment methods
Knowledge	
Demonstrate an understanding of basic research methodology including both quantitative and qualitative techniques	Supervisor's report, JCP, DONCS
Demonstrates an understanding of the research governance framework including the implications for the local employer (NHS Trust or equivalent) of research.	Supervisor's report, DONCS
Demonstrates an understanding of the work of research ethics committees and is aware of any ethical implications of a proposed research study	Supervisor's report, DONCS
Demonstrate an understanding of how to design and conduct a research study	Supervisor's report, DONCS
Demonstrate an understanding of the use of appropriate statistical methods	Supervisor's report, DONCS
Describe how to write a scientific paper	Supervisor's report, DONCS
Demonstrate a knowledge of sources of research funding	Supervisor's report, DONCS
Use research methods to enrich learning about aetiology and outcomes within general psychiatry	Supervisor's report, DONCS

Skills Able to carry out a thorough literature search, critically analyse existing knowledge, synthesise information and summarise the relevant findings coherently.	Supervisor's report, JCP
Able to write a comprehensive literature review of a proposed topic of study	Supervisor's report, JCP
Able to communicate clearly and concisely with non-medical professionals, i.e. other members of the multidisciplinary team, and staff from other agencies, regarding the	Supervisor's report, JCP

importance of applying research findings in everyday practice. Able to translate research findings to everyday clinical practice. Inclusion of research findings in case summaries and formulations and in letters to medical colleagues. Able to appreciate the 'scientific unknowns' in the relevant field psychiatric practice Adopt the principles of evidence based practice at a service level	 CBD, DONCS, mini-PAT, supervisor's report Supervisor's report, CBD, JCP Supervisor's report, CBD, DONCS
Attitudes demonstrated through behaviours Be able to appreciate the limitations and controversies within the relevant area of scientific literature	Supervisor's report, CBD, DONCS

Good Medical Practice, Domain 2: Safety and Quality

- *Contribute to and comply with systems to protect patients*
- *Respond to risks and safety*
- *Protect patients and colleagues from any risk posed by your health*

Intended learning outcome 10	
Develop the ability to conduct and complete audit in clinical practice	
10a Audit	**Assessment methods**
Knowledge Demonstrate a knowledge of different audit methods Demonstrate a knowledge of methods of sampling for audit Demonstrate a knowledge of obtaining feedback from patients, the public, staff and other interested groups	 Supervisor's report, DONCS Supervisor's report, DONCS Supervisor's report, DONCS

Demonstrate an understanding of the structures of the NHS and social care organisations (or equivalents)	Supervisor's report, DONCS
Demonstrate an understanding of quality improvement methodologies	Supervisor's report, DONCS
Demonstrate an understanding of the principles of change management	Supervisor's report, DONCS
Skills	
Carry out audit projects under supervision in LD	Supervisor's report, DONCS
Be able to set standards that can be audited	Supervisor's report, DONCS
Be able to measure changes in practice	Supervisor's report, DONCS
Be able to effectively apply audit principles to own work, to team practice and in a service wide context, including to relevant organisational and management systems	Supervisor's report, DONCS
Be able to supervise a colleague's audit project	Supervisor's report, DONCS
Attitudes demonstrated through behaviours	
Hold a positive attitude to the potential of audit in evaluating and improving the quality of care	Supervisor's report, DONCS
Show willingness to apply continuous improvement and audit principles to own work and practice	Supervisor's report, DONCS
Show willingness to support and encourage others to apply audit principles	Supervisor's report, Mini-PAT, DONCS

Intended learning outcome 11	
To develop an understanding of the implementation of clinical governance	
11a Organisational framework for clinical governance and the benefits that patients may expect	**Assessment methods**
Knowledge Demonstrate a knowledge of relevant risk management issues; including risks to patients, carers, staff and members of the public	CBD, CP, supervisor's report,
Demonstrate a knowledge of how healthcare governance influences patient care, research and educational activities at a local, regional and national level	Supervisor's report, DONCS
Demonstrate a knowledge of a variety of methodologies for developing creative solutions to improving services	Supervisor's report, DONCS
Skills Participate in audit and other clinical governance processes in LD	Supervisor's report DONCS
Develop and adopt clinical guidelines and integrated care pathways	Supervisor's report, DONCS
Report and take appropriate action following serious untoward incidents	Supervisor's report, CBD, CP, DONCS
Assess and analyse situations, services and facilities in order to minimise risk to patients, carers, staff and the public	Supervisor's report, CBD, CP, DONCS
Monitor the safety of services	Supervisor's report, DONCS
Demonstrate ability to deviate from care pathways when clinically indicated	Supervisor's report, CBD,

Question existing practice in order to improve service	CP Supervisor's report, CBD, CP, DONCS
Attitudes demonstrated through behaviours Demonstrate ability to consciously deviate from pathways when clinically indicated	Supervisor's report, CBD, CP
Demonstrate willingness to take responsibility for clinical governance activities, risk management and audit in order to improve the quality of the service	Supervisor's report, CBD, CP, DONCS
Be open minded to new ideas	Supervisor's report, CBD, CP, DONCS
Support colleagues to voice ideas	Supervisor's report, CBD, CP, DONCS

Good Medical Practice, Domain 3: Communication, partnership and teamwork

- *Treat patients as individuals and respect their dignity*
- *Work in partnership with patients*
- *Work with colleagues in the ways that best serve patients' interests*

Intended learning outcome 13	
Demonstrate effective communication with patients, relatives and colleagues. This includes the ability of the doctor to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances	
Intended learning outcome 13	**Assessment methods**
Knowledge	
Skills Competently assess patients with LD who may have significant communication problems	ACE, Mini-ACE, CBD

Communicate with people with LD and their families and other professionals	ACE, Mini-ACE, DONCS
Prepare legal reports in LD	CBD, DONCS
Attitudes demonstrated through behaviours Demonstrate respect, empathy, responsiveness, and concern for patients, their problems and personal characteristics	ACE, Mini-ACE, CBD
Demonstrate an understanding of the need for involving patients in decisions, offering choices, respecting patients' views	ACE, Mini-ACE, CP, CBD
Ensure that dress and appearance are appropriate to the clinical situation and patients' sensitivity	ACE, Mini-ACE, supervisor's report

Intended learning outcome 14	
To demonstrate the ability to work effectively with colleagues, including team working	
Intended learning outcome 14	**Assessment methods**
Knowledge Liaise with other medical/psychiatric specialties with particular emphasis in gaining competence in specialties with specific relevance to LD; such as neurology, neurophysiology, paediatrics, clinical genetics for example	CBD, DONCS
Maintain and apply a current working knowledge of the law as it applies to working relationships	DONCS, supervisor's report
Demonstrate an understanding of the responsibility of the team with regard to patient safety	CBD, Mini-PAT supervisor's report
Demonstrate an understanding of how a team works and develops effectively	CBD, Mini-PAT, DONCS

Demonstrate an understanding of time management, values based practice and information management	CBD, Mini-PAT, DONCS
Skills	
Skillfully participate in inter-agency working, for example, with education and social services, and including the ability to work in schools and residential settings	CBD, DONCS, supervisor's report
Facilitate the leadership and working of other members of the team	CBD, Mini-PAT, DONCS
Recognise and resolve dysfunction and conflict within teams when it arises	CBD, Mini-PAT, DONCS
Competently manage a service, or a part of the service, alongside consultant trainer	CBD, Mini-PAT, DONCS, supervisor's report
Show competence in supervised autonomous working	CBD, Mini-PAT, DONCS, supervisor's report
Use effective negotiation skills	CBD, Mini-PAT, DONCS, supervisor's report
Be able to work with service managers and commissioners and demonstrate management skills such as understanding the principles of developing a business plan	Mini-PAT, DONCS, supervisor's report
Manage change, with the involvement of service users and carers in teamwork.	Mini-PAT, DONCS, supervisor's report
Utilise team feedback	Mini-PAT, DONCS, supervisor's report
Manage complaints made about services	Mini-PAT, DONCS, supervisor's report
Competently participate in the NHS Appraisal Scheme	Mini-PAT, DONCS, supervisor's report
Attitudes demonstrated through behaviours	

Be prepared to question and challenge the performance of other team members when standards appear to be compromised	Mini-PAT, CBD, DONCS, supervisor's report

Intended learning outcome 15	
Develop appropriate leadership skills	
Intended learning outcome 15	**Assessment methods**
Knowledge Demonstrate an understanding of the differing approaches and styles of leadership	Mini-PAT, DONCS, supervisor's report
Demonstrate an understanding of the role, responsibility and accountability of the leader in a team	Mini-PAT, DONCS, supervisor's report
Understand and contribute to the organization of urgent care in the locality	Mini-PAT, DONCS, supervisor's report
Demonstrate an understanding of the structures of the NHS and social care organisations	Mini-PAT, DONCS, supervisor's report
Demonstrate an understanding of organisational policy and practice at a national and local level in the wider health and social care economy	Mini-PAT, DONCS, supervisor's report
Demonstrate an understanding of the principles of change management	Mini-PAT, DONCS, supervisor's report
Understand the principles of identifying and managing available financial and personnel resources effectively	Mini-PAT, DONCS, supervisor's report
Skills Demonstrate a range of appropriate leadership and supervision skills including: • Coordinating, observing and being assured of effective team working • Setting intended learning outcomes • Planning	Mini-PAT, DONCS, supervisor's report

• Motivating • Delegating • Organising • Negotiating • Example setting • Mediating / conflict resolution • Monitoring performance	
Demonstrate ability to design and implement programmes for change, including service innovation	Mini-PAT, DONCS, supervisor's report
Displays expertise in employing skills of team members to greatest effect	Mini-PAT, DONCS, supervisor's report
Acts as impartial mediator in conflicts over roles and responsibilities	Mini-PAT, DONCS, supervisor's report
Competently manage a clinical service (or a part of it) under Consultant supervision across a range of settings that might include community and inpatient care (the trainee taking on the role and duties of the Responsible Clinician, or equivalent)	Mini-PAT, DONCS, supervisor's report
Attitudes demonstrated through behaviours Work collaboratively with colleagues from a variety of backgrounds and organisations	Mini-PAT, DONCS, supervisor's report
Be prepared to question and challenge the performance of other team members when standards appear to be compromised	CBD, DONCS, Mini-PAT, supervisor's report

Intended learning outcome 16	
To demonstrate that the doctor has the knowledge, skills and behaviours to manage time and problems effectively and to successfully undertake other appropriate management functions	
16b Communication with colleagues	**Assessment methods**
Knowledge Demonstrate an understanding of the requirements of outside agencies for reports that are timely, accurate and appropriate Develop an understanding of the principles behind the management of LD services and service delivery Demonstrate an understanding of the different service models and their implications for health services for people with LD	Mini-PAT, CBD, DONCS, supervisor's report Mini-PAT, CBD, DONCS, supervisor's report Mini-PAT, CBD, DONCS, supervisor's report
Skills Prepare and deliver reports for Mental Health Tribunals, Managers' Hearings, Coroners Courts and Courts of Law Understand the roles and responsibilities of an expert witness Competence to work with managers and in abilities such as preparing a business case, policy development, project management for example	Mini-PAT, CBD, DONCS, supervisor's report Mini-PAT, CBD, DONCS, supervisor's report Mini-PAT, CBD, DONCS, supervisor's report
Attitudes demonstrated through behaviours Produce reports that are comprehensive, timely, accurate, appropriate and within limits of expertise	Mini-PAT, CBD, DONCS, supervisor's report

Intended learning outcome 17	
To develop the ability to teach, assess and appraise	
Intended learning outcome 17	**Assessment methods**
Knowledge Demonstrate an understanding of the basic principles of adult learning	Supervisor's report, DONCS
Identify learning styles	Supervisor's report, DONCS
Develop a knowledge of different teaching techniques and demonstrate how these can be used effectively in different teaching settings relevant to general psychiatry, in a hospital or community based clinical setting	Supervisor's report, AoT, DONCS
Use a variety of teaching methods	AoT, DONCS, supervisor's report
Evaluate learning and teaching events	AoT, DONCS, supervisor's report
Facilitate the learning process and assess performance	AoT, DONCS, supervisor's report
Organise educational events	AoT, DONCS, supervisor's report
Attitudes demonstrated through behaviours Demonstrate a professional attitude to teaching	Supervisor's report, AoT, DONCS, mini-PAT

17b Assessment	**Assessment methods**
Knowledge	
Skills Use appropriate, approved assessment methods	Supervisor's report, DONCS
Give feedback in a timely and constructive manner	Supervisor's report, DONCS
Provide supervision to others undertaking these tasks	Supervisor's report, DONCS
Attitudes demonstrated through behaviours Be at all times honest when assessing performance	Supervisor's report, Mini-PAT, DONCS
17c Appraisal	**Assessment methods**
Knowledge Demonstrate an understanding of the principles of appraisal (including the difference between appraisal and assessment)	Supervisor's report, DONCS
Demonstrate an understanding of the structure of appraisal interviews	Supervisor's report, DONCS
Skills Conduct appraisal effectively and at the appropriate time	Supervisor's report, DONCS
Attitudes demonstrated through behaviours Show respect and confidentiality for the appraisee	Supervisor's report, DONCS

Good Medical Practice, Domain 4: Maintaining Trust

- *Be honest and open and act fairly with integrity*
- *Never discriminate unfairly against patients or colleagues*
- *Never abuse patients' trust or the public's trust in the profession*

Intended learning outcome 19	
To ensure that the doctor acts in a professional manner at all times	
19a Doctor patient relationship	**Assessment methods**
Knowledge Demonstrate an understanding of complex ethical and legislative issues relevant to LD	Supervisor's report, CBD, DONCS
Skills Support and advise colleagues (both medical and non-medical) in dealing with complex professional interactions	Supervisor's report, CBD, DONCS
Attitudes demonstrated through behaviours	
19c Confidentiality	**Assessment methods**
Knowledge Develop a good understanding of the needs for information of a range of agencies	Supervisor's report, CBD, DONCS
Appreciate the different sensitivities of patients to a range of information held about them particularly in relation to psychological material	Supervisor's report, CBD, DONCS
Be aware of the principles and legal framework of disclosure	Supervisor's report, CBD, DONCS
Demonstrate an understanding of the issues around confidentiality in LD and in particular, the implications of disclosing information about diagnoses, degrees of risk and any sharing of information about the patient	Supervisor's report, CBD, DONCS

Develop a clear understanding of local complaints procedures	Supervisor's report, CBD, DONCS
Skills Advise others (including non-healthcare professionals) on the safe and appropriate sharing of information	Supervisor's report, CBD, DONCS
19e Risk management	**Assessment methods**
Knowledge Demonstrate a knowledge of matters such as health and safety policy	Supervisor's report, CBD, DONCS
Skills	
Attitudes demonstrated through behaviours Work in collaboration with patients and the multi-disciplinary team to enable safe and positive decision-making	Supervisor's report, CBD, DONCS
19f Recognise own limitations	**Assessment methods**
Knowledge	
Skills Provide clinical supervision Competence to work autonomously as well as within a framework of supervision	Supervisor's report, CBD, DONCS
Attitudes demonstrated by behaviours	

10. METHODS OF LEARNING AND TEACHING

The curriculum is delivered through a number of different learning experiences, of which experiential workplace learning with supervision appropriate to the trainee's level of competence is the key. This will be supported by other learning methods as outlined below: -

- Appropriately supervised clinical experience
- Psychotherapy training
- Emergency psychiatry experience
- Interview skills
- Learning in formal situations
- Teaching
- Management experience
- Research
- ECT Training
- Special interest sessions

Appropriately supervised clinical experience

Trainees must at all times participate in clinical placements that offer appropriate experience i.e. direct contact with and supervised responsibility for patients. **All training placements must include direct clinical care of patients.** Placements based on observation of the work of other professionals are not satisfactory. **Each placement must have a job description and timetable. There should be a description of potential learning objectives in post.** Training placements should not include inappropriate duties (e.g. routine phlebotomy, filing of case notes, escorting patients, finding beds, etc) and must provide a suitable balance between service commitment and training.

The clinical experience in the Advanced Training Programme in Psychiatry of Learning Disability Psychiatry will consist of the equivalent of three years full time experience at least two years of which are within designated Psychiatry of Learning Disability posts. This would comprise experience of:

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

One year of this could be within designated Psychiatry of Learning Disability services for children.

The third year could comprise either further community-based experience as above, perhaps with an emphasis on:

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

A year's experience in either Child LD or Forensic LD would not provide dual accreditation. Shorter periods e.g. 6 months in a medium or high secure LD setting, with six months of low secure LD would also be acceptable for a year's programme. This is determined by the local LD Training Programme Director according to the individual trainee's needs.

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

Clinical placements in advanced training in Psychiatry of Learning Disability Psychiatry should last l2 months for a full-time trainee. This gives sufficient time for a realistic clinical experience and allows the completion of treatment programmes and time to build up and close down a clinical service. However, placements of up to 15 months may be acceptable if there are problems with rotational dates. It must be emphasised that advanced training in Psychiatry of Learning Disability Psychiatry is not simply an extension of Core Psychiatry Training and the duties performed by advanced trainees must reflect this. There should not be a routine expectation that the higher trainee continues to work at a level appropriate for Core Psychiatry training. The specialty registrar (ST4-6) works more independently and has a greater supervisory, leadership and managerial role. There must be opportunity for the specialty registrar to develop

supervisory skills. The clinical load should not be so heavy so as to jeopardise the research, teaching and managerial functions.

Psychotherapy training

The aim of psychotherapy training is to contribute to the training of future consultant psychiatrists in all branches of psychiatry who are psychotherapeutically informed, display advanced emotional literacy and can deliver some psychological treatments and interventions. Such psychiatrists will be able to:

- Account for clinical phenomena in psychological terms
- Deploy advanced communication skills
- Display advanced emotional intelligence in dealings with patients and colleagues and yourself.
- Refer patients appropriately for formal psychotherapies
- Jointly manage patients receiving psychotherapy
- Deliver basic psychotherapeutic treatments and strategies where appropriate
-

A senior clinician with appropriate training (preferably a consultant psychotherapist) should be responsible for organising psychotherapy training within a School in line with current curriculum requirements. There are two basic requirements: -

Case based discussion groups (CBDG) are a core feature of early training in psychotherapeutic approach to psychiatry. They involve regular weekly meetings of a group of trainees and should last around one and one and a half hours. The task of the meeting is to discuss the clinical work of the trainees from a psychotherapeutic perspective paying particular attention to the emotional and cognitive aspects of assessment and management of psychiatric patients in whatever setting the trainee comes from. Trainees should be encouraged to share their feelings and thoughts openly and not to present their cases in a formal or stilted manner. Most trainees should attend the group for about one year. Attendance and participation in the CBDG will be assessed.

Undertaking specific training experiences treating patients is the only reliable way to acquire skills in delivering psychotherapies. The long case also helps in learning how to deal with difficult or complicated emotional entanglements that grow up between patients and doctors over the longer term. Patients allocated to trainees should be appropriate in terms of level of difficulty and should have been properly assessed. Trainees should be encouraged to treat a number of psychotherapy cases during their training using at least two modalities of treatment and at least two durations of input. This experience must be started in Core training and continued in Advanced Training, so that by the end of Core Training the trainee must have competently completed at least two cases of different durations. The psychotherapy supervisor will assess the trainee's performance by using the SAPE.

Care should be given in the selection of psychological therapy cases in Advanced Training in Psychiatry of Learning Disability Psychiatry to make the experience gained is relevant to the trainee's future practice as a consultant. For example trainees may wish to develop skills in behavior modification or in the use of cognitive approaches with people who have learning disabilities.

The psychotherapy tutor should have selected supervisors. Psychotherapy supervisors need not be medically qualified but they should possess appropriate skills and qualifications both in the modality of therapy supervised and in teaching and supervision.

Emergency Psychiatry

Trainees must gain experience in the assessment and clinical management of psychiatric emergencies and trainees must document both time spent on-call and experience gained (cases seen and managed) and this should be "signed off" by their Clinical Supervisor/Trainer.

A number and range of emergencies will constitute relevant experience. During Core Psychiatry training, trainees must have experience equivalent to participation in a first on call rota with a minimum of 55 nights on call during the period of core specialty training (i.e. at least 50 cases with a range of diagnosed conditions and with first line management plans conceived and implemented.) (Trainees working part time or on partial shift systems must have equivalent experience.)

Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes Core Psychiatry trainees from the initial assessment of deliberate self-harm patients or DGH liaison psychiatry consultations, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.

Psychiatric trainees should not provide cross specialty cover for other medical specialties except in exceptional circumstances where otherwise duty rotas would not conform to the European Working Time Directive. No trainee should be expected to work to a level beyond their clinical competence and experience.

Where daytime on call rotas are necessary, participation must not prevent trainees attending fixed training events.

Advanced trainees in General Psychiatry must have opportunities to supervise others as part of their experience of emergency psychiatry. They should not routinely perform duties (such as clerking emergency admissions) that would normally be performed by less experienced practitioners.

Interview skills

All trainees must receive teaching in interviewing skills in the first year Core Psychiatry Training (CT1). The use of feedback through role-play and/or video is recommended. Soliciting (where appropriate) the views of patients and carers on performance is also a powerful tool for feedback.

Learning in formal situations

Learning in formal situations will include attending a number of courses for which the trainee should be allowed study leave: -

- It is essential that trainees in Core Psychiatry Training attend an MRCPsych course that comprises a systematic course of lectures and /or seminars covering basic sciences and clinical topics, communication and interviewing skills.
- Local postgraduate meetings where trainees can present cases for discussion with other psychiatrists, utilising information technology such as slide presentations and video recordings.
- Journal clubs, where trainees have the opportunity to review a piece of published research, with discussion chaired by a consultant or specialty registrar (ST4-ST6), Postgraduate meetings where trainees can present and discuss audit.
- Multi-disciplinary/multi-professional study groups.
- Learning sets which can stimulate discussion and further learning.
- Trainees must also exercise personal responsibility towards their training and education and are encouraged to attend educational courses run by the College's divisional offices.

Experience of teaching

It is important that all trainee psychiatrists have experience in delivering education. In Core Psychiatry training, trainees should have opportunities to assist in 'bedside' teaching of medical students and delivering small group teaching under supervision. Advanced trainees in Psychiatry of Learning Disability Psychiatry should be encouraged to be involved in teaching CT1-3 trainees on the MRCPsych course and to be involved in the design, delivery and evaluation of teaching events and programmes.

Management experience

Opportunity for management experience should be available in all training programmes and should begin with simple tasks in the clinical, teaching and committee work of the hospital or service. Attending courses and by shadowing a

medical manager to get insight into management. For example, the final month of a ST4 placement could be spent working with a manager. "Hands on" experience is especially effective, e.g. convening a working group, and it may be possible for a trainee to be given a relevant management task to complete. Opportunity for involvement in administration and collaboration with non medical staff at local level on the ward or unit, at Trust level or on the training scheme itself to gain familiarity with and an understanding of management structure and process as part of a trainee's professional development as a psychiatrist.

ECT Training

All Core Psychiatry training programmes must ensure that there is training and supervision in the use of ECT so that trainees become proficient in the prescribing, administration and monitoring of this treatment.

Research

Opportunities must be made available for trainees to experience supervised quantitative or qualitative research and a nominated research tutor should be available within the programme to advise trainees on the suitability of projects. In Core Psychiatry training, research may be limited to case reports or a small literature review. In advanced training in Psychiatry of Learning Disability Psychiatry, trainees should have the opportunity to participate in original research

Special interest sessions

It is educationally desirable that Advanced Trainees in Psychiatry of Learning Disability Psychiatry have the ability to gain additional experiences that may not be available in their clinical placement. Two sessions every week must be set aside during each year from St4-6 for such personal development, which may be taken in research or to pursue special clinical interests. Special interest sessions are defined as “a clinical or clinically related area of service which cannot be provided within the training post but which is of direct relevance to the prospective career pathway of the trainee”. For instance, a special interest session in autism and ADHD diagnosis would be of direct relevance to a trainee wishing to subsequently work in a neurodevelopmental post.

Special interest sessions may also be used for gaining psychotherapy experience that builds upon the experience the trainee had in Core Training. This experience must be appropriately managed, supervised and assessed. The Training Programme Director must prospectively approve the use of special interest time. Special interest and research supervisors must provide reports for the trainee’s ARCP as required by the School of Psychiatry.

11. THE ASSESSMENT SYSTEM FOR ADVANCED TRAINING IN PSYCHIATRY OF LEARNING DISABILITY PSYCHIATRY

Purpose

The Royal College of Psychiatrists Assessment System has been designed to fulfill several purposes:

- Providing evidence that a trainee is a competent and safe practitioner and that they are meeting the standards required by Good Medical Practice
- Creating opportunities for giving formative feedback that a trainee may use to inform their further learning and professional development
- Drive learning in important areas of competency
- Help identify areas in which trainees require additional or targeted training
- Providing evidence that a trainee is progressing satisfactorily by attaining the Curriculum learning outcomes
- Contribute evidence to the Annual Review of Competence Progression (ARCP) at which the summative decisions regarding progress and ultimately the award of the Certificate of Completion of Training (CCT) are made.

Assessment blueprint

The Assessment Blueprint supplement to this Curriculum shows the assessment methods that can possibly be used for each competency. It is not expected that all trainees will be assessed by all possible methods in each competency. The learning needs of individual trainees will determine which competencies they should be assessed in and the number of assessments that need to be performed. The trainee's Educational Supervisor has a vital role in guiding the trainee and ensuring that the trainee's assessments constitute sufficient curriculum coverage.

Trainees must pass the MRCPsych examination and successfully complete core training before entering Advanced Training in General Psychiatry.

Workplace Based Assessment (WPBA) 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 will continue the process established in the Foundation Programme and will extend throughout Core Psychiatry Training and Advanced Training in General Psychiatry. It must be understood that WPBA's are primarily tools for giving formative feedback and in order to gain the full benefit of this form of assessment, trainees should ensure that their assessments take place at regular intervals throughout the period of training. All trainees 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 trainee and evidence of further development may be taken as evidence that a trainee demonstrates critical self-reflection. Educational supervisors will draw attention to trainees who leave all their assessments to the 'last minute' or who appear satisfied that they have completed the minimum necessary.

An individual WPBA is not a summative assessment, but outcomes from a number of WPBA's will contribute evidence to inform summative decisions.

The WPBA tools currently consist of:

- **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

- **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.

- **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 Trainee has recently been involved with and has written in their notes.

- **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.

- **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.*

- **Case Based Discussion Group Assessment (CBDGA)** has been developed by the College to provide structured feedback on a trainee's attendance and contribution to case discussion groups (also known as Balint-type groups) in Core Psychiatry Training.

- **Structured Assessment of Psychotherapy Expertise (SAPE)** has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case.

- **Case Presentation (CP)** developed at the College; this is an assessment of a major case presentation, such as a Grand Round, by the Trainee.

- **Journal Club Presentation (JCP)** similar to CP, and also developed at the College, this enables an assessment to be made of a Journal Club presented by the Trainee.

- **Assessment of Teaching (AoT)** has been developed at the College to enable an assessment to be made of planned teaching carried out by the Trainee, which is a requirement of this curriculum.

- **Direct Observation of non-Clinical Skills (DONCS)** has been developed by the College from the Direct Observation of Procedural Skills (DOPS). The DONCS is designed to provide feedback on a doctor's performance of non-clinical skills by observing them chairing a meeting, teaching, supervising others or engaging in another non-clinical procedure.

WPBA for Advanced Trainees

Doctors in Advanced Training Programmes should participate in at least one or two rounds of multi-source feedback a year and have at least one other WPBA performed a month. It is likely that the CbD will be an important assessment tool for these doctors because this tool permits a deep exploration of a doctor's clinical reasoning. The mini-ACE may be less important for most advanced trainees, except perhaps those engaged in areas of clinical work that they had not encountered in core training. As stated above, the College is developing the DONCS as a means of assessing performance of skills in situations that do not involve direct patient encounters. In time, it is possible that some psychiatric sub-specialty Advanced Training Curricula may introduce novel WPBA tools for specialised areas of work. Detailed information is contained in the Guide to ARCP panels.

12. Decisions on progress, the ARCP

Section 7 of the **Guide to Postgraduate Specialty Training in the UK** ("Gold Guide") describes the **Annual Review of Competence Progression** (ARCP). The ARCP is a formal process that applies to all Specialty Trainees. In the ARCP a properly constituted panel reviews the evidence of progress to enable the trainee, the postgraduate dean, and employers to document that the competencies required are being gained at an appropriate rate and through appropriate experience.

The panel has two functions: -

1. To consider and prove the adequacy of the trainee's evidence.
2. Provided the documentation is adequate, to make a judgment about the trainee's suitability to progress to the next stage of training or to confirm that training has been satisfactorily completed

The next section is a guide for ARCP panels regarding the evidence that trainees should submit at each year of Core Psychiatry and Advanced Specialty training in General Psychiatry. There are several different types of evidence including WPBA's, supervisor's reports, the trainee's learning plan, evidence of reflection, course attendance certificates etc. The evidence may be submitted in a portfolio and in time, this will be done using the College e-portfolio.

Trainees may submit WPBA's that have been completed by any competent healthcare professional who has undergone training in assessment. In a number of cases, we have stipulated that a consultant should complete the assessment. WPBA's in developmental psychiatry (i.e. in children and patients with learning disability) should be performed by a specialist child psychiatrist or Psychiatry of Learning Disability psychiatrist.

The trainee should map the evidence that they wish to be considered for each competency. A single piece of evidence may be used to support more than one competency.

13. Trainee and Trainer Guide to ARCPs in LD Psychiatry

This guide will assist trainer and trainees to decide what is appropriate evidence for the portfolio and the content of supervisors' reports. Evidence may be suitable for more than one Intended Learning Outcome.

It is anticipated that trainee will have a minimum of 12 WBPAs per year, to include one round of Mini-PAT, at least one ACE, one mini ACE, one JCP, several CBDs and one audit.

Training of LD psychiatrists occurs in a wide variety of services with different configurations and opportunities. This variation can be, for example, varied access to LD inpatient facilities- some services are 'mainstreamed' and LD psychiatrists provide support, rather than direct care. Therefore experience of the use of the MHAct may be primarily consultative. Other variations may include a lack of Core trainees so that teaching/supervision may be of other disciplines or more junior trainees.

Intended learning outcome	ST4 Community Orientated LD	ST5 (Community but could be specialty)	ST6 (Specialty but could be community)
Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include: **Presenting or main complaint** **History of present illness** **Past medical and psychiatric history** **Systemic review** **Family history** **Socio-cultural history** **Developmental history**			
	By the end of ST4, the trainee will be able to assess and manage routine LD cases of mental illness, challenging behaviour, ongoing epilepsy, autistic disorder	By the end of ST5, the trainee will be able to assess and manage more complex cases of people who have a range of levels of LD	By the end of ST6, the trainee will be able to assess and manage complex cases across the ability range of LD including cases of mental illness, challenging behaviour, autistic spectrum

			disorder, dementia, those in need of secure care and including transition to adulthood. The trainee will be able to offer psychiatric expertise and consultation to others in the management of the above
1b Patient examination, including mental state examination and physical examination	CBD of an OP case: a patient the trainee has fully assessed, including a developmental, seizure and behavioural history with collateral history as appropriate. CBD of an IP case: a patient the trainee has fully assessed, including a including a developmental history seizure and behavioural history with collateral history, as appropriate. ACE conducted with an OP LD patient (and their carers) not previously known to the trainee, to include	CBD of a case: a complex patient the trainee has fully assessed including a developmental, seizure and behavioural history with collateral history as appropriate. ACE of the trainee performing an assessment of a complex patient the trainee has fully assessed including a developmental, seizure and behavioural history with collateral history as appropriate.	CBD of a case: a typical patient the trainee has fully assessed within this specialist area (e.g forensic, child LD neuropsychiatry etc) including a collateral history and detailed developmental or forensic history, depending on area ACE of a case: a typical patient the trainee has fully assessed within this specialist (e.g. forensic, child LD neuropsychiatry etc) including a collateral history and detailed developmental or forensic history,

	mental state examination. ACE conducted with an IP LD patient not previously known to the trainee, to include mental state examination (may be on an AMH ward)		depending on area. (over three years ACE/ CBD to include: examples of epilepsy, dementia, autistic spectrum disorder, challenging behaviour, mental illness, transition to adulthood; case log to include also case mix of levels of learning disability)
4 Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies			
	By the end of ST4, the trainee will demonstrate competence in urgent assessment of routine cases, risk assessment and appropriate understanding of use of mental health legislation in LD, including incapacity.	By the end of ST5, the trainee will demonstrate competence in utilising mental health legislation appropriate to LD and demonstrate associated report writing skills	By the end of ST6, the trainee will be able to appropriately use incapacity and mental health legislation in LD, and including safeguarding of vulnerable adults, across a range of cases. The trainee will be able to advise others about the use of the above legislation, and chair

			multidisciplinary reviews involving the above. The trainee will be able to undertake complex multidisciplinary risk assessment
	CBD of urgent assessment in LD	CBD of urgent assessment of complex LD case	CBD of urgent assessment of complex LD case
4c Mental health legislation	CBD of a Mental Health Act Tribunal Report (or equivalent) the Trainee has written.	CBD of relevant mental health legislation and the management of a complex patient	Case Log over three years to include examples of use of Mental Health Act for assessment, treatment and community sections in LD(or opinions on the above for 'mainstreamed' LD patients)
4d Broader legal framework	Evidence of satisfactory completion of an appropriate course to gain approval to exercise powers under the relevant mental health legislation CBD of a case involving consent and issues of capacity/incapacity	DONC of trainee participation in a case review involving the safeguarding of vulnerable adults or children.	Over three years case log and written reflective pieces to evidence use consent/capacity/ incapacity legislation; safeguarding; potential restriction of liberty to inform supervisors' reports

5 Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions			
	By the end of ST4, the trainee will be able to demonstrate psychological understanding of cases and therapeutic engagement with patients who have LD, their families and carers	By the end of ST5 the trainee will demonstrate the ability to manage aspects of LD cases using significant psychological management.	BY the end of ST6, the trainee will demonstrate ability to work psychologically with individuals, families and carers and with other disciplines in integrated psychological management of cases.
5a Psychological therapies	ACE on a case previously unknown to the trainee requiring initial therapeutic engagement eg transition to adult services CBD on a case requiring predominantly psychological management Supervisors' report	Written reflective work on complex psychological issues and management around individual or carer as basis for CBD (SAPE if applicable) and supervisors' report	Written reflection of a range of individual and carer/ family interventions; as well as portfolio evidence of integrated work with other disciplines on psychological management; for CBD (SAPE if applicable) and supervisors' report.

7 Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states			
7a Management of severe and enduring mental illness	One round of Mini-PAT Supervisors' reports	One round of Mini-PAT Supervisors' reports	One round of Mini-PAT Supervisors' reports
8To develop an understanding of research methodology and critical appraisal of research literature			
	By the end of ST4, the trainee should be able to frame an appropriate research question, conduct a relevant literature search, write a comprehensive review of this literature and write a research protocol (this may be for a project that the trainee will conduct or it may be in 'shadow' form)	By the end of ST5, the trainee should demonstrate the ability to collect data and enter it into standard computer software (this may be from the trainee's own research or audit) and be able to demonstrate the incorporation of research findings in their everyday practice	By the end of ST6 should demonstrate the ability to prepare findings of research, audit or similar work for dissemination beyond the trainee's workplace and be able to communicate the importance of applying research findings to colleagues
8a Research techniques	Special Interest supervisors' reports	Special Interest supervisors' reports	Special Interest supervisors' reports Poster presentation of audit/research at regional/national meeting
8b Evaluation and critical appraisal of research	JCP of LD research paper	JCP of LD research paper or from a related specialty	JCP of LD research paper or from a related specialty

9 To develop the habits of lifelong learning			
	In this stage of training, the trainee will continue to demonstrate commitment to their professional development and to professionally-led regulation	In this stage of training, the trainee will continue to demonstrate commitment to their professional development and to professionally-led regulation	In this stage of training, the trainee will continue to demonstrate commitment to their professional development and to professionally-led regulation
9a Maintaining good medical practice		Supervisors' reports	Supervisors' reports
9b Lifelong learning	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self reflection	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self-refection	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self-reflection
9c Relevance of outside bodies	Evidence of continued GMC registration	Evidence of continued GMC registration	Evidence of continued GMC registration
10 Demonstrate the ability to conduct and complete audit in clinical practice			
	By the end of ST4, the trainee will have completed an audit project in LD and will be able to demonstrate the application of audit	By the end of ST5 the trainee will be able to demonstrate the ability to conduct an audit project without direct supervision, be able to	By the end of ST6, the trainee will demonstrate the ability to supervise a colleague's audit project and will have

	principles to their own work.	set standards and be able to demonstrate how the results of an audit project have contributed to quality improvement	been involved in a service-wide quality improvement project) if not completed in ST5)
10a Audit	Completed audit report Supervisor's report	Completed audit cycle report	Evidence in portfolio of supervision of more junior staff in Audit project or lead multidisciplinary audit project Supervisor's report
11 to develop an understanding of the implementation of clinical governance			
	By the end of ST4, the trainee will demonstrate an awareness of risk management issues and healthcare governance issues	By the end of ST5, the trainee will demonstrate an understanding of risk management issues and healthcare governance issues	By the end of ST6, the trainee will demonstrate an ability to handle a Singular Untoward Incident (SUI) and ability to work nationally, regionally or locally to develop and implement clinical guidelines and care pathways (if not completed in ST5)
11a Organisational framework for clinical governance and the benefits that patients may expect	CBD on risk management of simple cases;	CBD on risk aspects of complex case; Learning from SUI	Supervisors' reports

	Review of SUI cases Supervisors' reports	Supervisors' reports	
13 Demonstrate effective communication with patients, relatives and colleagues. This includes the ability of the doctor to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances			
	By the end of ST4, the trainee will be able to actively contribute to multidisciplinary meetings/ reviews in LD services; develop a therapeutic alliance with people with LD and their carers; where appropriate undertake and collate long term histories and information from a variety of informants, and utilise within case management	By the end of ST5, the trainee will be able to chair a multidisciplinary review of a patient who presents to an LD service with a common problem	BY the end of ST6, the trainee will be able to chair multidisciplinary reviews, including presence of patients and carers. Able to integrate information and contributions as appropriate towards formulation and care plans
	Appropriate contribution to Multidisciplinary Reviews evidenced in minutes; CBD of a Mental Health Act Tribunal Report (or equivalent) the Trainee has written	DONCS of chairing a multidisciplinary review	DONC of chairing a multidisciplinary review in a subspecialty

14Demonstrate the ability to work effectively with colleagues, including team working			
	By the end of ST4, the trainee will demonstrate effective verbal and written communication skills with multidisciplinary and multiagency teams and demonstrate awareness of team dynamics	By the end of ST5, the trainee will demonstrate how to recognise dysfunctional teams and dynamics and demonstrate skills to minimise the impact of this on the patient	By the end of ST6, the trainee will demonstrate ability to work within a variety of multidisciplinary teams, including multi-agency working. They will demonstrate skills in advocacy for patients' needs and services and ability to challenge other professionals if required
	CBD of case with evidence of appropriate multidisciplinary management; Written reflections of interagency team dynamics and interaction with them One round of Mini-PAT Supervisors' reports	CBD of complex case with evidence of appropriate multidisciplinary management Written reflections of dysfunctional team dynamics and management of them. One round of Mini-PAT Supervisors' reports	CBD of case with evidence of appropriate multidisciplinary management in a sub specialist area e.g. epilepsy, offending; childhood; One round of Mini-PAT Supervisors' reports

15 Develop appropriate leadership skills			
	By the end of ST4 the trainee should be able to demonstrate the ability to effectively chair a multi-disciplinary team meeting The trainee should be able to describe the role of a leader and different approaches and styles of leadership	By the end of ST5 the trainee should be able to demonstrate the ability to manage a discrete area of the service under consultant supervision.	By the end of ST6, the trainee should be able to manage a discrete area of service in a sub-specialty area, under consultant supervision
	One round of Mini-PAT Supervisors' reports	One round of Mini-PAT Supervisors' reports	One round of Mini-PAT Supervisors' reports
16 To demonstrate that the doctor has the knowledge, skills and behaviours to manage time and problems effectively			
	By the end of ST4 the trainee should demonstrate the ability to participate in a management meeting or to shadow a senior colleague	By the end of ST5, the trainee should demonstrate the ability to participate in a project group or similar	By the end of ST6, the trainee should have taken a leading part in a change management project
16b Communication with colleagues	Supervisors' reports	Supervisors' reports	Supervisors' reports
17 To develop the ability to teach, assess and appraise			

	By the end of ST4, the trainee will demonstrate an ability	By the end of ST5, the trainee will demonstrate an	By the end of ST6, the trainee will demonstrate an ability

	to use a number of different teaching methods	understanding of the basic principles of adult learning and of different learning styles and an ability to conduct workplace-based assessments (WPBA's) for foundation or core trainees	to organise (including evaluate) educational events (if not completed in ST5) and an ability to conduct an appraisal of a colleague
17a The skills, attitudes, behaviours and practices of a competent teacher	Evidence of teaching /presentation JCP assessment	Evidence of attending train the trainer courses JCP assessment	DONC of appraising / supervising / giving feed back to a junior colleague
17b Assessment		Assesses junior colleagues using WPA tools evidence in portfolio (if not completed in ST4)	
17c Appraisal	Record of discussion of educational supervisor's ARCP report	Record of discussion of educational supervisor's ARCP report	Record of discussion of educational supervisor's ARCP report
19 To ensure that the doctor acts in a professional manner at all times			
	By the end of ST4 the trainee will demonstrate an understanding of the issues surrounding confidentiality and the appropriate sharing of information and the need for safe and	By the end of ST5, the trainee will demonstrate an understanding of the need for safe and positive decision-making with respect to risk management around more complex	By the end of ST6 will not only exemplify the highest standards of professionalism in their own practice but will also demonstrate an ability to support and advise colleagues in dealing with complex

	positive decision-making with respect to risk management in LD services	cases	professional interactions, including the safe and appropriate sharing of information
19a Doctor patient relationship	One round of miniPAT	One round of miniPAT	One round of miniPAT
19b Confidentiality	CBD of case with information sharing with other agencies	Written reflection of case with difficult issues of consent and confidentiality	
19d Risk management	Evidence of formulating risk assessment and management plans Supervisors' reports	Evidence of formulating risk assessment and management plans Supervisors' reports	Evidence of chairing multidisciplinary risk management meeting Supervisors' reports
19e Recognise own limitations	Log of cases where discussion with a senior colleague has been sought, due to knowledge limitations, and lessons learnt.	Log of cases where discussion with a senior colleague has been sought, due to knowledge limitations, and lessons learnt.	Log of cases where discussion with a senior colleague has been sought, due to knowledge limitations, and lessons learnt.
19f Probity	Supervisors' reports	Supervisors' reports	Supervisors' reports
19g Personal health	Supervisors' reports	Supervisors' reports	Supervisors' reports

A Competency Based Curriculum for Specialist Core Training in Psychiatry

CORE TRAINING IN PSYCHIATRY CT1 – CT3

Royal College of Psychiatrists

2013

(GMC approved 01 July 2013, updated March 2016, May, & June 2017)

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This curriculum is divided into five Parts:

Contents

1. Introduction

Defining the objectives of the skills of all psychiatrists in training has relied on a number of documents; *Good Medical Practice* produced by the GMC, *Good Psychiatric Practice* produced by the Royal College of Psychiatrists (2009), the *Medical Leadership Competency Framework; The Core & General Training Curriculum* published in 2007, the draft curricula statements and outlines produced by faculties and sections of the Royal College of Psychiatrists, as well as *The Curriculum for Basic Training* from the Royal Australian & New Zealand College of Psychiatrists, *The Handbook of Psychiatric Education and Faculty Development* published by the American Psychiatric Association, *The CanMED 2005 Framework & Curricula for training from other medical specialities in the UK*, notably general practice and general medicine.

What is set out in this document is the generic knowledge, skills and attitudes, or more readily assessed behaviour, that we believe is common to all psychiatric specialties. This document should be read in conjunction with *Good Medical Practice* and *Good Psychiatric Practice,* which describe what is expected of all doctors and psychiatrists. Failure to achieve satisfactory progress in meeting many of these objectives at the appropriate stage would constitute cause for concern about the doctor's ability to be adequately trained.

Achieving competency in core and generic skills is essential for all specialty and subspecialty training. Maintaining competency in these will be necessary for relicensing and recertification, linking closely to the details in *Good Medical Practice* and *Good Psychiatric Practice.* Therefore doctors in training in advanced psychiatry will need to continue to display the competencies that were acquired in Core Psychiatry Training throughout their training.

2. Rationale

The purposes of the curricula are to outline the competencies that trainees must demonstrate and the learning and assessment processes that must be undertaken:

- To complete Core Psychiatry Training
- For an award of a Certificate of Completion of Training (CCT) in one of the six psychiatric specialties. The curricula build upon competencies gained in Foundation Programme training and Core Psychiatry Training and guides the doctor to continuing professional development based on *Good Psychiatric Practice* after they have gained their CCT.

3. Specific features of the curriculum

The curriculum is outcome-based and is learner-centred. Like the Foundation Programme Curriculum, it is a spiral curriculum in that learning experiences revisit learning outcomes. Each time a learning outcome is visited in the curriculum, the purpose is to support the trainee's progress by encouraging performance in situations the trainee may not have previously encountered, in more complex and demanding situations and with increasing levels of autonomy. The details of how the curriculum supports progress is described in more detail in the Trainee and Trainer Guide for ARCPs for Core Psychiatry that are set out later. The intended learning outcomes of the curriculum are structured under the *Good Medical Practice* (2013) headings that set out a framework of professional competencies.

The curriculum is learner-centred in the sense that it seeks to allow trainees to explore their interests within the outcome framework, guided and supported by an educational supervisor. The Royal College of Psychiatrists has long recognised the importance of educational supervision in postgraduate training. For many years, the College recommended that all trainees should have an hour per week of protected time with their educational supervisor to set goals for training, develop individual learning plans, provide feedback and validate their learning.

The competencies in the curriculum are arranged under the *Good Medical Practice* headings as follows:

1. Knowledge, Skills and Performance
2. Safety and Quality
3. Communication, Partnership and Teamwork
4. Maintaining Trust

They are, of course, not discrete and free-standing, but overlap and inter-relate to produce an overall picture of the Psychiatrist as a medical expert.

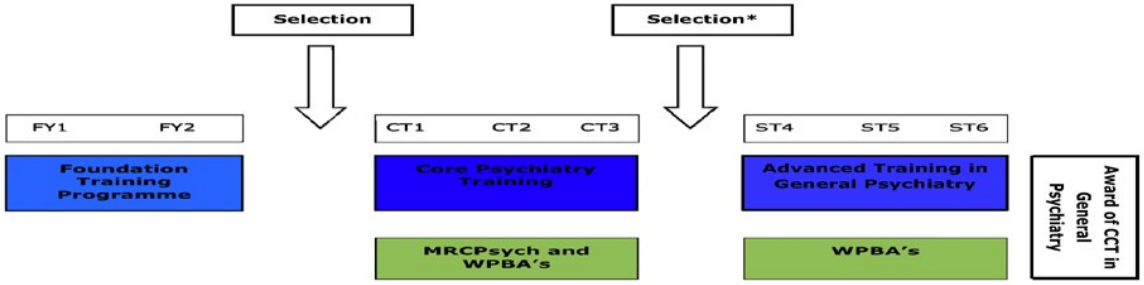
It is important to recognise that these headings are used for structural organisation only. The complexity of medical education and practice means that a considerable number of the competencies set out below will cross the boundaries between different categories. Moreover, depending on circumstances, many competencies will have additional components or facets that are not defined here. This curriculum is based on meta-competencies and does not set out to define the psychiatrist's progress and attainment at a micro-competency level.

With these points in mind, this curriculum is based on a model of intended learning outcomes with specific competencies given to illustrate how these outcomes can be demonstrated. It is, therefore, a practical guide rather than an all-inclusive list of prescribed knowledge, skills and behaviours.

4. Training pathway

Psychiatry trainees have to successfully complete the three-year Core Psychiatry Training programme before applying in open competition for a place in a programme leading to a Certificate of Completion of Training (CCT) in one of the six psychiatry specialties. Trainees who were appointed to Psychiatry Specialty Training prior to August 2008 were generally appointed to 'run-through' training posts.

The six psychiatry specialties are Child and Adolescent Psychiatry, Forensic Psychiatry, General Psychiatry, Old Age Psychiatry, the Psychiatry of Learning Disability and Medical Psychotherapy. In addition, there are two sub-specialties of General Psychiatry; Substance Misuse Psychiatry and Rehabilitation Psychiatry and Liaison Psychiatry is a sub-specialty of both General Psychiatry and Old Age Psychiatry. For example, a trainee wishing to specialise in General Psychiatry would follow the below pathway:



*Selection at this point may be open or by internal competition. See text for explanation

Figure 1, Training pathway to obtain a CCT in General Psychiatry

5. Core Training in Psychiatry

The core training programme in psychiatry is comprised of:

- Completion of a minimum of 36 months post-foundation/internship in a core training programme approved by the GMC from CT1 to CT3 (or at a level above CT1 to CT3).
- During core training trainees must take the MRCPsych Examination which is comprised of:
  - 2 MCQ written papers
  - A Clinical Assessment of Skills and Competencies (CASC).

Trainees must obtain a pass in all sections of the MRCPsych Examination and achieve all core competencies before they can be considered to have successfully completed/exited core training. An ARCP outcome 1 will then be issued to trainees.

Trainees who leave core training without achieving the core competencies or passing all sections of the MRCPsych Examination can still undertake the Examinations and complete any outstanding competencies whilst in a non-training post.

6. Advanced Training in Psychiatry

The Advanced Training Programme in Psychiatry is comprised of completion of a minimum of 36 months of advanced training in one of the six GMC approved psychiatric specialties listed below from levels ST4 to ST6.
Trainees must achieve the competencies as set out in the appropriate advanced curriculum and achieve an ARCP outcome 6 on completion of the training programme.

- General Psychiatry
- Old Age Psychiatry
- Forensic Psychiatry
- Child and Adolescent Psychiatry
- Psychiatry of Learning Disability
- Medical Psychotherapy

7. Certificates of Completion of Training (CCT)

Trainees wishing to obtain a CCT in one of the six GMC approved psychiatric specialties must complete an entire programme of training (core and advanced), the whole of which has been approved by the GMC and pass all sections of the MRCPsych Examination.

8. Career Pathways in Psychiatry

General Psychiatry

The clinical experience in the Advanced Training Programme in General Psychiatry will consist of the equivalent of three years full time experience and will be comprised of:

- 2 years in designated General Psychiatry posts. One year may be in a GMC approved sub-specialty of General Psychiatry in either:
  - Substance Misuse
  - Liaison Psychiatry
  - Rehabilitation Psychiatry

Successful completion of a year in any of the above sub-specialties will lead to an endorsement on the GMC Specialist Register.

- The third year could also be spent in another area of General Psychiatry but will not lead to an endorsement on the GMC Specialist Register as these areas are not GMC recognised sub-specialties:
  - Peri-natal Psychiatry
  - Neuropsychiatry
  - Eating Disorder Psychiatry
  - Or another psychiatric specialty or general psychiatry post.

Experience gained in General Psychiatry must include properly supervised in-patient and out-patient management, with both new patients and follow-up cases, and supervised experience of emergencies and 'on call' duties. Training placements will afford experience in hospital and/or community settings. Increasingly training in General Psychiatry will be delivered in functional services that specialize in a single area of work such as; crisis, home treatment, early interventions, assertive interventions or recovery models. Thus not all posts will provide all experiences as detailed.

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:

- Twelve months in an old age placement, i.e. a placement that can offer both in-patient and community experience and two six-month placements in inpatient and community settings. The inpatient experience must include managing detained patients under supervision.
- Twelve months in another old age psychiatry setting.
- A third twelve months may be spent in GMC approved liaison sub-specialty of Old Age Psychiatry, General Psychiatry (or one of its sub-specialties) or in any other psychiatric specialty where the training is available, i.e., forensic psychiatry, psychotherapy, learning disability psychiatry, child & adolescent psychiatry.
- Successful completion of a year of Liaison Psychiatry will lead to an endorsement on the GMC Specialist Register

Trainees should get experience working with older adults in the following settings:

- In-patient wards for treatment of functional illness
- Assessment wards
- Continuing care and respite wards
- Joint psychiatric/geriatric wards
- Day hospitals
- Sheltered housing
- Residential care in various settings
- Home assessment and treatment
- Out-patients

Psychiatry of Learning Disability

The clinical experience in the Advanced Training Programme in Psychiatry of Learning Disability will consist of the equivalent of three years full time experience at least two years of which are within designated Psychiatry of Learning Disability posts. This would comprise of experience with:

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

One year of this could be within designated Psychiatry of Learning Disability services for children.

The third year could comprise of either further community-based experience as above, perhaps with an emphasis on:

- Neuropsychiatry
- Neurodevelopmental disorders
- Brain injury
- Experience within designated Psychiatry of Learning Disability posts in Forensic Psychiatry
- Experience within designated posts in a relevant psychiatric specialty: e.g. General Psychiatry or one of its subspecialties

Child & Adolescent Psychiatry

The clinical experience in the Advanced Training Programme in Child & Adolescent Psychiatry will consist of the equivalent of three years full time experience.

Forensic Psychiatry

The clinical experience in the Advanced Training Programme in Forensic Psychiatry will consist of the equivalent of three years full time experience.

Medical Psychotherapy

The clinical experience in the Advanced Training Programme in Medical Psychotherapy will consist of the equivalent of three years full time experience.

9. Dual Training

Trainees may apply in open competition for entry into dual training programmes after completing Core Training. Trainees must be interviewed for both specialties. A trainee will be given a national training number indicating that the programme is a dual programme.

Trainees are expected to complete the programme in full and obtain the competencies set out in both curricula. Application to the GMC for a CCT should only take place when both programmes are complete. The two CCTs should be applied for and awarded on the same date and the expected end of training date for both CCTs therefore becomes the same date. (Gold Guide 6.34).

Where a trainee wishes to curtail the programme leading to dual certification and to apply to the GMC for a single CCT, the trainee 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. (Gold Guide 6.34).

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

- The competencies for a single CCT as stipulated in the curriculum for that specialty.
- The time spent for a single CCT as stipulated in the curriculum for that specialty.
- Confirmation from the Training Programme Director that the competencies 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.

Training Combinations with a minimum of four years' duration

General Psychiatry & Old Age Psychiatry which must consist of:

2 years in designated General Psychiatry posts (one year may be in a GMC approved sub-specialty of General Psychiatry in either:

- Substance Misuse
- Liaison Psychiatry
- Rehabilitation Psychiatry

A year could also be spent in another area of General Psychiatry but will not lead to an endorsement on the GMC Specialist Register as these areas are not GMC recognised sub-specialties:

- Peri-natal Psychiatry
- Neuropsychiatry
  Eating Disorder Psychiatry

2 years in designated Old Age Psychiatry Posts.

A trainee who wishes to pursue a single CCT in either old age psychiatry or general psychiatry must ensure they have completed the minimum of 36 months which must consist of two years in either old age psychiatry posts or general psychiatry posts & one further year in another psychiatric specialty or sub-specialty post as listed above.

Training combinations with a minimum of five year's duration

General Psychiatry & Medical Psychotherapy which must consist of:

2 years in designated General Psychiatry posts one year may be in a GMC approved sub-specialty of General Psychiatry in either:

- Substance Misuse
- Liaison Psychiatry
- Rehabilitation Psychiatry

Trainees could also spend 12 months in another but will not lead to an endorsement on the GMC Specialist Register:

- Peri-natal Psychiatry
- Neuropsychiatry
- Eating Disorder Psychiatry

3 years in designated Medical Psychotherapy Placements.

A trainee who wishes to pursue a single CCT in either general psychiatry or medical psychotherapy must ensure they have completed the minimum of 36 months which must consist of two years in either general psychiatry posts and one year in another psychiatry specialty, most likely to be medical psychotherapy or 3 years in designated medical psychotherapy posts.

Forensic Psychiatry & Medical Psychotherapy which must consist of:

- 2 years in designated Forensic Psychiatry placements
- 2 years in designated Medical Psychotherapy Placements
- 1 year in a Forensic Medical Psychotherapy setting

A trainee who wishes to pursue a single CCT in either forensic psychiatry or medical psychotherapy must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated forensic psychiatry posts or 3 years in designated medical psychotherapy posts. Forensic Psychiatry & General Psychiatry which must consist of:

- 3 years in designated Forensic Psychiatry placements
- 2 years in designated General Psychiatry placements

Child & Adolescent Psychiatry & Forensic Psychiatry which must consist of:

- 2 years in designated Forensic Psychiatry placements.
- 2 years in designated Child & Adolescent Psychiatry Placements
- 1 year in a Forensic Psychiatry setting for adolescents & children.

A trainee who wishes to pursue a single CCT in either forensic psychiatry or child & adolescent psychiatry must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated forensic psychiatry posts or 3 years in designated child & adolescent psychiatry posts

Child & Adolescent Psychiatry & Psychiatry of Learning Disability which must consist of:

- 2 years in designated Psychiatry of Learning Disability placements.
- 2 years in designated Child & Adolescent Psychiatry Placements
- 1 year in a Psychiatry of Learning Disability setting for adolescents & children.

A trainee who wishes to pursue a single CCT in either Psychiatry of Learning Disability or Child & Adolescent Psychiatry must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated Child & Adolescent Psychiatry posts & 2 years' in Psychiatry of Learning Disability posts and one year in either Child & Adolescent Psychiatry or another psychiatry specialty.

10. GMC Sub-Specialty Endorsement and Special Interest Sessions

Trainees 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:

- Substance Misuse Psychiatry
- Liaison Psychiatry
- Rehabilitation Psychiatry

Trainees 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 trainees can apply for the endorsement on the GMC Specialist Register.

Trainees wishing to obtain an endorsement must inform the College in advance.

Training for an endorsement must be of 12 months' whole time equivalent (wte) training on a GMC approved training programme. Less than 12 months wte will not be accepted and the endorsement sub-specialty MUST be clearly marked on the Deanery ARCP form.

Special interest sessions do not count towards endorsement as they do not fit the criteria in terms of educational and clinical supervision.

11. Acting Up

Up to a maximum of three months whole time equivalent (for LTFT trainee the timescale is also three months, Gold Guide 6.105) spent in an 'acting up' consultant post may count towards a trainees CCT as part of the GMC approved specialty training programme, provided the post meets the following criteria:

- The trainee follows local procedures by making contact with the Postgraduate Dean and their team who will advise trainees about obtaining prospective approval
- The trainee is in their final year of training (or possibly penultimate year if in dual training)
- 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 trainee's TPD
- The trainee still receives one hour per week education supervision either face to face or over the phone by an appropriately accredited trainer
- Trainees retain their NTN during the period of acting up
- All clinical sessions are devoted to the 'acting up' consultant post (i.e., there must be no split between training and 'acting up' consultant work). Full-time trainees cannot 'act up' in a part-time consultant post.
- The post had been approved by the RA in its current form
- If a trainee is on call there must be consultant supervision
- If the period is sat 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 educational supervisor has been received and there is a satisfactory ARCP outcome

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

12. Accreditation of Transferable Competences Framework (ATCF)

Many of the core competences are common across curricula. When moving from one approved training programme to another, a trainee doctor who has gained competences in core, specialty or general practice training should not have to repeat training already achieved. The Academy of Medical Royal Colleges (the Academy) has developed the Accreditation of Transferable Competences Framework (ATCF) to assist trainee doctors in transferring competences achieved in one core, specialty or general practice training programme, where appropriate and valid, to another training programme.
This will save time for trainee doctors (a maximum of two years) who decide to change career path after completing a part of one training programme, and transfer to a place in another training programme.

The ATCF applies only to those moving between periods of GMC approved training. It is aimed at the early years of training. The time to be recognised within the ATCF is subject to review at the first Annual Review of Competence Progression (ARCP) in the new training programme. All trainees achieving Certificate of Completion of Training (CCT) in general practice or a specialty will have gained all the required competences outlined in the relevant specialty curriculum. When using ATCF, the doctor may be accredited for relevant competences acquired during previous training.'

The Royal College of Psychiatrists accepts transferable competences from the following specialties core medical training, Paediatrics and Child Health and General Practice. For details of the maximum duration and a mapping of the transferable competences please refer to our guidance .

13. RESPONSIBILITIES FOR CURRICULUM DELIVERY

It is recognised that delivering the curriculum requires the coordinated efforts of a number of parties. Postgraduate Schools of Psychiatry, Training Programme Directors, Educational and Clinical Supervisors and trainees all have responsible for ensuring that the curriculum is delivered as intended.

Deanery Schools of Psychiatry

Schools of Psychiatry have been created to deliver postgraduate medical training in England, Wales and Northern Ireland. The Postgraduate Deanery manages the schools with advice from the Royal College. There are no Schools of Psychiatry in Scotland. Scotland has four Deanery Specialty Training Committees for mental health that fulfil a similar role.

The main roles of the schools are:

1. To ensure all education, training and assessment processes for the psychiatry specialties and sub-specialties meet GMC approved curricula requirements
2. To monitor the quality of training, ensuring it enhances the standard of patient care and produces competent and capable specialists
3. To ensure that each Core Psychiatry Training Programme has an appropriately qualified psychotherapy tutor who should be a consultant psychotherapist or a consultant psychiatrist with a special interest in psychotherapy.
4. To encourage and develop educational research
5. To promote diversity and equality of opportunity
6. To work with the Postgraduate Deanery to identify, assess and support trainees in difficulty
7. To ensure that clear, effective processes are in place for trainees to raise concerns regarding their training and personal development and that these processes are communicated to trainees

Training Programme Directors/Tutors

The Coordinating/Programme Tutor or 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/Tutor must be recognized in their job plan, with time allocated to carry out the duties adequately. One programmed activity (PA) per week is generally recommended for 25 trainees. In a large scheme 2 PA's per week will be required. For example, a Training Programme Director for General Psychiatry in advanced training:

1. Should inform and support College and Specialty tutors to ensure that all aspects of clinical placements fulfil the specific programme requirements.
2. Oversees the progression of trainees through the programme and devises mechanisms for the delivery of co-ordinated educational supervision, pastoral support and career guidance.
3. Manages trainee performance issues in line with the policies of the Training School/Deanery and Trust and support trainers and tutors in dealing with any trainee in difficulty.
4. Ensures that those involved in supervision and assessment are familiar with programme requirements.
5. Will provide clear evidence of the delivery, uptake and effectiveness of learning for trainees in all aspects of

the curriculum.

6. Should organise and ensure delivery of a teaching programme based on the curriculum covering clinical, specialty and generic topics.
7. Will attend local and deanery education meetings as appropriate.
8. Will be involved in recruitment of trainees.
9. Ensures that procedures for consideration and approval of LTFT (Less Than Full Time Trainees), OOPT (Out of Programme Training) and OOPR (Out of Programme Research) are fair, timely and efficient.
10. Records information required by local, regional and national quality control processes and provides necessary reports.
11. Takes a lead in all aspects of assessment and appraisal for trainees. This incorporates a lead role in organisation and delivery of ARCP. The Tutor/Training Programme Director will provide expert support, leadership and training for assessors (including in WPBA) and ARCP panel members.

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 Core Psychiatry Programme and in addition:

1. Will implement, monitor and improve the core training programmes in the Trust(s) in conjunction with the Directors of Medical Education and the Deanery and ensure that the programme meets the requirements of the curriculum and the Trust and complies with contemporary College Guidance & Standards (see College QA Matrix) and GMC Generic Standards for Training.
2. Will take responsibility with the Psychotherapy Tutor (where one is available) for the provision of appropriate psychotherapy training experiences for trainees. This will include:
   - Ensuring that educational supervisors are reminded about and supported in their task of developing the trainee's competencies in a psychotherapeutic approach to routine clinical practice.
   - Advising and supporting trainees in their learning by reviewing progress in psychotherapy
   - Ensuring that there are appropriate opportunities for supervised case work in psychotherapy.

Medical Psychotherapy Tutor

Where a scheme employs a Psychotherapy Tutor who is a Consultant Psychiatrist in Psychotherapy there is evidence that the Royal College of Psychiatrists' Psychotherapy Curriculum is more likely to be fulfilled than a scheme which does not have a trained Medical Psychotherapist overseeing the Core Psychiatry Psychotherapy training (Royal College of Psychiatrists' UK Medical Psychotherapy Survey 2012). This evidence has been used by the GMC in their quality assurance review of medical psychotherapy (2011-12).

It is therefore a GMC requirement that every core psychotherapy training scheme must be led by a Medical Psychotherapy Tutor who has 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 in line with the GMC requirement of medical psychotherapy leadership in core psychotherapy training (GMC medical psychotherapy report and action plan, 2013).

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 trainees have the opportunity to complete the psychotherapy requirements of the core curriculum
- Advises and supports core and higher trainees in their learning by reviewing progress in psychotherapy
- Oversees the establishment and running of the core trainee Balint/case based discussion group
- Provides assessment and oversees the waiting list of therapy cases for core trainees and higher trainees
- Monitors the selection of appropriate short and long therapy cases in accordance with the core curriculum
- Selects and supports appropriate therapy case supervisors to supervise and assess the trainees
- Ensures the therapy 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 therapy case supervisors are trained in psychotherapy workplace based assessment
- 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

Supervision

Supervision in postgraduate psychiatry training encompasses three core aspects:

- Clinical Supervision
- Educational Supervision
- Psychiatric 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

This guidance sets out the varied roles consultants inhabit within a supervisory capacity. Key principles underpinning all types of supervision include:

- Clarity
- Consistency
- Collaboration
- Challenge
- Compassion

Clinical Supervisors / Trainers

The clinical work of all trainees must be supervised by an appropriately qualified senior psychiatrist. All trainees must be made aware day-to-day of who the nominated 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 trainee 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 trainee**. No trainee should be expected to work to a level beyond their competence and experience;** no trainee should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise. Trainees should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence; **both trainee and supervisor should at all times be aware of their direct responsibilities for the safety of patients in their care.**

The clinical supervisor:

1. Should be involved with teaching and training the trainee in the workplace.
2. Must support the trainee in various ways:
    a) direct supervision, in the ward, the community or the 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

3. May delegate some clinical supervision to other members of clinical team as long as the team member clearly understands the role and the trainee is informed. The trainee must know who is providing clinical supervision at all times.
4. Will perform workplace-based assessments for the trainee and will delegate performance of WPBA's to appropriate members of the multi-disciplinary team
5. Will provide regular review during the placement, both formally and informally to ensure that the trainee is obtaining the necessary experience. This will include ensuring that the trainee obtains the required supervised experience in practical procedures and receives regular constructive feedback on performance.

Time for providing clinical supervision must be incorporated into job planning, for example within teaching clinics.

Educational Supervisors / Tutors

An Educational Supervisor/tutor will usually be a Consultant, Senior Lecturer or Professor who has been appointed to a substantive consultant 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 will work with a small (no more than five) number of trainees. Sometimes the Educational Supervisor will also be the clinical supervisor/trainer, as determined by explicit local arrangements.

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

The educational supervisor/tutor:

1. Works with individual trainees 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 and attitudes.
2. Will act as a resource for trainees who seek specialty information and guidance.
3. Will liaise with the Specialty/Programme tutor and other members of the department to ensure that all are aware of the learning needs of the trainee.
4. Will oversee and on occasions, perform, the trainee's workplace-based assessments.
5. Will monitor the trainee's attendance at formal education sessions, their completion of audit projects and other requirements of the Programme.
6. Should contribute as appropriate to the formal education programme.

7. Will produce structured reports as required by the School/Deanery.
8. In order to support trainees, will: -
    a) Oversee the education of the trainee, act as their mentor and ensure that they are making the necessary clinical and educational progress.
    b) Meet the trainee at the earliest opportunity (preferably in the first week of the programme), to ensure that the trainee 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 trainee and the necessary paperwork signed and a copy kept by both parties.
    c) Ensure that the trainee receives appropriate career guidance and planning.
    d) Provide the trainee with opportunities to comment on their training and on the support provided and to discuss any problems they have identified.

Psychiatric Supervision

Psychiatrists in training require regular reflective 1:1 supervision with a nominated substantive consultant who is on the specialist register. This will usually be the nominated consultant who is also providing clinical, and often education, supervision.

Psychiatric supervision is required for all trainees throughout core and higher levels and must be for 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 competencies and is informed by psychodynamic, cognitive coaching models. It is imperative that consultants delivering psychiatric supervision have protected time within their job plans to deliver this. This aspect of supervision requires 0.25 PA per week.

The psychiatric supervisor is responsible for producing the supervisor report informing the ARCP process and will ensure contributions are received from key individuals involved in the local training programme including clinical supervisors. Often the psychiatric supervisor will also be the nominated educational supervisor.

Assessors

Assessors are members of the healthcare team, who need not be educational or clinical supervisors, who perform workplace-based assessments (WPBA's) for trainee psychiatrists. In order to perform this role, assessors must be competent 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 trainees.

Trainees

1. Must at all times act professionally and take appropriate responsibility for patients under their care and for their training and development.
2. Must ensure they attend the one hour of personal supervision per week, which is focused on discussion of individual training matters and not immediate clinical care. If this personal supervision is not occurring the trainee should discuss the matter with their educational supervisor/tutor or training programme director.
3. Must receive clinical supervision and support with their clinical caseload appropriate to their level of experience and training.
4. Should be aware of and ensure that they have access to a range of learning resources including:
    a) a local training course (e.g. MRCPsych course, for Core Psychiatry trainees)

b) a local postgraduate academic programme
c) the opportunity (and funding) to attend courses, conferences and meetings relevant to their level of training and experience
d) appropriate library facilities
e) the advice and support of an audit officer or similar
f) supervision and practical support for research with protected research time appropriate to grade

5. Must make themselves familiar with all aspects of the curriculum and assessment programme and keep a portfolio of evidence of training.
6. Must ensure that they make it a priority to obtain and profit from relevant experience in psychotherapy.
7. Must collaborate with their personal clinical supervisor/trainer to:
   a) work to a signed educational contract
   b) maximize the educational benefit of weekly educational supervision sessions
   c) undertake workplace-based assessments, both assessed by their clinical supervisor and other members of the multidisciplinary team
   d) use constructive criticism to improve performance
   e) regularly review the placement to ensure that the necessary experience is being obtained
   f) discuss pastoral issues if necessary
8. Must have regular contact with their Educational Supervisor/tutor to:
   a) agree educational objectives for each post
   b) develop a personal learning and development plan with a signed educational contract
   c) ensure that workplace-based assessments and other means of demonstrating developing competence are appropriately undertaken
   d) review examination and assessment progress
   e) regularly refer to their portfolio to inform discussions about their achievements and training needs
   f) receive advice about wider training issues
   g) have access to long-term career guidance and support
9. Will participate in an Annual Review of Competence Progression (ARCP) to determine their achievement of competencies and progression to the next phase of training.
10. Should ensure adequate representation on management bodies and committees relevant to their training. This would include Trust clinical management forums, such as Clinical Governance Groups, as well as mainstream training management groups at Trust, Deanery and National (e.g. Royal College) levels.
11. On appointment to a specialty training programme the trainee must fully and accurately complete Form R and return it to the Deanery with a coloured passport size photograph. The return of Form R confirms that the trainee 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 trainee re-affirms his/her commitment to the training and thereby remains registered for their training programme.

12. 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.
13. Must inform the postgraduate dean and the Royal College of Psychiatrists of any changes to the information recorded.
14. Trainees must 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.

15. Must make themselves aware of local procedures for reporting concerns about their training and personal development and when such concerns arise, they should report them in a timely manner.

14. CORE PSYCHIATRY TRAINING

The purpose of Core Specialty Training in psychiatry is to prepare the practitioner for entering Advanced Training; it must therefore provide an essential range of competencies. These competencies include knowledge of common psychiatric disorders and their treatment as well as skill in a range of assessment and therapeutic approaches. The competencies must be gained through working in a range of service settings, across the development range, and must include direct experience of delivering psychological therapy.

Core psychiatric competencies are indicated in blue script. Some Core competencies are coloured red. These must be completed by the end of the first year of Core Psychiatry training and they are also relevant to trainees in other specialties (eg General Practice) who are in a psychiatry placement.

Psychiatry trainees must achieve both the red and blue competencies (which will be assessed by workplace based assessments, the MRCPsych examinations, or both) before being eligible to enter advanced training in psychiatry.

15. The Intended Learning Outcomes for Core Psychiatric Training

***Good Medical Practice*, Domain 1: Knowledge, skills and performance**

- Develop and maintain professional performance
- Apply knowledge and experience to practice
- Record work clearly, accurately and legibly

Intended learning outcome 1	
Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include: • **Presenting or main complaint** • **History of present illness** • **Past medical and psychiatric history** • **Systemic review** • **Family history** • **Socio-cultural history** • **Developmental history**	
1a Clinical history	**Assessment methods**
Knowledge Define signs and symptoms found in patients presenting with psychiatric and common medical disorders Recognise the importance of historical data from multiple sources Define abuse, including physical, emotional or sexual, including fabricated or induced illness, and emotional or physical neglect , which has led, or may lead, to significant harm to a child or young person Describe the potential impact of trauma (Trainees will encounter patients who have experienced difference forms of trauma and will be expected to be competent in working with them; this will include but not be limited to, patients who have experienced sexual abuse, forced migration, immigration detention, sexual violence and domestic violence) on the development of psychiatric disorders.	ACE, mini-ACE, CBD. MCQ, CASC Mini-ACE, CBD CBD,MCQ, CASC CBD, CASC

Skills Elicit a complete clinical history, including psychiatric history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social, trauma (as described, ILO 1, 1a) history and developmental history	ACE, mini-ACE, CASC

Overcome difficulties of language, physical and sensory impairment Gather this factual information whilst understanding the meaning these facts hold for the patient and eliciting the patient's narrative of their life experience	ACE, mini-ACE, CASC ACE, mini-ACE, CASC
Attitudes demonstrated through behaviours Show empathy with patients. Appreciate the interaction and importance of psychological, social and spiritual factors in patients and their support networks	ACE, mini-ACE, CASC

1b Patient examination, including mental state examination & physical examination	**Assessment Methods**
Knowledge Define the components of mental state examination using established terminology Recognise physical signs and symptoms that accompany psychiatric disorders Recognise and identify the different types of mental distress and their phenomenology Recognise how the stage of cognitive and emotional development may influence the aetiology, presentation and management of mental health problems	 ACE, mini-ACE, CBD, CP, CASC ACE, mini-ACE, CASC ACE, mini-ACE, CASC ACE, mini-ACE, CBD, CP, CASC
Skills Perform a reliable and appropriate examination including the ability to obtain historical information from multiple sources, such as family and other members of the patient's social network, community mental health resources, old records Elicit and record the components of mental state examination Make a clear and concise case presentation Assess for the presence of general medical illness	 ACE, mini-ACE, CASC ACE, mini-ACE, CBD, CASC CBD, CP, CASC ACE, mini-ACE, CBD, CASC

Recognise and identify the effects of psychotropic medication in the physical examination	ACE, mini-ACE, CBD, CASC
Attitudes demonstrated through behaviours	
Respect patients' dignity and confidentiality	ACE, mini-ACE, CASC
Acknowledge cultural issues	ACE, mini-ACE, CBD, CASC
Appropriately involve family members	ACE, mini-ACE, CASC
Demonstrate an understanding of the importance of working with other Health and Social Care professionals and team working	CBD, CP, CASC
Show a willingness to provide explanation to patients of investigations and their possible unwanted effects	ACE, mini-ACE, CASC

Intended learning outcome 2	
Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses	
2a Diagnosis	**Assessment methods**
Knowledge	
State the typical signs and symptoms of common psychiatric disorders including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; and organic disorders	ACE, Mini-ACE, CBD, MCQ, CASC CBD, CP, MCQ, CASC
Be familiar with contemporary ICD or DSM diagnostic systems with the ability to discuss the advantages and limitations of each	CBD, CP, MCQ CASC
State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorders; anxiety disorders; disorders	

of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood	
Skills Use the diagnostic system to accurately construct a differential diagnosis for common presenting problems Use the diagnostic system accurately in identifying specific signs and symptoms that comprise syndromes and disorders across the age range Formulate and discuss differential diagnosis	CBD, CP, MCQ CBD, CP, CASC CBD, CP, CASC
Attitudes demonstrated through behaviours Show an awareness of the advantages and limitations of using a diagnostic system	CBD, CP, CASC
2b Formulation	**Assessment methods**
Knowledge Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorders across the age range, including trauma (as described, ILO 1, 1a) history Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorders across the age range, including trauma (as described, ILO 1, 1a) history	CBD, CP, CASC CBD, CP, CASC
Skills Integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted	CBD, CP, CASC
Attitudes demonstrated through behaviours Provide explanation to the patient and the family which enables a constructive working relationship	ACE, mini-ACE, CBD, CASC

Intended learning outcome 3
Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains

3a Individual consideration	**Assessment methods**
Knowledge	
Skills Develop an individualised assessment and treatment plan for each patient and in collaboration with each patient	ACE, Mini-ACE, CBD, CASC
Attitudes demonstrated through behaviours Be able to explain to patients, families, carers and colleagues the process and outcome of assessment, investigation and treatment or therapeutic plan	ACE, Mini-ACE, CASC
3b Investigation	**Assessment methods**
Knowledge Define the indications for the key investigations that are used in psychiatric practice Define the risks and benefits of investigations, including those of psychotherapeutic and genetic investigations Demonstrate knowledge of the cost effectiveness of individual investigations	CBD, CP, MCQ CBD, CP, MCQ CBD, CP, MCQ, CASC
Skills Interpret the results of investigations Liaise and discuss investigations with colleagues in the multi-professional team in order to utilise investigations appropriately	CBD, CP, MCQ, CASC CBD, CP, MCQ, CASC
Attitudes demonstrated through behaviours	

3c Treatment Planning	Assessment methods
Knowledge	
Explain the evidence base for physical and psychological therapies including all forms of psychotherapies, brief therapy, cognitive behavioural therapy, psychodynamic therapy, psychotherapy combined with psychopharmacology, supportive therapy and all delivery systems of psychotherapy (that is individual, group and family)	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Show a clear understanding of physical treatments including pharmacotherapy, including pharmacological action, clinical indication, side-effects, drug interactions, toxicities, appropriate prescribing practices, and cost effectiveness; electro-convulsive therapy and light therapy	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Show a clear understanding of the doctor/ patient relationship and its impact on illness and its treatment	ACE, Mini-ACE, CBD, CP, MCQ, CASC, CBDGA
Apply knowledge of the implications of coexisting medical illnesses to the treatment of patients who have psychological disorders	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Demonstrate knowledge of CPA (Care Programme Approach) processes	CBD, CP, MCQ, CASC
Skills	
Accurately assess the individual patient's needs and whenever possible in agreement with the patient, formulate a realistic treatment plan for each patient for adult patients with common presenting problems.	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Be able to do the above with psychiatric problems as they present across the age range	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Educate patients, carers and other professionals about relevant psychiatric and psychological issues	ACE, Mini-ACE, CBD, CP, CASC
Demonstrate an understanding of how professional and patient perspectives may	ACE, Mini-ACE, CBD, CP, MCQ,

differ and the impact this may have on assessment and treatment	CASC, CBDGA
Explain to patients what is involved in receiving the full range of psychiatric treatments and manage their expectations about these treatments described under 'knowledge'	ACE, Mini-ACE, CBD, CASC
Monitor patients' clinical progress and re-evaluate diagnostic and management decisions to ensure optimal care	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Be skilled in multi-agency working	ACE, CBD, CP
Attitudes demonstrated through behaviours Show appropriate behaviour towards patients and their symptoms and be conscious of socio-cultural contexts	ACE, Mini-ACE, CBD, CASC
Clearly and openly explain treatments and their side-effects.	ACE, Mini-ACE, CBD, CASC
Consider the impact of the mental illness in an adult patient directly and indirectly on children and young people in the adult's care or who are likely to come into contact with the adult.	ACE, mini-ACE, CBD, CASC
Demonstrate an understanding of the impact of their own feelings and behaviour on assessment and treatment	CBD, CP, CBGGA
Show respect for the patient's autonomy and confidentiality while recognising responsibility towards safeguarding others	ACE, Mini-ACE, CBD, CP, CASC
Recognise, value and utilise the contribution of peers and multi-disciplinary colleagues to develop the effectiveness of oneself and others	CBD, CP, CBDGA
Provide care and treatment that recognises the importance to patients of housing,	CBD, CP, CASC

employment, occupational opportunities, recreational activities, advocacy, social networks and welfare benefits Ensure that the employment of legal powers for detention (or to enforce treatment) balances the duty of care to the patient and the protection of others Be prepared to test out the feasibility and acceptability of decisions	CBD, CP, CASC
3d Substance misuse	**Assessment methods**
Knowledge Demonstrate an understanding of the effects of alcohol and illicit drugs on health and psychosocial wellbeing Be aware of the link between risk and substance misuse Demonstrate an understanding of support services and agencies Demonstrate an understanding of legislation with regard to illicit drugs Demonstrate an understanding of the role of specialist drug and alcohol teams	ACE, Mini-ACE, CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC
Skills Offer advice on the effects of alcohol and illicit drugs on health and psychosocial wellbeing Work with other agencies, including those in the non-statutory sector	ACE, Mini-ACE, CBD, CASC ACE, Mini-ACE, CBD, MCQ, CASC
Attitudes demonstrated through behaviours Provide non-judgmental help and support	ACE, Mini-ACE, CBD, CP, CASC

Intended learning outcome 4	
Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies	
4a All clinical situations	**Assessment methods**
Knowledge Demonstrate knowledge of risk assessment and management	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Demonstrate an understanding of the roles of other professionals and agencies responsible for protecting children and young people and work in partnership with them.	CBD, CP, MCQ, CASC
Demonstrate an awareness of the risk factors that have been linked to the abuse and neglect of children and young people	ACE, CBD, mini-ACE, CP, MCQ, CASC
Skills Comprehensively assess immediate and long-term risks to patients and others during assessment and treatment	ACE, Mini-ACE, CBD, CP, CASC
Routinely employ safe, effective and collaborative management plans	ACE, mini-ACE, CBD, CP
Demonstrate a working knowledge of local child protection procedures and activate these if you have a concern about the welfare of a child or young person	ACE, mini-ACE, CBD, CASC
Demonstrate the ability to look out for signs that a child or young person may at risk from abuse or neglect	

Attitudes demonstrated through behaviours Maintain high standards of professional and ethical behaviour at all times.	ACE, Mini-ACE, CBD, CP, CASC, mini-PAT
Work within your competence in child protection issues. Demonstrate a readiness to get advice from named or designated professionals or if they are not available from an experienced colleague.	ACE, mini-ACE, CBD, CP, CASC
4b Psychiatric emergencies for all specialties	**Assessment Methods**
Knowledge Apply the principles of risk assessment and management	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Shows awareness of child protection issues when addressing psychiatric emergencies. Has basic knowledge of child protection procedures	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Know the principles underlying management and prevention of violence, hostage taking, self harm, suicide, absconsion, escape and recall of a restricted patient	ACE, Mini-ACE CBD, CP, MCQ, CASC
Be familiar with the policy and principles regarding management of seclusion	ACE, Mini-ACE, CBD, CP
Skills Resuscitation	DOPS, CASC
Be able consistently to assess risk and utilise the full resources of the available Mental Health Services in the management of high risk situations	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Be competent in making a clinical assessment with regard to potential dangerousness of an individual to themselves or others	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Be able to prioritise what information is needed in urgent situations	ACE, Mini-ACE, CBD, CP, MCQ, CASC
	ACE, Mini-ACE, CBD, CP, MCQ,

Competent in the supervision and management of challenging behaviour and medical complications in relation to the range of clinical conditions presenting as psychiatric emergencies. Shows good judgement in the choice of treatment settings and in referral decisions	CASC
Assess and manage a patient involved in an incident	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Risk assess situations in which incidents may occur or have occurred and institute appropriate management including contingency planning, crisis management and de-escalation techniques	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Short term control of violence including emergency use of medication, rapid tranquillisation, use of restraint and seclusion	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Post event management	CBD, CP, MCQ, CASC
Assess and manage a patient involved in an incident	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Provision of reports and documentation relating to incidents	CBD, CP, CASC
Working with multidisciplinary and multi-agency colleagues to assess and manage incidents	CBD, CP, CASC
Consider the need for emergency supervision support and feedback for staff, victim, other patients, carers as required	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Attitudes demonstrated through behaviours	
Be able to work under pressure and to retain professional composure and to think clearly when working in emergency situations	ACE, Mini-ACE, CBD, CP, MCQ, CASC, mini-PA
Be able to prioritise work appropriately when confronted with clinical crises	ACE, Mini-ACE, CBD, CP,CASC, Mini-PAT

Keep mandatory training up to date	Supervisors' reports
Maintain professionalism in face of considerable clinical and legal pressure	ACE, Mini-ACE, CBD, CP, CASC, Mini-PAT
Offer help and support to others (patients, staff and carers)	ACE, Mini-ACE, CBD, CP, CASC
Provision of appropriate documentation of incidents	CBD, CP
Follow appropriate policies and procedures	ACE, Mini-ACE, CBD, CP
4c Mental health legislation	**Assessment Methods**
Knowledge	
Demonstrate an understanding of the contemporary mental health legislation and its local implementation with regard to assessment and treatment of patients, including mentally disordered offenders	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Understand and make appropriate use of the Mental Health Act in relation to capacity and consent	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Skills	
Apply the legislation appropriately at all times, with reference to published codes of practice	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Attitudes demonstrated through behaviours	
Act with compassion at all times	ACE, Mini-ACE, CBD, CP, CASC
Work with attention to the detail of the legislation	ACE, Mini-ACE, CBD, CP, CASC

4d Broader legal framework	Assessment methods
Knowledge • Know the legal responsibilities of psychiatrists with regard, for example, to agencies such as the relevant driving authority	ACE, Mini-ACE, CBD, CP, MCQ, CASC
• Demonstrate an understanding of human rights legislation (Human Rights Act and European Convention of Human Rights) and its relevance to psychiatric practice	CbD, CP, CASC
• Demonstrate understanding of the proportionality concept as it applies to restricting a patients human rights	CbD, CP, CASC
Skills • To consider and utilise human rights concepts in patient management and difficult ethical scenarios	CbD, CP, CASC
• To utilise the concept of proportionality when restricting a patients human rights	CbD, CP, CASC
• Demonstrate consideration of how restrictions may impact on patients' human rights	CbD, CP, CASC
Attitudes demonstrated through behaviours Act in accordance with contemporary codes of practice	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Be sensitive to the potential conflict between legal requirements and the wishes of the patient	ACE, Mini-ACE, CBD, CP, MCQ, CASC, CBDGA
• Respect for patients wishes, willingness to discuss and highlight potential breaches of human rights. Always show respect for patients' human rights.	CbD, CP, CASC

Intended learning outcome 5	
Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions	
5a Psychological therapies	**Assessment methods**
Knowledge Apply contemporary knowledge and principles in psychological therapies	CBD, CP, MCQ, CASC, SAPE, PACE
Skills Foster a therapeutic alliance with patients	ACE, Mini-ACE, CBD, CP, CASC, CBDGA
With appropriate supervision, commence and monitor therapeutic treatment in patients, based on a good understanding of the mechanisms of their actions	CBD, CP, SAPE, PACE
Demonstrate the capacity to deliver basic psychological treatments in at least two modalities of therapy and over both longer and shorter durations	CBD, CP, SAPE, PACE

Attitudes demonstrated through behaviours Respond appropriately to supervision	 CBD, CP, SAPE, PACE

Intended learning outcome 6	
Demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan	
6a Record keeping	**Assessment methods**
Knowledge Define the structure, function and legal implications of medical records and medico-legal reports Demonstrate a knowledge of the relevance of contemporary legislation pertaining to patient confidentiality Awareness of issues surrounding copying correspondence to patients	 CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC ACE, Mini-ACE, CBD, CP, MCQ, CASC
Skills Record concisely, accurately, confidentially, and legibly appropriate elements of the history, examination, investigation, differential diagnosis, risk assessment and management plan	CBD, CP, supervisors report
Attitudes demonstrated through behaviours Complete case records and all forms of written clinical information in a consistent, timely and responsible fashion	CBD, CP, supervisors reports

Intended learning outcome 7	
Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states	
7a Management of severe and enduring mental illness	**Assessment methods**
Knowledge	
Define the clinical presentations and natural history of patients with severe and enduring mental illness	CBD, CP, MCQ, CASC
Define the role of rehabilitation and recovery services	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Define the concept of recovery	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Define the concept of quality of life and how it can be measured	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Awareness of disability/housing benefits that patients may be entitled to claim	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Skills	
Maintain hope whilst setting long term, realistic goals	ACE, Mini-ACE, CBD, CP, CASC
Develop long-term management plans	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Act as patient advocate in negotiations with services	ACE, Mini-ACE, CBD, CP, CASC
Demonstrate skills in risk management in chronic psychiatric disorders	ACE, Mini-ACE, CBD, CP, CASC
Demonstrate skills in pathway care management	ACE, Mini-ACE, CBD, CP, CASC

Attitudes demonstrated through behaviours	
Treat each patient as an individual	ACE, Mini-ACE, CBD, CP, CASC
Demonstrate an appreciation of the effect of chronic disease states on patients and their families	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Develop and sustain supportive relationships with patients with severe and enduring mental illness	ACE, Mini-ACE, CBD, CP, mini-PAT
Demonstrate an appreciation of the impact of severe and enduring mental illness on patients, their families and carers	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Demonstrate an appreciation of the importance of co-operation and collaboration with primary healthcare services, social care services, and non-statutory services	ACE, Mini-ACE, CBD, CP, MCQ, CASC

Intended learning outcome 8	
To develop an understanding of research methodology and critical appraisal of the research literature	
8a Research techniques	**Assessment methods**
Knowledge	
Demonstrate an understanding of basic research methodology including both quantitative and qualitative techniques	JCP, MCQ
Skills	
Attitudes demonstrated through behaviours	
8b Evaluation and critical appraisal of research	**Assessment methods**
Knowledge	
Demonstrate an understanding of the principles of critical appraisal	JCP, MCQ
Demonstrate an understanding of the principles of evidence-based medicine, including the educational prescription	JCP, MCQ

Demonstrate knowledge of how to search the literature using a variety of databases	JCP, MCQ
Skills Formulate relevant questions from your clinical practice and answer them from the best available evidence Assess the importance of findings, using appropriate statistical analysis	 JCP, MCQ JCP, MCQ
Attitudes demonstrated through behaviours Strive to base your practice on best evidence	 CBD, CP, supervisors report

Intended learning outcome 9	
To develop the habits of lifelong learning	
9a Maintaining good medical practice	**Assessment methods**
Knowledge Maintain and use systems to update knowledge and its application to any aspect of your professional practice; keep up to date with clinical advances and legislation concerning patient care; the rights of patients and their relatives and carers; and research Maintain a system in order to keep abreast of major clinical and research developments	 Supervisors report, MCQ Supervisors report, JCP
Skills	
Attitudes demonstrated through behaviours Share evidence in a way to facilitate modifying practice based on new evidence Share evidence with the wider team to facilitate modification of practice	 Supervisors report, JCP
9b Lifelong learning	**Assessment methods**
Knowledge Define and explain the rationale of 'continuing professional development' Demonstrate an understanding of the concept of a personal development plan	 Supervisors report Supervisors report
Skills Recognise and use learning opportunities, reflect, appraise and, if necessary, change practice	 Supervisors report

Attitudes demonstrated through behaviours Be at all times self-motivated and eager to learn Show a willingness to accept criticism and to learn from colleagues	 Supervisors report Mini-PAT Supervisors report, Mini-PAT
9c Relevance of outside bodies	**Assessment methods**
Knowledge Demonstrate an understanding of the relevance of professional regulatory bodies and specialist societies including the General Medical Council (GMC) and the Medical Royal Colleges Demonstrate a familiarity with relevant guidance issued by the GMC, including 'Good Medical Practice' and 'Protecting Children and Young People'	 Supervisors report, MCQ Supervisors' Report, CBD, MCQ
Skills Recognise situations in which it may be appropriate to involve these bodies	 Supervisors report, CBD
Attitudes demonstrated through behaviours Accept the responsibilities of professional regulation	 Supervisors report

***Good Medical Practice*, Domain 2: Safety and Quality**

- Contribute to and comply with systems to protect patients
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by your health

Intended learning outcome 10	
Develop the ability to conduct and complete audit in clinical practice	
10a Audit	**Assessment methods**
Knowledge	
Demonstrate an understanding of the importance of audit and its place within the framework of clinical governance	Supervisors report, MCQ
Demonstrate an understanding of the audit cycle	Supervisors report, MCQ
Demonstrate an understanding of the differences between audit, surveys and research	Supervisors report, MCQ
Skills	
Identify relevant topics and appropriate standards	Supervisors report, MCQ
Implement findings and reassess	Supervisors report, MCQ
Able to effectively apply audit principles to own work, to team practice and in a service wide context	Supervisors report, MCQ
Able to undertake and present an audit	Supervisors report, MCQ
Attitudes demonstrated through behaviours	
Hold a positive attitude to the potential of audit in evaluating and improving the quality of care	Supervisors report, MCQ
Show willingness to respect audit findings and adapt practise appropriately	Supervisors report, MCQ

Intended learning outcome 11
To develop an understanding of the implementation of clinical governance

11a Organisational framework for clinical governance and the benefits that patients may expect	**Assessment methods**
Knowledge	
Demonstrate an understanding of the component parts of clinical governance	Supervisors report, MCQ
Show awareness of the advantages and disadvantages of clinical guidelines	Supervisors report, MCQ
Show an appreciation of the importance of reporting serious and untoward incidents	Supervisors report, MCQ
Skills	
Actively participate in a programme of clinical governance	Supervisors report, Mini-PAT
Aim for clinical effectiveness and best practice at all times	Supervisors report, Mini-PAT
Attitudes demonstrated through behaviours	
Prepared to learn from mistakes and complaints	Supervisors report, MCQ
Receptive to the scrutiny of peers and colleagues	Supervisors report, Mini-PAT
Demonstrate ability to consciously deviate from pathways when clinically indicated	Supervisors report, CBD, Mini-PAT

Intended learning outcome 12
To develop reflective practice including self reflection as an essential element of safe and effective psychiatric clinical practice

12a Reflective Practice	**Assessment methods**
Knowledge Demonstrate an understanding of the necessity and opportunities for continuing reflective practice as a doctor and psychiatrist. Be able to evaluate the professional value of experiential emotional development for the practitioner in enhancing their safety and effectiveness as psychiatrists.	CBD, supervisor report Supervisor report
Skills Demonstrate self reflection over time through written reflection and educational supervision in reflective practice notes.	Supervisor report
Attitudes demonstrated through behaviours Demonstrate the use of self-reflective practice to consider conscious emotions (prejudice, bias and personal feelings) which may limit clinical capacities Demonstrate awareness that unconscious bias, prejudice and feelings may be manifest in behaviour by being open to feedback from others. Show a deepening insight into your contribution to the building of therapeutic relationships, the obstacles encountered and the limitations of being able to do so, with therapeutic realism. Show a recognition of the emotional impact of psychiatric work on all clinicians and professionals working clinically.	ACE, mini-ACE, CBD, supervisor report CBD, Supervisor report SAPE, supervisor report CBD, supervisor report

Shows a continuing commitment to personal work to remain emotionally literate, effective and attuned to oneself and others so as to maintain appropriate boundaries with patients and colleagues to deliver safe and effective patient care.	CBD, supervisor report
12b Complaints	**Assessment methods**
Knowledge Show awareness of local complaints procedures	Mini-PAT, CBD, CP, supervisors report
Show awareness of the systems of independent review in the National Health Service	Mini-PAT, CBD, CP, supervisors report, MCQ
Skills Appropriately manage dissatisfied patients, relatives and carers and anticipate potential problems	Mini-PAT, CBD, CP, CBDGA, supervisors report
Attitudes demonstrated through behaviours Act with honesty and sensitivity	Mini-PAT, CBD, supervisors report
Be prepared to apologise if appropriate and accept responsibility	Mini-PAT, CBD, supervisors report
Act in a prompt and decisive fashion	Mini-PAT, CBD, supervisors report
12c Personal health	**Assessment methods**
Knowledge Demonstrate an understanding of and compliance with, the doctor's responsibilities to patients and the public	Supervisors report, MCQ
Demonstrate an understanding of occupational health services and support facilities for doctors	Supervisors report, MCQ

Skills Recognise when to obtain advice and treatment for personal mental and physical health problems Develop appropriate coping mechanisms for stress and be able to seek help if appropriate	Supervisors report, MCQ Supervisors report, Mini-PAT
Attitudes demonstrated through behaviours Recognise personal health as an important issue Recognise the manifestations of stress on self	Supervisors report, MCQ Supervisors report, CBDGA

***Good Medical Practice*, Domain 3: Communication, partnership and teamwork**

- Treat patients as individuals and respect their dignity.
- Work in partnership with patients.
- Work with colleagues in the ways that best serve patients' interests.

Intended learning outcome 13
Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances

13a Within a consultation	**Assessment methods**
Knowledge Demonstrate a knowledge of how to structure the clinical interview to identify the patients concerns and priorities, their expectations and their understanding	ACE, Mini-ACE, CBD, CP, MCQ, CASC
Demonstrate a knowledge of how and when to telephone a patient at home	ACE, Mini-ACE, CBD, CP, CASC
Be aware of limits of your expertise	ACE, Mini-ACE, CBD, CP, CASC
Skills Demonstrate interviewing skills, including the appropriate initiation of the interview, the establishment of rapport, the appropriate use of open ended and closed questions, techniques for asking difficult questions, the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence and summary statements	ACE, Mini-ACE, CASC
Solicit and acknowledge expression of the patients' ideas, concerns, questions and feelings	ACE, Mini-ACE, CASC
Understand the ways in which patients may communicate that are not directly verbal and have symbolic or unconscious elements	CBD, CP, CBDGA

Communicate information to patients in a clear fashion	ACE, Mini-ACE, CASC, mini-PAT
Appropriately close interviews	ACE, Mini-ACE, CASC
Stay within limits of expertise	ACE, Mini-ACE, CBD, CP, Mini-PAT
Communicate both verbally and in writing to patients whose first language may not be English in a manner that they understand	ACE, mini-ACE,CASC
Be able to use interpreters and translators appropriately	ACE, mini-ACE,CASC
Be able to communicate using aids with those who have sensory impairments e.g. deafness	ACE, mini-ACE,CASC
Avoid jargon and use familiar language	ACE, mini-ACE,CASC
Give clear information and feedback to patients.	ACE, mini-ACE,CASC
Share information with relatives and carers when appropriate	ACE, mini-ACE, CBD, CP,CASC
Use appropriate Information Technology (IT) skills	ACE, mini-ACE, CBD CASC

Attitudes demonstrated through behaviours Demonstrate respect, empathy, responsiveness, and concern for patients, their problems and personal characteristics	ACE, mini-ACE, CBD, CASC, CBDGA
Demonstrate an understanding of the need for involving patients in decisions, offering choices, respecting patients' views	ACE, mini-ACE, CBD, CASC, mini-PAT
Ensure that dress and appearance are appropriate to the clinical situation and patients' sensitivity	ACE, Mini-ACE, CASC
Demonstrate an understanding of the impact of trauma (as described, ILO 1, 1a) history on patients (if included)	Mini-ACE, ACE, CASC, CBD

Intended learning outcome 14	
Demonstrate the ability to work effectively with colleagues, including team working	
14a Clinical teamwork	**Assessment methods**
Knowledge Demonstrate an understanding of the roles and responsibilities of team members	CBD, CP, Mini-PAT, MCQ
Demonstrate an understanding of the roles of primary healthcare and social services	CBD, CP, MCQ
Skills Communicate and work effectively with team members	CBD, CP, Mini-PAT
Attitudes demonstrated through behaviours Show respect for the unique skills, contributions and opinions of others	CBD, CP, Mini-PAT
Recognise and value diversity within the clinical team	CBD, CP, Mini-PAT
Be conscientious and work cooperatively	CBD, CP, Mini-PAT

Intended learning outcome 15	
Develop appropriate leadership skills	
15a Effective leadership skills	**Assessment methods**
Knowledge Demonstrate an understanding of the relationship between clinical responsibility and clinical leadership	CBD, CP, mini-PAT
Skills	
Attitudes demonstrated through behaviour Display enthusiasm, integrity, determination and professional credibility	CBD, mini-PAT, supervisors report

Intended learning outcome 16	
Demonstrate the knowledge, skills and behaviours to manage time and problems effectively	
16a Time management	**Assessment methods**
Knowledge Demonstrate a knowledge of which patient or tasks take priority	CBD, CP, mini-PAT, supervisors report
Skills Manage time effectively	Mini-PAT, supervisors report
Prioritise tasks, starting with the most important	Mini-PAT, supervisors report
Work increasingly efficiently as clinical skills develop	Mini-PAT, supervisors report
Recognise when to re-prioritise or call for help	Mini-PAT, CBD, supervisors report
Attitudes demonstrated through behaviours Have realistic expectations of tasks to be completed	Mini-PAT, CBD, supervisors report
Be willing to consult and work as part of a team	Mini-PAT, CBD, supervisors report
16b Communication with colleagues	**Assessment methods**
Knowledge Write clinical letters, including summaries and reports	Mini-PAT, CBD, supervisors report
Use e-mail, internet and the telephone.	Mini-PAT, CBD,supervisors report
Communicate effectively with members of the multi-professional team	Mini-PAT, CBD, supervisors report
Demonstrate a knowledge of how and when to telephone colleagues, including those in primary care	Mini-PAT, CBD, supervisors report

Skills Use appropriate language Select the most appropriate communication methods	 Mini-PAT, supervisors report Mini-PAT, CBD, supervisors report
Attitudes demonstrated through behaviours Be prompt and respond courteously and fairly Show an appreciation of the importance of timely and effective use of all communication methods, including electronic communication Demonstrate awareness of the need for prompt and accurate communication with primary care and other agencies Show courtesy towards all members of the Community Mental Health Team and support staff, including medical secretaries and clerical staff	 Mini-PAT, CBD, supervisors report Mini-PAT, CBD, supervisors report Mini-PAT, CBD, supervisors report Mini-PAT, CBD, supervisors report
16c Decision making	**Assessment methods**
Knowledge Demonstrate a good understanding of clinical priorities	 Mini-PAT, CBD, CP, supervisors report
Skills Analyse and manage clinical problems	 Mini-PAT, CBD, CP, supervisors report
Attitudes demonstrated through behaviours Be flexible and willing to change in the light of changing conditions Be willing to ask for help	 Mini-PAT, CBD, supervisors report Mini-PAT, CBD, supervisors report

16d Continuity of care	Assessment methods
Knowledge Demonstrate an understanding of the relevance of continuity of care	Mini-PAT, CBD,CP, supervisors report
Demonstrate understanding of policy and procedure relating to out-of-hours (eg on-call) working	Mini-PAT, supervisors report
Skills Ensure satisfactory completion of reasonable tasks at the end of the shift/day with appropriate handover	Mini-PAT, supervisors report
Make adequate arrangements to cover leave	Mini-PAT, supervisors report
Make appropriate decisions in the best interests of patients when on-call	Mini-PAT, CBD, supervisors report
Attitudes demonstrated through behaviours Recognise the importance of punctuality and attention to detail	Mini-PAT, CBD, supervisors report
Show flexibility for cover of clinical colleagues	Mini-PAT, supervisors report
Respond appropriately to requests when on-call	Mini-PAT, CBD, supervisors report

Intended learning outcome 17	
To develop the ability to teach, assess and appraise	
17a The skills, attitudes, behaviours and practices of a competent teacher	**Assessment methods**
Knowledge Demonstrate an understanding of the basic principles of adult learning	AoT, supervisors report, Mini-PAT

Skills Identify learning outcomes	AoT, supervisors report, Mini-PAT
Attitudes demonstrated through behaviours Demonstrate a professional attitude to teaching Ensure that feedback from teaching activities is used to develop (and if necessary change) teaching style	AoT, supervisors report, Mini-PAT AoT, supervisors report, Mini-PAT
17b Assessment	**Assessment methods**
Knowledge Demonstrate a knowledge of the principles of assessment Demonstrate an understanding of the use of different assessment methods Demonstrate an understanding of the difference between formative and summative assessment	supervisors report, Mini-PAT supervisors report, Mini-PAT supervisors report, Mini-PAT
Skills	
Attitudes demonstrated through behaviours Be at all times honest when assessing performance	supervisors report, Mini-PAT
17c Appraisal	**Assessment methods**
Knowledge Demonstrate an understanding of the principles of appraisal (including the difference between appraisal and assessment)	Supervisors report, Mini-PAT
Skills	
Attitude demonstrated through behaviours	

***Good Medical Practice*, Domain 4: Maintaining trust**

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse patients' trust or the public's trust in the profession.

Intended learning outcome 18	
To ensure that the doctor is able to inform and educate patients effectively	
18a Educating patients about illness and its treatment	**Assessment Methods**
Knowledge Understand the impact of stigmatisation – relating to both mental and physical illness – and its impact on the care of patients	ACE, Mini-ACE, CBD, CP, MCQ.CASC
Develop an awareness of how established practices may perpetuate and reinforce stigma	CBD, CP, MCQ
Be aware of strategies to enhance patient understanding and potential self-management	ACE, Mini-ACE, CBD, MCQ, CASC
Demonstrate awareness of methods to improve treatment concordance	ACE, Mini-ACE, CBD, MCQ, CASC
Skills Negotiate individual treatment plans including relapse prevention plans	ACE, Mini-ACE, CBD, MCQ, CASC
Advises patients accurately and sensitively	
Attitudes demonstrated through behaviours Appreciate differing perspectives and beliefs with regard to illness	ACE, Mini-ACE, CBD, MCQ, CASC

18b Environmental and lifestyle factors	Assessment methods
Knowledge Demonstrate an understanding of factors that influence the aetiology and course of mental disorder, including social deprivation and, if relevant, trauma (as described, ILO 1, 1a) history	ACE, Mini-ACE, CBD, MCQ, CASC

Skills	
Advise on environmental and lifestyle changes	ACE, Mini-ACE, CBD, CASC
Work with other health and social care workers	CBD, CP, Mini-PAT, CASC
Attitudes demonstrated through behaviours	
Be aware of potential personal prejudices	CBD, CP, Mini-PAT, CBDGA

Intended learning outcome 19	
To ensure that the doctor acts in a professional manner at all times	
19a Doctor patient relationship	**Assessment methods**
Knowledge	
Demonstrate an understanding of all aspects of professional relationships including the power differential between psychiatrists and patients	CBD, CP, mini-PAT
Demonstrate an understanding of the boundaries surrounding consultation	CBD, CP, mini-PAT, SAPE
Demonstrate an understanding of the rights of patients, carers and the public	CBD, CP
Demonstrate an understanding of the factors involved when the doctor-patient relationship ends	CBD, CP, SAPE
Skills	
Develop therapeutic relationships that facilitate effective care	CBD, CP, SAPE
Deal with behaviour that falls outside the boundary of the doctor/patient relationship	CBD, CP, supervisors report
Demonstrate the management of ending professional relationships with patients using clear and appropriate communications	ACE, Mini-ACE, CBD, SAPE
Attitudes demonstrated through behaviours	
Adopt non-discriminatory behaviour to all patients and recognise their individual needs	CBD, Mini-PAT, CBDGA
Respect the patient's autonomy to accept or reject advice and treatment	ACE, Mini-ACE, CBD, CBDGA

At all times be open and honest with patients and carers	ACE, Mini-ACE, CBD, Mini-PAT
Ensure that a decision to end a professional relationship with a patient is fair and does not contravene guidance	ACE, Mini-ACE, CBD, SAPE
19b Valuing diversity	**Assessment methods**
Knowledge	
Define 'cultural diversity' and applies this definition in respect to clinical practice	CBD, CP, Mini-PAT, MCQ
Describe current equal opportunity legislation including for people with disabilities.	CBD, CP MCQ
List the different approaches there are to developing skills in meeting the needs of diverse populations and can compare and contrast these	CBD, CP, MCQ
Can explain how to apply equal opportunity legislation in their practice as a health care provider and as an employer	CBD, CP, MCQ
Critically appraise the use of key terms, such as race, ethnicity, culture, multiculturalism, asylum-seeker, physical and/or learning disabilities and inequalities of access to healthcare	CBD, CP, MCQ
Evaluate and explain the relevance of cultural diversity training in healthcare	CBD, CP, MCQ
Identify and explain strategies to challenge prejudice effectively and identify local policy in this area to ensure robustness	CBD, CP, supervisors report
Skills	
Can demonstrate the skill to evaluate institutional prejudices in a balanced manner and how these relate to trainee's own perspectives	CBD, CP, CBDGA supervisors report
Learn to use reflective practice as a tool for seeing attitudes and prejudice	CBD, CP, CBDGA supervisors report

Attitudes demonstrated through behaviours Demonstrate respect for patients and colleagues who encompass without prejudice, diversity of background and opportunity, language, culture and way of life. Assess the impact (both positive and negative) of your attitudes on your clinical practice Evaluate your own attitudes and perceptions (including personal bias) of different groups within society Evaluate and justify the approaches used in your own clinical practice Uses reflective practice with supervisors to consider other perspectives on attitudes and perceptions (which may include others' recognition of unconscious personal bias)	ACE, Mini-ACE, CBD, supervisors report, Mini-PAT CBD, CP CBDGA supervisors report CBD, CP supervisors report CBD, CP supervisors report CBD, CP, CBDG supervisors report
19c Confidentiality	**Assessment methods**
Knowledge Demonstrate an understanding of contemporary legislation and practice in relation to patient confidentiality	ACE, Mini-ACE, CBD, CP, Mini-PAT, MCQ
Skills Use and share patient information appropriately Demonstrate a capacity to limit information sharing appropriately without either undue restriction or disclosure	CBD, CP, mini-PAT, CASC CBD, supervisors report, Mini-PAT, CASC
Attitudes demonstrated through behaviours Respect the rights and limitations of patient confidentiality	ACE, Mini-ACE, CBD, CP, CASC

In situations where a child or young person may be at risk of significant harm, always put the interest of the child or young person first	ACE, mini-ACE, CBD, CP, CASC
19d Consent	**Assessment methods**
Knowledge Demonstrate an understanding of the components of informed consent, including suggestibility	ACE, Mini-ACE, CBD, MCQ, CASC
Demonstrate an understanding of the basis of capacity	ACE, Mini-ACE, CBD, MCQ, CASC
Demonstrate an understanding of the legal framework for capacity (e.g. Mental Capacity Act)	ACE, Mini-ACE, CBD, MCQ, CASC
Skills Give appropriate information in a manner which patients are able to understand, adapting techniques and materials according to need	
Attitudes demonstrated through behaviours Continually respect the individual and fluid nature of consent	
19e Recognise own limitations	**Assessment methods**
Knowledge Demonstrate an appreciation of the extent of one's own limitations and when to ask for advice	ACE, Mini-ACE, CBD, Mini-PAT
Recognise the potential benefits of seeking second opinions in advance of problems arising	ACE, Mini-ACE, CBD, Mini-PAT
Skills	
Attitudes demonstrated through behaviours Be willing to consult and admit mistakes	ACE, Mini-ACE, CBD, Mini-PAT
Be prepared to accept clinical and professional supervision	ACE, Mini-ACE, CBD, Mini-PAT, supervisors report

19f Probity	Assessment methods
Knowledge Demonstrate understanding of professionally prescribed codes of ethical conduct and practice	CBD, CP, CBDGA, mini-PAT
Skills	
Attitudes demonstrated through behaviours Behave at all times in accordance with contemporary standards of professional practice Demonstrate probity in relationships with pharmaceutical representatives and companies	CBDGA, mini-PAT, supervisors report Mini-PAT, supervisors report

16. METHODS OF LEARNING AND TEACHING

The curriculum is delivered through a number of different learning experiences, of which experiential workplace learning with supervision appropriate to the trainee's level of competence is the key. This will be supported by other learning methods as outlined below: -

1. Appropriately supervised clinical experience
2. Psychotherapy training
3. Emergency psychiatry experience
4. Interview skills
5. Learning in formal situations
6. Teaching
7. Management experience
8. Research
9. ECT Training

Appropriately supervised clinical experience

Trainees must at all times participate in clinical placements that offer appropriate experience i.e. direct contact with and supervised responsibility for patients. **All training placements must include direct clinical care of patients.** Placements based on observation of the work of other professionals are not satisfactory. **Each placement must have a job description and timetable. There should be a description of potential learning objectives in post.** Training placements should not include inappropriate duties (e.g. routine phlebotomy, filing of case notes, escorting patients, finding beds, etc) and must provide a suitable balance between service commitment and training.

In Core Psychiatry Training the Curriculum Outcomes are met by way of a trainee working in a purpose-designed programme. Within the programme each placement should be clearly designated as providing experience in general psychiatry, one of its three recognised sub specialties, or one of the five other recognised specialties. Placements may be of four or six months' duration. Where placements offer a mixture of experience between specialities/sub specialties, the proportion of time spent in each clinical area should be clearly stated. Posts should provide the trainee with the experience and assessments necessary to achieve full coverage of the curriculum. Individual programmes of training provided by Deaneries must be able to meet contemporary requirements with regard to examination eligibility. Trainees are required to complete the minimum numbers and types of workplace-based assessment (WPBA) appropriate to their level of training and opportunities for this must be made available within the placements.

The first twelve months of Core Psychiatry Training should normally be in General Psychiatry, or a combination of psychiatry of old age and General Psychiatry. Each individual placement does not necessarily have to include both hospital and community experience but each training scheme must provide an overall balance of hospital and community experience. So that the programme must ensure that the rotation plan for an individual trainee enables them to gain the breadth of experience required. This will require monitoring by the trainee through their portfolio and by the scheme through its operational management processes.

The contribution of placements to Core Psychiatry Training programmes is as follows: -

General Psychiatry

Experience gained in General Psychiatry must include properly supervised in-patient and out-patient management, with both new patients and follow-up cases, and supervised experience of emergencies and 'on call' duties. Training placements will afford experience in hospital and/or community settings. Increasingly training in General Psychiatry will be delivered in functional services that specialise a single area of work such as, crisis, home treatment, early interventions, assertive interventions or recovery models. Thus not all posts will provide all experiences as detailed below. During their rotation a trainee must document experience in all of the below; a trainee may need two or more complimentary placements (e.g. an in-patient placement and a home treatment team placement) to achieve the required breadth of experience: -

- Assessment of psychiatric emergencies referred for admission.
- Assessment and initial treatment of emergency admissions.
- Day to day management of psychiatric inpatients.
- Participation in regular multi-disciplinary case meetings.
- Prescribing of medication and monitoring of side-effects.
- Administration of ECT.
- Use of basic psychological treatments.
- Use of appropriate mental health legislation.
- Assessment of new outpatients.
- Continuing care of longer-term outpatients.
- Psychiatric day hospital.
- CMHT- joint assessments in the community with other professionals.
- Crisis intervention.
- Home treatment.

Other placements may offer experience as follows: -

a) **Substance misuse:** trainees in General Psychiatry should receive appropriate experience in this area. Where a specific service exists for the treatment of alcohol and/or drug dependence it should be possible to offer a whole time or part time placement. For this to be regarded as sub-specialty experience, the trainee must spend at least half their time in the service.

b) **Liaison psychiatry:** experience in liaison psychiatry may be gained during General Psychiatry training or via a specialist training post. All trainees should receive adequate supervised experience in the assessment and management of deliberate self-harm, psychiatric emergencies in general and surgical wards and the accident and emergency department. Other valuable experience might include training in renal units, pain clinics and intensive care units.

c) **Rehabilitation:** attachment to a rehabilitation team with particular emphasis on the care of patients with severe chronic disability is recommended. Such experience should involve not only inpatient care but also community facilities including day centres, hostels, supervised lodgings and sheltered workshops.

d) **Eating disorders, neuropsychiatry and perinatal psychiatry:** as these potential sub-specialties become established, it will be possible to offer whole or part time specialist training posts.

Psychiatry of old age

Particular importance is attached to experience in this area because of the increasing numbers of elderly people in the population and the special considerations needed in diagnosis and treatment. The psychiatry of old age should constitute a separate attachment within the rotational training scheme. It is important that trainees gain experience in the acute and chronic functional disorders of older people, in addition to the assessment and management of organic illnesses. This should include both hospital and community experience and an opportunity to work as part of the multidisciplinary team. Experience of pharmacological and non-pharmacological strategies and treatments should be gained, including the drugs used to treat cognitive and behavioural symptoms in dementia.

Forensic psychiatry

Some experience may be gained in General Psychiatry but a specialist attachment in forensic psychiatry is recommended. Apart from the experience of the provision of psychiatric care in secure settings it is valuable for trainees to accompany consultants when patients are seen at prisons, hospitals, secure units, remand centres and other establishments. It may be helpful for trainees to prepare shadow court reports for discussion with their

consultants. Specific instruction is needed in the principles of forensic psychiatry, detailed risk assessment and management and medico-legal work.

Psychiatry of learning disability

There should be sufficient exposure to give the trainee an awareness of the nature and scope of the problems with an emphasis on integrated psychiatric and psychological treatment rather than basic physical care. Trainees must get experience of community facilities as well as hospital care.

Child and adolescent psychiatry

Trainees should play an active part in patient care and not be expected to adopt a passive observer role. The experience should include extensive community experience and include both medical and psychological approaches to treatment.

Not all trainees will have the opportunity to have a post in child and adolescent psychiatry during Core Psychiatry Training. Aspects of developmental psychiatry are important for all psychiatric trainees whatever specialty within psychiatry they subsequently choose. Trainees need to understand child development and the influences that can foster this or interfere with it. To do this they need to understand the bio-psycho-social approach and the varying balance of influences at different stages of development. They need to understand both aberrant development and also how normal development can be disrupted. Whilst this is best learned through clinical experience in a developmental psychiatry post (child and adolescent psychiatry or adult learning difficulties), there will be a few trainees who have to gain these skills through in other ways. The knowledge base will come from clinical experience coupled with lectures, seminars and private study including study for examinations. Those who do not get a post in developmental psychiatry are strongly advised to negotiate a clinical attachment during another placement to best prepare them to undertake the child and adolescent WPBAs that they will be expected to achieve during this stage of their training.

All Core Psychiatry Training (CT1-3) trainees are likely to be responsible for seeing young people who present to Accident and Emergency Departments with self-harm whilst they are undertaking out of hours on call duties. This means that they have to understand safeguarding issues and the assessment of risk for these young people. To ensure that they are supported in this, there are competencies appropriate to CT1-3 in safeguarding (Intended Learning Outcome 2) and Managing Emergencies (Intended Learning Outcome 4). In addition, it has become increasingly clear that developmental disorders such as ADHD and autism can continue into adult life and that they have been under-recognised in adulthood. Competence in recognising these disorders is required for all trainees. Depression is an important illness that often starts in adolescence and this is referred to in the ARCP Guide to Core Psychiatry Training.

Psychotherapy training

The aim of psychotherapy training is to contribute to the training of future consultant psychiatrists in all branches of psychiatry who are psychotherapeutically informed, display advanced emotional literacy and can deliver some psychological treatments and interventions. Such psychiatrists will be able to:

- Account for clinical phenomena in psychological terms
- Deploy advanced communication skills
- Display advanced emotional intelligence in dealings with patients and colleagues and yourself.
- Refer patients appropriately for formal psychotherapies
- Jointly manage patients receiving psychotherapy
- Deliver basic psychotherapeutic treatments and strategies where appropriate

The Psychotherapy Tutor (who has undergone higher/advanced specialist training in Medical Psychotherapy with a CCT (Certificate of completion of Training) in Medical Psychotherapy or equivalent) is responsible for organising psychotherapy training within a School in line with current curriculum requirements. There are two basic requirements:

Case based discussion groups (CBDG) are a core feature of early training in psychotherapeutic approach to psychiatry. They involve regular weekly meetings of a group of trainees and should last around one and one and a half hours. The task of the meeting is to discuss the clinical work of the trainees from a psychotherapeutic perspective paying particular attention to the emotional and cognitive aspects of assessment and management of psychiatric patients in whatever setting the trainee comes from. Trainees should be encouraged to share their feelings and thoughts openly and not to present their cases in a formal or stilted manner. Most trainees should attend the group for about one year. Attendance and participation in the CBDG will be assessed

Undertaking specific training experiences treating patients is the only reliable way to acquire skills in delivering psychotherapies. The long case also helps in learning how to deal with difficult or complicated emotional entanglements that grow up between patients and doctors over the longer term. Patients allocated to trainees should be appropriate in terms of level of difficulty and should have been properly assessed. Trainees should be encouraged to treat a number of psychotherapy cases during their training using at least two modalities of treatment and at least two durations of input. This experience must be started in Core training and continued in Advanced Training, so that by the end of Core Training the trainee must have competently completed at least two cases of different durations. The psychotherapy supervisor will assess the trainee's performance by using the SAPE.

Care should be given in the selection of psychological therapy cases in Advanced Training in General Psychiatry to make the experience gained is relevant to the trainee's future practice as a consultant. For example trainees intending to specialise in rehabilitation psychiatry may well wish to develop skills in the cognitive behaviour therapy of psychosis, while trainees with an interest in personality disorders should consider developing their knowledge of treatments such as dialectical behaviour therapy, mentalisation based therapy and cognitive analytic therapy.

The psychotherapy tutor should have selected supervisors. Psychotherapy supervisors need not be medically qualified but they should possess appropriate skills and qualifications both in the modality of therapy supervised and in teaching and supervision.

Short Case

The short therapy case needs to be completed with a satisfactory SAPE (Structured Assessment of Psychotherapy Expertise) undertaken by the clinical supervisor of the case and a PACE (Psychotherapy Assessment of Clinical Expertise) completed by the Psychotherapy Tutor, a Consultant Psychiatrist in Psychotherapy. The short therapy case is usually between 12 and 20 sessions of therapy. The precise number of therapy sessions is agreed with respect to the patient's needs with the clinical supervisor. The short case would be a derivative of a cognitive model and a psychodynamic case would be acceptable.

Long Case

The long therapy case is a core psychotherapy curriculum requirement so needs to be completed with two satisfactory SAPEs (Structured Assessment of Psychotherapy Expertise) undertaken by the clinical supervisor of the case. A SAPE undertaken early in the therapy after deriving a formulation and presenting this to the supervisor should be coupled with a SAPE undertaken when the case is established or towards the end.

Following completion of the therapy a PACE (Psychotherapy Assessment of Clinical Expertise) should be completed by the Psychotherapy Tutor, a Consultant Psychiatrist in Psychotherapy. Given that the PACE may be completed by someone other than the clinical supervisor a summary outlining the progress of the therapy should be written by the trainee and agreed with the clinical supervisor.

The long therapy case is over 20 sessions of therapy. The precise number of therapy sessions is agreed with respect to the patient's needs with the clinical supervisor.

Emergency Psychiatry

Trainees must gain experience in the assessment and clinical management of psychiatric emergencies and trainees must document both time spent on-call and experience gained (cases seen and managed) and this should be "signed off" by their Clinical Supervisor/Trainer.

A number and range of emergencies will constitute relevant experience. During Core Psychiatry training, trainees must have experience equivalent to participation in a first on call rota with a minimum of 55 nights on call during the period of core specialty training (i.e. at least 50 cases with a range of diagnosed conditions and with first line management plans conceived and implemented.) (Trainees working part time or on partial shift systems must have equivalent experience.)

Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes Core Psychiatry trainees from the initial assessment of deliberate self-harm patients or DGH liaison psychiatry consultations, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.

Psychiatric trainees should not provide cross specialty cover for other medical specialties except in exceptional circumstances where otherwise duty rotas would not conform to the European Working Time Directive. No trainee should be expected to work to a level beyond their clinical competence and experience.

Where daytime on call rotas are necessary, participation must not prevent trainees attending fixed training events.

Advanced trainees in General Psychiatry must have opportunities to supervise others as part of their experience of emergency psychiatry. They should not routinely perform duties (such as clerking emergency admissions) that would normally be performed by less experienced practitioners.

Interview skills

All trainees must receive teaching in interviewing skills in the first year Core Psychiatry Training (CT1). The use of feedback through role-play and/or video is recommended. Soliciting (where appropriate) the views of patients and carers on performance is also a powerful tool for feedback.

Learning in formal situations

Learning in formal situations will include attending a number of courses for which the trainee should be allowed study leave: -

- It is essential that trainees in Core Psychiatry Training attend an MRCPsych course that comprises a systematic course of lectures and /or seminars covering basic sciences and clinical topics, communication and interviewing skills. These courses must follow the standards for College approved academic courses
- Local postgraduate meetings where trainees can present cases for discussion with other psychiatrists, utilising information technology such as slide presentations and video recordings.
- Journal clubs, where trainees have the opportunity to review a piece of published research, with discussion chaired by a consultant or specialty registrar (ST4-ST6), Postgraduate meetings where trainees can present and discuss audit.
- Multi-disciplinary/multi-professional study groups.
- Learning sets which can stimulate discussion and further learning.
- Trainees must also exercise personal responsibility towards their training and education and are encouraged to attend educational courses run by the College's divisional offices.

Experience of teaching

It is important that all trainee psychiatrists have experience in delivering education. In Core Psychiatry training, trainees should have opportunities to assist in 'bedside' teaching of medical students and delivering small group teaching under supervision.

Management experience

Opportunity for management experience should be available in all training programmes and should begin with simple tasks in the clinical, teaching and committee work of the hospital or service. Attending courses and by shadowing a medical manager to get insight into management. "Hands on" experience is especially effective, e.g. convening a working group, and it may be possible for a trainee to be given a relevant management task to complete.

Opportunity for involvement in administration and collaboration with non medical staff at local level on the ward or unit, at Trust level or on the training scheme itself to gain familiarity with and an understanding of management structure and process as part of a trainee's professional development as a psychiatrist.

ECT Training

All Core Psychiatry training programmes must ensure that there is training and supervision in the use of ECT so that trainees become proficient in the prescribing, administration and monitoring of this treatment.

Research

Opportunities must be made available for trainees to experience supervised quantitative or qualitative research and a nominated research tutor should be available within the programme to advise trainees on the suitability of projects. In Core Psychiatry training, research may be limited to case reports or a small literature review. In advanced training in General Psychiatry, trainees should have the opportunity to participate in original research.

17. ASSESSMENT SYSTEM FOR CORE PSYCHIATRY TRAINING

Purpose

The Royal College of Psychiatrists Assessment System has been designed to fulfill several purposes:

- Providing evidence that a trainee is a competent and safe practitioner and that they are meeting the standards required by Good Medical Practice
- Creating opportunities for giving formative feedback that a trainee may use to inform their further learning and professional development
- Drive learning in important areas of competency
- Help identify areas in which trainees require additional or targeted training
- Providing evidence that a trainee is progressing satisfactorily by attaining the Curriculum learning outcomes
- Contribute evidence to the Annual Review of Competence Progression (ARCP) at which the summative decisions regarding progress and ultimately the award of the Certificate of Completion of Training (CCT) are made.

Assessment blueprint

The Assessment Blueprint supplement to this Curriculum shows the assessment methods that can possibly be used for each competency. It is not expected that all trainees will be assessed by all possible methods in each competency. The learning needs of individual trainees will determine which competencies they should be assessed in and the number of assessments that need to be performed. The trainee's Educational Supervisor has a vital role in guiding the trainee and ensuring that the trainee's assessments constitute sufficient curriculum coverage.

Assessment methods

The assessment system consists of the following elements: -

(i) Two written papers 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).

(ii) The Clinical Examination (Clinical Assessment of Skills and Competencies - CASC) is a summative assessment of a doctor's competence in the core skills of psychiatric practice. The Clinical Assessment of Skills and Competencies (CASC) is an OSCE type examination consisting of two parts, completed in one day. On passing the CASC, the doctor will be awarded Membership of the Royal College of Psychiatrists (MRCPsych).

Information for candidates about the written and clinical parts of the MRCPsych Examination can be found at www.rcpsych.ac.uk/exams.aspx

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

(iii) Workplace Based Assessment (**WPBA**) 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 will continue the process established in the Foundation Programme and will extend throughout Core Psychiatry Training and Advanced Training. It must be understood that WPBA's are primarily tools for giving formative feedback and in order to gain the full benefit of this form of assessment, trainees should ensure that their assessments take place at regular intervals throughout the period of training. All trainees 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 trainee and evidence of further development may be taken as evidence that a trainee demonstrates critical self-reflection. Educational supervisors will draw attention to trainees who leave all their assessments to the 'last minute' or who appear satisfied that they have completed the minimum necessary.

An individual WPBA is not a summative assessment, but outcomes from a number of WPBA's will contribute evidence to inform summative decisions.

The WPBA tools currently consist of:

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.

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.

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 Trainee has recently been involved with and has written in their notes.

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.

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.* Trainees should nominate 10-12 suitable assessors who they currently work with for the mini-PAT assessment. Ideally this should include no more than 2 assessors in any one position (i.e. 2 consultants, 2 nurses, 2 peers, 2 juniors, 2 admin, 2 healthcare professionals etc). Trainees 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 trainee's educational supervisor. The trainee must discuss/agree with their clinical supervisor those who are to be nominated. A valid mini-PAT requires at least 6 responses.

Case Based Discussion Group Assessment (CBDGA) has been developed by the College to provide structured feedback on a trainee's attendance and contribution to case discussion groups (also known as Balint- type groups) in Core Psychiatry Training.

Structured Assessment of Psychotherapy Expertise (SAPE) has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case.

Psychotherapy Assessment of Clinical Expertise (PACE) has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case. Should be completed by the Psychotherapy Tutor, a Consultant Psychiatrist in Psychotherapy.

Case Presentation (CP) developed at the College; this is an assessment of a major case presentation, such as a Grand Round, by the Trainee.

Journal Club Presentation (JCP) similar to CP, and also developed at the College, this enables an assessment to be made of a Journal Club presented by the Trainee.

Assessment of Teaching (AoT) has been developed at the College to enable an assessment to be made of planned teaching carried out by the Trainee, which is a requirement of this curriculum.

Direct Observation of non-Clinical Skills (DONCS) has been developed by the College from the Direct Observation of Procedural Skills (DOPS). The DONCS is designed to provide feedback on a doctor's performance of non-clinical skills by observing them chairing a meeting, teaching, supervising others or engaging in another non-clinical procedure.

Further information on WPBA's can be found on the College website via the following link: http://www.rcpsych.ac.uk/traininpsychiatry/corespecialtytraining/portfolioonlinesign-up/portfolioonlineinformation.aspx

For those in Core Training the following table shows the minimum number of each assessment that need to be undertaken. The minimum number has been arrived at in the light of the reliability of each tool, together with an estimate of the numbers that are likely to be needed to ensure a broad coverage of the Curriculum. Many trainees will require more than this minimum, none will require fewer. More detail is given in the guidance to ARCP panels.

WPBA	**Minimum number required per year**		
	CT1	**CT2**	**CT3**
ACE	2	3	3
mini-ACE	4	4	4
CbD	4	4	4
DOPS	*	*	*
mini-PAT	2	2	2
CBDGA	2	-	-
SAPE	-	1	2
PACE	-	1**	1**
CP	1	1	1
JCP	1	1	1
AoT	*	*	*
DONCS	*	*	*

* There is no set number to be completed in Core Psychiatry training; they may be performed as the opportunity

arises
** The two PACE assessments can be undertaken whenever appropriate for the short and long cases. However they are usually undertaken in CT2/CT3.
- Not required

18. Decisions on progress, the ARCP

Section 7 of the **Guide to Postgraduate Specialty Training in the UK** ("**Gold Guide**") describes the **Annual Review of Competence Progression (ARCP).** The ARCP is a formal process that applies to all Specialty Trainees. In the ARCP a properly constituted panel reviews the evidence of progress to enable the trainee, the postgraduate dean, and employers to document that the competencies required are being gained at an appropriate rate and through appropriate experience.
The panel has two functions: -

1. To consider and prove the adequacy of the trainee's evidence.
2. Provided the documentation is adequate, to make a judgment about the trainee's suitability to progress to the next stage of training or to confirm that training has been satisfactorily completed

The next section is a guide for ARCPs regarding the evidence that trainees should submit at each year of core psychiatry training. There are several different types of evidence including WPBA's, supervisor reports, the trainee's learning plan, evidence of reflection, course attendance certificates etc. The evidence may be submitted in a portfolio and in time, this will be done using the College e-portfolio.

Trainees may submit WPBA's that have been completed by any competent healthcare professional who has undergone training in assessment. In a number of cases, we have stipulated that a consultant should complete the assessment. WPBA's in developmental psychiatry (i.e. in children and patients with learning disability) should be performed by a specialist child psychiatrist or learning disability psychiatrist.

The trainee should map the evidence that they wish to be considered for each competency. A single piece of evidence may be used to support more than one competency.

19. Guide to ARCPs in Core Psychiatry Training

There is no fixed order of posts in CT2 and 3; so there are many outcomes that may be achieved in either of the years CT2 or 3. The important factor to be recalled is that all the outcomes must be completed by the end of CT3.

Intended learning outcome	CT1	CT2	CT3
Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include: • **Presenting or main complaint** • **History of present illness** • **Past medical and psychiatric history** • **Systemic review** • **Family history** • **Socio-cultural history** • **Developmental history**			
	By the end of ST1 the trainee should demonstrate the ability to take a history and perform an examination on an adult patient who has any of the common psychiatric disorders, including affective disorders; anxiety disorders; psychotic disorders; and personality disorders	By the end of CT2, the trainee should demonstrate the ability to independently take a competent history and perform an examination on adult patients who present with a full range of psychiatric disorders including disorders of cognitive impairment; substance misuse disorders; and organic disorders	By the end of CT3, the trainee should demonstrate the ability to take a history and perform an examination of patients with psychiatric disorders who have a learning disability or are children and be able to perform a competent assessment of a patient with medically unexplained symptoms or physical illness and psychiatric disorder
1a Clinical history	ACE conducted with an adult patient not previously known to the trainee	ACE taking a history from a person with cognitive impairment if not completed in CT1	ACE taking a history from a not previously known patient who is either physically unwell or has medically unexplained

		ACE taking a history from a person with a substance misuse problem, if not completed in CT1	symptoms, if not completed in CT2 ACE taking a history from a not previously known child or patient with learning disability, including an interview with parent or carer when appropriate, if not completed in CT2. This assessment must be conducted by an appropriate specialist
1b Patient examination	ACE conducted with an adult patient not previously known to the trainee, to include mental state examination and an appropriate physical examination CBD of a case presentation of a patient the trainee has fully assessed, including a collateral history Mini-ACE's of patients to demonstrate skillful identification of psychopathology	Mini-ACE, including an appropriate physical examination, to recognise and identify the effects of psychotropic medication Mini-ACE of assessment of cognition, if not performed in CT1 Mini-ACE of assessment of the physical effects of substance misuse, if not completed in CT1	Mini-ACE to determine mood disturbance in a physically ill patient, if not completed in CT2 Mini-ACE of an examination of a child or a patient with learning disability including an appropriate physical examination, if not completed in CT2. This assessment must be conducted by an appropriate specialist

2 Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses			
	By the end of CT1 the trainee should demonstrate the ability to construct a formulation on an adult patient who has any of the	By the end of CT2, the trainee should demonstrate the ability to independently construct a formulation on adult patients who present	By the end of CT3, the trainee should demonstrate the ability to construct a formulation of patients with psychiatric

	common psychiatric disorders, including affective disorders; anxiety disorders; psychotic disorders; and personality disorders	with a full range of psychiatric disorders including disorders of cognitive impairment; substance misuse disorders; and organic disorders	disorders who have a learning disability or are children
2a Diagnosis	CBD of differential diagnosis in a patient with a common presenting problem	CBD in a person presenting to older adults service if not completed in CT1	CBD of differential diagnosis in a child or patient with learning disability, if not completed in CT2. This assessment must be conducted by an appropriate specialist
2b Formulation	CBD of an adult patient with a common presenting problem to describe the factors in the aetiology of the problem	CBD of an adult patient with a more complex problem, to describe the factors in the aetiology of the problem, if not completed in CT1	CBD to discuss the assessment of a child or patient with learning disability, if not completed in CT2. This assessment must be conducted by an appropriate specialist CBD to discuss the assessment of a child or patient with learning disability focusing on the possibility of maltreatment, neglect or exploitation, if not completed in CT2. This assessment must be conducted by an appropriate specialist

3 Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains			
	By the end of CT1 the trainee should demonstrate the ability to describe further investigations and negotiate treatment with an adult patient who has any of the common psychiatric disorders, including affective disorders; anxiety disorders; psychotic disorders; and personality disorders	By the end of CT2, the trainee should demonstrate the ability to describe further investigations and negotiate treatment on adult patients who present with a full range of psychiatric disorders including disorders of cognitive impairment; substance misuse disorders; and organic disorders	By the end of CT3, the trainee should demonstrate the ability to negotiate treatment options in more challenging situations and with patients with psychiatric disorders who have a learning disability or are children
3a Individual consideration	Mini-ACE negotiating a treatment plan or discussing investigations with patient, family and/or carers		Mini-ACE's discussing treatment options in more challenging situations such as with a reluctant patient, i.e. someone with limited insight, an acutely physically ill patient and a patient whose first language is not English, if not completed in CT2
3b Investigation	CBD to discuss planning investigations in an adult patient with a common presenting problem	CBD to discuss planning investigations in an adult patient with a more complex problem, if not completed in CT1 CBD of planning investigation of a person with suspected dementia or delirium, if not completed in CT1	CBD to discuss referral for specialist psychotherapeutic assessment, if not completed in CT2

3c Treatment planning	Mini-ACE and CBD, repeated several times, focusing on different conditions CBD to discuss psychological treatment of a case		CBD to demonstrate awareness of issues in prescribing in common physical disease states, such as liver or cardiac disease, if not completed in CT2 CBD of treatment planning for a child or a patient with learning disability, if not completed in CT2. This assessment must be conducted by an appropriate specialist
18c Alcohol and other drug use	CBD, Mini-ACE or ACE of giving brief advice concerning the effects of alcohol, tobacco and other drugs on health and wellbeing		

4 Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies			
	By the end of CT1, the trainee should demonstrate the ability to perform a competent risk assessment and construct a defensible risk management plan for an adult patient with a common psychiatric disorder	By the end of CT2, the trainee should demonstrate the ability to perform a competent risk assessment and construct a defensible risk management plan for an older adult patient and in more challenging situations	By the end of CT3, the trainee should demonstrate the ability to perform a competent risk assessment and construct a defensible risk management plan for patients with psychiatric disorders who have a learning disability or are children and be able to

			perform a competent assessment of a patient who may require intervention using mental health or capacity legislation
4a All clinical situations	Mini-ACE of risk assessment interview CBD of a risk assessment and management plan	Mini-ACE of risk assessment interview with an older person, if not completed in CT1	
4b Psychiatric emergencies	Several Mini-ACE's of assessing risk in emergency situations (A&E Departments, Crisis Team, out-of hours), at least one must be conducted by a consultant assessor	CBD of the assessment and management of a violent or other serious untoward incident. This may involve management of violence, absconsion or seclusion, if not completed in CT1	Mini-ACE of assessment for rapid tranquilisation, if not completed in CT2 CBD of an emergency in child or adolescent psychiatry or in the psychiatry of learning disabilities, if not completed in CT2. This assessment must be conducted by an appropriate specialist
4c Mental health legislation	CBD of emergency assessment		CBD or mini-ACE of using Mental Health legislation in relation to capacity and consent, if not completed in CT2 CBD of Mental Health legislation as applied to the mentally disordered offender
4d Broader legal framework			Clinical supervisor report

5 Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions			
	By the end of CT1, the trainee should demonstrate the ability to think in psychological terms about patients who have mental health problems and to foster therapeutic alliances	By the end of CT2, the trainee should demonstrate the ability to conduct a course of brief or long psychological therapy under supervision	By the end of CT3, the trainee should demonstrate the ability to conduct a second course of psychological therapy of a different duration and in a different modality from that conducted in CT2
5a Psychological therapies	CBDGA (Two in the year)	SAPEs for long or short case (must achieve at least satisfactory in all domains) see p.73 PACE for short and long cases	SAPEs for a different modality and duration from CT2 (must achieve at least satisfactory in all domains) see p.73 PACE for short and long cases CBD to discuss psychological therapy in routine psychiatric practice, if not completed in CT2

6 Demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan			
	By the end of CT1, the trainee should demonstrate the ability to properly record appropriate aspects of clinical assessments and management plans	During CT2, the trainee should continue to demonstrate the ability to properly record appropriate aspects of clinical assessments and management plans	By the end of CT3, the trainee will be able to describe the structure, function and legal implications of medical records and medico-legal reports
6a Record keeping	To be assessed every time a CBD is conducted (at least four in the year)	To be assessed every time a CBD is conducted (at least four in the year)	To be assessed every time a CBD is conducted (at least four in the year, one of which should include a medico-legal report that the trainee has written, this latter may be in 'shadow form')

7 Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states			
	By the end of CT1, the trainee should be able to describe long-term severe and enduring mental illnesses and the issues involved in the care and treatment of people with these problems	By the end of CT2, the trainee should demonstrate the ability to assess capacity in a person who has cognitive impairment and be able to construct a medication treatment plan of an older person's mental illness	By the end of CT3, the trainee should demonstrate the ability to construct a treatment plan for a patient who has a severe and enduring mental illness and for either a child or person with learning disability who has a long-term neurodevelopmental disorder

7a Management of severe and enduring mental illness	CBD of a review of the care or treatment of a patient who has a severe and enduring mental illness	Mini-ACE assessing capacity in a person with cognitive impairment, if not completed in CT1 CBD of psycho-pharmacological management of an older person's illness, if not completed in CT1	CBD of a care of a person who has a severe and enduring mental illness. The focus is to explore how well the trainee can understand the illness from the patient's point of view. May be completed in CT2 or CT3 CBD/mini-ACE of a care of a person who has a severe and enduring mental illness. The focus is the trainee's understanding of

			quality of life. May be completed in CT2 or CT3 Mini-ACE's assessing several aspects of capacity or changes in capacity in a single patient over time, if not completed in CT2 CBD to discuss understanding of the assessment of capacity and its consequences if not completed in CT2 ACE of history taking from a paediatric neuropsychiatry case or a child with ADHD or autism or a person with learning disability who has one of these problems, if not completed in CT2. This assessment must be conducted by an appropriate specialist CBD to discuss management of a child with a long-term condition or with a person with learning disability, if not completed in CT2. This assessment must be conducted by an appropriate specialist

8 To develop an understanding of research methodology and critical appraisal of the research literature			
	By the end of CT1, the trainee should demonstrate the ability to base their practice on best evidence		By the end of CT3, the trainee should demonstrate an understanding of basic research methodology and critical appraisal applied to the study of psychiatric illness and its treatment
8a Research techniques			JCP to demonstrate an understanding of basic research methodology, if not completed in CT2 JCP to demonstrate an understanding of the research techniques used in psychological therapies, if not completed in CT2
8b Evaluation and critical appraisal of research	JCP to demonstrate application of evidence to a clinical problem the trainee has encountered		JCP to demonstrate use of critical appraisal techniques, if not completed in CT2 JCP to demonstrate an understanding of the research base in psychological therapies and the particular difficulties in conducting research in this area, if not completed in CT2

9 To develop the habits of lifelong learning			
	By the end of CT1, the trainee should demonstrate the ability to use learning opportunities to the greatest effect	During CT2, the trainee should continue to demonstrate the ability to use learning opportunities to the greatest effect	By the end of CT3, the trainee should demonstrate the ability to use systems to maintain up-to-date practice and demonstrate an understanding of the relevance of professional bodies
9a Maintaining good medical practice		Supervisors' reports	Supervisors' reports Evidence of having passed all components of the MRCPsych examination.
9b Lifelong learning	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self reflection	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self-refection	An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self-reflection
9c Relevance of outside bodies	Evidence of continued GMC registration Evidence of registration with the Royal College of Psychiatrists	Evidence of continued GMC registration Evidence of registration with the Royal College of Psychiatrists	Evidence of continued GMC registration Evidence of registration with the Royal College of Psychiatrists

10 Demonstrate the ability to conduct and complete audit in clinical practice			
		By the end of CT2, the trainee should demonstrate the ability to perform and present an audit project	By the end of CT3, the trainee should demonstrate the ability to independently perform an audit project and apply its findings to the service as well as their own practice
10a Audit		Evidence of presentation of at least one complete audit project if not completed in CT1	Evidence of presentation of a second complete audit project demonstrating application to a service if not completed in CT2

11 to develop an understanding of the implementation of clinical governance			
	By the end of CT1, the trainee should demonstrate participation in clinical governance work, including an awareness of the importance incident reporting and knowledge of relevant clinical guidelines		By the end of CT3, the trainee should demonstrate the ability to deviate from clinical guidelines when clinically appropriate to do so
11a Organisational framework for clinical governance and the benefits that patients may expect	Supervisors' reports	Supervisors' reports	Supervisors' reports

12 To develop reflective practice including self reflective as an essential element of safe and effective psychiatric clinical practice.			
	By the end of CT1, the trainee should demonstrate self reflective recognition that the emotions of professionals in relation to their patients are valid and potentially important information with which to enhance their understanding of their patients.	During CT2, the trainee should continue to demonstrate reflective recognition in the responses of others of a variety of emotional perspectives different professionals take in relation to their patients and the impact of such differences in patient care.	By the end of CT3, the trainee should demonstrate a capacity to use self reflection to manage disturbance in patients with evidence of a change process in their understanding of the boundaries of safe and effective practice for them and others.
	Supervisor's report	Supervisor's report	Supervisor's report

13 Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances			
	By the end of CT1, the trainee should demonstrate the ability to competently conduct clinical interviews with patients	During CT2, the trainee should continue to demonstrate the ability to conduct clinical interviews with patients who have increasingly complex needs	By the end of CT3, the trainee should demonstrate the ability to conduct clinical interviews in increasingly challenging situations, including with children or people who have learning disabilities
13a Within a consultation	Mini-ACE's to demonstrate a skillful approach to communicating, including use of emotional	Two rounds of Mini-PAT	Mini-ACE or ACE of interviews with a child or patient with a learning disability, if not performed in CT2. This

	sensitivity Two rounds of Mini-PAT		assessment must be conducted by an appropriate specialist Mini-ACE/ACE of interview with a patient who has chronic delusions and hallucinations (if not completed in CT2) Two rounds of Mini-PAT

14 Demonstrate the ability to work effectively with colleagues, including team working			
	By the end of CT1, the trainee should demonstrate the ability to work effectively as a member of a mental health team	By the end of CT2, the trainee should demonstrate the ability to work effectively as a member of a mental health team that works with older people	By the end of CT1, the trainee should demonstrate the ability to work effectively as a member of a mental health team that works with children or with people who have learning disabilities
14a Clinical teamwork	CBD of patient who is being seen by other members of the MDT Two rounds of Mini-PAT Supervisors' reports	CBD of older person who is being seen by members of the older persons' CMHT, if not performed in CT1 Two rounds of Mini-PAT Supervisors' reports	CBD of child or patient with learning disability who is being seen by other health or social care agencies, if not performed in CT2. This assessment must be conducted by an appropriate specialist Two rounds of Mini-PAT Supervisors' reports

15 Develop appropriate leadership skills			
	By the end of CT1, the trainee should demonstrate the ability to take on appropriate leadership responsibility, for example by acting as rota coordinator	By the end of CT2, the trainee should demonstrate the ability to take on appropriate leadership responsibility in increasingly challenging situations, for example by acting as a representative on a working group	By the end of CT3, the trainee should demonstrate the ability to take a lead in an aspect of the work of a mental health team
15a Effective leadership skills	Two rounds of Mini-PAT Supervisors' reports	Two rounds of Mini-PAT Supervisors' reports	Two rounds of Mini-PAT DONCS/CBD focused on the trainee's participation in a multi-disciplinary meeting planning the care of patients, if not completed in CT2 Supervisors' reports

16 Demonstrate the knowledge, skills and behaviours to manage time and problems effectively			
	By the end of CT1, the trainee should demonstrate the ability to organise their work time in the context of a mental health service effectively, flexibly and	By the end of CT2, the trainee should demonstrate the ability to organise their work time more independently	By the end of CT3, the trainee should demonstrate awareness of the importance of continuity of care

	conscientiously and be able to prioritise clinical problems		
16a Time management	Two rounds of Mini-PAT	Two rounds of Mini-PAT	CBD focused on the trainee's contribution over a period of several months to the care of a patient with enduring mental health needs. May be completed in CT 2 or 3 Two rounds of Mini-PAT
16b Communication with colleagues	Two rounds of Mini-PAT Supervisors' reports	Two rounds of Mini-PAT Supervisors' reports	Two rounds of Mini-PAT Supervisors' reports
16c Decision making	Supervisors' reports	Supervisors' reports	Supervisors' reports
16d Continuity of care	Supervisors' reports	Supervisors' reports	Supervisors' reports
16e Complaints	Supervisors' reports	Supervisors' reports	Supervisors' reports

17 To develop the ability to teach, assess and appraise			
	By the end of CT1, the trainee should demonstrate the ability to construct an effective learning plan	By the end of CT2, the trainee should demonstrate the ability to participate in appraisal	By the end of CT3, the trainee should demonstrate the ability to teach in a variety of settings and to conduct assessments
17a The skills, attitudes, behaviours and practices of a competent teacher	An effective individual learning plan outlining learning needs, methods and evidence of attainment	As CT1	As CT1 Completed AoT forms with evidence of reflection on feedback, if not completed in CT2

17b Assessment			Evidence of assessing Foundation Programme Doctors and/or clinical medical students, if not completed in CT2
17c Appraisal		Record of discussion of educational supervisor's ARCP report	Record of discussion of educational supervisor's ARCP report

18 To ensure that the doctor is able to inform and educate patients effectively			
	By the end of CT1, the trainee should demonstrate the ability to advise patients about the nature and treatment of common mental illnesses, so the patient may be more able to participate in their treatment and the ability to advise patients about environmental and lifestyle factors and the adverse effects of alcohol, tobacco and illicit drugs		By the end of CT3, the trainee should demonstrate the ability to help a patient with a relapsing illness construct a relapse prevention plan.
18a Educating patients about illness and its treatment	Mini-ACE or CBD of advising a patient about the nature and treatment of their illness		Mini-ACE of negotiating a relapse prevention plan, if not completed in CT2 CBD around a patient with an enduring mental health problem focused on the trainee's understanding of how services may perpetuate and reinforce stigma.

			May be completed in CT2 or CT3
18b Environmental and lifestyle factors	Mini-ACE or CBD of advising a patient on environmental and lifestyle changes		

19 To ensure that the doctor acts in a professional manner at all times			
	By the end of CT1, the trainee should demonstrate an understanding of the tensions that can exist in the doctor patient relationship, issues relating to confidentiality and the sharing of information, professional codes of practice and conduct and responsibility for personal health		By the end of CT3, the trainee should demonstrate skills in limiting information sharing appropriately, skills in obtaining consent and performing a risk assessment in children or people with learning disabilities who have a mental health problem
19a Doctor patient relationship	CBD to demonstrate understanding of the emotional and professional tensions that can exist in the doctor patient relationship,		
19b Valuing diversity	CBD to demonstrate awareness of the impact of cultural factors on practice. Reflective practice notes Supervisors' report		CBD to demonstrate a critical awareness of the impact of institutional practices on personal clinical practice in the area of cultural diversity, if not completed in CT2 Reflective practice notes

			Supervisors' report
19c Confidentiality	CBD to demonstrate appropriate sharing of information		CBD to demonstrate capacity to limit information sharing appropriately, if not completed in CT2
19d Consent	Mini-ACE of obtaining consent for treatment of a psychiatric disorder		Mini-ACE of obtaining informed consent in a child or patient with learningdisabilities , if not completed in CT2. This assessment must be conducted by an appropriate specialist
19e Risk management	CBD of risk assessment and management of an adult patient with a common psychiatric problem		CBD of risk assessment and management in an adult patient with a more complex psychiatric problem, if not completed in CT2 CBD of risk management in a child or patient with learning disabilities , if not completed in CT2. This assessment must be conducted by an appropriate specialist
19f Recognise own limitations	CBD to demonstrate an appreciation of the extent of one's own limitations		
19g Probity	Supervisors' reports	Supervisors' reports	Supervisors' reports
19h Personal health	Supervisors' reports	Supervisors' reports	Supervisors' reports

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR207

Safe patients and high-quality services

Job descriptions for consultant psychiatrists

COLLEGE REPORT

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For full details of reports available please visit the College website at www.rcpsych.ac.uk/publications/collegereports.aspx

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Contents

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Introduction

The role of a consultant psychiatrist is changing, in line with the wider recognition that the management of mental and physical well-being of our patients is an inextricable aspect of our care for the whole person. Psychiatrists have been at the forefront of driving integrated practice and have used their skills and knowledge to develop innovative services that better meet the needs of patients and their carers. The guidance in this document is provided to support such changes, innovation and service development (Academy of Medical Royal Colleges, 2012a).

There is a clear expectation and demand from patients and carers for more time from their psychiatrists, and for the relationship to be one of partnership and co-production. The psychiatrist plays a key role in understanding the patient's diagnosis and formulation, their needs and wishes, and the adaptations and treatments that might be needed to allow the patient to achieve those. To undertake this work to a satisfactory standard the psychiatrist requires sufficient time to spend with their patients.

Psychiatrists welcome and value the work done by other professionals within a multidisciplinary team. It has never been the case, nor should it be, that all patients need to see a psychiatrist. However, it is expected that patients with more complex needs and those who present a significant risk to themselves or others should have the support of a psychiatrist in their assessment, care planning and, where appropriate, ongoing care. Again, psychiatrists need to have sufficient training and time to undertake this important work.

The guidance set out in this document is designed to help psychiatrists and service managers determine how to meet these aspirations within the resources available. The guidance is designed with a focus on providing safe and high-quality services for patients and their carers. Services will, of course, vary in different settings and in different parts of the country. However, the parameters set in this document should guide those responsible for the commissioning, provision and delivery of services.

Clinical role

The consultant psychiatrist is a highly skilled clinician who has been trained to deliver expert clinical care, ensuring the delivery of safe, high-quality services for patients. The clinical role of a consultant psychiatrist sits alongside other important roles, including inspiring and training the next generation of doctors and mental health professionals. Consultants are at the forefront of research and innovation and play a significant part in the running of successful organisations.

Whatever the subspecialty in psychiatry, the primary duty of a consultant is to care for patients. The consultant psychiatrist has particular expertise in diagnosis and treatment of long-term mental health conditions and their interface with physical ill health. The ability to diagnose, formulate and manage complex and severe disorders is an important skill of the consultant psychiatrist and is of direct benefit to patients and carers, and also supportive to the wider multidisciplinary team.

The consultant psychiatrist has a role as the personal physician for a group of patients, not only those with complex and severe disorders, but also those for whom the particular skill-set of the psychiatrist is important. This may include medication management, physical well-being in the face of long-term conditions, and engaging constructively in a shared care discourse. This is alongside the role of offering expert advice and leading in the care pathway planning, assessment and support for patients cared for primarily by other members of the multidisciplinary team.

The consultant psychiatrist has a key role in the implementation of legislation providing a framework for the care and treatment of people with mental illness, acting as a responsible clinician or medical officer, participating in statutory reporting and informing the potential mental health review tribunals, and supporting the assessment of patients who may require detention in hospital. Although other professionals also play key roles in some of those areas, it is necessary that the consultant psychiatrist has sufficient time to discharge the responsibilities under the legislation.

The consultant psychiatrist has an increasing role in the oversight and implementation of mental capacity legislation and the interface of this act with other legislative frameworks. The consultant psychiatrist requires enough time to undertake assessments and reports in support of the lawful implementation of legislation such as the Deprivation of Liberty Safeguards.

Benefits of consultant psychiatrist care

The key benefits of consultant-delivered care can be summarised as:

- rapid and appropriate decision-making
- improved outcomes
- more efficient use of resources
- general practitioner (GP) access to a consultant opinion
- access to skilled clinical opinion.

Consultants should play a key role, where appropriate, in ensuring that:

- patients receive a thorough assessment of their circumstances, taking account of their history and current situation;
- patients are given a clear diagnostic formulation that is in line with internationally recognised standard classificatory systems, the DSM (American Psychiatric Association, 2013) and the ICD (World Health Organization, 1992);
- patients are given a clear understanding of how this formulation might affect their need for care and treatment, and are informed of treatment options that are available to them;
- patients are supported to develop a set of realistic recovery goals and a care plan that will allow them most appropriately to reach these goals; and
- patients with enduring illnesses are provided with continuity of care.

Leadership role

Psychiatrists bring an important perspective to the leadership of an organisation. This includes their expertise regarding the prevention, cause and treatment of mental and physical illness; their understanding of healthcare systems; their familiarity with evaluating complex information and evidence while managing uncertainty; and their links with external partners and stakeholders. Importantly, psychiatrists will often have experience from working within an organisation over many years. This 'institutional knowledge' can be vital to ensure an organisation is aware of its past when planning the future.

Due to the nature of delivery of healthcare interventions, particularly for mental health conditions, psychiatrists work in teams that bring together members from other professions. In that position, psychiatrists are likely to be the most senior members trained in the diagnosis and treatment of mental disorders and therefore have a key role in the clinical leadership of treatments these teams deliver.

Through the continuous personal development framework psychiatrists are most up to date with the evidence-based treatments that should be provided and thus they should also play a key role in leading service and quality improvement locally, regionally and nationally. Organisations need to work actively on medical engagement, internal decision-making and job-planning processes to ensure that psychiatrists are able to provide input into regional and national bodies, including local commissioning groups, the Royal College of Psychiatrists, universities and the National Health Service (NHS). Support for this work comes from the General Medical Council, chief medical officers and the national Departments of Health.

Psychiatrists invariably work in multidisciplinary teams. They provide senior clinical leadership and expertise which should optimise the performance of the team, helping to ensure that the care needs and safety of patients are appropriately met. This leadership may be expressed in formal roles but also experienced more informally via the psychiatrist's actions, integrity, values, credibility and consistency. Working in teams can be both rewarding and stressful and psychiatrists will often play an important role in supporting and promoting a positive culture. They are often uniquely positioned to help identify and resolve complex problems and support staff through change.

Consultant psychiatrists will also lead and manage teams in a way that supports the development of a culture of continuous improvement and learning. Again, this may occur in a variety of ways and at different levels within the organisation. Psychiatrists should promote reflection and review of standards, performance and policies.

Participation in clinical audit and quality improvement systems will be important. Consultants should offer expertise in the evaluation and management of risk and patient safety and should contribute to the review of near misses, adverse events and critical incidents. They should help promote standards in information governance systems, confidentiality and privacy. This may include:

- Ensuring that the voice of patients and carers is captured and listened to.
- Facilitating regular time and space for team reflection.
- Monitoring quality and performance of the service through tracking key measures over time.
- Involving a wide range of stakeholders and data/information in helping the team identify their key improvement priorities.
- Utilising the quality improvement approach to think systemically about complex problems, developing potential change ideas and testing these in practice using the organisation's quality improvement framework.
- Deploying resources to identified and agreed quality improvement projects and supporting staff in finding space and time for quality improvement.
- Supporting team members in developing an appropriate level of skill in quality improvement.
- Empowering the team to resolve local issues on a daily basis using the tools and methods of quality improvement without staff having to seek permission.
- Promoting awareness and understanding of quality improvement, and sharing learning and successes from quality improvement work.
- Taking a lead role as mental health experts in their local communities and work with primary care and local authorities, the third sector, patient/carer groups and employers to improve public mental health and reduce stigma.

Educational and academic role

All consultants will have important roles in education, training and supervision. These roles may focus on medical students, doctors in training and other healthcare professionals. Consultants will often have a key role in sharing knowledge with patients and carers so as to optimise joint decision-making. The majority of consultant psychiatrists will not have a formal academic role but the NHS Constitution stresses the importance of helping patients participate in research should they wish to do so. Psychiatrists can have an important role in facilitating this outcome within their services.

Consultant psychiatrists need to consider these roles both in terms of their own education and in terms of the education they provide to others including patients, carers and colleagues, both medical and non-medical.

Each consultant is committed to individual life-long learning to ensure that they keep up to date in the skills required for their role; this forms part of the NHS appraisal process. Continuing professional development (CPD) includes mandatory training that is required by the employing organisation as well as the mandatory training required for specific roles that the consultant may hold, for instance a clinical and/or educational supervisor.

The consultant should have a responsibility for training of not only medical colleagues, including medical students and doctors in training, but also members of other professions.

The consultant has a key role, in partnership with patients and their carers, including young carers, to explain in straightforward language the treatment options alongside the potential risks and benefits for interventions that are being considered.

Developing a better understanding of illness and pursuing more effective treatments is an intrinsic part of the role of the consultant psychiatrist. The breadth of training and education in basic sciences, as well as in social and psychological sciences, and experience gained in research techniques uniquely positions the consultant psychiatrist to work in this area.

A more detailed description of the consultant psychiatrist's role is given in an occasional paper published by the Royal College of Psychiatrists (2010). The College also provides a tailored programme of support and guidance for new consultants called StartΨell (www.rcpsych.ac.uk/workinpsychiatry/newconsultantsstartΨell.aspx).

Job descriptions and job plans

The Royal College of Psychiatrists provides an important service to those employing consultant psychiatrists by reviewing new job descriptions and offering advice to ensure that they are of a standard that enables the consultant to deliver high-quality care. As the NHS evolves and the pressures on services increase, these job descriptions can be complex and introduce new models of care. The information in this document will assist those drawing up and reviewing job descriptions as to the standards expected.

Within the NHS, the consultant timetable is agreed through a process of job planning. The British Medical Association & NHS Employers (2011) have produced a guide to consultant job planning to facilitate and improve this process. The information in this document should assist those involved in job plans by providing guidance about workload factors that will influence the ability of the consultant psychiatrist to effectively deliver safe and high-quality services.

Increasingly, employer organisations are using electronic job planning tools to record job plans. These tools can be helpful in recording clinical activity and collating necessary information before the job planning meetings and can be linked to appraisals.

There is always a need for flexibility in agreeing a job plan according to local needs and circumstances, but the College is setting guidelines that it believes provide satisfactory levels of safety for patients and services. Organisations should have clear and justifiable reasons for deviating from these guidelines in the job planning process. Increasingly, organisations are using IT-based tools to record clinical activity and performance against measures of quality and safety. These tools are generally helpful but require context and discussion during the job planning process, for example considering the workforce, gaps in the service and admin support available to the consultant. Most consultants also use supporting professional activities (SPA) time to carry out audits, teaching, training and service development work. This work needs to be acknowledged within the job planning discussion.

As services evolve and more integration takes place, there are increasing demands on medical staff to carry out physical health checks on patients under the care of psychiatric services. These physical examinations and interventions require extra clinical time during clinics and training time to develop skills in managing these patients. These

extra clinical demands also need to be taken into consideration during the job planning meetings.

In some specialties, for instance intellectual disability and child and adolescent mental health services (CAMHS), a care and treatment review (CTR) process has also been introduced (NHS England, 2015). These meetings involve health and social care professionals working together to avoid admission or facilitate early discharge. They are usually led by commissioners. These meetings have a significant impact on the consultant workload, depending on their frequency.

Rehabilitation, forensic, old age, CAMHS, general adult, intellectual disability and perinatal psychiatry can have patients in out-of-area placements and there is an expectation that consultants from the local area would maintain an oversight of these patients and try to bring them back under the care of local services as quickly as possible. This requires considerable liaison and coordination between services, which can be time consuming, and needs to be taken into account during a job planning cycle.

Many psychiatrists work in the independent sector. The standards and guidance in this document will be equally relevant to them. Programmed activities (PAs) is an NHS term but one PA equates reasonably well to a half-day session.

General principles

1. There should be sufficient consultant capacity and clarity of arrangements to provide the range of activities required, allowing for routine, emergency and out-of-hours work as well as cross-cover arrangements.
2. Job descriptions and job plans should be drawn up in a way that provides the consultant with sufficient time to undertake their roles and responsibilities in a safe way and to a high standard.
3. Job descriptions and job plans for consultant psychiatrists should be flexible enough to ensure that they are able to provide consultant-type activity in an immediate and responsive way. This includes the ability both to respond to immediate clinical requests, for example from team members, and to deal quickly with educational and management tasks. These issues occur unpredictably throughout the working week.
4. Supporting professional activities (SPAs) are vital to safe and effective practice. The standard for full-time (10 PA) posts (excluding posts in Wales) would be an allocation of 2.5 SPAs, with all less-than-full-time posts having a proportionate allocation of direct clinical care and SPAs, with a minimum of 1.5 SPAs for the purposes of appraisal and revalidation.
5. The consultant contract in Wales was amended on 1 December 2003 in an agreement between the BMA Cymru Wales, the Welsh

Assembly Government and NHS health in Wales. The principle amendments include:

- a basic 37.5 hour working week;
- typically 7 sessions of direct clinical care; and
- session duration of 3–4 hours.

6 Additionally, the Mental Health (Wales) Measure 2010 seeks to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs and it places new legal duties on local health boards and local authorities to improve service delivery.

7 Many factors affect the effectiveness of the role of the consultant and it is important that these factors are considered during job planning. They include the availability of other clinical and administrative staff working alongside consultants, and the working environment available to consultant psychiatrists. Further guidance on office accommodation is available in College position statement PS06/2016 (Royal College of Psychiatrists, 2016). Consultants working without sufficient administrative support will be forced to undertake such tasks at the expense of the activities for which they are trained and which they wish to deliver. Consultants working with less support from training grade and specialty doctors will need sufficient time to undertake the tasks which could otherwise be delivered by those doctors. Consequently, consultants working in well-resourced mental health teams will be able to focus on patients with more severe and complex disorders, whereas if there is only limited availability of other professional skills the consultant will provide direct care to a broader patient cohort.

8 The recruitment and retention of consultants requires careful strategic planning. Flexibility and variety in job planning is an important ingredient of making this a long-term success. Where feasible, consideration should be given to supporting consultants develop and contribute their expertise to the NHS. This may be in areas of clinical, educational, management and research work. Job descriptions that offer greater variety of these roles may also offer advantages in terms of job satisfaction and supporting resilience, especially posts associated with high turnover of staff. For example, in-patient adult psychiatry posts may be better sustained by designing posts that have 5 or 6 PAs based on the ward (excluding the standard allocation of 2.5 SPAs), the remaining PAs focused on an area of special interest, such as medical education, research, management or alternative clinical roles.

9 The demands of a consultant job role will be affected by geographical factors and the wider health economy where the consultant works. Sufficient time must be included within job plans to reflect these factors and to allow the doctor to undertake their work to a high standard.

10 Where the job description goes beyond the immediate specialty of the post-holder, it should refer explicitly to:

- cross-cover between subspecialties, including on-call arrangements;
- locally agreed responsibilities for extended age range, including children and young people's services; and
- agreed responsibilities for physical healthcare beyond those routinely undertaken by a psychiatrist.

11 Cross-cover arrangements need to be clearly spelled out in job descriptions. The College notes that there has been a widespread move towards provision of 7-day services. This is a laudable move. However, it is important that job plans explicitly provide for like-for-like cover for planned absences such as study leave and CPD leave. Similar like-for-like cover should be available for less-than-full-time consultants. Contingency arrangements for unplanned leave with appropriate and adequate cross-cover should also be specified explicitly. This will ensure that high-quality patient care is available 7 days a week even when the consultant is on leave.

12 Job planning needs to be a transparent and open process. Individual appraisals are private discussions but individual job plans need to be publicly available to:

- assure that the job is doable and sustainable;
- ensure that patients are receiving care to appropriate standards;
- determine the level of medical and allied health professional staffing needed to make the job viable;
- provide assurance that different jobs within the team or organisation are equitable and adequately supported; and
- allow some degree of flexibility in job planning over the annual cycle.

13 Clear line management for the post-holder should be provided to ensure optimal performance and support. Professional line management of doctors should be conducted by a single named individual who should usually be a medical professional. Operational line management will be determined by the service configuration and needs. Arrangements should be clear and unambiguous.

14 Arrangements to support the safe provision of these services should include the allocation of additional CPD opportunities where the skills and experiences differ significantly from those covered within the RCPsych curriculum. No consultant should be expected to work beyond their level of training and competency.

Specific tasks

This section sets out in general terms the roles that may be undertaken by a consultant psychiatrist, with examples of tasks included within the role. These are not the only roles undertaken but provide a framework for considering in a job description. Different jobs will have a different balance of tasks. Specific roles for each subspecialty are included in the subspecialty sections that follow.

Clinical roles

Abbreviations used in the tables: CMHT, community mental health team; CPA, care programme approach; CPD, continuing professional development; GMC, General Medical Council; GP, general practitioner; MAPPA, multi-agency public protection arrangements; NHSE, NHS England; NHSI, NHS Improvement; NICE, National Institute for Health and Care Excellence; NIHR, National Institute for Health Research; QI, quality improvement; RCPsych, Royal College of Psychiatrists; WPBA, workplace-based assessment

Community roles	
Role description	**Tasks**
New out-patients or home visits, including meetings with relatives (including children) and carers	Assessment, diagnosis and formulation of management plan Shared decision-making with patients and carers
Follow-up out-patients or home visits	Ongoing review of formulation and management plans Shared decision-making with patients and carers
Team meetings	Communication about patients and carers, sharing organisational policies and objectives
Multidisciplinary patient reviews	CPA, MAPPA, safeguarding, risk reviews, care and treatment reviews
Clinical advice to team members	Regular or *ad hoc* supervision on clinical matters
Liaison with colleagues	Discussion about patient care with primary care, secondary care and colleagues in other psychiatric teams
Mental health and capacity legislation	Meeting the requirements of emergency work, community treatment orders, assessments of capacity
Clinical administrative tasks	Including rating of outcome measures, cluster allocation, completion of risk assessment tools, recording of capacity assessments etc.
Physical health support to patients	Including monitoring of physical parameters and lifestyle and motivational advice pursuant to the well-being of the patient

In-patient roles	
Role description	**Tasks**
Direct clinical work with patients and carers, including young carers	Assessment, diagnosis and treatment Ensuring physical health is considered alongside psychological and social issues. Shared decision-making with patients and carers
Multidisciplinary reviews	Patient assessments, CPA reviews, MAPPA meetings, risk reviews
Clinical team meetings	Decision-making meetings Reviewing daily workload
Mental health and capacity legislation	Assessments, report-writing, attendance at mental health tribunals and managers' hearings, assessments of capacity
Clinical advice to team members	Regular or *ad hoc* supervision on clinical matters
Liaison with colleagues and other services	Speaking with other professionals involved in patient care – primary care, CMHTs, general hospitals

Leadership roles	
Role description	**Tasks**
Leadership role	Implementing and reviewing standards, innovation in service delivery, clinical governance, patient safety, modelling high-quality patient care, supporting colleagues, building relationships with GPs and other external organisations
Lead clinical roles[1]	Provide leadership role for specific and defined areas of development or practice Provide appraisal and job planning support to other consultants
Lead consultant	Provide leadership and often line management for consultants and other medical staff within the service, often lead for quality within a directorate
Clinical director	Similar role to that of lead consultant, often including wider management responsibilities including budgets; drive clinical strategic developments within a service area
Medical director	Senior medical leadership role within an organisation usually including the responsible officer role as well as a wide range of corporate roles
Regional and national leadership	RCPsych roles, Department of Health advice, work for Care Quality Commission and NICE, support for NHSE and NHSI directorate activities
Most consultants	Leadership of clinical teams, safety and quality, QI work and audits

1. For example, audit, risk, patient safety, Mental Health Act work, information governance, clinical governance, specific service development.

Educational and academic roles	
Role description	**Tasks**
Supervision of trainees and non-consultant doctors	Each trainee requires 1 hour of trainee-centred educational supervision per week Additional supervision will be required for clinical work; other non-consultant doctors require at least monthly supervision Clinical and educational supervisor; support for revalidation and annual portfolio review through WPBA
Meeting requirements for revalidation	Revalidation activities including CPD and QI activities and reflection on serious incidents
Organisation of academic programmes[1]	College tutor, director of medical education, programme director, head of school
Examination roles	RCPsych examiners, developing curriculum and examinations
Training medical students	One-to-one and small-group teaching, lectures, examining and skills-based workshops, education
Education	Lectures, small-group teaching, skills workshops, work with Health Education England, the Northern Ireland Medical and Dental Training Agency and the GMC
Research	Clinical, service and basic science research, peer reviewing of papers, grant applications, trust research and development activities, Involvement with clinical research networks and other NIHR activities, partnership with universities, academic health science networks

1. Including department programme, trainee doctor programme, medical student programmes, college tutor and deanery roles.

Job descriptions and job plans in this document are built around a full-time post being 10 programmed activities (PAs) per week, of which 7.5 are for direct clinical care. The College recognises that this terminology applies only to psychiatrists working in NHS services, however, the principle of a PA being equivalent to a half-day session and the expectation that a consultant psychiatrist provides important roles alongside direct patient care applies equally well to other settings for service delivery.

The College accepts that there are financial pressures on organisations to increase the productivity of all staff, including consultant psychiatrists. The College believes, however, that moving away from the ratio of 7.5 direct clinical care PAs to 2.5 PAs for supporting professional activities is a false saving. Organisations that seek to reduce the number of supporting professional activities for consultant psychiatrists risk losing the expertise of these individuals with key roles in education, leadership, innovation, service development and acting as ambassadors of the organisation in links with primary care and other services. These are roles vital for the success of any healthcare organisation.

Although much of the guidance in this document is about expectations for direct face-to-face care, the College recognises that there are other forms of communicating with patients and their carers that are not only acceptable but may be more convenient, including telephone contact and, with appropriate safeguards, email and other forms of

electronic communication. The College strongly supports the principle that communication with patients and carers should be flexible and convenient for them. Sensible local discussions can be held as to the necessary time to undertake this work to an appropriate standard.

Training

Consultants supervising core training grade doctors or GP training doctors should have 30 min per new patient to review the patient and discuss the formulation and management with the trainee doctor. There should also be time at the end of each clinic to go through the ongoing management plans of patients seen for follow-up.

Consultants should have 0.5 PAs in their job plan for each training grade doctor they supervise, reflecting the formal 1 h of supervision required each week, the additional *ad hoc* supervision and administrative tasks needed for training, including clinical and educational supervisor's roles. There are additional training requirements to maintain the clinical and educational supervisor roles. These educational requirements also include giving lectures on MRCPsych courses, attending annual reviews of competency progression (ARCPs) and performing selection interviews.

Research and innovation

Consultants can play a key role in leading research and innovation for patient benefit. For some, this will be a very significant part of their role. However, all consultants should be expected to support research and the careful evaluation of new treatments and methods of service delivery.

General adult psychiatry

General adult psychiatrists form the core of mental health services. They usually work in a multidisciplinary team and are based in the community or in-patient unit, or both. Some general adult psychiatrists work with defined groups of patients at certain stages of the patient journey, for example in crisis (crisis response and home treatment teams (CRHTs)), in a first episode of psychosis (early intervention) or with those who have proven difficult to engage elsewhere (assertive outreach).

Over the past decade many, if not most, mental health providers across the UK have adopted a 'functionalised' model of care, which involves splitting community and in-patient care. Such a split does offer some benefits, most notably in the in-patient setting, with fewer consultants responsible for patient care on busy in-patient units. However, for the patient this introduces a significant interface in their care pathway. This interface has the potential of creating a significant discontinuity in the care provided to patients, and appropriate planning to manage this interface needs to be explicitly specified in job descriptions where functionalised models of care have been adopted.

Clinical role

The volume of clinical work has grown dramatically since the previous Adult Psychiatric Morbidity Survey in 2007. The latest survey (NHS Digital, 2016) uncovered an increase in common mental disorder rates in women; increase in self-harm in men and women; emergence of young women as a high-risk group with high rates of self-harm, post-traumatic stress disorder (PTSD) and bipolar disorder. Particularly high rates of common mental disorder are seen in those claiming UK government's Employment and Support Allowance (ESA) and there has been an increase in service use in this group, from one in four to one in three. Black and minority ethnic individuals are less likely to be in receipt of treatment. These factors need to be considered in job plans, and the traditional reliance on using population figures as a guide may therefore need to be more nuanced, to include guidance on case-loads as well as case mix (numbers of patients with illnesses in the more severe clusters) and population demographics (age, gender, ethnicity etc.).

Population figures may mask factors that determine case-loads, for instance presence of nursing homes, bail hostels, supported rehab care placements. For example, for general adult psychiatrists in

England, Wales and Scotland, a few patients on community treatment orders (CTOs) can add significantly to a consultant's workload.

Job plans should make express reference to quality benchmarks, such as National Institute for Health and Care Excellence (NICE) quality standards. Reference to specific benchmarks, for example the expectation that community consultants need to be able to individually review patients every 2–4 weeks while their drug treatment is being changed should help determine viable case-loads.

Safe and effective working with patients depends on the presence of an effective multidisciplinary team. General adult psychiatry is facing a significant recruitment crisis and it is not unusual for trusts to rely on locum medical staff and agency nursing staff for service provision. Some of the locum medical staff may not be qualified to supervise junior medical staff and short-term locums are usually not involved in management activities, which may add to the workload of substantive staff. These factors need to be borne in mind when designing and approving job plans.

- **Agency staff** in mental health teams can hamper continuity of care and can be especially anti-therapeutic for patients with personality disorders, who are forming a larger proportion of case-loads in both community and in-patient settings.
- Safe and effective delivery of clinical services is underpinned by a **good clinical administrative system**. Electronic patient records have become quite commonplace and digital dictation is becoming the norm. With that has come a move towards rationalising administrative support in various organisations. However, as consultant roles become busier with greater clinical case-loads, it is vital that administrative support is viewed in all its complexity and not reduced to a 'typist' role. Rather, it should be seen as support to help consultants prioritise their time, ensure deadlines are met and, more pertinently, help consultants manage their busy case-loads.
- **Performance dashboards** can play a significant role in improving the effectiveness of clinical care and are increasingly becoming available to consultants. Adequate time needs to be provided in the job plan to enable consultants to engage with and make the most of electronic patient records.

Leadership role

Consultant general adult psychiatrists play a key role in modelling high-quality patient care, in building relationships with key stakeholders of the local health economy (such as GPs, Social Services and other community-based stakeholders), and in driving continuous quality improvement, all to ensure that patients have a caring, responsive and safe pathway of care.

In a standard 10 PA job plan, of the 2.5 SPAs, it is estimated that 1.5 SPAs will be needed to meet CPD, appraisal and revalidation requirements. Good job planning should lead to 1 SPA being used specifically for clinical leadership roles with linked SMART (specific, measurable, attainable, relevant and time-bound) objectives. The effectiveness of this SPA can be increased by engaging in a team job planning process. Team-based job planning is particularly relevant to community mental health teams where different sectors can show significant variations in morbidity, referral rates and the level of community support available. Such team-based job planning should allow more equitable allocation of resources and better use of individual consultants' leadership SPAs to help deliver team-based SMART objectives (smoking cessation, improving physical healthcare outcomes for patients etc.).

Educational role

There is an increasing demand on consultant time in educational matters, and this is encroaching on protected teaching time. It is important to ensure that job descriptions take into account the different grades of trainees. For example, foundation trainees may need additional support, especially in a 4-month placement, compared with higher specialist trainees. College guidance suggests allocating 30 min per new patient for discussion with core trainees/GP trainees and foundation trainees. This is in addition to the protected weekly clinical supervision time. On an in-patient unit, a consultant may be the supervisor for multiple trainees/specialist grade doctors. The educational role of the consultant in such cases will require additional time and this needs to be reflected in their job plan. It needs to be borne in mind that protected teaching and clinical supervision time may often be required in clinical settings such as out-patient clinics.

Information to support job descriptions and job plans

Full-time community posts

The clinical work of a community-based general adult psychiatrist can be broken down as set out below. The allocation of these tasks within a job description will depend on the clinical role expected of the consultant and the other staff available to undertake a proportion of these tasks.

- It is reasonable for a full-time community consultant to have 5 PAs per week for **direct patient care** in out-patient or community assessments.
- **New patients in the out-patient clinic** require 1 h for an appointment. Follow-up appointments require 30 min. Clinics should be structured so that only 3 of the 4 hours of PA are booked in with

routine patients, allowing space for urgent cases, liaison with other professionals and the completion of administrative tasks not finalised during the allocated time for each patient.

- Time within a job plan should be allocated for patients to be seen outside routine out-patient settings for those who are unlikely or unable to attend. Additional time must be allocated for travel for those off-site **visits**.
- Time within a job plan needs to be made available for **emergency assessments in the community** if they are to be undertaken by consultant staff. If such assessments are to be undertaken by other members of the multidisciplinary team, time should be available in the consultant's job plan for the clinical support and supervision of decisions made. A minimum of 1 PA per week is likely to be required for emergency work.
- Time needs to be identified within the consultant job plan for the consultant to be available for the **community team** to discuss issues that might arise with patients and, if appropriate, to review patients about whom there are particular concerns.
- Multidisciplinary working includes a weekly **multidisciplinary team meeting** to discuss patient care – this requires 0.5 PA. An additional 0.5 PA should be included in the job plan for support and advice to members of the multidisciplinary team about patient care outside the team meeting.
- All community job descriptions must include **case-load analysis** that should provide some information on the number of new referrals, break-down of numbers of cases by clusters/diagnosis and, where applicable, average numbers of patients on a community treatment order (CTO) over the past 1–3 years. This should be accompanied by an indicative follow-up timetable that should allow the calculation of a viable case-load range for the job. Ideally these calculations should be mapped to NICE or similar quality standards to ensure that patients are receiving high-quality care (e.g. patients undergoing medication change need to be reviewed every 2–4 weeks).
- In Northern Ireland, patients under promoting quality care (PQC) will need more frequent reviews and multidisciplinary meetings and this should be factored into job plans.
- For **mental health legislation work**, including CTO work, and for attendance at multidisciplinary **complex patient reviews**, a minimum of 0.5 PA per week is required. Patients placed on a CTO may need more frequent reviews to determine the need for CTO renewal or capacity assessments and they also require regular reports for tribunal and managers' hearings. This means that on average about 0.5 PA should be allocated for 3–4 patients on CTOs depending on complexity and the number of tribunal hearings.
- If an employer required a consultant to spend more time undertaking emergency work, participating in multidisciplinary patient reviews, or if the number of patients on CTO exceeds the pro

rata time allocation, this would need to be offset by a **reduction in out-patient clinics and home visits**.

- Most jobs will need **1 programmed activity (PA) for clinical administration**. Most clinicians are reporting a significant increase in clinical administrative duties, including dealing with the rising number of requests for housing support, Driver and Vehicle Licensing Agency (DVLA), occupational health, incapacity benefit and personal independence payments (PIP, formerly disability living allowance (DLA)) assessments, to name a few. Less-than-full-time consultants will require a proportionally greater amount of clinical administration time and SPA time.

Model job plan for a full-time community general adult consultant	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work/home visits	4
Clinical administration	1
Multidisciplinary team meeting/support for team members outside the meeting	1
Emergency clinical work	1
Mental Health Act work/complex patient reviews	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Full-time in-patient posts

- In-patients are the most unwell individuals in the service. It is expected therefore that each consultant should have sufficient time within their timetable to personally review each patient at least once a week. Consultants should have time to **visit the ward each day** in order to be available for day-to-day decisions requiring consultant input.
  - There are different models of providing consultant input into in-patient wards, with some teams having brief daily reviews of workload, following which team members see patients individually and implement the decisions made. In other areas, more traditional ward rounds take place, with patients being reviewed by multidisciplinary teams.
  - All full-time in-patient jobs are likely to require 5 PAs of **ward-based clinical activity** which are allocated to both clinical team meetings and direct contact with patients. The exact nature of the work will reflect the mix of patients on the ward.

- All in-patient consultants spend a significant amount of time on **mental health legislation work**. Organisations must make judgements, based on previous experience, as to the amount of time this involves for each consultant. Each statutory hearing or tribunal is likely to require 1 PA both in the preparation of the report and attendance at the tribunal (a total of 2 PAs). This work is likely to require a minimum of 2 PAs per week for all in-patient consultants. However, the increase in approved clinician, or responsible medical officer, work and the tendency towards longer and more complex tribunals may mean that 2 PAs for in-patient consultants may not be adequate.
- **Other clinical administrative tasks** concerning in-patient care (e.g. unscheduled telephone calls, correspondence, checking of blood tests) require 0.5 PAs per week – this is spread throughout the week.
- In-patient consultants would expect to work alongside and support junior colleagues, year 1–3 core trainees (CT1–3) and/or specialty doctors, who would be able to undertake some of the medical tasks required with appropriate supervision. However, this needs to be balanced with time required for additional clinical supervision. With the expansion in foundation training placements in psychiatry, many in-patient units provide placements for F1 and F2 trainees. These trainees require closer supervision and this needs to be factored into the consultant's job plan.
- Principles of case-load analysis discussed for community psychiatrists also apply to in-patient consultants. Some units in the country operate assessment wards with rapid turnover of patients. These patients require fuller initial assessments with more frequent assessments before triaging to an appropriate longer-stay unit if needed. An analysis of numbers admitted, length of stay, numbers discharged, numbers of involuntary admissions, numbers of patients lacking capacity etc. should allow calculation of a viable timetabled job plan. Similar principles apply for specialist in-patient units such as mood disorder or personality disorder units.
- Wards differ according to the complexity and illness of patients – patients with shorter lengths of stay require more consultant time. It is unlikely that consultants can manage more than between 15 and 20 beds without additional medical input from another senior doctor, approved as competent under the relevant mental health legislation, or a year 4–6 specialist trainee (ST4–6).
- Consultants working on psychiatric intensive care units need to have sufficient time to review patients more frequently than once a week, reflecting the illness severity, risks and complexity

of the patients. These patients often need consultant review two to three times a week. In a psychiatric intensive care unit, all patients are treated compulsorily and hence there is a need for proportionally increased time for mental health legislation work.

Model job plan for a full-time in-patient general adult consultant	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5
Mental health legislation work	2
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Mixed jobs: sector-based consultants

The principles set out for community or in-patient care posts apply to mixed posts, with time needing to be allocated for travel between the two. The advantages of mixed posts are the opportunities for continuity of care and the fact that the consultant often knows the patients who transfer between parts of the system. Sector-based posts are likely to require a balance of 3 PAs for ward-based and clinical sessions and 4.5 PAs for community-based clinical work. The population size of community patches and the number of in-patient beds need to be adjusted according to the sessional commitment. Case-load analysis in these cases should consider data for both community and in-patient elements.

It would not be feasible for a consultant with both community and in-patient responsibilities to visit the ward each day. However, any consultant with in-patients should be readily available to the ward staff to discuss issues that might arise with their patients and they should have flexibility within their timetable to be able to attend the ward at short notice if their presence is necessary.

Crisis and home treatment team consultants

Consultants work in teams designed to provide intensive support to patients as an alternative to hospital admission. As such, consultants need to have sufficient time within their timetable to personally review all patients, or supervise a senior ST4–6 or a Section 12-approved specialty doctor, or other such clinical professional, managing such patients. If the teams have a broader remit, consultants need sufficient time for involvement with patients with complex disorders and those deemed at particular risk as well as sufficient time to provide support and advice to multidisciplinary colleagues and other doctors

in the team.

Mixed in-patient and home treatment team posts

Some consultants manage the whole acute care pathway, that is both in-patient and home treatment. There are advantages to such posts because of continuity of care. Time within the job plan needs to be allocated for travel involved. Again, consultants need sufficient time to review patients to provide high-quality and safe care. Any consultant with in-patients should be readily available to the ward staff to discuss issues that might arise with their patients and they should have flexibility within their timetable to be able to attend the ward at short notice if their presence is necessary. Given the complexity and numbers involved, case-load analysis benchmarked to quality standards is vital.

Assertive outreach and early intervention services

Consultants working in assertive outreach or early intervention services will need to spend more time in care planning and communication than those in general adult services, although face-to-face time for an individual contact is unlikely to be substantially different. Travel time is likely to be increased, and job planning will need to reflect these differences. As a consequence, it is likely that less time will be spent in overall face-to-face contact (clinics) with patients and more time will be spent in multidisciplinary planning meetings.

Old age psychiatry

The epidemiology and presentation of mental illness in older people is different to working-age adults. Older people with mental illness often have a unique and complex set of physical, psychological and social factors complicating their care. For these reasons older people need dedicated in-patient and community mental health teams to look after them.

Old age psychiatry services can offer expertise and care for people of any age with a primary dementia, as well as people with mental disorder and physical illness or frailty which contribute to, or complicate the management of, their mental illness. This may include people under 65, people with psychological or social difficulties related to the ageing process or end-of-life issues, or people whose needs are best met by a service for older people.

A consultant in old age psychiatry has a particular expertise in the psychiatric care of older patients, including specialist knowledge of organic disorders and the complexities associated with (at times multiple) physical comorbidity. In addition to the general roles set out in the background to this document, old age psychiatrists have specific expertise as listed below. There is an increasing recognition of the need to ensure patients are seen by the most appropriate services according to needs rather than just age. Some patients with functional illness will be still working and living very active lives as they approach 65. Their psychiatric care may continue to be undertaken by adult mental health services.

Clinical role

- Assessment, diagnosis and formulation of management plans with patients and carers for both functional and organic illness in the elderly.
- Expertise in the management of psychiatric illness in patients with complex and/or multiple physical disorders. On occasion this may include patients under the age of 65 who experience physical frailty.
- Expertise in pharmacological, psychological and behavioural interventions to manage behaviours that challenge in the context of a dementia diagnosis, including patients in long-term settings.
- Particular expertise in the diagnosis and management of delirium.
- Expertise working in varied settings, including residential/nursing homes, general hospitals and patients' own homes, with multi-professional and multi-agency teams.

Leadership role

- Leading the development of clinical standards and implementation of national guidance in old age psychiatry.
- Development and monitoring of outcome measures for patients in old age psychiatry.

Information to support job descriptions and job plans

- In old age psychiatry services there are many different models of service provision, ranging from highly centralised services, in-patient units on general hospital sites and well-resourced specialist memory service assessment, through rural services with admission beds on several different sites, to memory assessment services incorporated within mainstream out-patient clinics. Consultants work with a broad range of multidisciplinary staff and often away from their administrative base.
- In addition to expertise in mental health legislation, knowledge of capacity-based legislation is required and time to implement these is needed in all job plans. In relevant jurisdictions, this may include roles as Deprivation of Liberty Safeguards assessors or other types of mandatory second-opinion work.
- Old age psychiatrists see many patients in their own homes, in residential or nursing homes or in community settings, with fewer attending out-patient clinics than is the case in adult psychiatry. This will involve travelling and therefore reduce the numbers of patients that can be seen, but in doing so makes services more outreaching and patient focused.
- Old age psychiatrists, like general adult psychiatrists, can be appointed to solely in-patient, community or mixed jobs. The majority of consultant old age psychiatry posts are now appointed to either community or in-patient settings. Liaison old age psychiatry can also be part of these roles.

Full-time community old age psychiatry posts

- The **clinical work** of a community-based old age psychiatrist can be described in the categories defined under community roles earlier in the document. The support from other clinical members of the team will determine the time needed to be allocated to the separate roles.
- The balance of **out-patient and home visit work** within an old age psychiatry community-based post will be different to an adult psychiatry post. Fewer patients are seen within the out-patient clinic. The growth in demand for memory assessment services and early diagnosis requires dedicated senior medical time for this purpose.

- New patients in an out-patient clinic require a minimum of 1 h for assessment, with 30 min for follow-up appointments. Acknowledging the greater focus on community-based assessments, a minimum of 1.5 h for new assessments and 1 h for follow-up assessments to incorporate travel time is a reasonable standard. Clearly, if the geographical area covered is large, these times will need to be extended. Time should be allocated within community and out-patient sessions to allow for emergency assessments, liaison with other colleagues and completion of necessary clinical administrative tasks.
- **Liaison** with primary and secondary care old age medicine services is an important part of old age psychiatry consultant role.
- Job plan time needs to be allocated for **mental health capacity legislation work**. As with all consultant appointments, time in the job plan needs to be allocated for supervision of doctors in training. The principles for this would be similar to those within general adult psychiatry.
- Multi-professional working requires **meetings** to discuss patient care and individual meetings with other clinicians; 1 PA should be allocated for this in all job plans.
- Flexibility within job planning is needed to accommodate **roles depending on team structure**, such as supervision of non-medical prescribing, involvement in adult protection meetings. This needs to be reflected in the expectations of the number of out-patient and community sessions undertaken.

Model job plan for a full-time community old age consultant

Description	Professional activities (PAs) per week
Direct clinical care	7.5
Out-patient/community work	4.5
Multidisciplinary team meeting and supervision	1
Emergency work	1
Mental health legislation/adult protection and mental capacity legislation work	0.5
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

- It is difficult to be precise about the required number of old age consultants per population served. Many factors influence the appropriate case-load for an old age consultant, such as:
  - Demographics – high numbers of old people, especially aged over 80, equate to high numbers of people with dementia, depression and comorbid presentations.

- Support – if there is a poorly resourced multidisciplinary team this places more pressure on consultant time. In turn, this lowers the catchment population which can be managed successfully.
- Interface with other services – such as the relationship with other services for working-age adults and where old age services deal with above-average numbers of people with substance misuse, intellectual disability, offenders, and so on, consultant allocation needs to be increased. Similarly, service arrangements for people with young-onset dementia will have an impact on consultant workload.
- Care home numbers – care homes can create heavy demand owing to capacity legislation. The use of antipsychotic drugs in care homes is high and creates demand for consultant review.
- The presence of older people's consultation/liaison teams may reduce or increase workload for community consultants, depending on how services are structured. Services offering proactive assessment in general hospitals have heavier demand than reactive services.
- A number of other factors, such as the co-location of teams and services, referral patterns from primary care, and the extent and nature of local authority services and other third sector services. Further guidance on these factors and job planning is contained in a report published by the College's Faculty of the Psychiatry of Old Age (2015).

In-patient posts

In-patient beds in old age psychiatry are divided into two categories, functional illness beds and beds for dementia assessment and treatment.

Beds for functional illness in elderly patients

Patients admitted to these beds are potentially the most unwell within psychiatric services. They often have complex physical comorbidity and can have comorbid symptoms suggestive of dementia. Consultants in these posts should have sufficient time within their timetable to personally review each patient at least once a week. The consultant should be available to visit the ward daily to participate in multi-professional decision-making and complex risk management decisions. Some commissioned services involve responsibility for everyone over the age of 65 transferring to older people's services. This changes the mix of patients for whom a consultant is responsible and this needs to be reflected within job planning.

Model job plan for a full-time consultant – functional illness	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity	**5**
Work relating to mental health and capacity legislation	**2**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

As with general adult psychiatry, it is likely that a whole-time in-patient consultant for functionally ill elderly patients can manage between 15 and 20 beds without additional support from another senior doctor or an ST4–6 competent and approved under the appropriate section of mental health legislation. The consultant would expect to supervise a more junior doctor to assist in the management of the physical healthcare needs of these patients.

Assessment and treatment beds for dementia

The focus to increase care in the community for this group of patients will result in only the most complex and challenging patients being admitted to in-patient beds. The length of stay of such patients is expected to reduce and thus the amount of consultant time traditionally available for this bed base needs to be increased. In many in-patient settings most patients are initially subject to assessment under mental health legislation. In relevant jurisdictions, their continuing care in the majority of cases will be subject to ongoing compulsory treatment under the Mental Health Act and on occasion to Deprivation of Liberty Safeguards under the principles of the Mental Capacity Act 2005. Dedicated time needs to be allowed to undertake an increasing number of mental health review tribunals.

Model job plan for a full-time consultant – dementia assessment and treatment	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity	**5**
Work relating to mental health and capacity legislation	**2**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

It is likely that a full-time consultant on a dementia assessment and treatment ward can manage up to 25 patients without additional support from another senior doctor, but would expect to supervise a more junior doctor to assist in the management of physical healthcare needs of this patient group.

In some areas where there are continuing care beds, the need for medical time will depend on the nature of admissions, but approximately 1 PA for 12 beds would be an average requirement.

Liaison work

The model for liaison services in old age psychiatry is variable. Where there is no designated liaison service, the CMHT often provides a consultancy service. Whichever model is commissioned, clear allocation of consultant time needs to be in place. This sessional time is in addition to the clinical commitments outlined previously.

The service design needs to be supported by non-medical liaison staff who will require clinical supervision and leadership from the consultant involved in the service delivery.

Sector-based posts

In areas where consultants provide both in-patient and community services, the principles set out for general adult psychiatry on pp. 14–16 will apply.

Child and adolescent psychiatry

The primary role of a consultant child and adolescent psychiatrist is to use their skills as a medical expert to achieve best patient care for children, young people and their families/carers. With knowledge of child development, physical health, pharmacology, emotional health, families, complex systems and interpersonal relationships, as well as psychiatric disorders and substance misuse, child psychiatrists are best placed to apply an integrated biopsychosocial model in understanding, diagnosing and managing mental illness, emotional disturbance and abnormal behaviour.

Clinical role

In addition to the general roles set out above, a consultant child and adolescent psychiatrist will have specific expertise in the following areas.

- Carrying out **complex clinical assessments** including components needing specific expertise (i.e. a comprehensive developmental history), and identifying and managing physical health problems in children and young people jointly with primary care and paediatricians.
- Management of **complex clinical information** from many sources to formulate management of the relative effectiveness of medication, therapeutic approaches for the child/young person and family, and therapeutic/consultation approaches within the child's/young person's network.
- Knowledge of **adult mental health** – child psychiatrists are well placed to identify and arrange appropriate management of parental mental health concerns and to facilitate transition to adult mental health services if needed.
- Specialist knowledge of **interpersonal and systemic dynamics** – assessment and management of family, care network, educational and support system issues.
- Knowledge and skills in **outcome measurement** – this will enable the consultant to lead the monitoring of the effectiveness of interventions.
- Managing **clinical complexity** and severity through direct clinical assessment/treatments, case management and consultation.

- Managing the **complexity of information**, including knowledge of mental illness, child development, interpersonal/family dynamics, the Children Act 2004, criminal justice, mental health and mental capacity legislation, to reach decisions in the best interests of children and young people.
- Making child **safeguarding** referrals, attending safeguarding meetings, preparing reports and documentation and participating in multi-agency meetings in the area of legal and policy guidance around child safeguarding. This area has become more complex over the years and time has to be identified clearly in consultant job plans to undertake those tasks.
- Taking part in and attending care programme approach (CPA) reviews, care and treatment reviews (CTRs) and looked after children (LAC) meetings for those admitted to in-patient units, including children and young people placed out of area (either in health or social care placements), all of which have increased in recent years. Time needs to be identified for these roles.
- Assessment and advice to social care and youth justice with regard to the developmental, mental health and welfare, and criminogenic (youth criminal justice) needs of children and young people.

Leadership role

- Communicate with commissioners in health and other sectors about population needs, mental illness prevalence, best treatment strategies and service design to meet the developmental and mental health needs of children, young people and their families/carers.
- Advocate for the mental health, educational and care needs of young people as well as the prevention of distress and disorder and promotion of emotional well-being.
- Carry out specific leadership roles in medical management, academic roles, roles in medical education and national roles, for instance for the Royal College of Psychiatrists and in a national advisory capacity, as applicable.

Information to support job descriptions and job plans

Factors that should be taken into consideration in a job description include the following.

Patient factors

Assessments and work with children and young people take place in the context of the family/care environment, as well as educational and professional networks. Multiple sources of information are required.

The child/young person as well as family and other key informants will need to be interviewed. More than one patient may be the focus of referral within a family. Full assessment may require joint interviews with social workers, youth justice workers and allied professionals. It will likely involve visits/observations within the home, school or other settings, as well as assimilation of assessments by other professionals, for example, psychometric or neuropsychological assessments.

Child and adolescent psychiatry covers all psychiatric specialties, including the full range of psychiatric disorders, disorders specific to childhood, substance misuse, forensic psychiatry, intellectual disability, neuropsychiatry and liaison services. Many adult mental disorders start in childhood or adolescence, and mental and physical comorbidity is often present. There is focus on maximising developmental potential, resilience and social/educational function.

The nature of referrals and service demands will vary depending on local commissioning, and whether an individual service is designed to address a wide range of problems or more discrete diagnostic groups (e.g. substance misuse, intellectual disability, autism, attention-deficit hyperactivity disorder). Complexity of clinical presentation will also vary, with factors such as demographics, deprivation indices and service provision (local community team *v.* regional or specialist services) being of relevance.

Consultations to other professionals and agencies form a significant part of the child and adolescent psychiatrist's work. These consultations can last between 15 and 90 min and can take place in a variety of settings. Time to travel to external consultations should be factored into job planning.

A standard community follow-up appointment would be 1 h and for new patients 90 min. More complex cases (e.g. neurodevelopmental assessments, childcare-related assessments or assessments for the criminal courts) can take longer, in excess of 180 min, often over two to three appointments; uncomplicated medication reviews may be shorter.

Geographical and demographic factors

Factors within the catchment area to consider include:

- deprivation indices
- inner city *v.* rural
- ethnicity
- transient populations
- presence of children's homes, specialist schools and secure settings
- nature of other children's services in the area (e.g. the size and remit of the community paediatric, intellectual disability, challenging behaviour services; provision of parenting, early intervention, safeguarding services by other agencies).

Service structure

There are many different consultant roles within child and adolescent psychiatry. Community jobs can include, for example, sessions dedicated to subspecialties (intellectual disability, neurodevelopmental, liaison, substance misuse, etc.). The size and skill mix of the medical staffing and supporting multidisciplinary team vary considerably. This will have an impact on the nature of work a consultant will be required to undertake, including a need to provide consultation to and joint assessments with team members, clinical supervision to medical staff and collaborative work with other professionals and agencies.

Engagement in service development, strategic planning and team management/leadership will vary in response to local structures and expectations, with an impact on time available for direct clinical work. Engagement as case manager, with liaison, networking and administrative responsibilities for individual cases, will also vary.

On-call arrangements vary. Job descriptions will need to reflect the demand and potential for direct clinical work, particularly for consultants who are first on call (i.e. where there is no trainee or staff grade doctor as first contact).

Jobs that entail split roles, for example working across two clinical teams, will require additional non-direct clinical time to safely provide input to both teams. This also applies to roles that cover larger regions rather than discrete catchment areas.

Additional roles

Supervising psychiatric trainees and specialty doctors requires adequate time in the job plan for educational and clinical supervision and for undertaking assessments. Although consultant child and adolescent psychiatrists are likely to be involved in team leadership, additional team or service responsibilities require adequate time allocation. Child and adolescent mental health teams are often smaller than adult or other mental health teams and have limited service management, such that the leadership role requires adequate recognition and time in the job plan. In keeping with the general principles of job planning, it is vital that adequate SPAs are included in the job plan to enable psychiatrists to take on specific leadership roles and to promote recruitment and retention.

Reasonable workload

Assuming there is an adequate number of consultant child and adolescent psychiatrists in an area and an adequate team in place, the following are guidelines as to what might be expected of a reasonable weekly workload for a full-time consultant with no additional educational, leadership or management responsibility roles. This summary is indicative and for guidance purposes only. It will need to be adapted according to local needs, local structures and work patterns, and to

accommodate any additional roles, including supervision of doctors in training (adequate time for training must be included in the job plan) and travel.

Tier 3 generic community CAMHS

The individual consultant case-load will vary. Based on experience of the choice and partnership approach, published workload data, survey of Royal College of Psychiatrists' members, analysis of child and adolescent mental health services mapping data and feedback from consultants, the range of typical case-load responsibilities is presented. The expectations of an individual consultant should be negotiated locally taking into consideration the complexity of cases, nature of the clinical work, skill mix of the team and other factors as described earlier. A workload towards the lower end of the range would be appropriate for consultants engaged in a highly complex or high-risk clinical case-load, or where there are less than adequate consultant or multidisciplinary staffing numbers or skill mix. A work-load towards the upper end would be appropriate for a case-load of predominantly uncomplicated medication reviews.

An indicative reasonable case-load would be 1–2 new/initial assess-ments a week (including clinical interview, information gathering and report writing), and 10–17 follow-up case slots a week. Follow-up slots will most often be individual interviews, family meetings, case reviews, but could also include network meetings, consultation, safeguarding meetings, etc. This will approximately equate to 40–80 new/initial assessments per year. Additional individuals and families are likely to be seen as emergency and unpredictable cases. This would include psychiatric assessment of cases held by other team members.

Owing to the variation of service design, commissioning arrangements and multidisciplinary teams, it is difficult to recommend numbers of consultants.

Tier 3 generic community CAMHS	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Initial assessments/new cases	1
Complex case reviews/liaison with other agencies/case management/provision of treatment/work relating to out-of-area patients	4
Emergency work/unpredictable cases	1
Clinical administrative tasks	0.5
Multidisciplinary team meeting, consultation, support and supervision for team members	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Tier 4 in-patient unit

The job plan should allow for daily ward visits by the consultant, at least a weekly face-to-face review of each patient, team meetings, complex case review meetings (such as CTRs) and sufficient time for liaison with families and other agencies.

The case-load, using bed numbers as the currency, will vary depending on the nature of the unit, number of urgent *v.* planned admissions, and skill mix of the staffing complement. An indicative case-load for a 10 PA consultant is 10–12 beds with Tier 4-related out-patient assessments and follow-up work. For a unit entirely focused on emergency admissions, the case-load will be towards the lower end. For a unit operating in a less acute setting or with many planned admissions, the case-load would be towards the upper end. The designated whole-time equivalent (WTE) consultant time may be adjusted slightly up or down depending on acuity of presentation and age range of the patient group, presence of non-consultant grade psychiatrists and availability of experienced senior multidisciplinary team members.

Tier 4 in-patient unit	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Ward-based clinical activity including clinical decision meeting, interviewing patients and carers	**4.5**
Liaison with families and other agencies	**2.5**
Clinical administrative tasks	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

Tier 4 out-patient services

Services that provide specialist assessment and treatment, often via a liaison and consultation model (e.g. community forensic psychiatry, CAMHS), on a regional basis require a different job planning approach. Although direct assessments are an important component of this work, the significantly greater proportion of indirect contacts (discussion with professionals via telephone or face to face, including professionals' meetings) needs to be recognised. Services of this type often provide across wider geographical areas and by their nature provide for children and families with needs in multiple domains, with multiple accommodation histories, high-risk profiles and often in complex legal systems; specific recognition of the greater travel and background reading involved is also required.

Addictions psychiatry

A consultant in addictions psychiatry is a doctor with a Certificate of Completion of Training (CCT) in general psychiatry with endorsement in substance misuse, working to provide a full range of services to people with substance misuse and addiction disorders. This can be within the NHS or, as is increasingly the case, within the non-statutory sector. In addition to the general roles set out in the job descriptions and job plans section of this document (pp. 10–17), a consultant in addictions psychiatry has specific expertise as listed below.

Clinical role

- Assessment, diagnosis and management of people with addiction problems as well as those with mental illness.
- Extensive clinical expertise in addictions, with the ability to integrate mental health, physical health and addiction disorders.
- Expert in a wide range of treatments for addictions, including pharmacological, psychological and behavioural.
- Ability to assess and manage complex or high-risk people, including pregnant women, elderly people, children and adolescents.
- Particular expertise in diagnosing and managing dual diagnosis.
- Expertise in complex prescribing such as injectable opiates for the treatment of addiction.
- Clinical supervision of GPs providing addiction services.
- Clinical supervision and mentorship for non-medical prescribers (NMPs).
- Providing addiction advice and liaison to general practice and other specialties within psychiatry and acute medicine.

Leadership role

- Leading clinical governance, safety and innovation in substance misuse services.
- Being the designated medical practitioner for NMP trainees.
- Liaison with commissioners to define and improve outcomes.
- Ensuring implementation of national guidance and standards in substance misuse.

- Providing clinical input into commissioning and procurement exercises, for example making valid assessments of need, through to setting and monitoring appropriate standards.
- Developing partnerships between different provider organisations.

Information to support job descriptions and job plans

Community consultants

Summary of a direct patient care timetable for a full-time consultant with no specific educational or leadership role is shown below.

For out-patient work, 1 h for a new patient assessment and 30 min for a follow-up assessment is necessary. Some time in clinics needs to be kept for urgent appointments requested by patients or other members of the team. Some of the patients seen in clinic and other settings will be patients seen and followed up by the consultant – many will be for a consultant opinion and then follow-up by other professionals and other teams.

Community psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work, including face-to-face reviews of patients, seeing patients for consultations from other services	4
Supervision of other prescribers such as GPs and NMPs and management of prescribing	0.5[1]
Multidisciplinary team meeting and support for team members outside the meeting	1
Liaison and advice to other services including GPs and acute hospitals	1
Administrative tasks related to direct clinical care (e.g. treatment outcome profiles, National Drug Treatment Monitoring System (NDTMS))	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

1. May need to be increased depending on the number of other prescribers who are being supervised.

Tier 4 in-patient detoxification unit

The job plan should allow daily ward visits by the consultant, at least a weekly face-to-face review of each patient, team meetings and sufficient time for liaison with families and other agencies. This would be suitable for a 20-bed unit with junior doctor support. A consultant providing sole medical input would have responsibility for a maximum of 12 beds.

In-patient detoxification (tier 4) psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Ward-based clinical activity including clinical decision meeting and interviewing patients and carers	5
Supervision of multidisciplinary team	1
Liaison with families and other agencies	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Commissioning

Most addiction psychiatrists are involved in the commissioning and tendering processes with services as addiction services are usually recommissioned on a 3 to 5 year timescale. This work usually involves at least 1 PA per week.

Forensic psychiatry

Consultant forensic psychiatrists have expertise in providing services for and working with patients who have a complex mix of disorders of mental health which have often proved treatment resistant, and who, generally as a consequence, are considered to pose a risk of serious harm to others. More often than not, the social circumstances of this patient group have been and/or still are difficult and complicated. Most patients have already been convicted of at least one serious criminal offence and very few are previously unknown to other psychiatric services. In addition to a high standard of general psychiatric skills, highly skilled risk assessment and management is, thus, a core part of the work.

The range of medical and social problems presented by this group of patients means that forensic psychiatrists have to be highly skilled in both multidisciplinary and inter-agency working. Agencies outside health services include the police, the courts, prison and probation service personnel, Social Services, housing authorities and a range of third sector organisations.

The complexity of the mix of psychotic illness, developmental disorders, substance use disorders and post-traumatic states together with social disadvantage presented by most patients means that most of them need longer in treatment and care than patients in many other areas of psychiatry, and that substantial periods of this will include therapeutic use of physical and procedural as well as relational security. Forensic psychiatrists, therefore, must be particularly skilled in managing institutional settings, engaging in routine reflective practice and participation in peer and independent review.

Forensic psychiatrists are routinely expected to provide expert evidence throughout the legal system – criminal courts, family courts, other civil courts and tribunals – and at all levels, and must have training and experience commensurate with this.

Given that most of the people referred to forensic psychiatric services have been violent and/or sexually abusive to others, but also many have themselves been victims of substantial and long-standing abuse, forensic psychiatrists must have special skills in relation to managing victim issues.

Demand for forensic mental health services means that many patients and others with mental health needs have to be managed and treated outside the core services, at best in other psychiatric specialty services or in out-of-area independent healthcare sector centres, at worst while remaining in prison, so forensic psychiatrists must have strong consultation–liaison skills.

Highly developed communication skills are essential to ensuring safety in this high-risk field, whether in the long-term relationships with patients and their families, within the clinical team, with other agencies involved in safe service delivery or in responding to the constant shifts in requirements for service development and provision.

Forensic psychiatrists in the UK are entirely bound by medical ethics, and fully subscribe to GMC and Royal College of Psychiatrists' practice guidance.

Forensic psychiatry is a fascinating specialty, but demanding of expertise and time, and requires continuous attention to maintenance of acquired skills and professional development.

Clinical role

- The detailed assessment, treatment and management of people with complex mental health needs who also pose a significant risk of harm to others. This includes expertise in:
  - medication for treatment-resistant conditions;
  - management of complex, multi-source information to develop a formulation and treatment plan that integrates biological, psychological and social perspectives;
  - physical health screening and medical liaison with colleagues in primary and secondary care;
  - appropriate use of psychosocial interventions;
  - risk assessment and management in a variety of settings including the community, in-patient settings, custodial settings and transition between them;
  - an understanding of the effects of different aspects of security on patient autonomy, rehabilitation and recovery;
  - appropriate use of mental health and other legislation, safeguarding processes, appointeeship and Court of Protection;
  - therapeutic risk-taking to support safe rehabilitation and recovery;
  - detailed knowledge of local service provision;
  - expertise in managing patients' transitions between different settings; and
  - assessment and management of victim-related issues.
- Second opinions and advice to colleagues on diagnosis and risk management.
- Support and advice to services which also deal with this patient group, including the criminal justice system, child welfare services, providers of supported accommodation and complex community care packages.
- Review of out-of-area placements.

Leadership role

- Consultants are responsible for providing leadership within their teams to ensure the delivery of high-quality care for patients. Maintaining patients' rights and the safety of others requires the consultant to manage and contain any anxiety within the multidisciplinary team to provide safe treatment. Supporting recovery and rehabilitation requires full understanding of the limits of one's own skills and both the wealth of skills provided by other disciplines within the team and the ability to ensure that they are applied to the full where appropriate.
- Consultants provide leadership in reflective practice.
- Consultants oversee the development of clinical standards and implementation of national guidance in forensic psychiatry.
- Forensic services are high-cost services and consultants will always work in partnership with commissioners to develop clinically robust and cost-effective patient care pathways.

Information to support job descriptions and job plans

- There are different models of service provision and different consultant roles within these models. In some services, consultants oversee a group of patients along the whole length of their care pathway, providing both in-patient and community care, whereas in other services consultants provide care in either community settings or in-patient settings. In some services, the consultant provision to prisons is provided by a number of consultants giving sessional input, seeing new and follow-up referrals. In other services, specialist liaison roles have emerged – such as with intellectual disability services or with child and adolescent services.
- Consultant forensic psychiatrists generally have an important role in teaching and training within and outside the discipline. This means allowance must be made not only for teaching time, but also suitable time for personal development.
- Time for quality improvement and/or association with national network oversight schemes should be evident in job planning given the consultant's role in positively influencing their development and the exceptional requirements for vigilance over service provision.

The following table includes guidance on workloads given that job descriptions can vary in the range of tasks undertaken within the consultant role. It offers examples of what workload may be expected within a professional activity (1 PA), but we stress that this is guidance only as the nature of tasks and the case-load mix may vary

between services. It is broadly expected that consultants will deliver 7.5 sessions of direct clinical activity per week, but this too will vary according to the extent of their managerial or academic roles.

Consultant forensic psychiatrist	
Description	**Professional activities (PAs) per week**
Direct clinical care[1]	Maximum 7.5
Per 2–4 in-patients in secure environment: low, medium or high. Factors such as patient complexity, acuteness, gender, age, length of stay, resources available, nature of care (e.g. stepped down), team composition will also determine which end of the range is reasonable	1
Per 5–15 community forensic patients. Factors such as patient complexity, acuteness, resources available, team composition will determine which end of the range is reasonable	1
Prison session: per 2–3 new patients or up to 6 follow-up patients (or a combination of these) assuming a 3 h session and patients readily available to be seen. Regarding parole reports, if a brief report is required for patients under active care, this will be in the form of a clinical letter. If a more detailed report is required and is part of contracted activities, up to 1 PA per patient is likely to be required spread over more than one session	1
Assessments for advice: assuming 1 referral every 7–14 days. Service provision differs around the country, with some services only providing an assessment service for potential admission to secure care while others provide advice and support in the management of high-risk patients. Factors such as patient complexity, acuteness, age, resources available, team composition and type of service being provided will determine which end of the range is reasonable	1
Consultancy/liaison/diversion: some services provide this as part of their assessment service (see previous point), whereas other services provide regular access to a forensic service for advice or consultancy through a regular clinic or time slot for case discussion and advice	1
Per 15–30 out-of-area treatments from catchment area: factors such as distance from base unit, resources available, team composition and type of service being provided (e.g. level of attendance at CPA (promoting quality care in Northern Ireland (PQC)) meetings, whether annual or 3 monthly) will determine which end of the range is reasonable	1
Per 15–30 high secure patients from catchment area: factors such as distance from base unit, resources available, team composition and type of service being provided (e.g. level of attendance at CPA (PQC) meetings, whether annual or 3 monthly) will determine which end of the range is reasonable	1
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

1 In each case the level of time and expertise available from junior doctors and/or staff grade doctors will partly determine which end of the range is reasonable – generally, up to 7.5 sessions will be made up from a mixture of the roles given in the table.

Note: for probity to be maintained, any fee-paying work must be explicitly reflected in the consultant's job plan. There are a number of ways this can be organised: time-shifting – up to 1 PA a week can be time-shifted without this interfering with NHS or other clinical activity; a number of PAs can be allocated for work that attracts a fee to be undertaken within the job plan, with fees being paid to the employer; or part-time contracts for consultants to accommodate fee-paying work outside the consultant job plan.

Rehabilitation psychiatry

Rehabilitation psychiatrists work with people with long-term and complex mental health problems, the majority of whom have a diagnosis of schizophrenia. Although many people with severe and enduring mental health problems experience ongoing active symptoms of illness, impairments in cognition and drive, social stigma and the secondary handicaps consequent on the illness, those who are referred for rehabilitation are often those whose problems are of such complexity or severity that they could not be discharged home following an acute admission or whose needs cannot be met by general adult services. These problems include treatment resistance (non-response to first-line medications), cognitive impairment (most commonly affecting executive function and verbal memory), pervasive negative symptoms (e.g. apathy, amotivation, blunted affect), and co-existing problems (e.g. substance misuse, pre-morbid intellectual disability, developmental disorders such as those on the autism spectrum). These complex problems contribute to major impairments in social and everyday functioning and to challenging behaviours that impede recovery and increase the risk of adverse outcomes. Comorbid, chronic physical health problems are also commonly present.

Consultants in rehabilitation psychiatry have expertise in the assessment and long-term treatment and management of this patient group. They adopt a biopsychosocial approach that embraces recovery-oriented practice. They work within multidisciplinary teams in a variety of settings, such as:

- in-patient rehabilitation wards (including: local short- and long-term high-dependency (high-support) rehabilitation units; regional units for people with challenging behaviours and complex needs; low, medium and high secure rehabilitation units within local, regional or national forensic services)
- local community rehabilitation units
- local long-term complex care units (in hospital or community sites)
- local community rehabilitation teams
- local specialist functional CMHTs providing intensive support and early intervention for people with psychosis.

Clinical role

In addition to the general roles of the consultant as set out on pp. 14–16, the consultant in rehabilitation psychiatry has the following specific expertise.

- Detailed assessment and management of patients with complex mental health needs in rehabilitation settings. This includes:
  - expertise in medication management for treatment-resistant conditions
  - physical health screening and medical liaison with colleagues in primary and secondary care
  - appropriate use of psychosocial interventions
  - appropriate use of mental health and mental capacity legislation, safeguarding processes, appointeeship and Court of Protection
  - detailed knowledge of local supported accommodation provision
  - expertise in managing patients' transitions between different settings.
- Second opinions and advice to colleagues on the diagnosis and management of patients with complex mental health needs.
- Support and advice to services that provide supported accommodation and complex community care packages for this group.

Leadership role

- The consultant in rehabilitation psychiatry has to employ their leadership skills in their everyday clinical practice as well as their experience in conflict resolution and good communication to manage the powerful dynamics that can lead to challenges in working with other agencies and services when dealing with patients with complex needs.
- Rehabilitation psychiatrists use their clinical leadership skills to facilitate successful partnership working with voluntary sector agencies that facilitate social inclusion, including those that provide supported accommodation, vocational training and employment.
- Rehabilitation psychiatrists should sit on the local 'placement' panel to ensure the appropriate placement of patients in facilities that are tailored to their needs, that opportunities for local treatment and support have been fully explored prior to a placement being made out of area, and that there is ongoing review of an individual's suitability for local repatriation at the earliest opportunity (Royal College of Psychiatrists, 2011).

Information to support job descriptions and job plans

Workload expectations will vary according to the degree of complexity of patients in the particular service, the proportion of patients on compulsory treatment and the associated medico-legal work, as well as the staffing of the rest of the team, including the amount of CT1–3, ST4–6 and specialty doctor time. Similarly, the geographic spread of workplaces needs to be considered, given the importance of having both community and rehabilitation consultant provision in all catchment areas and working closely with other mental health specialties as well as other services to address needs of patients with serious mental illness.

Bearing these issues in mind, we suggest the following summary guide to the direct patient contact time required for a consultant in rehabilitation psychiatry.

Rehabilitation psychiatry patient time requirements	
Description of service	**Professional activities (PAs) per week**
High-dependency (high-support) in-patient rehabilitation unit (average 14 beds, most patients on compulsory treatment, average length of stay 12 months): direct patient care, referral assessment and meeting, in-reach to acute wards, MDT meeting, CPA/PQC meetings, family interventions, mental health legislation work, clinical administration	7.5
Long-term high-dependency (high-support) unit (average 14 beds, most patients on compulsory treatment, average length of stay >5 years): direct patient care, assessment of referrals, CPA/PQC meetings, family interventions, mental health legislation work, clinical administration	5
Community rehabilitation team (average case-load 100, some patients under CTO): direct patient care, home visits, CPA/PQC meetings, weekly team meeting, family interventions, mental health legislation work, clinical administration	5
Community rehabilitation unit (average 14 beds, many patients on compulsory treatment, average length of stay 18 months): direct patient care, CPA/PQC meetings, assessment of referrals, family interventions, mental health legislation work, clinical administration	4
Long-term complex care unit (average 10 beds, most patients not on compulsory treatment, average length of stay 5–10 years): direct patient care, CPA/PQC meetings, assessment of referrals	2
Other specialist tasks: assessment of patients placed out of area and attendance at their CPA/PQC meetings, membership of placement funding panel (usually monthly), assessment and advice to colleagues regarding patients with complex needs, assistance to supported housing providers	1.0

For guidance on consultant input to secure rehabilitation units please see the forensic psychiatry section.

Liaison psychiatry

Liaison psychiatrists specialise in the management of psychiatric problems in the general medical setting. They have expertise in working at the interface between physical and mental illness, including psychological reactions to physical illness, medically unexplained symptoms and the management of self-harm in the general hospital.

Many liaison psychiatry services now assess and manage adults of all ages. Team members may have specific expertise in working with younger or older adults, if not both. In future there might be expansion of liaison psychiatry services into primary care and other community settings which may affect this guidance.

Clinical role

In addition to the general consultant roles set out on pp. 14–16, a liaison psychiatrist has the following specific expertise:

- understanding the interface between physical illness and mental illness (e.g. comorbid mood disorders, medically unexplained symptoms, organic mental states);
- diagnosis and formulation of management plans in complex cases, advising medical teams on appropriate integrated care;
- assessing and managing risk (e.g. suicide risk, violence/aggression, absconding) relating to psychiatric conditions in general hospital settings;
- bridging the gap between primary and secondary care with regard to the management of psychosomatic conditions in the community (e.g. medically unexplained symptoms);
- prescribing and giving advice to medical teams on psychotropic medication;
- providing expertise, and fulfilling a statutory role, in managing medico-legal issues in the general hospital, including application of mental health and mental capacity legislation;
- understanding the medical issues in assessing patients with medically unexplained symptoms; and
- understanding the medical issues in mental health problems associated with long-term conditions.

Leadership role

- Setting goals and targets for the team according to local and national drivers.
- Liaising with clinical leaders, managers and commissioners from acute and mental health trusts/boards and clinical commissioning groups with a focus on service development and improvement.
- Due to the nature of the job most liaison psychiatrists will have a clinical leadership role within their teams, which will include clinical supervision of colleagues, and wider clinical responsibilities as mentioned earlier. Within the job plan, the former would be included in PAs for direct patient care and the latter in the PAs for supporting professional activities.
- The line manager for a consultant is usually a clinical director or equivalent. Consultants may provide clinical supervision and advice for non-medical team members, but line management for such staff would usually be provided by the team manager or another senior nurse. Clear local arrangements should be in place for supervision of non-medical team members.

Educational role

A liaison psychiatrist will play a role in challenging stigma and discrimination towards psychiatric patients and professionals by raising awareness of the issue, through presentations/teaching sessions, and through informal discussions with various professionals in the general hospital. A consultant will have a role in training to help general hospital colleagues to recognise and manage common mental health conditions and know when to refer.

It is a common experience that there is a demand from trainees of various levels to spend time in liaison psychiatry teams. If there are any trainees within the team then consultants should have sufficient allocated PAs in their job plan (1 h per week) for each trainee they supervise.

Information to support job descriptions and job plans

There is great variation in liaison mental health services across the country, reflecting local demographics, needs and priorities, available resources and historic development of services. This has resulted in a patchy delivery of liaison services.

A liaison mental health service may include some or all of the following components:

- emergency department liaison psychiatry
- self-harm service

- psychiatric liaison service for general hospital adult in-patients (all ages)
- out-patient clinics
- additional specialised services (e.g. for substance misuse, chronic fatigue syndrome, medically unexplained symptoms, psycho-oncology).

There is a wide variation in the composition and size of the teams. Workload may differ according to the local referral criteria (e.g. age range, referral sources, catchment area), hours of operation and other resources available (e.g. separate alcohol and substance misuse liaison services). Many liaison psychiatry teams provide services for both patients of working age and older adults (often with specialist sub-teams in larger hospitals), and some provide services for 16- to 18-year-olds. If the consultant is covering more than one hospital then travel time should be taken into consideration in their job plan.

There are four models of care that have been suggested in commissioning guidance for liaison psychiatry services (Aitken et al, 2014a).

1. **Core liaison psychiatry services** – operating during working hours or providing an extended hours service.
2. **Core 24 liaison psychiatry services** – operating over 24 h, 7 days a week.
3. **Enhanced 24 liaison psychiatry services** – operating over 24 h, 7 days a week, with extensions to fill local gaps in service and some out-patient services.
4. **Comprehensive liaison psychiatry services** – operating over 24 h, 7 days a week, and providing enhanced in-patient and out-patient services to specialties at major centres.

The expected workload of a consultant liaison psychiatrist, therefore, depends on the nature of the post. Services covering large acute hospitals with regional and tertiary services will have patients with higher levels of medical complexity where psychiatric factors also tend to be more complex. They require a higher proportion of consultant time than purely accounted for by the total number of beds.

The distribution of clinical activities is for guidance only and should be adapted according to local needs in terms of the leadership role, the model of services and staffing of the team. For example, a liaison service in a large hospital may need increased PA time in the job plan of the consultant for leadership/service development and interface meetings with the acute hospital.

High-level summary of differences between models[1]				
Description	Core	Core 24	Enhanced 24	Comprehensive
Example number of beds	500	500	500	2000
Consultants	2	2	4	5
Other medical	0.6	2	2	2
Nurses	2 band 7 6 band 6	6 band 7 7 band 6	3 band 7 7 band 6	2 band 8b 17 band 6 10 band 5
Other therapists	0	4	2	16
Team manager band 7	1	1	1	3
Clinical service manager band 8	0.2	0.2–0.4	0.2–0.4	1
Admin band 2, 3 and 4	2.6	2	2	12
Business support (band 5)	0	1	1	1
Total whole-time equivalent	14.4	25.2–25.4	22.2–24.4	69
Hours of service	9 to 5	24/7	24/7	24/7
Age	16+	16+	16+	16+
Older person	Yes	Yes	Yes	Yes
Drug and alcohol	No	Yes	Yes	Yes
Out-patient	No	No	Yes	Yes
Specialties	No	No	No	Yes
Approximate costs	£0.7M	£1.1M	£1.4M	£4.5M

1. Detailed descriptions of these models and their differences in terms of staff size and skill mix can be found in Aitken et al (2014a,b,c) and Brightey-Gibbons et al (2017).

A summary of a direct patient care timetable for a full-time consultant with no specific leadership or educational role	
Description	Professional activities (PAs) per week
Direct clinical care	7.5
Face-to-face contact with patients in clinic or wards	4
Multidisciplinary team meeting and support for team members outside the meeting	1
Emergency work/unpredictable cases/clinical administration	1
Mental health legislation work/complex patient reviews or liaison with other specialties	1.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Intellectual disability psychiatry

Consultant psychiatrists in intellectual disability (learning disability) work in varied clinical settings from in-patient settings to community services. In their training, intellectual disability psychiatrists require experience working with adults, children and offenders in both community and in-patient services. Intellectual disability services are moving towards delivering care using a care pathways approach where care is delivered and monitored for quality and complexity. The contributions of consultant psychiatrists in services is greatest when dealing with the complex difficulties that people present with. The consultant psychiatrist plays a pivotal role in how resources are managed through their assessment and understanding of the clinical presentations and risks that people with intellectual disability can pose.

Clinical role

The clinical role of the consultant psychiatrist in intellectual disability involves:

- assessment and diagnosis of mental disorders as they present in people with intellectual disability
- a deep understanding of the complex factors that contribute to mental disorders – physical, psychological and social
- the application of legislation frameworks as they relate to people with intellectual disability
- knowledge of the presentation of mental disorders in people with neurodevelopmental disorders
- providng clinical expertise to commissioning bodies and care providers.

Leadership role

Consultant psychiatrists in intellectual disability assume leadership roles in services, providing:

- clinical leadership to teams
- leadership in service development
- leadership in educational roles in services and in the broader NHS
- leadership in the profession through the Royal College of Psychiatrists and other national bodies.

Educational role

Consultant psychiatrists in intellectual disability provide education to colleagues in psychiatry:

- direct clinical supervision and educational supervision is required when working with trainees and non-training grade doctors
- education is also provided to non-medical colleagues on the presentation of mental health difficulties in people with intellectual disability.

Information to support job descriptions and job plans

Patient factors

Patients with intellectual disability require more time in consultations owing to various factors including cognitive and communication problems, short attention span and need for additional breaks. Patients are often dependent on carers and professional informants for support and to provide information, requiring multiple discussions. On occasions, patient behaviour can interrupt appointments or require home visits. Patients with intellectual disability frequently have significant physical health problems, some associated with complex genetic syndromes. Psychiatrists will often directly manage epilepsy as part of a patient's ongoing care, or need to advise and support GPs on physical healthcare in relation to some genetic disorders.

A standard community follow-up appointment slot would be 30 min and for a new patient 90 min (occasionally split if patient does not tolerate lengthy appointments). More complicated new cases (e.g. children, forensic) or autism assessments/court reports can take much longer, in excess of 180 min (usually split). For home visits, travel needs to be factored in.

Geographical and demographic factors

Catchment population is only part of the picture. The following factors need to be considered:

- inner city *v.* rural, reflecting density of population, ethnicity, deprivation indices and transient populations;
- local group homes where people are placed by other local authority providers;
- closure of institutions can improve local resources and skills base but also increase local case-loads;
- proximity to local support networks and academic hubs for CPD;
- local organisations active in providing quality services (mixed housing projects offering appropriate and good-quality support to those with challenging behaviour, for dementia care, autism,

sensory impairment, employment, day service), and availability of other supported activities;

- return-to-area projects; and
- the commitment of local authorities and health commissioners to support intellectual disability services.

Local trust factors

The number of consultants required reflects the local configuration of services. Factors to consider include:

- expectations and roles of other mainstream mental health services
- clarity on eligibility criteria to services
- cut-offs in terms of degree of intellectual disability: there is an exponential rise in the number of patients who move into borderline intellectual disability
- age boundaries or lifespan services
- discrete community/in-patient 'functionalised' post or split roles both in the community and for in-patients
- well-resourced supporting teams including other medical staff, secretarial and other allied professions: community nurses, speech and language therapists, occupational therapists, dietitians, psychologists and physiotherapists
- pooled budgets and coterminous criteria with Social Services; if not existent, health professionals may be working in isolation with some clients
- the availability of specialist teams (epilepsy, challenging behaviour, dementia, autism/Asperger's syndrome, forensic)
- direct case management expectations for complex or high-risk patients
- out-of-area quality assurance roles (post-Winterbourne View) – commissioners may require assessment and management of clients placed out of area.

Assuming that there is an adequate team in place, the following are guidelines on what might be expected of a consultant post in different areas.

General adult intellectual disability posts

Community only

Time allocation should be:

- new patient assessment 90 min; complex cases 120 min+;
- a pervasive developmental disorder assessment with diagnosis 240 min; routine follow-up 30 min;
- a WTE post might expect to carry an active case-load of 100 patients, with 30–40 new referrals each year;
- CPA/PQC review or vulnerable adults meeting minimum 60 min (more if MAPPA or forensic issues);
- weekly team meeting 120 min;
- mental health legislation work including assessments 120 min;
- managing community treatment order patients: managers and review tribunal meetings, 2 h each at least yearly (more if regular recall);
- report preparation 4 h+.

In-patient acute assessment and treatment

One WTE consultant for up to 20 acute beds. The unit would need a well-resourced multidisciplinary team including social work involvement and additional medical support (e.g. 0.5 WTE specialty doctor or 1 WTE CT3).

Job plan for consultant psychiatrist in community intellectual disabilities	
Description	**Professional activities (PAs) per week**
Direct clinical care	**7.5**
Out-patient work/community visits	**5**
Multidisciplinary team meeting	**1**
Clinical administrative tasks	**1**
Complex patient reviews	**0.5**
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	**2.5**

Forensic intellectual disability posts

Legal reporting standards have increased considerably. Time is required for face-to-face contact with teams and tribunals, as well as patient-related direct and non-direct activity.

In-patient posts: high secure, medium secure and low secure settings

For forensic intellectual disability bed-based services, a full-time consultant could lead services with:

- 15–17 high secure unit beds with national assessment duties; or
- 12–15 medium secure unit beds as well as regional assessment duties (there may be scope for regional court work, local community liaison links and advice; local prison sessions may require additional support); or
- 15–20 longer-term rehabilitation style low secure unit beds as well as regional court work, local community liaison links and advice; prison sessions may require additional support.

Job plan for a full-time consultant psychiatrist in in-patient intellectual disability service	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
In-patient work	5
Multidisciplinary team meeting	1
Clinical administrative tasks	1
Mental health legislation work	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Forensic community-based services

The role to include:

- liaison links
- risk assessment support to local consultants in existing community services
- direct case management for a small number of higher-risk individuals
- court diversion

- in relevant jurisdictions, possible role in managing forensic community treatment orders/Section 37 guardianships and previously compulsorily treated/restricted patients resettled into the local community.

Specialist forensic out-patient activity

Making some allowance for time required to travel, 1 WTE consultant for non-residential services could support:

- 40 new referrals per year:
  - one direct contact of 2 h
  - indirect contacts of 6 h in total
  - report preparation and liaison of 6 h
- 80 out-patient follow-up visits:
  - two direct contacts six monthly (one annual CPA/PQC)
- 72 indirect contacts – liaison and consultancy to intellectual disability and forensic teams:
  - monthly meetings with four area intellectual disability teams and two medium secure units minimum.

Child and adolescent intellectual disability posts

There are few dual-trained child and adolescent and intellectual disability consultants. Many child and adolescent specialists trained in intellectual disability are now working within joint child and adolescent services. Many new post appointments may be general child and adolescent consultants who have had 'special interest' sessions taken in intellectual disability (some lasting a full year). Some may have had no or very limited intellectual disability experience. There is a need to ensure that where there are split posts (mainstream with intellectual disability sessions), these clearly state how the intellectual disability sessions will be protected, so that patient care is not compromised.

Perinatal psychiatry

Consultant perinatal psychiatrists have expertise in the prevention, assessment and management of mental disorder newly occurring or coexisting with pregnancy or the postpartum period, including the assessment and facilitation of the mother–infant relationship in the context of maternal mental illness.

Posts may include in-patient mother and baby unit, perinatal community and maternity liaison responsibilities.

Clinical role

In addition to the general consultant roles set out on pp. 14–16, consultants in perinatal psychiatry have the expertise listed below.

- Understanding of the normal psychological changes that take place in pregnancy and in the early postnatal period, in relation to identity, becoming a parent, couple relationship and the developing relationship with the infant from pregnancy onwards.
- Understanding of psychopharmacokinetic and psychopharmacodynamic alterations occurring in pregnancy, the early puerperium and in breastfeeding.
- Understanding of physical problems which may arise during the patient journey through pregnancy and the puerperium, including the physiology and complications of childbirth.
- Understanding of legislation and guidance in relation to child protection and welfare.
- Understanding of embryology, fetal and early infant development.
- Understanding of the normal mother–infant relationship and its development through early childhood.
- Understand the prediction, prevention, detection and management of mental disorder in pregnant and postnatal women, the interrelationship between mental disorder and pregnancy and the postpartum period, and the wider effects of mental disorder on child development and the mother–infant relationship.
- Diagnose and formulate management plans in complex cases, including decisions on prescribing in pregnancy and breastfeeding.
- Assess and manage risk, including suicide risk, in relation to the pregnancy, and risk to children. Deliver care which responds to maternity time scales.

- Provide prescribing advice on psychotropic medication in pregnancy and breastfeeding to women and their families, general psychiatry, maternity and primary care services.
- Provide expert assessment of the mother–infant relationship in the context of acute maternal mental disorder.
- Understanding of policies and national guidelines relating to perinatal psychiatry, and maternal and child health, including those from the Maternal Deaths Enquiry, NICE, Scottish Intercollegiate Guidelines Network (SIGN), and relevant government strategic policy documents.
- Work in a collaborative way with other psychiatric services, maternity services, primary care, health visiting and childcare social work to ensure optimum outcomes for the patient and her child.
- Work by involvement of the woman, and her family where appropriate, as an active partner in treatment, including facilitation of the patient's ability to make informed decisions about her care and the welfare of her pregnancy/child.

Leadership role

- Awareness of service specification framework and commissioning guidelines as these develop. Leading on the process of revision and accreditation of own and other perinatal services, in accordance with national guidelines.
- Skills in the participation in, and responsibility for, clinical governance activities, including audit of practice in relation to other perinatal specialist services, and encouraging and supporting colleagues in their participation.
- Liaising with health commissioners and providers to promote an understanding of the epidemiology and needs of the patient group, including updates in evidence-based practice, to inform service development and delivery.
- Advocating for the mental health needs of pregnant and postnatal women and for the promotion of infant health and development in the context of maternal mental illness.
- Developing partnerships between agencies involved in the care of pregnant and postnatal women who experience mental disorder, including primary care, health visits, maternity services, childcare social work, general psychiatry and the voluntary sector.

Educational role

- Challenging stigma and discrimination against pregnant and postnatal women with mental disorder, by teaching and raising awareness with the public, public representatives, professionals and patients.
- Designing and delivering training packages on awareness, prevention and detection of perinatal mental health disorders to meet the needs of local maternity, primary care, Social Services and other psychiatric colleagues.
- Enhancing public mental health through physical health promotion in pregnancy, and education for patients and professional groups on transgenerational effects of poor maternal mental health.

Information to support job descriptions and job plans

The expected workload of a full-time consultant perinatal psychiatrist is dependent on a range of factors, including whether all elements of service provision are included, the size and composition of in-patient and community teams, number of maternity units, geographical distribution and the population served. In addition, those providing maternity liaison services in larger centres will have to take account of a 'drifting in' of more complex cases to centres of maternity expertise.

Perinatal job plan for mother and baby unit	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Multidisciplinary team meetings and support for team members outside the meeting Meetings with patients and carers	3
Complex patient reviews/child safeguarding meetings/Mental Health Act work	0.5
Clinical administrative tasks	0.5
Out-patient and maternity liaison work	1.5
Multidisciplinary team meeting Support for team members outside the meeting	0.5
Emergency work/maternity liaison visits	0.5
Complex patient reviews, including multi-professional meetings for high-risk patients/ child safeguarding meetings/mental health legislation work	0.5
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Perinatal job plan for community and maternity liaison roles	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patients work/home visits	3
Multidisciplinary team meeting/support for team members outside the meeting	1
Emergency work/liaison visits	1
Complex patient reviews/child safeguarding meetings/mental health legislation work	2
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Eating disorders psychiatry

Eating disorders are a group of very complex psychiatric disorders that include anorexia nervosa, bulimia nervosa, binge eating disorders and atypical eating disorders. The complexity of these disorders can be gauged from the fact that at 12 months of treatment only 50% of adolescents with anorexia nervosa go into remission and at 6 months only 40% of patients with bulimia nervosa go into remission, with relapse common. Research indicates that childhood onset of eating disorder carries a high risk of continuity into adulthood. Hospital treatment of patients with eating disorders appears to be associated with worse prognosis; the number of patients with eating disorders who needed hospitalisation has doubled in last three years. More than six out of every ten people with eating disorders experience other psychiatric comorbidities such as depression, anxiety and obsessive–compulsive disorder (OCD). Eating disorders carry the highest risk of mortality among all the psychiatric disorders because of significant level of medical complexities associated with restriction of food intake. Patients with eating disorders also carry higher risks of self-harm and suicide. People with eating disorders display a distorted attitude towards eating, weight and shape and may have irrational fear of becoming fat.

The treatment of eating disorders involves individual and family-based therapies, management of physical and psychiatric risks and nutritional support. Consultant psychiatrists, with their comprehensive psychiatric, medical and psychological training, offer clinical leadership to eating disorder service teams. Besides offering consultation on management and supervision to team colleagues, consultant psychiatrists are also able to use their expertise in mental health legislation (Mental Health Act 1983, Mental Capacity Act 2005 and other forms of legislation, e.g. Children Act 2004) to offer best possible care to the patients and safeguard their interests.

Clinical role

Apart from the general roles applicable to consultants (pp. 14–16), consultant psychiatrists working in an eating disorder service have very specific roles.

- Psychiatric assessment of patients to establish eating disorder and other psychopathology.

- Leading on medical assessment of patients with eating disorders and offering suitable advice by ordering necessary investigations, liaising with medical, paediatric, GP and accident and emergency (A&E) colleagues in order to manage physical complications of the eating disorder patients.
- Psychiatric and medical risk assessment and management.
- Liaising with children's services, Social Services, education authorities, GPs, medical and psychiatric colleagues in CMHTs and families to offer comprehensive care to patients with eating disorders.
- Help with implementation of national (NICE eating disorder guideline (National Institute for Health and Care Excellence, 2017), MARSIPAN (Royal College of Psychiatrists et al, 2016) and Junior MARSIPAN (Royal College of Psychiatrists, 2012), local guidelines and pathways.
- Work with team colleagues to help the eating disorder teams achieve NHS England and Department of Health eating disorder service-related directives (i.e. access and waiting time directives).
- Work with team colleagues to help eating disorder teams comply with use of routine outcome measures (ROMs) and effective use of different eating disorder specific tools for better screening and diagnosis of eating disorder patients and also for effective monitoring of their progress with treatment.
- Offer suitable therapeutic input to patients with eating disorders in different modalities such as enhanced cognitive–behavioural therapy (CBT-E), family therapy and dialectical behaviour therapy (DBT).
- Offer supervision to eating disorder team colleagues in complex case management of eating disorder patients (e.g. patients on CPA).
- Offer management and monitor progress of psychiatric comorbidities among eating disorder patients such as depression, anxiety, OCD and autism spectrum disorder.
- Offer psychopharmacological management both licensed and off-licence, as indicated in NICE guidelines, and monitor such patients.
- Knowledge and use of mental health legislation (the Mental Health Act 1983, Mental Capacity Act 2005, Children Act 2004) and other applicable legal frameworks in the management of patients with eating disorders and to safeguard their needs.
- Write reports to help eating disorder patients in relation to legal frameworks such as mental health review tribunals and courts and their social care, work, training, education and accessing benefits.

Leadership role

- Take a leadership role in developing guidelines and pathways to set, develop and embed eating disorder services.
- Take a leadership role in liaison with managers in local and regional negotiations with commissioners and providers to attract and generate funding for eating disorder service.
- Take a leadership role and offer psychiatric expertise in contract negotiations and employing suitable staff with required training and qualifications to the eating disorder teams.
- Take a leadership role in being part of local and regional clinical networks to enhance understanding about eating disorders and promote co-working among professionals with varied backgrounds and colleagues from third sector to deliver high-quality of care.
- Take leadership roles in clinical governance, audit and standard setting of an eating disorder service and monitoring of patient feedback and outcome measures in collaboration with other colleagues in the team, and to use patient and carer feedback to set direction of the service.
- Take a leadership role in setting and running suitable transition groups between young people's eating disorder service, adult services, tier 3 CAMHS services, adult CMHTs and tier 4 regional eating disorders in-patient units for effective transition of care of patients with eating disorders to suitable services.
- Take a leadership roles in the Faculty of Eating Disorders of the Royal College of Psychiatrists and similar forums such as NHS England policy-making bodies to contribute to national policy-making and direction-setting in the field of eating disorders.

Educational role

Key components of the leadership role within the specialty:

- Take an active role in training and teaching of staff from eating disorder service teams and wider mental health services staff to improve their understanding and knowledge of latest evidence-based practice in eating disorders.
- Take an active role in education of people from wider networks such as parents, carers, social workers, schools and colleges, youth centre staff, school nurses, GPs and other medical and paediatric colleagues to reduce stigma about eating disorder patients and promote awareness, early detection, diagnosis and management of such patients for better prognosis.
- To educate and train primary and secondary care staff in early recognition and referral of eating disorder patients to suitable services.

- Take active role and contribute to innovation and research in the field of eating disorder.
- Offer educational and clinical supervision to junior and senior psychiatric trainees and offer teaching to medical students.

Information to support job descriptions and job plans

- There is a wide variation in staffing, set-up and delivery of eating disorder services across the country.
- The variation is pronounced in terms of staff background and numbers between young people's, adult and in-patient eating disorder services, though the principles of evidence-based treatment remain the same. There is evidence in young people under 18 to suggest that community-based treatment (out-patient and day patient services) work as well as or better than in-patient treatment for this group.
- For in-patient eating disorder service jobs 1.5–2.5 PAs of consultant psychiatrists are needed for each 3 beds.
- The need for consultant psychiatrist time can change based on availability of non-career grade doctors and trainee doctors in the eating disorder services.
- Consultant psychiatrists should have 7.5 DCCs (direct clinical care) and 2.5 SPAs split for a 10 PA WTE job.

Eating disorders consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Triage/CPA/PQC review	1.0
Assessment clinics/out-patient/in-patient review	2.5
Emergency/in-reach/ward round	1.0
Case management/CBT/family therapy group	1.0
Multidisciplinary team meeting/case discussion/supervision	1.0
Clinical administrative tasks and professional meetings	1.0
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Neuropsychiatry

A consultant in neuropsychiatry has a particular expertise in the psychiatric care of patients with organic psychiatric conditions including comorbid neuropsychiatric conditions associated with acquired brain injuries, sleep disorders, epilepsy and other neurological conditions. They also have specialist knowledge of and skills in managing functional neurological conditions, neurocognitive disorders and complex neurodisability. In addition to the general consultant roles set out on pp. 14–16, a consultant neuropsychiatrist has the specific expertise listed below.

Clinical role

- Assessment, diagnosis and formulation of management plans with patients and carers for comorbid neuropsychiatric conditions associated with various neurological conditions, epilepsy, acquired brain injuries and sleep disorders.
- Assessment, diagnosis and formulation of management plans with patients and carers for functional neurological conditions.
- Expertise in the management of psychiatric illness in patients with complex neurodisabilities.
- Expertise in pharmacological, psychological and behavioural interventions to manage behavioural problems associated with neurological conditions, acquired brain injury and complex neurodisability.
- Expertise in assessment, diagnosis and formulation of management plans with patients and carers for neurocognitive disorders in younger adults, and in neurosciences settings associated with neurological conditions or drug and alcohol misuse.
- Particular expertise in the diagnosis and management of delirium in neuropsychiatry settings.
- Expertise in assessment and management of neuropsychiatric conditions associated with neurosurgical procedures such as epilepsy surgery and other procedures such as vagal nerve stimulation and deep brain stimulation.
- Expertise working in varied settings, including neuroscience centres, neurorehabilitation settings, specialist in-patient settings, general hospitals, residential/nursing homes and patients' own homes, with multi-professional and multi-agency teams.
- Availability to provide psychiatric opinion and assessment of patients for primary care, secondary hospital care, neuropsychiatry services and colleagues in other psychiatric subspecialties.

Information to support job descriptions and job plans

In neuropsychiatry services there are many different models of service provision, ranging from highly specialised out-patient services, neuropsychiatric in-patient units and liaison with neurosciences centres to neurorehabilitation centres. In these services, consultants work with a broad range of multidisciplinary staff from mental health, neurosciences, neurorehabilitation and primary care services. The workload of a neuropsychiatrist would vary depending on the kind of service provided and local referral criteria.

In addition to expertise in mental health legislation, knowledge of capacity-based legislation is required and time to implement these is needed in all job plans.

Neuropsychiatrists, like general adult psychiatrists, can be appointed to solely in-patient, out-patient, neurosciences liaison neuropsychiatry or mixed jobs.

Full-time out-patient neuropsychiatry

The expected workload of a full-time consultant neuropsychiatrist is dependent on a range of factors, including which elements of service provision are included, the size and composition of teams, sources of referral, types of specialist clinics provided and geographical area served.

The clinical work of an out-patient-based neuropsychiatrist can be broken down as set out under ‘Clinical roles’ (p. 66). The allocation of these tasks within a job description will depend on the clinical role expected of the consultant and the other staff available to undertake a proportion of these tasks.

It is reasonable for a full-time out-patient neuropsychiatry consultant to have 5 PAs per week for direct patient care in out-patient assessments. New patients in the out-patient clinic require approximately 75 min. Follow-up appointments require 45 min. These times are increased when a new patient is assessed during a home visit; up to 2 h should be allowed. Consultation liaison visits to in-patients will also vary and times to provide assessment are variable, depending on the patient and the context in which they are being seen. Clinics should be structured so that there is time built into the clinic to supervise trainee assessment and see the patient.

Time needs to be made available within a job plan for emergency assessments in the clinic if they are to be undertaken by consultant staff. If such assessments are undertaken by other members of the multidisciplinary team, time should be available in the consultant’s job plan for the clinical support and supervision of decisions made. A minimum of 1 PA per week is likely to be required for emergency work.

Multidisciplinary working entails a weekly multidisciplinary team meeting to discuss patient care. This requires 1 PA, which includes time for support and advice to members of the multidisciplinary team about patient care outside the team meeting.

Additional clinical administration time is needed for review of neuroradiological or neurophysiological investigations and for attendance at multidisciplinary complex patient reviews – a minimum of 0.5 PA per week is required, but some jobs will need specific extra neurophysiological time and expertise (e.g. in a sleep clinic).

If an employer wishes a consultant to spend more time undertaking emergency work or participating in multidisciplinary patient reviews, this would need to be offset by a reduction in out-patient clinics and home visits.

Neuropsychiatry consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient work	5
Multidisciplinary team meeting and support for team members outside the meeting	1
Emergency clinical work	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Full-time in-patient neuropsychiatry posts

It is expected that each consultant should have sufficient time within their timetable to personally review each patient at least once a week. Consultants should have time to visit the ward each day to be available for day-to-day decisions requiring consultant input.

The principles underpinning safe and effective in-patient work are as set out in the section on general adult psychiatry (pp. 14–16).

Full-time neurosciences liaison neuropsychiatry posts

This job would require a balance between the two jobs, a neurosciencs post and a liaison neuropsychiatry post. There could be a combination of between 1 and 3 PAs for out-patient clinics and 1–3 PAs for ward assessment and advice role. In total, these two roles should amount to 5 PAs.

A weekly ward round would be required to review the patients on a neurosciences ward. This is likely to require 1 PA. Clinical liaison and multidisciplinary work would require 1 PA.

Other administrative tasks concerning in-patient care include, for example, unscheduled telephone calls, correspondence, checking of blood results and other investigations including neurophysiology and scans – 0.5 PA in total.

Liaison neuropsychiatry consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7.5
Out-patient clinics (1–3 PAs) Ward-based clinical activity including clinical decision meeting and interviewing patients and carers (1–3 PAs)	5
Ward round	1
Multidisciplinary work	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	2.5

Other mixed neuropsychiatry posts

There could be other mixed neuropsychiatry posts that could have different elements of the two jobs in different proportions, based on the local service and commissioning arrangement and nature of specialist neuropsychiatry services. It is anticipated that these services would have appropriate balance of clinical sessions based on the earlier job examples in this section.

Medical psychotherapy

Medical psychotherapists integrate the delivery of talking therapies with other effective biopsychosocial interventions. They promote the therapeutic value of relationships, partnerships and the application of knowledge from the neurosciences. They have a range of skills that are particularly helpful for patients who present with complex difficulties such as personality disorders, medically unexplained symptoms. They specialise in diagnostic and therapeutic complexity and can bring understanding to complex patient's interactions with healthcare professionals and teams, so that the patient may be better helped.

Clinical role

In addition to the general consultant roles set out on pp. 14–16, the consultant medical psychotherapist has specific expertise in:

- delivering psychological and social interventions to reduce distress in families, in communities, and in the broader systems in which an individual lives
- providing clinical supervision to a range of staff
- ensuring robust clinical governance frameworks for psychological therapy services
- developing and maintaining psychological, social and cultural health in institutions
- promoting public understanding of mental health.

Leadership role

With their training in organisational and team relations, medical leadership and expertise across a range of psychotherapeutic models, medical psychotherapists are well placed to offer expert advice on service and organisational development.

Their expertise is most applicable to psychological treatment services and specialist services for those with complex needs. These may include specialist personality disorder services, services for individuals with medically unexplained symptoms, services for people with treatment-resistant affective and anxiety-related disorders, eating disorder services, perinatal services and integrated models of care organised across agencies, as well as advising on the psychological basis of organisational principles generally. Consultant psychiatrists

in medical psychotherapy may also be involved in:

- developing existing psychological treatment services in keeping with the evidence base
- advising on innovations in psychotherapeutic practice
- establishing and monitoring a clinical governance framework for psychological treatments
- developing protocols regarding the use of psychological and pharmacological interventions
- planning and developing new services in line with national, regional and local priorities
- advising on the mental health of the workforce, psychologically minded practice and the support that teams require to sustain compassionate care, and
- bringing their distinctive medical and psychological perspective to the leadership of their organisation.

Information to support job descriptions and job plans

In addition to their own direct contact with patients, consultants in medical psychotherapy play a key role in supporting other staff in the management of patients. This activity is clinical work and should be considered as direct patient care. Consultants in medical psychotherapy should have at least 3 PAs for supporting professional activities, reflecting their major contribution to education and training for the whole clinical workforce.

Consultant psychiatrists in medical psychotherapy also commonly work in psychological therapies services alongside psychology teams and adult psychotherapists. Medical line management must be in place for consultant psychiatrists in medical psychotherapy, in order to oversee the fulfilment of clinical governance requirements, the requirement for provision of a consultant peer group for appraisal and revalidation and the requirement that consultants should work to a suitable personal development and job plan.

The GMC requirements for good medical practice must be met for consultant psychiatrists in medical psychotherapy as they would be for any other doctor. Line management by psychologists or operational managers is not a suitable arrangement to ensure the above standards are met.

Medical psychotherapy consultant job plan	
Description	**Professional activities (PAs) per week**
Direct clinical care	7
Referrals management as part of a single point of entry for psychological therapy services including management of waiting list	0.5
Therapeutic assessments of complex cases in out-patients, on the wards, or in patient homes as indicated	1
Treatment of complex cases in out-patients, on the wards or in patient homes as indicated (e.g. individual psychotherapy, group psychotherapy, family therapy)	2.5
Supervision including direct clinical supervision of clinical staff, indirect clinical supervision of other supervisors and clinical managerial supervision of those managing clinical services	1.5
Reflective practice meetings, Balint groups and away day facilitation	1
Clinical administrative tasks	0.5
Supporting professional activities (CPD, QI activity, supervision, appraisal and job planning)	3

Academic psychiatry

A clinical academic has undertaken all the necessary training to become a clinical consultant as well as sufficient postgraduate research training to function as a productive clinical scientist at a senior level (usually senior lecturer or above).

Academic training varies and may involve a period as a junior researcher or research student, or a combined clinical academic training as a National Institute for Health Research (NIHR) academic clinical fellow or through one of the clinical lectureship schemes of the devolved administrations. This may be followed by a Medical Research Council, Wellcome or NIHR clinical training fellowship to MD or PhD level, followed by some years of research at the equivalent of a postdoctoral researcher level (often as a research fellow) where additional research training and experience is acquired. By the time the doctor comes to a clinical senior lecturer level, in addition to having an MD or a PhD , they have written and published a number of peer-reviewed papers in international journals, achieved research grant funding and presented their work at national and international conferences. Hence, they will have an established international profile in their research field, and have begun the process of supervising others in research (e.g. BMedSci, MSc, PhD students).

Clinical academics lead research portfolios to improve the understanding, diagnosis, prevention and treatment of mental disorders. They therefore have a pivotal role in raising the profile of psychiatry nationally and internationally (particularly through an improved understanding of its scientific base, firmly embedded in medicine and basic sciences), engaging students into psychiatry through teaching and research, inspiring and nurturing interest in the next generation of potential psychiatrists and contributing to new developments of direct benefit to health services and patient care. Academic psychiatrists also have an important role in generating evidence to improve understanding and treatment of psychiatric conditions, as well as facilitating the application of evidence to clinical practice.

Clinical academics are also generally very active in public engagement and thus make important contributions to the public understanding and recognition of psychiatry and allied disciplines.

All consultants have considerable academic knowledge and skills. Important clinically based research can be carried out by consultants whose main role is clinical but who have sessions set aside for academic work. With this dual capacity in mind, all clinical academic job descriptions should specify that academic appointees are required to have either two appraisals for the purposes of revalidation – one from their NHS trust and the other from their university – or a joint appraisal.

Clinical role

A clinical academic psychiatrist combines clinical practice with a senior academic role which will usually include both research and teaching. The clinical role of an academic psychiatrist will often be linked to their research interests and may therefore provide a specialist service and greater opportunities for patient engagement in research, which may be invaluable for collecting and reflecting on supporting information for revalidation. They are highly trained and motivated individuals who lead the specialty and ensure that psychiatry, and its central role in understanding and treating mental illness, moves forward for the benefit of our patients.

Leadership role

A clinical academic psychiatrist fulfils leadership roles in two main areas: as a clinical consultant and as a senior university academic. They will have a leadership role in the organisation, delivery and quality assurance of teaching and training in psychiatry to a number of groups, in particular to undergraduate medical students, as well as to other undergraduates (e.g. dentistry, psychology, neuroscience, nursing, social work, pharmacy, occupational therapy, law), clinical postgraduates and those in professional training (psychiatry trainees) for the MRCPsych. In addition, they will teach and supervise BSc/BMedSci research degrees and postgraduate MSc, MD and PhD students. They thus have a key role in recruiting and training psychiatrists of the future. In addition, as research involves collaborations between many different disciplines, well beyond the traditional clinical multidisciplinary teams, clinical academics are well placed to maximise the rich symbiosis of ideas and approaches from other medical specialties and intellectual disciplines (psychology, sociology, economics, systems theory, law, politics, physics, mathematics, biology, engineering, etc.).

The clinical academic is uniquely placed to translate clinical insights into research questions, assess quality of evidence, and ensure that the latest evidence is implemented and monitored in the clinical situation. Through publication, presentation and editorial responsibilities they make sure that relevant findings are disseminated and accessible. Also, through leadership roles in national and international committees and learned societies, clinical academics engage across a wide spectrum including policy makers and the public.

Educational and academic role

The clinical academic has a key role in furthering current understanding of, and treatment for, mental illness and in translating advances in basic science into benefits for patients and the general population. A major role is to generate new approaches, knowledge and services that help to drive forward improvements in diagnosis, treatment and outcome. Some clinical academics specialise in advancing teaching methodologies and content. Spanning the areas of knowledge, discovery, innovation, dissemination and implementation means that the clinical academic is uniquely placed to drive service developments and will often provide clinical leadership as well as leading programmes of clinical research. Successfully combining both clinical and academic leadership roles is demanding, and so clinical academics need to be both highly trained and motivated. The more senior the clinical academic, the more research, teaching and managerial leadership is expected alongside maintaining a key leadership role in clinical services.

Information to support job descriptions and job plans

All academic job descriptions should state clearly where the funding for the post originates, as this will indicate what the nature of the role will be. It would be expected that the funding falls into one of the categories below:

- clinical academic posts jointly funded by a university and the NHS
- clinical academic posts completely funded by the NHS
- clinical academic posts completely funded by a university.

Clinical academic job descriptions should have four elements:

- clinical research
- clinical training
- clinical governance
- direct clinical care.

The College strongly advocates a minimum direct clinical care of 2 sessions, with 1–1.5 of SPA time; it should be clear what this SPA time comprises (i.e. NHS/academic time).

References

Academy of Medical Royal Colleges (2012) *The Benefits of Consultant-Delivered Care*. AoMRC.

Aitken P, Robens S, Emmens T (2014a) *Liaison Psychiatry Services – Guidance*. Mental Health Partnerships. Available at http://mentalhealthpartnerships.com/resource/liaison-psychiatry-services-guidance (accessed 9 November 2017).

Aitken P, Robens S, Emmens T (2014b) *Developing Models for Liaison Psychiatry Services – Guidance*. Mental Health Partnerships. Available at https://mentalhealthpartnerships.com/wp-content/uploads/sites/3/3-developing-models-for-liaison-psychiatry-services.pdf (accessed 9 November 2017).

Aitken P, Robens S, Emmens T (2014c) *Model Service Specifications for Liaison Psychiatry Services – Guidance*. Mental Health Partnerships. Available at https://mentalhealthpartnerships.com/resource/model-service-specifications-for-liaison-psychiatry-services/ (accessed 9 November 2017).

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). APA.

Brightey-Gibbons F, Patterson E, Rhodes E, et al (2017) *Quality Standards for Liaison Psychiatry Services, Fifth Edition*. College Centre for Quality Improvement.

British Medical Association, NHS Employers (2011) *A Guide to Consultant Job Planning*. NHS Employers & BMA.

Faculty of the Psychiatry of Old Age (2015) *Guidance for Job Planning* (FR/OA/03). Royal College of Psychiatrists (www.rcpsych.ac.uk/pdf/FROA03.pdf).

National Institute for Health and Care Excellence (2017) *Eating Disorders: Recognition and Treatment* (NG69). NICE.

NHS Digital (2016) *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014*. Available at https://digital.nhs.uk/catalogue/PUB21748 (accessed 9 November 2017).

NHS England (2015) *Care and Treatment Review: Policy and Guidance*. NHS England.

Royal College of Psychiatrists (2010a) *Role of the Consultant Psychiatrist: Leadership and Excellence in Mental Health Services* (Occasional Paper OP74). RCPsych.

Royal College of Psychiatrists (2011) *In Sight and In Mind: A Toolkit to Reduce the Use of Out of Area Mental Health Services*. RCPsych.

Royal College of Psychiatrists (2012) *Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa* (College Report CR168). RCPsych.

Royal College of Psychiatrists (2016) *Guidance for Office Accommodation and Administrative Support for Consultant Posts* (Position Statement PS06/2016). RCPsych.

Royal College of Psychiatrists, Royal College of Physicians, Royal College of Pathologists (2014) *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, 2nd edn* (College Report CR189). RCPsych.

World Health Organization (1992) *International Classification of Diseases, 10th edition* (ICD-10). WHO.

Further reading

A range of resources and useful reference documents are available on the regional advisor pages of the College's website: http://rcpsych.ac.uk/workinpsychiatry/workforce/regionalofficerpositions.aspx

For full details of reports available, please visit the College website at www.rcpsych.ac.uk/publications/collegereports.aspx

Psychiatry of Learning Disability

Royal College of Psychiatrists Higher Specialty Curriculum (ST4 – ST6)

Version 1.0

August 2022

Purpose Statement

The specialty of Psychiatry of Learning Disability is currently undergoing a change in terminology to Psychiatry of Intellectual Disability, in line with current thinking and practice. The GMC is in support of the change, however in order for the change to be reflected in our CCT and specialist registers, the name must firstly be changed by legislation. Until this point in time we are required to continue using the term Psychiatry of Learning Disability in relation to our training curriculum and to the CCT awarded on successful completion of training.

Learning disability is defined as: 'A condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities'.

The diagnosis requires:

- IQ of below 70.
- Deficits in one or more areas of adaptive functioning, for example, communication, social participation, independent living.
- Onset during the developmental period (up to age 18).

Psychiatrists working with people with Learning disabilities assess and treat people with Learning disabilities who present with a wide range of psychiatric disorders and associated behavioural challenges. They also assess and manage Autism, ADHD and other neurodevelopmental conditions as well as epilepsy[1] in this patient group.

The need for psychiatrists across the specialties is growing throughout the UK[2] [3] [4]. People with Learning disabilities have higher rates of mental illness than the general population. The prevalence of clinically diagnosed mental ill-health in adults with Learning disabilities has been found to be around 40%[5]; across the Learning disability population, there is an association between severe to profound Learning disability and mental ill-health[6]. Psychiatrists work with people with Learning disabilities across service transitions with other psychiatric specialties across the UK.

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[1] RCPsych College Report (CR203) – Management of Epilepsy in Adults with Intellectual Disability (May 2017)

[2] Facing the Facts, Shaping the Future – Health and Care Workforce Strategy for England to 2027

[3] The commission to review the provision of acute inpatient psychiatric care for Adults in England, Wales and Northern Ireland

[4] The State of Care in Mental Health Services, 2014 – 2017, CQC (2014)

[5] Learning disability and mental health – Mencap 2019

[6] Cooper SA, Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *British Journal of Psychiatry* (2007); 190: 27-35

They work with other teams, within the health service (e.g., specialist Autism teams), external agencies (e.g., social care and education) and the independent and third sectors, to provide systemic, holistic[7] person-centred[8] care. Learning disability psychiatrists work in a range of clinical settings in the community and inpatient services. They work with children, adults and offenders with Learning disabilities.

NHS England has stated in the NHS Long Term Plan that it is important for people with Learning disabilities to access mainstream services with support from specialist services where necessary, but equally that many people with Learning disabilities need to access specialist services to optimise their mental health[9]. The 2016 NICE guidance on mental health problems in people with Learning disabilities[10] highlights the key role of specialists with expertise in treating mental health problems in this population.

The Welsh Government's 'Together for Mental Health' 10-year strategy published in 2012 highlights the need for primary mental health services to be skilled and supported by Learning Disability Specialist Teams[119].

The 2018 'Improving Lives' Programme for people with Learning disabilities includes the recommendation that people with complex needs have timely and easy access to specialist Learning disability services through maintaining multidisciplinary teams, and developing appropriate care services, including mental health and out of hours access[12].

The Scottish Mental Health Strategy[13] has identified the need to shift the balance of care towards mental health. Following on from this, the Scottish Government has included people with Learning disabilities in the new Mental Health Quality Indicators, so that people's experiences can be improved[14].

Northern Ireland has higher levels of mental ill health than any other region in the UK[15]. An independent review of Mental Health and Learning disability service provision identified that building up the range of specialist mental health services is required to meet that need[16].

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

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

[9] NHS England: National Plan – Building the right support (October 2015)

[10] Mental Health problems in people with learning disabilities: prevention, assessment and management (NICE guideline, NG54) (September 2016)

[11] Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales

[12] Learning Disability – Improving Lives Programme (June 2018), Wales

[13] Scottish Mental Health Strategy, 2017 – 2027 (March 2017)

[14] Mental Health Quality Indicator Profile, ISD Scotland (February 2019)

[15] Making life better: A whole system strategic framework for public health

[16] Evaluation of the 2009-2011 Bamford Action Plan (December 2011). *Department of Health, Social Services and Public Safety, Northern Ireland.*

Training in Psychiatry of Learning disability begins with recruitment to the training programme, after successful completion of Core psychiatric training and the MRCPsych examinations.

It is recommended that training in Psychiatry of Learning Disability is undertaken over a recommended 36 months whole time equivalent (WTE) in order to achieve the required capabilities and gain the necessary experience to practice as a Consultant Psychiatrist in Learning Disability. Successful completion of the training programme leads to entry on to the Specialist Register.

The Psychiatry of Learning disability curriculum builds on the clinical capabilities attained in Core psychiatric training such as advanced communication and interpersonal skills, examination skills, formulation, diagnosis and treatment to a mastery level. The particular focus at higher level is on adapting these skills to meet the needs of people with Learning disabilities. It also involves the further development of capabilities such as leadership and management, teaching, research and quality improvement.

By the end of ST6 trainees in Psychiatry of Learning disability will have developed the necessary capabilities to gain a CCT in this specialty registerable with the GMC, and will be ready to practice as a Consultant Psychiatrist in Learning Disability.

These capabilities include specialist skills in the assessment, formulation, diagnosis and management of mental disorders, behavioural challenges, neurodevelopmental disorders and epilepsy in people with Learning disabilities.

Trainees will have developed high level communication skills and specialist clinical expertise in the complex presentation of mental disorders in this population and be able to manage both simple and complex presentations at all levels of intellectual and communicative functioning.

They will also develop specialist capabilities in the delivery of psychological, pharmacological, and social interventions modified to meet the unique needs of people with Learning disabilities.

Training will be delivered in multidisciplinary teams in community, inpatient and settings across both health and social care services.

Trainees will have particular expertise in applying legal frameworks surrounding capacity/incapacity and mental disorder and be fully versed in the management of risk in patients with Learning disabilities.

They will practice systemic, holistic care for people throughout the patient journey, taking into account the psychological, biomedical and social context for each individual and be active advocates for their patients within the wider health and social care system.

People with Learning disabilities experience the same range of mental disorders as the wider population, albeit with a more varied presentation dependant on developmental level, cognitive profile and nature of any communication impairment. Higher level trainees will, therefore, gain experience of assessing and

managing the full range of mental illnesses as seen by other psychiatric specialties, allowing for flexibility and transferability of skills.

Psychiatry of Learning disability has limited interdependencies with other specialties.

The following is a list of medical specialists that a CCT holder in Psychiatry of Learning Disability will work with as part of the regular service delivery:

- Child and Adolescent Psychiatry
- General Psychiatry
- Forensic Psychiatry
- Old Age Psychiatry
- Liaison Psychiatry
- General Practitioners
- Secondary Care Specialists including Medicine and Surgery specialists, in particular we work closely with Neurology, Cardiology, Genetics and Sleep specialists.
- Paediatrics.

Wider professionals may include:

- Health professionals in the ID Multidisciplinary Team including Learning Disability nurses, speech and language therapists, Occupational therapists, Psychologists and psychotherapists, Physiotherapists.
- ID Crisis / Intensive Support Teams
- Neurodevelopmental teams e.g., Autism support teams.
- Primary care/secondary care ID liaison nurses
- Dental services including specialist dentists
- Dietitians
- Pharmacists
- Social workers.
- Education
- Police/probation/CJS
- Advocates / IMCAs
- Third sector
- Support providers
- Private sector providers
- Health and Social Care Commissioners
- Healthcare regulators e.g., CQC

The recommended three years spent in training will provide appropriate development of transferable skills and experience (e.g., advanced leadership, emergency psychiatry and complex decision making) as well as specialised skills and experience in Psychiatry of Learning disability. Trainees will also have transferrable skills and expertise in the diagnosis and management of neurodevelopmental disorders, including Autism and ADHD, which they can apply within the wider psychiatric population.

Trainees may also undertake dual training with Child and Adolescent Psychiatry[17] building upon skills from training in Psychiatry of Learning disability. The GMC approved dual-training programmes include shared capabilities and combinations of skills and experience for diverse service and population needs.

Due to these shared capabilities, dual training programmes can be undertaken in less than six years, the standard recommended training time for training in two psychiatric specialties.

The learning outcomes in the Psychiatry of Learning Disability curriculum are mapped to the Generic Professional Capabilities (GPC) Framework, ensuring ease of transfer between medical specialties.

Through attainment of the High-Level Learning Outcomes (HLOs), this curriculum will enable trainees to lead and work in multidisciplinary and multi-professional teams, provide leadership and participate in research, teaching and training across a variety of clinical settings. It will also enable trainees to gain experience in formulating person-centred, systemic, holistic management plans for people with Learning disabilities and their care and support networks.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

[17] GMC Approved Dual Training Programmes in Psychiatry

The below tables outline the High Level Outcomes (HLOs) and Key Capabilities (KCs) to be achieved under 16 key themes.

The reference in brackets below each HLO is to the GMC Generic Professional Capabilities. HLOs are mapped to the nine GPCs.

High Level Outcome 1 (GPC 1)	**Demonstrate the professional values and behaviours required of a Consultant Psychiatrist with reference to Good Medical Practice, Core Values for Psychiatrists (CR204) and other relevant faculty guidance.**
Themes	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
1.1 Professional Relationships	Work collaboratively and effectively with patients with learning disability, their families, their carers of all ages, and colleagues, while managing complex risk and system dynamics.
	Recognise, validate and actively address systemic and structural inequalities, intersectionality, and their impact on clinical outcomes for patients and their carers of all ages, and on working relationships with colleagues
	Consistently demonstrate, and promote in others, a person-centred holistic approach to patients with learning disability, their families and their carers of all ages that is empathic, compassionate and respects their dignity, whilst remaining realistically optimistic and honest.
	Demonstrate flexibility, leadership, use of initiative, prioritisation, and adaptability, effectively managing your time and resources and using new technologies as appropriate.
	Understand the fundamental role of multidisciplinary team working in learning disability practice and the role of the psychiatrist within this.
	Apply an understanding of how culture and community influence patients with learning disability and their families, affecting their interaction with services.
	Set and maintain professional boundaries with stakeholders, for example adult services, commissioners, support providers, legal professionals, the police and primary and secondary care.
	Advocate for your patients with learning disability; where necessary do so separately to the needs and wishes of other systems, for example families and carers, primary and secondary care and social care.
1.2 Professional Standards	Understand the impact of workload, patient, team and organisational dynamics on your own well-being.
	Use supervision and reflection effectively, recognising your skills, limitations and your duty of candour.
	Apply strategies to take care of your wellbeing, seeking timely support and guidance, including acknowledging if you have a protected characteristic which might impact on your training, or if you are having difficulties adapting to working in the UK, and support trainees and other colleagues to do so too.

	Actively use and promote reflective practice in your team to address the emotional impact of work on yourself, the individual and the team.
	Consistently demonstrate a positive and conscientious approach to the completion of your work.
	Make clear, accurate and contemporaneous records.
	Promote psychiatry of learning disability as a specialty, including acting as an advocate for patients, families and carers.
	Maintain appropriate professional standards whilst working clinically, as a leader within a healthcare organisation and with other stakeholders.
	Maintain appropriate confidentiality in learning disability practice and advise other professionals within and outside the health and social care setting.
	Identify and challenge stigma and discrimination against people with learning disability.
	Promote the resources available within the specialist team to the wider health and social care system, in order to enable optimal physical health of patients.
	Take responsibility for raising and addressing issues of patient safety and quality of care in a timely manner.
	Maintain appropriate professional attitudes and behaviour when managing situations of ambiguity and uncertainty
	Demonstrate an understanding of the principles of sustainability and how they underpin sustainable psychiatric practice.

High Level Outcome 2.1 (GPC 2)	**Demonstrate advanced communication and interpersonal skills when engaging with patients, their families, carers of all ages, their wider community, colleagues and other professionals.**
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
2.1 Communication	Demonstrate an understanding of your own style of verbal and nonverbal communication and the impact of this on professional relationships.
	Consistently communicate effectively with patients across the spectrum of cognitive ability, including those with neurodevelopmental disorders and relevant others, utilising a range of methods and adapting your style of communication to the patient's needs, making reasonable adjustments as appropriate.

	Demonstrate skills in supporting those for whom English is not their first language, including the use of interpreters, and providing information in other languages
	Develop and maintain therapeutic relationships with your patients with learning disability, their families and their carers of all ages.
	Communicate effectively with colleagues in the multidisciplinary team and promote interagency working through effective liaison with external organisations.
	Analyse complex information and express your professional opinion coherently through both written and verbal communication.
	Produce written reports within the limits of your expertise, which are coherent, comprehensive, timely, accurate, relevant, and as appropriate taking into account legal principles and requirements.
	Effectively explain to patients with learning disability, their families and their carers of all ages, the outcome of the assessment and the recommended care plan, considering their ideas, concerns and expectations.
High Level Outcome 2.2 (GPC 2)	**Demonstrate advanced skills in the psychiatric assessment, formulation, diagnosis and person-centred holistic* management of an appropriate range of presentations in a variety of clinical and non-clinical settings within Psychiatry of Learning Disability.**
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
2.2 Clinical Skills	Demonstrate a person-centred holistic approach to the assessment and treatment of mental disorders in patients with learning disability considering relevant social, cultural, spiritual and religious factors.
	Demonstrate a working knowledge of the genetic causes of learning disability and the associated behavioural phenotypes.
	Understand the principles of life span issues that affect people with learning disability and their families, and how these influence the management of transitions.
	Demonstrate an appropriate understanding of learning and behavioural stages of human development through the lifespan including awareness of normative as well as variations in presentations, for example with neurodevelopmental conditions and across cultures.
	Demonstrate proficiency in the assessment of capacity to consent to care and treatment in patients with learning disability.

	Demonstrate an understanding of the social determinants of health, including economic deprivation, inadequate nutrition, educational and environmental factors and the impact of these on the aetiology and presentation of mental disorders in patients with learning disability.
	Apply advanced knowledge of the pharmacodynamics, pharmacokinetics, efficacy, tolerability, interactions and adverse effects of psychotropic medication in patients with learning disability as appropriate when initiating, reviewing, changing or discontinuing regimes.
	Demonstrate proficiency in obtaining a detailed psychiatric history and performing a mental state examination in patients with learning disability in both routine and urgent settings.
	Assess patients from a range of different cultural, spiritual, and religious backgrounds, including asylum seekers and refugees, and demonstrate an understanding of how protected characteristics may impact on clinical presentation.
	Conduct a thorough physical examination, request relevant investigations and make referrals to other specialists where appropriate.
	Assess the general health of your patients, taking into account the impact of their physical health on their mental health needs and vice versa. This assessment should include consideration of nutritional, metabolic, endocrine and reproductive factors and disorders, and the physical and mental impact of substance use and addiction on clinical presentation.
	Demonstrate proficiency in the assessment and diagnosis of mental and neurodevelopmental disorders in patients with learning disability across the spectrum of cognitive ability using classification systems as appropriate.
	Demonstrate proficiency in the assessment of risk in people with learning disability leading to a formulation and risk management plan.
	Demonstrate proficiency in the construction of a comprehensive clinical formulation relevant to patients with learning disability and use this to devise a safe, effective and evidence-based management plan.
	Demonstrate proficiency in use of formulation to support the understanding of challenging behaviour in patients with learning disability, including the link between communication and behaviour.
	Demonstrate an understanding of the utility and limitations of clinical rating scales and psychometric testing for people with learning disability with learning disability.

	Demonstrate skills in the assessment and management of acute mental health crises in patients with learning disability.
	Demonstrate specialist skills in the assessment and management of cognitive impairment in older patients with learning disability.
	Demonstrate an understanding of the assessment and treatment of epilepsy in patients with learning disability.
	Demonstrate advanced knowledge of psychological and psychotherapeutic treatments in the management of mental and behaviour disorders in adults with learning disability.
	Understand the range of community and inpatient treatment options for mental and behaviour disorders in patients with learning disability.
	Work effectively across professional interfaces by collaborating and liaising with other medical and psychiatric specialities to support provision of holistic care and treatment for your patients with learning disability.
	Demonstrate proficiency in prescribing safely and effectively for patients with learning disability in routine and urgent settings, considering the research evidence base, prescribing guidelines, individual patient factors and the views of patients and their support networks.
	Demonstrate an understanding of how physical treatments can be used for the treatment of mental disorders and apply this under supervision.
	Work with others using a person-centred holistic approach to safely manage behavioural challenges and to support behavioural and environmental change.
	Evaluate the outcome of interventions and treatments in patients with learning disability.
	Work across a variety of service settings including care homes, supported living placements, day services, educational facilities and hospitals.

High Level Outcome 2.3 (GPC 2)	Apply advanced management skills within Psychiatry of Learning Disability in situations of uncertainty, conflict and complexity across a wide range of clinical and non-clinical contexts.
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
2.3 Complexity & Uncertainty	Demonstrate an understanding of unconscious processes including transference, countertransference, projection and the experience of splitting, and the impact of these on professional relationships.
	Demonstrate proficiency in recognising and managing clinical uncertainty, ambiguity, divergent views and complex co-morbidities and associated risks relating to those with learning disability.
	Consciously vary from established care pathways where clinically indicated and justify these decisions as needed.
	Understand and work within the limits of your clinical capabilities, seeking timely support and consultation when needed.
	Demonstrate an understanding of individual variation and the impact of social, cultural, spiritual and religious factors, including effects of deprivation, discrimination and racism.
	Work with others to promote therapeutic optimism and hope in the management and care of patients with learning disability.
	Manage divergent views about patient care leading to appropriate clinical interventions.

High Level Outcome 3.1 (GPC 3)	Apply advanced knowledge of relevant legislative frameworks across the UK to safeguard patients and safely manage risk within Psychiatry of Learning Disability.
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
3.1 Knowledge of legal and organisational frameworks in your UK jurisdiction	Apply the current legislation governing the care and treatment of people with learning disability and mental disorders in a variety of settings, including the use of emergency powers and compulsory treatment.
	Apply the principles of least restrictive practice and human rights, when considering the application of legal powers across different settings.
	Demonstrate an understanding of complex ethical issues relevant to the care of people with learning disability.

	Give testimony at appropriately convened settings to review the legal status of a patient.
	Meet the requirements to apply for relevant statutory approval where appropriate.
High Level Outcome 3.2 (GPC 3)	**Work effectively within the structure and organisation of the NHS, and the wider health and social care landscape.**
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
3.2 Working within NHS and organisational structures	Demonstrate understanding of the national health priorities for people with learning disability in your UK jurisdiction, including the rationale behind annual health checks and associated health plans.
High Level Outcome 4 (GPC 4)	**Demonstrate leadership and advocacy in mental and physical health promotion and illness prevention for patients within Psychiatry of Learning Disability and the wider community.**
Theme	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
4.1 Health promotion and illness prevention in community settings	Apply an understanding of the range of health inequalities faced by people with learning disability and the multiple factors that contribute to premature mortality.
	Demonstrate an understanding of public health as it applies to people with learning disability, including mortality and morbidity data and how this relates to health disparity.
	Work with primary care, secondary care and statutory services as required to support your patients with learning disability in having their health needs met.
	Promote a healthy lifestyle in patients with learning disability and an understanding of the interrelationship between the body and the mind including the management of sleep, mental and physical disorders.
	Develop an understanding of the local data and how this compares with regional/national data.
	Demonstrate knowledge of the screening required in your patients with a genetic cause of their learning disability with appropriate onward referral/advice.
	Demonstrate an understanding of the physical health conditions associated with the most significant causes of morbidity and mortality in people with learning disability and engage with the local mortality review process for people with learning disability.

	Demonstrate advanced understanding of the concept of diagnostic overshadowing and how this affects people with learning disability and the care they receive, including challenging when this occurs in both primary and secondary care.
	Demonstrate advocacy for your patients and support other health professionals to make reasonable adjustments.

High Level Outcome 5 (GPC 5)	**Demonstrate effective team working and leadership skills to work constructively and collaboratively within the complex health and social care systems that support people with mental disorder.**
Themes	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
5.1 Teamworking	Recognise the strengths and weaknesses within a team and demonstrate how to work with these, using emotional intelligence and maintaining an awareness of one's own cognitive biases.
	Work in collaboration with patients with learning disability, their families and carers of all ages, and the multi-disciplinary team.
	Appraise, question and challenge the performance of other team members when standards appear to be compromised, and escalate concerns appropriately.
5.2 Leadership	Understand the importance of leadership and the role of a consultant psychiatrist in learning disability, in the context of team and multiagency working.
	Develop and apply your own advanced leadership skills in a variety of clinical and non-clinical settings.
	Demonstrate inclusive leadership style and awareness of the impact of hierarchy and power within relationships with patients and colleagues.
	Demonstrate an understanding of how your own advanced leadership skills and behaviours impact on others and adapt your approach where appropriate to meet the needs of the team.
	Lead, support and supervise others in both clinical and non-clinical settings.
	Understand the principles of mentoring and its role in career development and apply this knowledge in your practice.
	Demonstrate an understanding of the principles underpinning the management and delivery of services for people with learning disability.

	Manage and lead on improving and adapting the service in which you work, including managing referrals and delegating work appropriately.

High Level Outcome 6 (GPC 6)	Identify, promote and lead activity to improve the safety and quality of patient care and clinical outcomes of a person with mental disorder.
Themes	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
6.1 Patient safety	Understand and apply the principles of clinical governance, taking into account the impact of human factors and team dynamics, to assure patient safety and quality of clinical care.
	Apply understanding of the serious incident review process taking appropriate action where required.
	Demonstrate knowledge of risk management issues for services for people with learning disability, including risks to patients, families, carers of all ages, staff and members of the public.
	Understand the role of environmental risk assessment in learning disability settings and apply the principles of this to the settings in which you work.
	Demonstrate knowledge of the relevant policies and procedures for patient safety in your organisation and how to escalate concerns if these arise.
6.2 Quality improvement	Demonstrate knowledge of a range of quality improvement methodologies for developing creative solutions to improve services and apply this knowledge through participation and leadership of activity in your service.
	Demonstrate knowledge of mechanisms for obtaining feedback from patients, the public, staff and other interested groups, and utilise the feedback obtained to implement/manage change.
	Understand the role of the 'expert by experience' in improving patient care and support patients with learning disability and their families and carers of all ages to undertake this role.
	Demonstrate a clear understanding of local complaints procedures and participate in handling complaints made about services.
	Participate in and lead on clinical governance activities, risk management and audit in order to improve the quality of the service.
	Apply audit principles, relevant clinical guidelines and integrated care pathways to your own work and team practice.

High Level Outcome 7 (GPC 7)	Lead on the provision of psychiatric assessment and treatment of those who are identified as being vulnerable within Psychiatry of Learning Disability. Demonstrate advocacy, leadership and collaborative working around vulnerability and safeguarding in patients, their families and their wider community.
Themes	**Key Capabilities (KCs). By the end of ST6, you will be able to:**
7.1 Safeguarding	Recognise any health concerns, emotional and economic pressures impacting on carers of all ages, which contribute to vulnerability and safeguarding concerns in your patients with learning disability.
	Work within legislative frameworks and local processes to anticipate and report safeguarding concerns, providing leadership when necessary.
	Understand the role and responsibilities of psychiatric services in safeguarding people with learning disability and their support networks.
	Demonstrate an understanding around the use of safe, approved restrictive interventions in psychiatric services and the guidance surrounding this and work with others to minimise the use of these in clinical practice.
	Recognise signs of abuse and trauma in people with learning disability, their families, carers of all ages and the wider community.
	Demonstrate applied knowledge of risk management, including risks to patients with learning disability, carers of all ages, staff and members of the public.
	Assess risk, capacity to consent and the need for detention in complex cases with learning disability.
	Demonstrate an understanding of the issues around confidentiality in learning disability practice.
	Include the views and voice of the person with learning disability when working within safeguarding processes, mindful of capacity.

High Level Outcome 8.1 (GPC 8)	Promote and lead on the provision of effective education and training in clinical, academic and relevant multi-disciplinary settings.
Theme	Key Capabilities (KCs). By the end of ST6, you will be able to:
8.1 Education & Training	Provide education and training to medical, multi-disciplinary and multi-agency colleagues including effective planning, delivery techniques and feedback using technology as appropriate.
	Demonstrate knowledge of the process of continuing professional development and its role in maintaining practice and supporting revalidation.
	Apply the principles of co-production in teaching and training with people with learning disability and their families/carers.
High Level Outcome 8.2 (GPC 8)	**Demonstrate effective supervision and mentoring skills as essential aspects of education to promote safe and effective learning environments.**
Theme	Key Capabilities (KCs). By the end of ST6, you will be able to:
8.2 Supervision	Apply knowledge of the principles of clinical and psychiatric supervision, providing safe and effective clinical supervision in both emergency and non-emergency situations, in a timely manner.
	Actively participate in clinical, psychiatric and educational supervision.

High Level Outcome 9 (GPC 9)	Apply an up-to-date advanced knowledge of research methodology, critical appraisal and best practice guidance to clinical practice, following ethical and good governance principles.
Theme	Key Capabilities (KCs). By the end of ST6, you will be able to:
9.1 Undertaking research and critical appraisal	Critically evaluate data, papers, reviews, and meta-analyses and implement findings in daily clinical practice.
	Translate research into local clinical practice and disseminate critical appraisal findings to wider communities.
	Apply knowledge of up-to-date appropriate statistical methods.
	Demonstrate proficiency in the use of objective evidence-based clinical assessment instruments.

	Work within ethical frameworks when carrying out or appraising research.
	Apply the principles of Research Study Protocols where available.
	Demonstrate practical contribution to an ethically approved research study where relevant research support is available.

Additional References

1. Health matters: reducing health inequalities in mental illness (December 2018)
2. NHS Long term plan - 2019
3. Learning Disabilities Observatory – People with learning disabilities in England 2015: Main report
4. Transforming Care for People with Learning Disabilities – Next Steps (January 2015)
5. Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. NHS England, ADASS and LGA joint report (October 2015)
6. Autism spectrum disorder in adults: diagnosis and management (CG142). NICE (June 2012)
7. The Learning Disability Mortality Review (LeDeR) Programme: Annual Report 2018. NHS England.
8. The five year forward view for mental health: A report from the independent Mental Health Taskforce to the NHS in England (February 2016)
9. Making change possible: A Transformation Fund for the NHS
10. Mental Health Under Pressure: Briefing. The Kings Fund
11. Transforming care: A national response to Winterbourne View Hospital. Department of Health (December 2012)
12. Winterbourne View – Time for Change: Transforming the commissioning of services for people with learning disabilities and/or autism (2014)

Core Psychiatry

Royal College of Psychiatrists Core Training Curriculum (CT1 – CT3)

Version 1.0

August 2022

Purpose Statement

The purpose of the Core Psychiatry curriculum is to train medical doctors to specialise in the assessment, diagnosis, treatment and management of patients with mental disorders in a wide range of clinical settings in collaboration with the patient, other health professionals, and relevant others including families and carers of all ages.

Psychiatrists of the future will be well-equipped to:

- Maintain their key focus on developing and achieving the necessary professional values and behaviours, professional skills, and professional knowledge to build strong therapeutic relationships with their patients, their carers and families and to provide safe person-centred care.
- Embrace continuing person-centred[1], holistic [2]advances in Psychiatry, as well as developments in technology and practice, which are consistent with the principles of sustainability.
- Have the relevant specialist knowledge and communication skills to operate effectively in a range of service delivery landscapes.

It is recommended that Core Psychiatry training is undertaken over 36 months (WTE).

By the end of CT3 in Psychiatry, trainees will be able to diagnose and manage a range of psychiatric presentations in clinical practice under appropriate supervision, taking into account the needs and complexities of each individual patient. They will have a person-centred, holistic understanding of the patient experience, gained through working with patients with mental disorders across the lifespan in a range of specialties. Working with capacity and risk issues will form key elements of their skillset, as will advocacy and the reduction of stigma.

During core training it is recommended that trainees gain experience of two psychotherapeutic modalities as well as experience working with patients across the lifespan, including six months in Child & Adolescent Psychiatry and/or Psychiatry of Learning Disability, and with those with neurodevelopmental conditions.

Trainees are required to have sufficient experience of working in emergency settings including out-of-hours environments, to develop capabilities in emergency psychiatry. Reasonable adjustments will be made as necessary to achieve this (see Psychiatry Silver Guide).

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

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

There will be a critical progression point at the end of the third year (CT3) to ensure trainees have the required experience and capabilities to progress to higher specialty training. Trainees will be required to meet all curriculum requirements, including passing the MRCPsych examination.

It is recommended that core trainees attend an approved postgraduate psychiatry course delivering the MRCPsych syllabus through the period of core training.

The course complements work experience, supervision, WPBAs with taught elements of relevant basic sciences and clinical psychiatry and associated communication skills and problem solving delivered by specialists in the field alongside peers and experts by experience to develop the relevant specialist/post graduate knowledge, skills and competencies needed to obtain the learning objectives of the post graduate psychiatric curriculum.

It is clear that the need for psychiatrists across the specialties is growing throughout the UK[3] [4] [5]. The Five Year Forward View for Mental Health[6] in England includes commitments to ensure access to high quality services for one million more people of all ages.

The Welsh Government's ten-year strategy to improve mental health and well-being[7] has identified a range of areas that require attention. This includes providing better perinatal mental health care; ensuring each health board has Child & Adolescent Liaison Psychiatry and crisis services available seven days a week; the establishment of effective mental health psychiatric liaison capacity for district general hospitals; and to better address mental health/substance misuse needs of frequent attenders of emergency departments.

The Scottish Mental Health Strategy[8] shifts the balance of care towards mental health, increasing the level of investment in mental health services and improving support in the crucial period from birth to young adulthood. This will help improve attachment and reduce trauma in early years and thus positively affect the developing brain and help to reduce mental disorders in adulthood.

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[3] "There are predicted to be two million more people with mental health conditions by 2030**."** *Facing the Facts, Shaping the Future – a draft healthy and care workforce strategy for England to 2027, Public Health England, 2017.*

[4] *Old Problems, New Solutions: Improving acute psychiatric care for Adults in England*, The Commission to review the provision of acute inpatient psychiatric care for adults, *2016.*

[5] *The State of Care in Mental Health Services 2014 to 2017*, Care Quality Commission, 2017

[6] *The Five-Year Forward View for Mental Health, NHS England, 2016*

[7] *Together for Mental Health, Welsh Government, 2012*

[8] *Mental Health Strategy 2017-2027, Scottish Government, 2017*

Northern Ireland has higher levels of mental ill heath than any other region in the UK[9] and it has been identified that building up the range of specialist mental health services is required to meet need[10].

[9] *Making Life Better*, *Northern Ireland Assembly, 2014*
[10] *Evaluation of the 2009-2011 Bamford Action Plan*, *Dept. of Health, Social Services and Public Safety, 2012*

The Core Psychiatry curriculum will be flexible and adaptable, ensuring capabilities can be enhanced proactively in response to greater understanding of mental disorders and will be able to accommodate future mental health policy across the UK through regular review. [11] [12] [13]

Psychiatry has limited interdependencies with other specialties, with the exception of General Practice, Paediatrics and Child Health and Core Medical Training within the context of Broad-Based Training (where available).

The professional values and behaviours, skills and knowledge that trainees develop and demonstrate in their early years of training will continue to be enhanced.

The Core curriculum will enable psychiatry trainees to work alongside members of multi-disciplinary and multi-professional teams.

The Core Psychiatry learning outcomes are mapped to the Generic Professional Capabilities Framework (GPCs) ensuring ease of transfer between medical specialties.

Through attainment of the High Level Outcomes (HLOs), Core Psychiatry trainees will demonstrate the ability to work in multidisciplinary and multi-professional teams, formulating person-centred holistic management plans, provide leadership, teaching and training, and participate in research in a variety of clinical settings.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK

[11] *Montgomery and shared decision-making: implications for good psychiatric practice (2018)*
[12] *GMC Good Medical Practice*
[13] *RCPsych Core Values for Psychiatrists* (2017)

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The below tables outline the High Level Outcomes (HLOs) and Key Capabilities (KCs) to be achieved under 16 key themes.

The reference in brackets below each HLO is to the GMC Generic Professional Capabilities. HLOs are mapped to the nine GPCs.

High Level Outcome 1 (GPC 1)	**Demonstrate the professional values and behaviours required of a medical doctor in psychiatry, with reference to Good Medical Practice, and Core Values for Psychiatrists (CR204) and other relevant faculty guidance.**
Themes	**Key Capabilities (KCs). By the end of CT3, you will be able to:**
1.1 Professional Relationships	Work collaboratively with patients, families, their carers of all ages and colleagues respecting their autonomy, diversity and valuing their contribution.
	Understand, recognise, validate and actively address systemic and structural inequalities, intersectionality, and their impact on clinical outcomes for patients and carers of all ages and on working relationships with colleagues.
	Consistently demonstrate a person-centred holistic clinical approach to patients that is honest, empathic, compassionate, and respects their dignity while maintaining therapeutic optimism and boundaries.
	Demonstrate flexibility, leadership, use of initiative, prioritisation, and adaptability, effectively managing your time and resources and using new technologies as appropriate.
1.2 Professional Standards	Understand the impact of workload, patient and organisational dynamics on your own well-being.
	Use supervision and reflection effectively recognising your skills, limitations and your duty of candour.
	Develop strategies to take care of your wellbeing, seeking timely support and guidance, including acknowledging if you have a protected characteristic which might impact on your training or if you are having difficulties adapting to working in the UK.
	Use the method of receiving, reflecting and responding to understand and manage the emotional impact of work on yourself, the individual and the team, including the impact of suicide and homicide.
	Consistently demonstrate a positive and conscientious approach to the completion of your work.
	Make clear, accurate and contemporaneous records.
	Demonstrate the ability to use reflective practice during psychiatric supervision throughout core training, and through consistent attendance at a Balint group or case-based discussion group for a recommended minimum of a year.

	Demonstrate an understanding of the principles of sustainability and how they underpin sustainable psychiatric practice.

High Level Outcome 2.1 (GPC 2)	**Demonstrate advanced communication and interpersonal skills when engaging with patients, their families, carers of all ages, their wider community, colleagues and other professionals.**
Theme	**Key Capabilities (KCs). By the end of CT3, you will be able to:**
2.1 Communication	Demonstrate an appropriate understanding of the ways in which you, as well as patients and others, communicate both verbally and non-verbally.
	Consistently demonstrate effective communication approaches with patients and relevant others, including those with neurodevelopmental disorders making reasonable adjustments and adaptations where appropriate, including the use of new technologies.
	Consistently use active listening skills and empathic language which respects the individual, removes barriers and inequalities, ensures partnership and shared decision-making and is clear, concise, non-discriminatory and non-judgemental.
	Demonstrate effective communication and shared decision making with patients, taking into consideration their ideas, values, concerns and expectations.
	Explain the outcome of assessment, treatment and management to patients, families, carers of all ages as well as relevant others.
	Demonstrate an inclusive approach which considers all aspects of communication, language, sensory and cognitive needs, as well as the ethnic, social, and cultural, context of a patient.

High Level Outcome 2.2 (GPC 2)	**Demonstrate skill in the psychiatric assessment, formulation, diagnosis and person-centred holistic management of an appropriate range of presentations in a variety of clinical and non-clinical settings.**
Theme	**Key Capabilities (KCs). By the end of CT3, you will be able to:**
2.2 Clinical Skills	Demonstrate an understanding of the history of psychiatry, the development of diagnostic concepts and psychiatric treatments, as well as the profession, and the historical relationships between psychiatry and society.
	Demonstrate an appropriate understanding of a person-centred holistic approach to mental disorders, including a knowledge of developmental, social, cultural, spiritual/religious, trauma, adversity, genetic and epigenetic risks (including resilience and vulnerability factors) and neuro-biological influences on mental disorders.
	Demonstrate an in-depth understanding of human psychology, including the importance of early relationships, attachment styles, parenting, the impact of adverse childhood experiences, and traumatic events throughout life.
	Demonstrate an appropriate understanding of learning and behavioural stages of human development through the lifespan including awareness of normative as well as variations in presentations, for example with neurodevelopmental conditions and across cultures.
	Demonstrate an appropriate in-depth understanding of social determinants of health including the lived environment, deprivation and disadvantage and the impact these have on the aetiology and presentation of mental disorder across the lifespan.
	Apply knowledge of the pharmacodynamics, pharmacokinetics, efficacy, tolerability, interactions, and short and long-term side effects of medication.
	Receive a full psychiatric history from, perform a Mental State Examination (MSE) on, and assess capacity of, patients within a range of mental and neurodevelopmental disorders across the lifespan, in routine, urgent and emergency situations incorporating appropriate terminology
	Also assess patients from a range of different cultural, spiritual, and religious backgrounds, including asylum seekers and refugees, and demonstrate an understanding of how protected characteristics may impact on clinical presentation.
	Assess the risk of self-harm, suicide, risk to others as well as other risks, and ensure a safety plan is in place.

2.2 Clinical Skills (continued)	Receive a collateral history from a range of informants involved in patient care.
	Conduct a thorough physical examination, undertaking relevant physical investigations and take responsibility for acting on your findings in a timely fashion.
	Thoroughly assess the general health of your 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.
	Demonstrate skills in assessing and managing patients with addictions.
	Demonstrate an understanding of the inherent power imbalance between doctor and patient, particularly for those with protected characteristics, which can result in barriers to clinical effectiveness.
	Demonstrate an understanding of individual variation and the impact of social, cultural, spiritual and religious factors, including effects of deprivation, discrimination and racism.
	Clearly and concisely present the history, mental state examination, diagnosis and differential diagnosis, and findings of the physical examination using appropriate classification systems to other professionals.
	Use an appropriate formulation framework to devise a safe, systemic, effective, collaborative and co-productive management plan to ensure continuity of care in the immediate, short and longer term.
	Where appropriate, safely prescribe evidence-based pharmacological treatment referring to relevant guidelines.
	Demonstrate an understanding of how Electro-Convulsive Therapy (ECT) and other physical treatments can be used for the treatment of mental disorders and apply this under supervision.
	Demonstrate appropriate psychotherapeutic capabilities through having delivered treatment in a minimum of two psychotherapeutic modalities over both short and long durations in a suitable setting, under the governance of the Medical Psychotherapy Tutor.

High Level Outcome 2.3 (GPC 2)	**Demonstrate an understanding of the various factors that contribute to complexity and uncertainty within psychiatric practice and the impact that they have on self, patients, carers of all ages, and colleagues.**
Theme	**Key Capabilities (KCs). By the end of CT3, you will be able to:**
2.3 Complexity & Uncertainty	Demonstrate an understanding of unconscious processes, including transference, countertransference, projection and splitting and the impact of these on yourself and others.
	Review treatment and management plans of patients when the outcome is not as expected or hoped for.
	Understand the limits of your clinical capabilities, seeking timely support and supervision when appropriate.
	Observe, absorb, contain and reflect on complex clinical/non-clinical situations to develop a balanced response.
	Manage increasing levels of uncertainty safely under supervision.

High Level Outcome 3.1 (GPC 3)	**Apply knowledge of relevant legislative frameworks across the UK to safeguard patients.**
Theme	**Key Capabilities (KCs). By the end of CT3, you will be able to:**
3.1 Knowledge of legal and organisational frameworks in your UK jurisdiction	Apply knowledge of the current legislation governing the care and treatment of people with mental disorders.
	Balance the duty of care to the patient and the protection of others with the restriction of human rights when considering the use of legal powers.
	Meet the requirements to apply for relevant statutory approval where appropriate.

High Level Outcome 3.2 (GPC 3)	Work effectively within the structure and organisation of the NHS, and the wider health and social care landscape.
Theme	Key Capabilities (KCs). By the end of CT3, you will be able to:
3.2 Working within NHS and organisational structures	Demonstrate working knowledge of local health and social care services, national health and care services and regulatory authorities through your interactions with them, both routinely and in unforeseen circumstances.

High Level Outcome 4 (GPC 4)	Apply core knowledge of mental and physical health promotion and illness prevention for patients and the wider community.
Theme	Key Capabilities (KCs). By the end of CT3, you will be able to:
4.1 Health promotion and illness prevention in community settings	Apply an understanding of the factors contributing to health inequalities, and the social, cultural, spiritual and religious determinants of health.
	Promote mental well-being and prevention of mental disorders within the context of societal change and social technology, identifying and challenging stigma and discrimination against people experiencing mental disorder.

High Level Outcome 5 (GPC 5)	Apply teamworking and core leadership skills to work constructively and collaboratively within the complex health and social care systems that support people with mental disorder.
Themes	Key Capabilities (KCs). By the end of CT3, you will be able to:
5.1 Teamworking	Demonstrate an awareness of how individual personal qualities, emotions and behaviours of both yourself and your team, impact on teamworking and the quality of patient care.
	Demonstrate a working knowledge of the roles and responsibilities of, and the interface between, multidisciplinary team members.

5.2 Leadership	Recognise the leadership skills of others in a range of contexts.
	Demonstrate the development and application of your own leadership skills.
	Demonstrate inclusive leadership style and awareness of the impact of hierarchy and power within relationships with patients and colleagues.

High Level Outcome 6 (GPC 6)	Participate in and promote activity to improve the safety and quality of patient care and clinical outcomes in your psychiatric practice of a person with mental disorder.
Themes	Key Capabilities (KCs). By the end of CT3, you will be able to:
6.1 Patient safety	Ensure patient safety is paramount by understanding the principles and engage with the systems of clinical governance that assure safety and quality of patient care.
6.2 Quality improvement	Demonstrate an understanding of the impact on quality improvement activities in improving patient outcomes and system performance.
	Undertake quality improvement activities relevant to your clinical practice.

High Level Outcome 7 (GPC 7)	Identify patients, their families and others from the wider community who may be vulnerable and work collaboratively in safeguarding their welfare.
Themes	Key Capabilities (KCs). By the end of CT3, you will be able to:
7.1 Safeguarding	Demonstrate knowledge of the individual and systemic factors contributing to the vulnerabilities and safeguarding concerns in people of all ages.
	Work within legislative frameworks and local procedures to raise and report safeguarding and welfare concerns in a timely manner and contribute to safeguarding processes.

High Level Outcome 8.1 (GPC 8)	Plan and provide effective education and training in clinical, academic and relevant multi-disciplinary settings.
Theme	Key Capabilities (KCs). By the end of CT3, you will be able to:
8.1 Education & Training	Apply the principles of lifelong learning to your own learning and teaching of others, including the principles of feedback.
High Level Outcome 8.2 (GPC 8)	**Demonstrate effective supervision and mentoring skills as essential aspects of education to promote safe and effective learning environments.**
Theme	Key Capabilities (KCs). By the end of CT3, you will be able to:
8.2 Supervision	Actively participate in clinical, psychiatric and educational supervision.
	Consider how unconscious processes are managed effectively and safely to help with ongoing clinical care via supervision and reflective practice.

High Level Outcome 9 (GPC 9)	Apply an up-to-date knowledge of research methodology, critical appraisal and best practice guidance to your clinical practice.
Theme	Key Capabilities (KCs). By the end of CT3, you will be able to:
9.1 Undertaking research and critical appraisal	Demonstrate knowledge of ethical frameworks and research methodologies when carrying out or appraising research.
	Discuss the differences between research, audit, and quality improvement and how these approaches can complement each other.
	Critically appraise research and understand generalisability of findings to different groups in the implementation of research findings in your clinical practice.
	Develop or participate in a research project where relevant research support is available.

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Psychiatry Silver Guide

Guidance for Psychiatric Training in the UK

Version 1.0

August 2022

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: specialtytraining@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.

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 trainees 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 trainee 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 trainees 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 trainees and trainers to ensure that opportunities are provided for trainees in all settings.

MRCPsych Examination

Prior to entering higher-specialty training at ST4, trainees 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 trainees participate in reflective practice. At core training, trainees are expected to undertake a short and long-case in psychotherapy under the governance of a medical psychotherapy tutor. Trainees 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

Trainees 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 trainees 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, psycho-therapy, 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.

Trainees 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, trainees 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.

Trainees are encouraged to attend relevant College faculty meetings, trainee conferences run by the Psychiatric Trainees' 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 trainees arrange to attend a course outside of region if applicable. Course organisers should aim to accommodate trainees from outside of region, for example by hosting hybrid (virtual/face to face) course sessions.)

In addition, trainees 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

Trainees 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).

Independent (self-directed) learning

Training in psychiatry is portfolio based, and trainees 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 RCPsych's e-learning modules within the TRoN platform.

3 Undertaking a specialty training programme

Once trainees 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 HEE North West.

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

3.2 Training numbers (applicable to core and specialty trainees)

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

Core trainees 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 that (subject to satisfactory progress) have an end point of the award of a CCT or CCT CP.

4 Routes to registration

4.1 Certificate of Completion of Training (CCT)

Psychiatry trainees 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 (Adult) psychiatry
- Child and adolescent psychiatry
- Forensic psychiatry
- Psychiatry of learning (intellectual) disability
- Medical psychotherapy
- Old age psychiatry.

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

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

Trainees 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 trainees wish to apply for consultant posts in these emerging specialties.

At core training level, trainees 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 to be re-named ‘Adult psychiatry’.
- Psychiatry of learning disability to be re-named ’Psychiatry of intellectual disability’.

- Endorsement in Substance-misuse psychiatry to be 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. Trainees 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 trainees 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 specialtytraining@rcpsych.ac.uk.

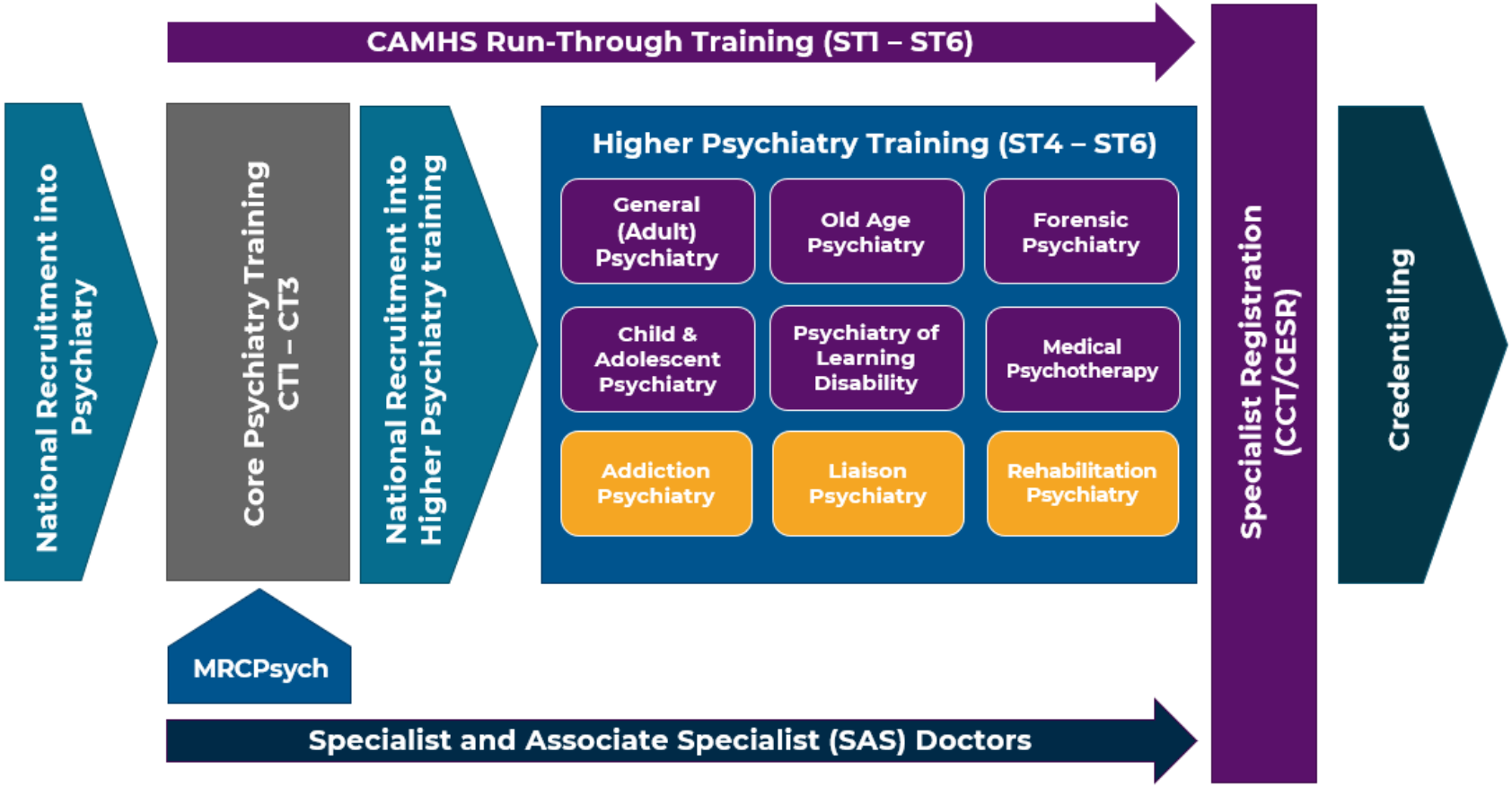

Figure 1. Psychiatry training pathway

4.2 Equivalence and non-traditional training routes

4.2.1 CESR

What is CESR and what are the eligibility requirements?

CESR is the alternate certificate to CCT. It is the means of obtaining specialist registration in the UK without completing a full UK training programme. The applicant must satisfy the GMC that their previous or current specialist experience, inclusive of previous or alternate qualifications, meets the requirements of the relevant specialty curriculum.

Applying for CESR

CESR provides a route for doctors who have not completed an approved UK based training programme to obtain specialist registration. Doctors who have undertaken a minimum of six months training or obtained a specialist qualification and acquired specialist medical experience or knowledge as a psychiatrist within a non-training post from either inside or outside the UK and are currently practising, may apply to the GMC for assessment of their capabilities.

The process consists of providing evidence (both primary and secondary) to demonstrate each high-level outcome (HLO) on the relevant curriculum. Those who have obtained membership of the Royal College of Psychiatrists (MRCPsych) are not required to demonstrate core capabilities but those without are required to demonstrate both core and higher specialty capabilities. The evidence submitted should be from the applicant's recent practice and any evidence submitted that is over six years old will be discounted.

Applications for CESR are made through the GMC, not through the College. Further information on the process and specialty specific guidance (SSGs) for each psychiatric specialty can be found on the GMC website. We would advise anyone who is thinking of undertaking the CESR route to contact us at equivalence@rcpsych.ac.uk, or book a CESR clinic session via the RCPsych CESR pages.

4.2.2 Combined Programme

The Combined Programme is for doctors who joined an approved specialist training programme at a later starting point, having already obtained some of the CCT curriculum capabilities from previous non-approved training posts. Traditionally, within psychiatry, this means entering at ST4 without having completed core psychiatry training in the UK.

Applications for Specialist Registration via the Combined Programme are made in the same way trainee doctors apply for CCT through the college.

Doctors must provide ARCPs from the latter stages of their training (inclusive of an ST outcome 6) and evidence of their psychiatric experience prior to entering higher training, such as the Certificate C – Core Competence Equivalence report. All evidence should be uploaded onto Portfolio Online. Trainees on the Combined Programme will be issued with a CCT through the Combined Programme, a separate certificate is not issued

The relevant educational bodies (HEE, HEIW, NES and NIMDTA) are required to notify the GMC at entry of any trainees on the CP pathway and will require a letter of support from the Royal College of Psychiatrists to assist with this.

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 trainees 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.

Trainees 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 trainees.

Trainees 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 trainees

Trainees are expected to undertake a short and long case by the end of CT3 prior to progressing to ST4.

It is recommended that the short case be a minimum of 12 sessions and the long case be between 20 and 40 sessions. Evidence is required via the PACE and SAPE assessments, with governing oversight by a medical psychotherapy tutor. Trainees should demonstrate attendance at Balint (or case-based discussion) groups.

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 trainees

To achieve the capabilities in Addiction psychiatry, it is recommended that trainees undertake two WPBAs (CbD) with the oversight of an Addiction psychiatry tutor.

5.1.3 Electro-convulsive therapy requirements for core trainees

It is recommended that trainees 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 (Adult) psychiatry post.
- Recommended **six months** in an Old age psychiatry post.
- Recommended **six months** in a Child and adolescent/learning (intellectual) 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 (Adult) setting 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 (Adult) psychiatry
- Child and adolescent psychiatry
- Forensic psychiatry
- Psychiatry of learning (intellectual) disability
- Medical psychotherapy
- Old age psychiatry.

Trainees 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 (Adult) psychiatry

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

- Two years in GMC approved General (Adult) psychiatry posts.
- At ST5 or ST6 level, trainees wishing to specialist in an area can opt for up to 12 month posts in either Addiction psychiatry, Liaison psychiatry, Rehabilitation psychiatry, Neuropsychiatry, Perinatal psychiatry, or Eating Disorder psychiatry, etc. Trainee placements in the more specialised services or some experience of other specialities will be facilitated through discussions between trainees, supervisors and the TPD.

As outlined in section 3.1, the current GMC endorsed General (Adult) psychiatry specialties are: Addiction psychiatry, Liaison psychiatry and Rehabilitation psychiatry, however there are significant opportunities for trainees interested in Eating Disorder psychiatry, Perinatal psychiatry and Neuropsychiatry.

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 trainees 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 (Adult) psychiatry must include properly supervised acute and community management. Increasingly, services and training in General (Adult) 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, trainee 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 trainees are able to achieve the key curriculum requirements.

It is recommended that trainees 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 (Adult) psychiatry will enable the continuing development of:

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in General (Adult) 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 trainees 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, audit, and/or involvement in ethically approved research.

Trainees 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 trainee's progress.

Academic trainees 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 trainee, the supervisors and the TPDs.

Over three years, trainees 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.

5.2.2 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 trainees 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 (Adult) psychiatry, Forensic psychiatry, Medical psychotherapy and Psychiatry of learning (intellectual) disability.
- Note: Successful completion of the capabilities within the Liaison psychiatry curriculum will lead to an endorsement on the GMC Specialist Register.

Trainees 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
- 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.

Each year trainees 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, audit, and/or involvement in ethically approved research.

Trainees 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 trainee's progress.

Academic trainees 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 trainee, the supervisors and the TPDs. Over three years, trainees 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

The clinical experience in the Advanced Training Programme in Child and adolescent psychiatry will consist of the equivalent of three years full time experience in approved placements in Child and adolescent psychiatry.

The trainee 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 trainees undertake one quality improvement activity at each stage of training.

The clinical experience will encompass seeing 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.

This 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. We recommend that trainees undertake assessment and treatment in two evidence-based psychological or psychotherapeutic modalities.

Not all trainees entering ST4-6 higher specialty training in CAP will have had the opportunity to undertake a CAP placement in core training. Similarly, not all trainees will have had psychotherapy experience with children and young people in core training. For this reason, it is recommended that trainees have supervised experience of under-taking evidence based psychological or psychotherapeutic therapies in two different modalities (e.g. cognitive behavioural therapy (CBT), systemic family therapy, and psychodynamic psychotherapy) with children and young people and families during the course of the training.

Academic trainees 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 liaison/ 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).
- Trainees 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 trainee's progress. Trainee placements in the more specialised services will be through discussions between trainees, supervisors and the TPD.

Trainees' caseloads will vary based on the placement (e.g., a trainee 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 trainees achieve the key capabilities in the curriculum. Caseloads should also enable trainees to prepare for independent practice as consultants in Child and adolescent psychiatry, being able to manage diverse needs and priorities as highlighted in the curriculum.

We recommend that full time trainees on placement 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 trainee will help the trainee 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 trainees gain experience of emergency child and adolescent psychiatry, via 55 (indicative) on-call shifts (including 'out-of-hours' work); reviewing at least 50 cases in this context during the course of their training in CAP.

CAP ST trainees 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 trainee, 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 trainee can develop the capabilities and skills in reflective practice and managing complexities to eventually progress towards the consultant role.

CAP ST trainees 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 trainees are recommended to undertake at least a structured review of research literature in one aspect of CAP/child mental health that is of an academic standard to be potentially published, in order to meet the recommended 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 trainees to ensure that this activity is achieved and reviewed as completed by the ARCP in ST5.

CAP run-through pilot programme

Trainees who wish to pursue training in Child and adolescent psychiatry from the outset can apply to join the CAP run-through pilot programme.

This pilot programme runs from ST1-ST6, with trainees undertaking compulsorily a six month WTE post in CAP plus a six month WTE in a paediatrics-linked post (paediatric liaison, improving medical knowledge and skills) usually in ST2.

Trainees will progress to ST4 higher training in CAP at the end of core training if they have successfully passed the MRCPsych examination and have achieved all the capabilities to complete core training. From ST4-6, these trainees will follow the same training programme as other CAP ST 4-6 trainees.

Trainees on this pathway still undertake core psychiatry training and will need to obtain the capabilities outlined in the core psychiatry curriculum and attend the core psychiatry academic programmes.

It is also recommended that trainees on the CAP run-through pilot programme during ST1-3 will participate on psychiatry out-of-hours on call.

The intake for CAP run-through pilot programme will extend from Aug 2018 – Aug 2022. After Aug 2022, trainees already on this pilot programme will continue as run-through trainees.

5.2.4 Psychiatry of learning (intellectual) disability

The clinical experience in the Higher Training Programme in Psychiatry of learning (intellectual) disability is recommended to consist of the equivalent of three years full time training in approved training placements in learning (intellectual) disability psychiatry. The trainee will work under the supervision of recognised clinical supervisors in Psychiatry of learning (intellectual) 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 (intellectual) disability.

The trainee 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 trainee.

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 (intellectual) disability psychiatry
- Neurodevelopmental disorders across the full IQ spectrum
- General (Adult) 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).

Clinical experience during higher training in psychiatry of Learning (Intellectual) 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.

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

Trainees 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 trainees 55 (indicative) on call shifts over their time in training. If a trainee 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 trainee 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 trainee and designed to ensure trainees 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 trainees will complete regular new patient assessments, covering a broad spectrum of clinical presentations and diagnostic complexity.

Trainees in learning (intellectual) 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.

In addition to developing specialist skills required of a consultant psychiatrist in learning (intellectual) disability, we recommend trainees to develop transferrable skills including leadership and management, emergency psychiatry, neuro-developmental assessment and complex decision making.

It is recommended that trainees:

- complete at least one project with a view to improving patient safety, health, and/or clinical outcomes per year and present their findings for wider learning
- engage in academic research with an aim to complete a research project of a standard appropriate for publication by the end of training.

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

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

- psychotherapeutic skills and capabilities through appropriate psychotherapy experiences building upon capabilities gained in core training
- transferable skills and experience (e.g., advanced communication, leadership, emergency psychiatry and complex decision making), as well as specialised skills and experience in learning (intellectual) 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.

Each year trainees 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, audit, and/or involvement in ethically approved research.

Trainees 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 trainee's progress.

Academic trainees 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 trainee, the supervisors and the TPDs. Over three years, trainees 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.

5.2.5 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 trainee, 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 trainees 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 trainee 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

- 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 trainees 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, audit, and/or involvement in ethically approved research.

Trainees 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 trainee's progress.

Academic trainees 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 trainee, the supervisors and the TPDs. Over three years, trainees 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 trainee 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 trainee 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 trainee 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 trainees 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 trainees to practice at as a consultant psychiatrist in medical psychotherapy enabling the trainee to work with complexity and apply psychological understanding using a range of psychotherapeutic approaches that are holistic and person-centred.

Trainees 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 trainees 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 trainees 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 trainees 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 psychiatry requirements

Core trainees should complete a recommended indicative 55 on-call (including out-of-hours experience) shifts, or equivalent, and 50 cases for WTE trainees.

7.1.2 Higher (Specialty training) Requirements

Specialty trainees should complete a recommended indicative 55 on-call (including out-of- hours experience) shifts, or equivalent, and 50 cases for WTE trainees.

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 trainees 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 trainees to meet this capability.

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

It is recommended that trainees meet the requirements to apply for relevant statutory approval where appropriate. Please note that trainees 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, trainees are competitively appointed to 'dual training' specialties through a single recruitment process. Where trainees are competitively appointed to a training programme leading to dual specialist registration, trainees 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 trainee wishes to curtail the programme leading to dual certification and to apply to the GMC for a single CCT, the trainee 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.

Trainees 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 (Adult) psychiatry and Old age psychiatry

We recommend:

- Two years (WTE) in designated general (adult) psychiatry posts; one year may be in a GMC approved sub-specialty of general (adult) 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 trainee who wishes to pursue a single CCT in either old age psychiatry or general (adult) psychiatry must ensure they have completed the recommended three years, which must consist of two years in either old age psychiatry posts or general (adult) psychiatry posts plus one further year in another psychiatric specialty or sub-specialty post as listed above.

8.2 Training combinations with a recommended five year duration

8.2.1 General (adult) psychiatry and medical psychotherapy

We recommend:

- Two years (WTE) in designated general (adult) psychiatry posts (please see section 4.2.1); one year may be in a GMC approved sub-specialty of general (adult) psychiatry in either:
  - addiction psychiatry
  - liaison psychiatry, or
  - rehabilitation psychiatry.
- Trainees could also spend one year in:
  - perinatal psychiatry
  - neuropsychiatry, or
  - eating disorder psychiatry.

All core general (adult) psychiatry capabilities must be achieved.

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

A trainee who wishes to pursue a single CCT in either general (adult) 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 (adult) psychiatry and forensic psychiatry

We recommend:

- Two years in designated general (adult) psychiatry posts. One year may be in a GMC approved sub-specialty of general (adult) psychiatry in either:
  - addiction psychiatry
  - liaison psychiatry, or
  - rehabilitation psychiatry.

  Alternatively, trainees 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 trainee who wishes to pursue a single CCT in either general (adult) psychiatry or forensic psychiatry must ensure they have completed the recommended three years, which must consist of two years in either general (adult) 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 trainee 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 (adult)psychiatry

This must consist of:

- Three years in designated forensic psychiatry placements.
- Two years in designated general (adult) 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 trainee 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 year' in either designated forensic psychiatry posts or three years in designated child and adolescent psychiatry posts.

8.2.6 Child and adolescent and psychiatry of learning (intellectual) disability

This must consist of:

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

A trainee who wishes to pursue a single CCT in either psychiatry of learning (intellectual) 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 (intellectual) disability posts, up to one year of which may be in a psychiatry of learning (intellectual) 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 trainee 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.

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.

Trainees undertaking a GMC approved training programme in general (adult) psychiatry or a dual training programme in general (adult) psychiatry may undertake training in one of the three GMC approved sub-specialties of general (adult) psychiatry and apply for an endorsement on completion of their training programme.

The three GMC approved sub-specialties of general (adult) psychiatry are:

- addiction psychiatry
- liaison psychiatry
- rehabilitation psychiatry.

Trainees 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 trainees can apply for the endorsement on the GMC Specialist Register.

Trainees 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, trainees 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 trainee. 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:

1. Proposed amendments are submitted via our online proforma to our Curricula and Quality Assurance Team.
2. Proposals are shared with the Curricula Revision Working Group (now Curricula Implementation Working Group, or CIWG) and Specialty Advisory Committees (SACs) (where required).
3. Once reviewed, proposals with recommendations from the CIWG and SACs are sent to the Curriculum and Assessment Committee (CAC) and Quality Assurance Committee (QAC) for review.
4. All amendments are sent to the Education and Training Committee (ETC) for sign off. Where additional information is required, this will be highlighted.
5. 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 trainees and trainers. These are set out below.

10.2.1 Key quality indicators for trainees

1	Trainees in psychiatry should be allocated to approved training posts that align to the appropriate level of training for the trainee, ensuring appropriate opportunities for achievement of curricula HLOs and key capabilities and that other relevant educational opportunities are provided.
2	Trainees in psychiatry should be provided with protected time to undertake professional development sessions where applicable.
3	Trainees in psychiatry should be provided with weekly one-hour psychiatric supervision sessions.
4	Trainees 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	Trainees 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	Trainees in psychiatry must be provided the opportunity to reflect on their training through access to reflective practice groups.
7	Trainees in psychiatry must be offered a comprehensive induction to each training post prior to starting in each role including regarding on-calls.
8	Trainees in psychiatry should be offered access to study leave and supported to take it with appropriate funding commensurate with their training level.
9	Trainees in psychiatry should be provided with protected time for research activities in line with curricula requirements outlined in HLO 9.
10	Trainees in psychiatry should be provided with the opportunity to undertake appropriately supervised training in ECT where possible.
11	Trainees in psychiatry should be provided with the opportunity and support to undertake at least one audit per year or participate or lead in a 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 trainee, 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 trainees are given time for professional development sessions sharing the responsibility for this with the trainee.
3	Trainers should timetable supervision with their trainees 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 trainees a placement specific personal development plan aligned with the curricula HLOs and key capabilities.
5	Trainers will ensure trainees have time to attend reflective practice groups as part of their working day on a regular basis.
6	Trainers will ensure trainees 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 trainees to take their study leave to further their development and fulfilment of the curricula capabilities.
9	Trainers will ensure trainees have time for research activities including linking trainees to relevant colleagues to complete this.
10	Trainers will ensure trainees have time to complete appropriate supervised training in ECT where possible.
11	Trainers will supervise or link trainees with appropriate colleagues to undertake audit or 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.

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.

6. Ensuring safe and effective patient care through training 2003731415
7. Establishing and maintaining an environment for learning
8. Teaching and facilitating learning
9. Enhancing learning through assessment
10. Supporting and monitoring educational progress
11. Guiding personal and professional development
12. 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

Health Education England (HEE) 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 trainee 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.

HEE 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 HEE. While HEE 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 trainee 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 trainees 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 trainees 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.

Trainees, 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.

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 trainees with performance difficulties should be made aware of the training needs before the placement commences and receive a robust handover; joint working with the trainee'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 trainees must be supervised by an appropriately qualified senior psychiatrist. All trainees 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 trainee 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 trainee.

No trainee should be expected to work to a level beyond their competence and experience; no trainee should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise. Trainees should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence; both trainee 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 trainee in the workplace.
- Must support the trainee 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 trainee is informed. The trainee must know who is providing clinical supervision at all times.
- Will perform workplace-based assessments for the trainee 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 trainee is obtaining the necessary experience. This will include ensuring that the trainee 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 substantive 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 trainees 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.

Trainees 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 (no more than five) number of trainees. 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 trainees will have an Educational Supervisor whose name will be notified to the trainee. The precise method of allocating Educational Supervisors to trainees, 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 trainees 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 trainees 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 trainee.
- Will oversee and on occasions, perform, the trainee's workplace-based assessments.
- Will monitor the trainee's attendance at formal education sessions, their completion of audit 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 trainees, an Educational Supervisor will:

- Oversee the education of the trainee, act as their mentor and ensure that they are making the necessary clinical and educational progress.
- Meet the trainee at the earliest opportunity (preferably in the first week of the programme), to ensure that the trainee 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 trainee and the necessary paperwork signed and a copy kept by both parties. It is recommended that trainees meet with their Educational Supervisors three times throughout their placement. In particular, a meeting midway through a placement is considered important.
- Ensure that the trainee receives appropriate career guidance and planning.
- Provide the trainee 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 trainee for the duration of their training period both within core and higher training.

Educational Supervision should beusually 1 PA per week for up to six trainees, agreed within job-planning

Training Programme Directors

The Coordinating/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. One programmed activity (PA) per week is generally recommended for 25 trainees. In a large scheme 2 PA's per week will be required.

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 trainees to gain the relevant competences, knowledge, skills, values, behaviours and experience
- take into account the collective needs of the trainees 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 trainees 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 trainees who will be placed with them. From time to time, however, it might be necessary for TPDs to recommend that trainees be moved at shorter notice
- produce timely reports on the training programme, on individual trainees and on the review of information regarding the quality of training, as required by HEE, 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 trainees 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 trainees. This will include:
- Ensuring that Psychiatric Supervisors are reminded about and supported in their task of developing the trainee's capabilities in a psychotherapeutic approach to routine clinical practice.
- Advising and supporting trainees 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 trainees 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 trainees have the opportunity to complete the psychotherapy requirements of the core curriculum.
- Advises and supports core and higher trainees in their learning by reviewing progress in psychotherapy.
- Oversees the establishment and running of the core trainee 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 trainees. 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 trainees and higher trainees.
- 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 trainees.
- 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 trainee 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 trainees.

It is not necessary for assessors to have prior knowledge of a trainee 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 trainees; nurses, psychologists/AHPs and social workers at band 7 **or equivalent** (e.g., grade 9 for social workers) can be assessors.
- For ST4-ST6 trainees; 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 trainees cannot assess each other, and ST4-6 trainees cannot assess each other but ST4-ST6 trainees can assess core trainees.

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

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

11.5 Trainee responsibilities

Responsibilities for trainees 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 trainee 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 trainees, it would be expected that organisation and initiation of meetings would sit with the trainee.
- 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 trainee 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 trainee 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 trainee re-affirms their commitment to the training and thereby remains registered for their training programme.
- Trainees 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.
- Trainees 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.

- Trainees 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 trainees where performance difficulties are highlighted, referral to specific support services should be considered. Referral should be made in discussion with the trainee and TPD and should be done in a timely manner, however if trainee 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 trainee's employer and should be involved when a trainee's heath is impacting on their fitness to work. Specialist Occupational Health advice may be sought if there are issues regarding fitness to train.
- Trainees 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 trainee 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.

Examples of poor performance (adapted from Paice, 2006):

- **The disappearing act**: Difficulty contacting a trainee; frequent sickness absences; lateness, not answering bleeps / phone / emails in a timely manner.
- **Low work rate:** Struggling to keep up with the work including struggling with performing duties, difficulties with time management, clerking patients, dictating letters, making decisions.
- **Ward rage:** Finding that you are on a 'short fuse'. Intemperate behaviour.
- **Rigidity:** Struggling to be flexible (F), finding it difficult to lead (appropriate to your stage of training) (L), difficulty being able to use initiative (I), prioritise work and adapt to changing circumstances (P), poor tolerance of ambiguity; finding it difficult to compromise and adapt (A) - FLIPA.
- **Bypass syndrome:** Awareness that other staff avoid seeking your opinion.
- **Career problem:** Difficulty with undertaking examinations; uncertainty regarding career choices
- **Insight failure**: Rejection of constructive criticism; defensiveness.

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

11.6.1 Support for poor performance

Trainee poor performance 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. Trainees 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)

Trainees 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. Trainees out of programme may also need approval from the RCPsych. Applications for OOP should be discussed with trainees' Training Programme Director (TPD) and Educational Supervisor (ES) as early as possible.

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

Types of out of programme that trainees 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, HEE undertook a pilot outlining a new route to taking time out of training called "OOP Pause". This allows trainees 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 trainee has enrolled onto, approval from the RCPsych is not needed. If a trainee 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 trainee the timescale is also three months WTE) spent in an 'acting up' consultant post may count towards a trainees CCT as part of the GMC approved specialty training programme, provided the post meets the following criteria:

- The trainee follows local procedures by making contact with the Postgraduate Dean and their team who will advise trainees about obtaining prospective approval.
- The trainee 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 trainee's TPD.
- The trainee still receives one hour per week psychiatric supervision either face-to-face or over the phone by an appropriately accredited trainer.
- Trainees retain their NTN during the period of acting up.
- Full time trainees 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 trainees 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 trainee 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 qualityassurance@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 trainee 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 trainee may use to inform their further learning and professional development.
- Drive learning in important areas of capability.
- Help identify areas in which trainees require additional or targeted training.
- Providing evidence that a trainee 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 can are mapped to each High Level Outcome (HLO) domain. It is not expected that all trainees will be assessed by all possible methods in each capability. The learning needs of individual trainees will determine which capabilities they should be assessed in and the number of assessments that need to be performed. The trainee's Psychiatric and Educational Supervisors have a vital role in guiding the trainee and ensuring that the trainee'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. Trainees 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 methods

The assessment system consists of the following elements:

13.3.1 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
- Adult psychiatry
- Old age psychiatry
- Psychotherapy
- Child and adolescent psychiatry
- Addiction psychiatry
- Forensic psychiatry
- Psychiatry of learning (intellectual) disability
- Critical review.

The percentage split/marks for each area are:

Organisation and delivery	5.50% / 8 marks
Adult	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 (intellectual) 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.

For further information about membership of the College, please visit our membership pages.

Trainees 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 Workplace based assessment (WPBA)

Workplace based assessment (WPBA) 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 will continue the process established in the foundation programme and will extend throughout core and higher specialty psychiatry training. It must be understood that WPBAs are primarily tools for giving formative feedback and in order to gain the full benefit of this form of assessment, trainees should ensure that their assessments take place at regular intervals throughout the period of training.

All trainees 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 trainee and evidence of further development may be taken as evidence that a trainee demonstrates critical self-reflection.

Clinical, Psychiatric and Educational supervisors will draw attention to those trainees 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 WPBA's will contribute evidence to inform summative decisions.

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 outlined as follows:

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

HLO themes have been mapped directly to the GMCs Generic Professional Capabilities (GPC) Framework.

The WPBA tools consist of:

- **Assessment of Clinical Expertise (ACE)** 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 Trainee, 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 Trainee 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 trainee's attendance and contribution to case discussion groups (also known as Balint- type groups) in Core psychiatry Training.
- **Direct Observation of non-Clinical Skills (DONCS)** has been developed by the College from the Direct Observation of Procedural Skills (DOPS). The DONCS is designed to provide feedback on a doctor's performance of non-clinical skills by observing them chairing a meeting, teaching, supervising others or engaging in another non-clinical procedure.
- **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.
- **Journal Club Presentation (JCP)** similar to CP, this enables an assessment to be made of a Journal article/research/audit project presented by the Trainee.
- **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. Trainees 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). Trainees 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 trainee's educational supervisor. **The trainee must discuss/agree in psychiatric supervision those who are to be nominated.**

- A valid mini-PAT requires at least six responses.
- **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.

Further information on training and assessments can be found on the RCPsych training pages. Recommended numbers per specialty can be found in Appendix 4.

The College is considering the introduction of a further 'entrustability' evaluation to be incorporated into WPBAs which would extend their scope.

The College is currently undertaking an Assessment review and early discussions are taking place with the GMC regarding best practice in medical assessments. The assessment review is anticipated to make recommendations in 2022 to both the RCPsych Council and the GMC. We will share further guidance on this when a decision has been reached.

13.3.3 Reflective practice

Reflective practice is important in ensuring trainees 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.

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 trainees 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 trainee will undertake a range of PDS during their higher training, according to their training and development needs.

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

A plan for professional development sessions must be created prospectively and agreed with the Educational Supervisor/Training Programme Director as part of a trainees' 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 trainee's clinical role and supervisors should encourage all trainees to take up this opportunity for a recommended one session per week for a year. The trainee 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, ASD assessment, 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 trainee'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 trainees 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 trainees 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 trainee 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 trainees 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. Trainees' 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 here. Updated guidance for psychiatrists will be added in due course.

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 trainee and their Educational Supervisor relating to the trainee's progress in the training programme. It enables the trainee, 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 trainees 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 trainee'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 trainee'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 trainee'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 trainees 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 trainees in a LAT post (Scotland only) and documents these accordingly.
- It provides advice to the Responsible Officer (RO) about revalidation of the trainee 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 trainee'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 trainee 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 ARCP panel will recommend an outcome described below for each foundation/specialty/sub-specialty for each trainee, including those on integrated clinical/academic programmes.

The ARCP outcome should not be a surprise to the trainee, and trainees 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,,

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 trainee on the basis of the submitted evidence, it must also take into account any mitigating factors on the trainee'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 trainee, 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

Trainees 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 trainee 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 trainee has already been appointed to a consultant post, the trainee 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. As an alternative approach, consideration could be given to achieving these capabilities within a post-CCT credential. Further information on credentialing will be developed in due course. The GMC's Credentialing Framework can be viewed here.

19 Less than full-time (LTFT) training

19.1 Overview

HEE, 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 trainees, 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.

Trainees 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 trainees 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 trainees.

Trainees 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 HEE, 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 trainee, HEE, 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 trainees 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 trainees 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 trainees 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: Trainees 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: Trainees 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. Trainees will continue to hold their training number/contract during this time out of their clinical programme. (Other routes may be available to trainees 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 trainees flexibility in developing their capabilities. We expect trainees and trainers to take responsibility for ensuring protected characteristics are taken into account, and that reasonable adjustments are made where possible. Trainees 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 trainees 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 trainees 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 trainees to ensure appropriate decisions are made regarding training.

All trainees 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 and impact on certification (or 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 demonstrate competence/capability and progression through the curriculum. The GMC has therefore determined that within each 12-month period where a trainee has been absent for a total of 14 days or more (when a trainee would normally be at work), a review will be triggered of whether the trainee needs to have their core training programme end date or CCT/CCT CP date extended. Generally, when a trainee 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 trainees 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 trainee to be honest and open, and to act with integrity. As such, trainees should ensure that HEE, 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 trainees 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. Trainees 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. Trainees 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 trainees to move between HEE, NES, HEIW and NIMDTA (via IDTs), there is no automatic entitlement or right for this to take place. Trainees 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 HEE, NES, HEIW or NIMDTA. Post funding and the training number/contract do not follow the trainee.

Transfers will only be considered during two time period windows each year, which will be advertised in advance. The timing of these windows allows trainees, 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 HEE, NES, HEIW or NIMDTA and the trainee. Requests to transfer will not be considered outside of these windows except in very exceptional circumstances. It would be expected that any trainee 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 trainees will move across national or local office boundaries without requiring an IDT:

- Educational or training reasons - HEE, 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 HEE, 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. Trainees would keep their original training number/contract.

- Rotation between HEE, NES, HEIW and NIMDTA as part of a planned training programme This arrangement applies in some specialties and across placements in HEE, 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 HEE, NES, HEIW or NIMDTA - Trainees 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 HEE, NES, HEIW or NIMDTA. Trainees will have no entitlement to transfer subsequently to the locality in HEE, 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 HEE, NES, HEIW or NIMDTA - Trainees who are successful in being appointed to a sub-specialty training programme in a different locality in HEE, NES, HEIW or NIMDTA will usually have no entitlement to transfer. They will remain under the management of the home locality in HEE, 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 specialtytraining@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 – understanding and applying the psychological, biological, social, cultural and spiritual context in the delivery of mental healthcare.

Mental capacity – is the ability to make decisions for yourself.

Mental disorder - means any disorder or disability of the mind, inclusive of personality disorders.

Person-centred – focuses on the patient as a person, with 'personhood' being its superordinate principle.

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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Dr Rajesh Mohan, Presidential Lead for Race and Equality

Ms Veryan Richards, Patient and Carer Representative

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General (Adult) 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 (Adult)

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

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East Midlands Deanery

East of England Deanery

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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 Trainees

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 for trainees.	Responsible for educational supervision for one or more trainees (no more than five trainees). Two meetings per year.
Protected time requirements	As part of clinical professional responsibility as a senior psychiatrist.	**0.25PA per week** per trainee protected time.	Usually **1 PA per week** for up to six trainees, agreed within job-planning
Supervision Level	Required for all trainees throughout core and higher training. Clinical supervision should be tailored to ensure patient safety and meet the developmental needs of individual trainees.	Required for all trainees throughout core and higher training.	Required for all trainees 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	**Aim** – to support and monitor educational progress. Works with individual trainees to develop and facilitate an individual learning plan

		maintaining appropriate 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.	to develop curriculum key capabilities.
Delegation	Clinical supervision can be delegated to other suitably qualified doctors or members of the clinical team including non-medical staff providing the role is understood and trainee aware.	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 trainee's training needs and that resources are in place to meet these.
Assessments	May perform WPBAs for trainee, if suitably qualified.	Responsible for producing the Psychiatric Supervision Report (PSR). Responsible for developing placement specific Personal Development Plans (PDPs) with their trainees, in collaboration with Educational Supervisor.	Oversees plan to complete WPBAs. Responsible for producing Educational Supervisor Report (ESR) **annually for trainees**.
CPD and recognition of trainer status	Must attend relevant local training for recognition of trainer status. This is typically run by Postgraduate Deaneries or equivalent bodies.	Capabilities developed during full postgraduate training in psychiatry. In addition, Psychiatric Supervisors are encouraged to undertake	Must attend relevant local training for recognition of trainer status. This is typically run by Postgraduate Deaneries or equivalent bodies.

		further training and attend updates run by RCPsych. Psychiatric Supervisors must have completed relevant training to receive recognition of trainer status.	

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	Audit 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		Educational Standards Manager

	Annual CT report	Regular contact with CTs through College system	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	Educational Standards Manager Training Manager

		• Curricula & Assessments Committee • Heads of School meetings • Education & Training Committee • Equivalence Committee • Specialty/sub-specialty advisory committees	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

25.1 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

* 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

25.2 General (Adult) psychiatry

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	1	1	1

25.3 Old age psychiatry

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

25.4 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

25.5 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

25.6 Psychiatry of learning (intellectual) 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

25.7 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

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

A Reference Guide for Postgraduate Foundation and Specialty Training in the UK

The Gold Guide
9th edition

Version: GG9 – 3rd August 2022

A Reference Guide for Postgraduate Foundation and Specialty Training in the UK:

The Gold Guide

Contents

Section 1: Introduction and background

1.1 This ninth edition of *A Reference Guide for Postgraduate Foundation and Specialty Training in the UK* (also known as the Gold Guide) sets out the arrangements agreed by the four UK health departments for specialty training programmes. It is maintained by the Conference of Postgraduate Medical Deans (COPMeD) on behalf of the four UK health departments.

1.1 i It incorporates, updates and supersedes the *Guide for Foundation Training in the UK* version 2019 (also known as the **Purple Guide**), which sets out the arrangements agreed by the four UK health departments for foundation training programmes.

1.2 This edition is a consolidation of earlier versions of the Gold and Purple Guides, and it replaces all previous versions. It aims to set out a framework with clear principles for the operational management of postgraduate foundation and specialty training to support consistent decision making by Postgraduate Deans and their support structures in a transparent way. It applies to all doctors in core and specialty training (including public health non-medical trainees) and to all foundation doctors across the UK. For the purpose of clarity, these doctors will be referred to as trainees throughout this document.

1.3 The Guide is applicable to all trainees in General Medical Council (GMC)-approved programmes, whether in substantive or locum appointment for training/ stand-alone foundation posts. Guidance for international postgraduate medical training schemes, the Medical Training Initiative and other similar bespoke schemes will be published elsewhere.

1.4 Throughout the Guide, any reference to specialty training includes general practice and core training. Where arrangements differ between specialty, general practice and core training, these differences are noted. Similarly, where there are differences for foundation training, these are referenced and defined. Furthermore, where specialty is mentioned, this also includes GMC-approved sub-specialty programmes.

1.5 It is a requirement of the GMC that doctors who wish to enter specialty training (whether through core/specialty programmes or locum appointments for training) should apply through an open, fair and transparent application process.

1.6 All doctors recruited into GMC-approved core and/or specialty training programmes are known as Specialty Registrars (STRs), normally annotated with the year and stage of training (e.g. ST3 for a trainee at the level of third year of the specialty training programme).

1.7 Where there is reference to Certificate of Eligibility for Specialist Registration (CESR), this also refers to Certificate of Eligibility for General Practice Registration

(CEGPR), Where arrangements differ between CESR, CEGPR, these will be noted in the Guide.[1]

1.8 Throughout this Guide, reference to Postgraduate Deans includes those nominated by Postgraduate Deans to act on their behalf, which includes Deputy and Associate Postgraduate Deans, Foundation School Directors, Heads of School, and Training Programme Directors for foundation and specialty training.

1.9 In the development of this Guide, the contribution of stakeholder colleagues from all four administrations is gratefully acknowledged.

1.10 This Guide is applicable UK wide but there are some national variations in its implementation to reflect organisational structures. These have been highlighted appropriately.

1.11 The Guide will not cover every eventuality. There are occasions where it may be necessary to derogate from the guidance defined in this Guide.

1.12 The Postgraduate Dean has discretion to offer flexibility in making derogations from the Gold Guide/Purple Guide in exceptional circumstances and for sound educational reasons such as to accommodate changes and innovations in training delivery. Examples might include (but are not limited to) additional experience/ capabilities through credentialing programmes, and 'step in and out of training' options including *Out of Programme – Pause* (OOP Pause).

1.13 This Guide is not a contractual document, and it does not address issues relating to terms and conditions of employment (e.g. pay, the 'period of grace', job plans and work schedules) of doctors in foundation, specialty or general practice training.

1.14 The standards and requirements set by the GMC are extensively referenced to ensure that the Guide is underpinned by them.

1.15 The primary purpose of entry into training is to be able to progress towards and achieve either completion of a foundation programme (and obtain a Foundation Programme Certificate of Completion) or core training or obtain a Certificate of Completion of Training or equivalent.

> 1.15 i If a trainee is unlikely to be able to undertake any training **for whatever reason** for a continuous period of more than two years, the Postgraduate Dean should review the maintenance of the training number/ contract[2] in line with paragraph 3.106 and consider whether the training number/contract should be withdrawn (in accordance with paragraph 3.99 iii), taking into account other relevant factors that affect suitability to continue in a

[1] From 2021, trainees completing a combined programme will be eligible for award of a Certificate of Completion of Training on completion, rather than a CESR(CP) or CEGPR(CP)

[2] In foundation training, the correct reference is the training contract.

training programme.[3] This is for well-founded educational reasons (such as the need to maintain foundation capabilities or to satisfy the requirements for remaining on the Medical Performers List for general practice).

1.15 ii Where a trainee has been out of training **for whatever reason** for a continuous period of more than two years as defined in paragraph 1.15 i and wishes to return to a specialty training programme, the same principles will apply. The Postgraduate Dean will assess suitability to return to (and continue in) a specialty training programme in accordance with paragraph 3.99 iii. Academic trainees are permitted to have a maximum of four years out of programme for research (paragraph 3.168) and this time would not be included in the period under consideration in paragraph 1.15.

1.16 The Gold Guide is published in electronic format and will be available on the four UK specialty training websites as well as on the COPMeD website. This will enable updating of the Guide to ensure that it reflects developments in postgraduate medical training. The review of the Gold and Purple Guides will be aligned and synchronised biennially. Gold Guide version control is the responsibility of COPMeD; however, the UK Foundation Programme Office will maintain governance responsibility for and advise on the components of the Gold Guide relating to foundation training.

1.17 Paragraph 1.2 describes the process by which the Gold Guide is supportive and formative. It is important that the use of language reflects that and is not pejorative. Progression is always described with respect to the stage of training as defined by the GMC-approved curriculum relevant to foundation or specialty training. Phrases such as 'insufficient' or 'unsatisfactory' must only be used in this context.[4] They must not be used to describe Annual Review of Competence Progression outcomes (paragraph 4.94).

[3] The decision to withdraw the training number/contract under paragraph 1.15 is at the discretion of the Postgraduate Dean and is not 'automatic' if the criteria for paragraph 1.15 are met. However, the reasons for flexibility must be stated clearly in a decision letter in accordance with the principles set out in paragraph 3.100.

[4] The terms 'must' and 'should' are used in accordance with Good Medical Practice. 'Must' is used for an overriding duty or principle (mandatory) and 'should' to describe or explain how an overriding duty will be met (advisory).

Section 2: Roles and responsibilities

The UK health departments

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

The UK Foundation Programme Office

2.2 The UK Foundation Programme Office (UKFPO) manages the national application process for the UK foundation programme, issues guidance on foundation training and promotes the consistent delivery of the foundation programme across the UK. It is funded by and is accountable to the four UK health departments. Working with partners, the UKFPO enables the sharing of good practice to help raise the standards of training.

Health Education England

2.3 Health Education England (HEE) 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 the following national functions:

i. HEE provides national leadership on planning and developing the healthcare and public health workforce.

ii. It promotes high-quality education and training that is responsive to the changing needs of patients and local communities via HEE's Quality Strategy and Quality Framework.

iii. As a multi-professional organisation, HEE has equally important but differing responsibilities to the different clinical professions.

iv. As with all statutory education bodies, HEE has clear responsibilities to deliver postgraduate medical and dental education as defined by the Medical Act 1983 and the Dentists Act 1984, and it also has responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment.

v. HEE ensures security of supply of the healthcare and public health workforce.

vi. It appoints and supports the development of Local Education and Training Boards (LETBs).[5]

[5] Following integration with NHS England and NHS Improvement, and planned changes to legislation, terminology for LETBs may be subject to change.

vii. It allocates and accounts for NHS education and training resources, and accounts for the outcomes achieved.

2.4 HEE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of LETBs, which are statutory committees of HEE. While HEE 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.

NHS Education for Scotland

2.5 NHS Education for Scotland (NES) is the national health board with statutory responsibilities to effect sustainable change through workforce development, education and training across the health and social care system in Scotland while working at UK level with partner organisations.

2.6 Since its creation in 2002, NES has led in educational design, delivery and quality management, and has provided wide-ranging support to workforce development. NES is the official provider of workforce statistics for NHS Scotland and supports national workforce planning. NES also designs and develops digital technologies supporting innovation and transformation.

2.7 The purpose of NES is to drive change and improve the quality of care experienced by citizens across Scotland by ensuring that it has the right staff, with the right skills, in the right place at the right time. NES is integral to improving outcomes for people, and to ensuring that a skilled and capable workforce underpins the design and delivery of services. As an organisation, it recognises the significant contribution it can make to improving population health, reducing inequalities and economic development.

2.8 NES has a Scotland-wide role in undergraduate and postgraduate education as well as in 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.

2.9 The overarching aim of the medical directorate in NES is to deliver first-class medical education and training for Scotland to ensure safe, effective care for patients, both now and in the future. Working with all its partners, NES aims to achieve this by:

i. organising and providing excellent training programmes that attract high-quality doctors to Scotland

ii. meeting and exceeding all regulatory standards through consistent application of best practice and the principles of continual improvement

iii. supporting the ongoing education and training of Scotland's trained doctors, together with those who support their work

2.10 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.

2.11 In addition, NES prepares professionals for practice in dentistry, pharmacy, clinical psychology, 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.

2.12 The Scotland Deanery of NES is responsible for managing the training of Scotland's postgraduate doctors in training, who deliver care every day while working in hospitals and general practices in NHS Scotland.

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

2.14 In the Scotland Deanery, Postgraduate Deans in both primary and secondary care provide strategic leadership and direction for postgraduate medical education and training to meet the requirements of the General Medical Council (GMC). They take advice from Medical Royal Colleges and Faculties to assist them.

Health Education and Improvement Wales

2.15 Established on 1 October 2018, Health Education and Improvement Wales (HEIW) is a Special Health Authority in NHS Wales. HEIW sits alongside Health Boards, Trusts, and Digital Health and Care Wales, and it 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.

2.16 The key functions of HEIW include:

i. 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

ii. being a reputable source of information and intelligence on the Welsh health and care workforce

iii. commissioning, designing and delivering high-quality, value-for-money education and training, in line with established standards

iv. using education, training and development to encourage and facilitate career progression

v. supporting education, training and service regulation by playing a key role in representing Wales, and working closely with regulators

vi. developing the healthcare leaders of today and the future

vii. providing opportunities for the health and care workforce to develop new skills

viii. promoting health and care careers in Wales, and Wales as a place to live

ix. supporting professional organisational development in Wales

x. continuously improving what HEIW does and how it does it

The Medical Deanery in HEIW

2.17 The Medical Deanery will continue to ensure the delivery of high-quality postgraduate medical education and training that supports service provision in NHS Wales by working with outside agencies to provide and recruit to sustainable high-quality medical training programmes that meet educational and curriculum requirements while maximising opportunities for access to community and rural placements, ensuring that patient safety is at the centre of training for the health service in Wales. This includes:

i. ensuring that a programme of support and assessment are in place across Wales to underpin the medical training programmes

ii. ensuring that the methods of providing medical education and training across Wales deliver to the highest standards, represent value for money and provide a range of learning methods/environments for trainees

The Northern Ireland Medical and Dental Training Agency

2.18 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:

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

ii. the recruitment, selection and allocation of doctors and dentists to foundation, core and specialty training programmes

iii. assessment of the performance of trainees through annual review and appraisal

iv. close partnership with local education providers (principally Health and Social Care Trusts, and general practices) to ensure that the training and supervision of trainees supports the delivery of high-quality, safe patient care

2.19 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.

2.20 There is a *Management Statement and Financial Memorandum* between the DoH and NIMDTA, setting out the relationship in detail.

2.21 NIMDTA was asked by the DoH in January 2019 to take on the function of being the single lead employer for doctors and dentists in training in Northern Ireland. This began in a phased fashion from August 2019.

Arrangements for the Defence Medical Services

2.22 The armed forces employ doctors in the period immediately following completion of F2 to undertake basic medical duties in a variety of home and deployed environments, known as General Duty Medical Officers (GDMOs). GDMOs are military officers who have already been selected, trained in military skills and commissioned into the armed forces. GDMOs undertaking general duties are not in formal training programmes but work under supervision in a similar way to specialty trainees, and generate an educational portfolio of their experiences and learning development as a doctor. Experience will be gained in the areas of primary care, trauma management, public health, occupational medicine and, importantly, leadership and management. Annual appraisal will be conducted, and evidence of experience will be mapped to GMC domains and the GDMO curriculum. This should be available for scrutiny at any selection interview. Time spent in these posts does not count towards a Certificate of Completion of Training (CCT).

2.23 The Defence Deanery, a part of the Defence Medical Academy, will continue to train medical officers in primary and secondary care specialties for practice in the armed forces. Consultants and general practice principals in the Defence Medical Services (DMS) will be by qualification, experience and personal quality equal to their NHS colleagues. Professional training will follow (as closely as possible) the pattern required for NHS trainees as well as meeting the needs of the DMS and the GMC requirements for the relevant curriculum.

2.24 Military candidates who wish to be considered for specialty training will be selected by the Defence Deanery from those who satisfy both the entry criteria and the person specification for the chosen specialty. These candidates will be presented before the relevant national specialty training selection panel as part of the national recruitment processes. They will be required to achieve at least the appointable score for that specialty but will not be in competition with civilians for NHS-funded appointments. They will be ranked accordingly along with their civilian colleagues. All such national selection panels will include representation from the Defence Deanery.

2.25 Successful military candidates for specialty training will be selected as required by the DMS. Those appointed as specialty trainees will be awarded a Defence Deanery National Training Number (NTN) by the Defence Postgraduate Medical Dean and the prefix of the NTN will remain 'TSD' to designate the trainee as a Defence Deanery trainee. They will hold this number until the completion of specialty training but those who (of their own choice) leave the armed forces through premature voluntary retirement will be required to relinquish their Defence Deanery NTN. If they wish to continue their specialty training as a civilian, they will have to seek an appropriate vacancy in a civilian training programme, for which they will have to compete.

2.26 For those who retire early for reasons beyond their control (e.g. medical reasons or because training is no longer available through the Defence Deanery in their specialty) and who still wish to continue training as a civilian (where possible in relation to any medical restrictions), the Defence Deanery will assist in applying for an inter-deanery transfer to a suitable NHS-funded specialty training programme. However, this will be subject to the availability of an appropriate NTN in a civilian training programme. The Defence Deanery NTN will then be relinquished.

2.27 All Defence Deanery specialty trainees occupy posts in specialty training programmes approved by the GMC, and their progress will be monitored as required by the GMC-approved curriculum and programmes of assessment for the relevant specialty. This could include attendance annually (or more frequently if required) before an assessment panel convened either by the host locality in HEE, NES, HEIW or NIMDTA, or by the Defence Deanery as appropriate, for Annual Review of Competence Progression (ARCP). The ARCP panels will normally be attended by the Defence Postgraduate Medical Dean or their nominated deputy and, as for civilian ARCP panels, a proportion of Defence Deanery ARCP panels must include external representation.

2.28 Following the successful completion of either a full programme of specialty training or a combined programme and an award of a CCT, any service medical officer seeking accreditation as a DMS consultant will be presented to an Armed Services Consultant Appointment Board for confirmation of NHS equivalence and suitability for consultant status in the armed forces.

The management of foundation and specialty training

2.29 HEE, NES, HEIW and NIMDTA are responsible for implementing foundation and specialty training in accordance with the GMC-approved curricula.

2.30 The day-to-day management (including responsibility for the quality management of training programmes) rests with the Postgraduate Deans, who are accountable to HEE, NES (which is accountable to the Scottish Government), the Welsh Ministers or NIMDTA (which is accountable to the DoH).

2.31 The responsible agencies above require Postgraduate Deans to have in place an education contract (often referred to as a Learning and Development Agreement)[6] with all providers of postgraduate medical education that sets out the standards to which postgraduate medical education must be delivered in accordance with GMC requirements and the monitoring arrangements. This includes providers of postgraduate training both in and outside of the NHS.

2.32 A range of issues will be covered in the education contract with the responsible agencies, which has a different purpose to the education contract/agreement between the trainee and the training organisation responsible for training programme management.

The General Medical Council

2.33 The GMC is an independent organisation that helps to protect patients and to improve medical education and practice across the UK. It does this by:

i. managing the UK medical register by deciding which doctors are qualified to work in the UK, and overseeing UK medical education and training

[6] In Scotland, the Service Level Agreement is equivalent to the education contract.

ii. setting the standards that doctors need to follow and making sure that they continue to meet these standards throughout their careers

iii. taking action to prevent a doctor from putting the safety of patients or the public's confidence in doctors at risk

2.34 The GMC is responsible for:

i. issuing provisional and full registration, certifying doctors who have successfully completed a full GMC-approved training programme or combined programme by awarding them a CCT, and for those whose skills, qualifications and experience are considered equivalent to a CCT, awarding them a full CESR/CEGPR

ii. establishing and overseeing standards and quality assurance in medical education and training

iii. making a revalidation decision about whether a doctor should continue to hold a licence to practise and taking action to withdraw a doctor's licence if they do not engage sufficiently

2.35 Standards for the management and delivery of medical education and training are set by the GMC in Promoting Excellence. All training programmes offering postgraduate medical education must conform to these standards.

2.36 Postgraduate Deans are responsible for the quality management of their foundation and specialty training programmes.[7] The requirements to quality manage the delivery and outcomes of foundation and specialty training through the Postgraduate Dean's sponsorship of training programmes is a key element of the GMC's Quality Assurance Framework.

2.37 The GMC quality assures medical education and training. There are four core elements to this:

1. Approval of postgraduate curricula and programmes of assessment, the training programmes designed to deliver curricula outcomes and the locations at which those programmes can be delivered

2. Proactive quality assurance of the management and delivery of training programmes – This includes requiring the Postgraduate Deans to declare periodically that they are aiming to meet the standards of Promoting Excellence and to complete a self-assessment questionnaire. The GMC then scrutinises the questionnaire, alongside other data and intelligence, and undertakes checks (including visits) for areas of change, risk, excellence, innovation or notable practice.

3. Reactive quality assurance of the management and delivery of training programmes – Postgraduate Deans are required to use data and

[7] Postgraduate Deans do not have governance responsibility for undergraduate medical training and education; consequently, it is not covered by the Gold Guide.

intelligence to monitor the local education providers they commission to deliver training and report any risks or issues above a given threshold to the GMC. If local action cannot adequately address serious risks or issues, the GMC supports the local system to resolve the issue through its enhanced monitoring process, which usually includes visits.

4. Collecting, analysing, and reporting data and intelligence – The GMC collects multiple sources of data (including data from its own national training surveys, ARCP data, College/Faculty examinations data and data on recruitment into training programmes) as well as additional intelligence on medical schools, postgraduate organisations, Colleges/ Faculties and local education providers. The GMC uses this data to identify changes, risks, excellence, innovation and notable practice, which then informs its quality assurance processes. Where possible, data is published in accessible and usable formats on the GMC website for others to use.

2.38 Curricula describe outcomes as the knowledge, skills, capabilities, behaviours and expected levels of performance a learner must acquire and demonstrate by the end of a period of education or training. They may be generic, shared or specialty specific. The Colleges and Faculties develop the specialty curricula and programmes of assessment in accordance with the GMC's standards in Excellence by Design. These provide a framework for the approval and provision of postgraduate medical education and training across the UK. Only GMC-approved curricula can be used for delivering specialty training programmes resulting in the award of a CCT. The GMC holds and maintains the list of registered medical practitioners (LRMP) including the specialist and GP registers. All doctors wishing to practise medicine in the UK must be registered with the GMC and hold a licence to practise. A list of relevant legislation is available at GMC | Our Role and the Medical Act 1983.

2.39 In order to be able to take up a substantive, fixed-term or honorary consultant post in the NHS in one of the four UK health administrations, a doctor is required to hold a licence to practise and to be listed on the GMC's specialist register. Further information is available at GMC | Before You Apply. In order to be eligible to take up a post as a general practitioner, a doctor is required to hold a licence to practise, and to be on the GP register and the national Medical Performers List (GMC | The GP Register).

Credentialing

2.40 The concept of credentialing to recognise clinicians' expertise in discrete areas of practice outside of the usual training pathways has been explored to support the service and workforce development focused on patient safety.

2.41 The GMC has introduced a framework for GMC credentials. The aim of GMC credentials is to enable a more flexible training response to patient and service needs, and to reduce risks to patient safety. They will provide consistent standards in areas of practice where concerns about patient safety may arise owing to gaps in training or service, where vulnerable patients are at risk, or to meet future service needs. These approved areas of practice follow the same standards, expectations and requirements as postgraduate curricula (paragraph 2.35).

2.41 i GMC credentials will be recognised on the LRMP to confirm a doctor is qualified and skilled in a specific area of practice. They will not be mandatory for practice in the credentialed area but will allow patients to make more informed choices. In areas where it is necessary for patient safety, doctors will be required to demonstrate ongoing competence to keep the credential on the LRMP.

2.41 ii GMC credentials will be approved, and quality assured against GMC standards for medical education and training. These processes are aligned to GMC processes for approving postgraduate curricula.

2.41 iii Doctors may achieve a credential by completing the training set out in the curriculum or by presenting a portfolio of evidence that shows they have met the required outcomes. A national panel will review the evidence showing that a doctor meets the requirements of the credential. It will then make a recommendation about whether the credential should be awarded. The credentialing body will describe how the panel will be convened, as part of the approvals process. In most cases, it will include representatives from the statutory education bodies, a representative from the credentialing body and an independent Chair.

2.41 iv In specific instances, the panel may also need to include specialists or experts in the field if these are not already represented by the credentialing body. For some areas of practice, it may be appropriate to use regional ARCP panels.

Entry to the specialist and GP registers

2.42 For those who are medically qualified, there are several routes of entry to these registers, which are held by the GMC. The GMC is responsible for awarding the certificates detailed below.

a) Certificate of Completion of Training (CCT)

A CCT confirms the satisfactory completion of a GMC-approved programme of training. Holding a CCT makes a doctor eligible to apply for inclusion on the GMC's specialist or GP registers.

i) Full programme of prospectively approved training

A doctor who has successfully completed a full programme of prospectively approved training is entitled to the award of a CCT.

ii) Combined programme

The combined programme route applies to trainees who enter a GMC-approved training programme (above the first year of the training programme) having undertaken training in non-approved posts prior to entry and then subsequently complete the remaining part of their training in a GMC-approved training programme. These trainees follow the same processes for award of their CCT.

b) Certificates of Eligibility (CESR/CEGPR)

The GMC has also implemented a system that assesses applications for eligibility for inclusion on the specialist or GP registers from doctors who have not completed a traditional training programme that has been prospectively approved by the GMC but who have gained the same level of knowledge, skills and experience required by the approved curriculum leading to a CCT for their specialty. There are different eligibility routes, which each have a different assessment.

i) Approved programme CEGPR

If a trainee has completed all parts of the GMC-approved general practice training programme but has failed to pass the curriculum required examinations while in training, they will not be eligible to apply for a CCT. They may instead be eligible to apply for a CEGPR through the approved programme route (CEGPR(AP)) provided that the examination is taken within six months of leaving the training programme.[8]

ii) Full CESR/CEGPR

The CESR/CEGPR route is for doctors who have not completed a GMC-approved training programme but who can demonstrate that they have completed the equivalent through a combination of training, qualifications and experience obtained anywhere in the world, including the UK. This would include those doctors who leave GMC-approved training without completing the full programme (including the required assessments/examinations) or a combined programme, or are not eligible for CEGPR(AP), as well as those who have never been in a GMC-approved training programme. These doctors apply directly to the GMC for an assessment of their training, skills, knowledge and experience against the CCT curriculum.

2.43 All routes to the specialist and GP registers are equal both as a matter of law and in confirming that the doctor holds the necessary knowledge, skills and experience to work as a senior doctor. All doctors entered on the specialist and GP registers hold the same practising rights and privileges in the UK.

2.44 The processes for entry to the specialist and GP registers can be found at GMC | Specialist or GP Applications. It is important that potential applicants for these registers appreciate that there are fixed time periods for the application submission (as defined on the relevant web pages) and that these must be adhered to.

The Royal Colleges and Faculties

2.45 The Academy of Medical Royal Colleges,[9] the Colleges and the Faculties develop the curricula and programmes of assessment in accordance with the GMC's standards in

[8] Please refer to the current MRCGP examination regulations for eligibility to sit examinations outside of training.

[9] The Academy of Medical Royal Colleges develops the foundation curriculum.

Excellence by Design. The GMC then considers the curricula and assessments against these standards for approval. Only GMC-approved curricula and programmes of assessment can be used for delivering specialty training programmes resulting in the award of a CCT.

2.46 The Colleges/Faculties and their delegated local representatives also work closely with HEE, NES, HEIW and NIMDTA, to ensure that curricula are delivered at a local level and to support the quality management of training delivered within training providers. Through their participation as external advisors on ARCP panels (section 4), the Colleges/Faculties also have a role in the quality management of the ARCP process.

2.47 All doctors in specialty training must enrol/register with the relevant College/ Faculty or intercollegiate body so that:

i. progress in their training can be kept under review and supported where required

ii. they can access the educational portfolio, logbooks and assessment documentation for the specialty

iii. eligible trainees can be recommended to the GMC for consideration of award of a CCT at the end of their specialty training programmes

Postgraduate medical training programmes

2.48 A programme is a formal alignment or rotation of posts that together comprise a programme of training in a given specialty or sub-specialty. Approval of training programmes and locations rests with the GMC. Postgraduate Deans submit their proposed training programmes and locations via GMC Connect. Support from the relevant Colleges/Faculties is required before approval of new programmes. Locations in a programme **must** be approved **before** a trainee trains there, in order for the time to count towards a Foundation Programme Certificate of Completion (FPCC) or CCT. A programme is not a personal programme undertaken by a particular trainee. Further guidance is available at GMC | Programme and Site Approvals.

2.49 All trainees must accept and move through suitable placements or training posts that have been designated as parts of the specialty training programme prospectively approved by the GMC. When placing trainees, Postgraduate Deans or their nominated deputies will take into account (wherever possible) the trainees' specific health needs or disabilities that affect their training. Placement providers are responsible for assessing and making reasonable adjustments if trainees require these. The need to do so should not be a reason for not offering an otherwise suitable placement to a trainee. The GMC has published advisory guidance (including supporting resources) to postgraduate training organisations on supporting doctors in training with long-term health conditions and disabilities. The guidance is available at GMC | Welcomed and Valued.

2.50 A programme may either deliver the totality of the curriculum through linked stages in an entirety to the FPCC/CCT or it may deliver component elements of the approved curriculum. For uncoupled training (paragraph 3.2), the two elements of core training and higher specialty training are separate programmes, and both require approval.

2.51 Postgraduate Deans are responsible for developing appropriate training programmes across educational provider units that meet curriculum requirements.

2.52 Postgraduate Deans will implement a range of models to manage their training programmes overall. The models will vary but rely on senior educators managing training in foundation/specialty programmes providing advice and programme management. Various models are in existence or in development that rely on joint working with the UKFPO or the Colleges/Faculties (usually through their Specialty Advisory Committees) to support this, for example Specialty Training Committees, Specialty Schools and Specialty Training Boards.

2.53 There are two types of training programmes in **specialty training**:

1. '**Run-through**' training, where progression to the next level of training is automatic (so long as the trainee satisfies all the required capabilities)

2. '**Uncoupled**' training programmes, where there are two or three years of core training followed by another open competition for higher specialty training posts and progression to completion of training (provided the trainee satisfies all the required capabilities)

2.54 The type of training programme(s) available depends on the specialty. Some specialties offer run-through programmes, others offer uncoupled programmes and some are piloting programmes through both routes. Information about training pathways will be documented in the relevant specialty curricula.

Foundation schools and Foundation School Directors

2.55 Foundation schools are conceptual groups of institutions bringing together medical schools, the local educational organisation, Trusts/Boards (acute, mental health and primary care organisations) and other organisations such as hospices. They aim to offer training to foundation doctors in a range of different settings and clinical environments. The schools are administered by a central team, which is supported by the education organisation. Foundation schools deliver training according to national guidance developed by the UKFPO with variation according to national policy. The Foundation School Director is the head of the foundation school and is accountable to the Postgraduate Dean. Supported by a foundation school manager/senior administrator and appropriate administrative staff, the Foundation School Director helps set the strategic direction of the school and is responsible for quality management in conjunction with HEE/NES/HEIW/NIMDTA quality management processes.

Training Programme Directors (foundation and specialty)

2.56 Training programmes are led by Training Programme Directors (TPDs), who can work at a local educational organisation (e.g. with foundation doctors) or at a Deanery/local office level (e.g. with specialty trainees), working with Foundation School Directors and Heads of School (or equivalent).

2.57 TPDs have responsibility for managing their assigned specialty training programme(s). They should:

i. participate in the local arrangements developed by the Postgraduate Dean, which may include Heads of School or Chairs of Training Boards, to support the management of the foundation or specialty training programme(s), and work with delegated UKFPO/College/Faculty representatives (e.g. Foundation School Directors, College/Faculty tutors, regional advisors) and national UKFPO/College/Faculty training committees or Specialty Advisory Committees to ensure that programmes deliver the foundation or specialty curriculum, and enable trainees to gain the relevant capabilities, knowledge, skills, attitudes and experience

ii. take into account the collective needs of the trainees in the programme when planning individual programmes

iii. with Directors of Medical Education provide support for educational and named clinical supervisors in the programme

iv. contribute to the ARCP process in the specialty

v. help the Postgraduate Dean manage trainees who are experiencing difficulties by supporting educational supervisors in their assessments and in identifying placements with enhanced support, where required

vi. 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 trainees who will be placed with them. From time to time, however, it might be necessary for TPDs to recommend that trainees be moved at shorter notice.

vii. produce timely reports on the training programme, on individual trainees and on the review of information regarding the quality of training, as required by HEE, NES, HEIW and NIMDTA

viii. have career management skills (or be able to provide access to them) and be able to provide career advice to trainees in their programme

ix. act as positive advocates for their foundation programme or 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)

Educational and clinical supervision (foundation and specialty)

2.58 An educational supervisor is a named trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. (Some training schemes appoint an educational supervisor for each placement.) The educational supervisor is jointly responsible with the trainee for the trainee's educational agreement.

2.59 The educational supervisor is responsible for collating evidence of the performance of a trainee in a training placement, providing feedback to the trainee and

agreeing action plans to ameliorate any concerns or issues identified (paragraphs 4.35 and 4.52–4.58).

2.60 Each trainee should have **a named clinical supervisor**[10] for each placement to ensure that educational governance requirements are met. This arrangement is distinct from the requirement for supervisory arrangements to meet local clinical governance requirements. A named clinical supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and for providing constructive feedback during a training placement. The purpose of the named clinical/educational supervisor meeting/review is defined in paragraphs 4.20–4.27.

The academic supervisor

2.61 Trainees in an academic programme should have a named academic supervisor. The named academic supervisor is responsible for overseeing a specified trainee's academic work and providing constructive feedback during an academic or related placement.

Governance arrangements for supervision

2.62 All trainees must have an educational and named clinical supervisor for each placement in their training programme. It is normal practice for these roles to be undertaken by different people but (in some elements of a rotation) the same individual may provide both educational and clinical supervision. In such a circumstance, the respective roles and responsibilities should be clearly defined. In integrated academic training, a trainee will also have a named academic supervisor.

2.63 Healthcare organisations that provide training placements should explicitly recognise that supervised training is a core responsibility, in order to ensure both patient safety and the development of the medical workforce to provide for future service needs. The commissioning arrangements and education contracts developed between HEE, NES, HEIW or NIMDTA and educational providers should be based on these principles, and they should apply to all healthcare organisations that are commissioned to provide postgraduate medical education.

2.64 Educational and named clinical supervisors should be trained specifically for their role and should demonstrate their competence in educational appraisal and feedback as well as in assessment methods, including the use of the specific in-work assessment tools approved by the GMC for the specialty. Educational and named clinical supervisors should hold a licence to practise and are required to be recognised and/or approved in line with GMC | Recognition and Approval of Trainers requirements.

2.65 Postgraduate Deans will need to be satisfied that those involved in managing postgraduate training have the required capabilities. This includes TPDs, educational supervisors, named clinical supervisors and any other agent who works on behalf of HEE,

[10] In addition to having educational and clinical supervisors, some specialties may include additional defined formal supervision arrangements for specific stages of training or modules in their curriculum.

NES, HEIW, NIMDTA or an employer to deliver or manage training. Postgraduate Deans must ensure quality management of such arrangements to meet the GMC framework. (More information is available in National Association of Clinical Tutors UK guidance – NACT UK Job Roles and Descriptions.) There should be explicit and sufficient time in job plans for both educational and clinical supervision of trainees.

2.66 **It will be essential that trainers and trainees understand human rights and equality legislation.** They must embed in their practice behaviours that ensure that patients and carers have access to medical care that:

i. is equitable

ii. respects human rights

iii. challenges unlawful discrimination

iv. promotes equality

v. offers choices of service and treatments on an equitable basis

vi. treats patients/carers with dignity and respect

Section 3: Undertaking a foundation or specialty training programme

3.1 The General Medical Council (GMC)-approved foundation programme is a two-year programme consisting of an appropriate balance of placements across different specialties and in different healthcare settings. Trainees achieve their Foundation Programme Certificate of Completion (FPCC) when the foundation programme is satisfactorily completed.

3.2 Once trainees have satisfactorily completed a specialty training programme comprising either run-through or core and higher training, 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 or GP registers.

3.3 Trainees who have entered training at a higher level after attaining some capabilities in training not prospectively approved by the GMC, and who have subsequently completed the remainder of the programme in approved posts, will be eligible for the award of CCT via the combined programme route. Award of the CCT will entitle them to apply for entry to the specialist or GP registers.

3.4 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.

Recruitment into training (foundation and specialty)

3.5 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.

3.6 Appointment processes must conform to employment law as well as to best practice in selection and recruitment.

Trainees with disabilities (foundation and specialty)

3.7 Applicants with disabilities must be considered alongside all other applicants for training programmes. Any such applicants will be treated in line with the laws on employment and equal opportunities. More information is available at GMC | Welcomed and Valued.

3.8 Following allocation to foundation or specialty schools, the Training Programme Directors (TPDs) must consider the needs of applicants with disabilities. Applicants should be informed of the Health Education England (HEE)/NHS Education for Scotland (NES)/Health Education and Improvement Wales (HEIW)/Northern Ireland Medical and Dental Training Agency (NIMDTA)/school's process to support those with a disability.

Applicants should inform their school at an early stage so that a suitable programme can be identified.

3.9 Postgraduate Deans and TPDs are encouraged to tailor individual training programmes to help trainees with disabilities to meet the requirements for satisfactory completion. The outcomes set out in the relevant curriculum should be assessed to the same standard but reasonable adjustments may need to be made to the method of education, training and assessment.

3.10 Employers must make reasonable adjustments if appointees with disabilities 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 the individual appointee's educational needs wherever possible.[11]

Recruitment into foundation training

3.11 In line with the GMC's standards in Promoting Excellence, access to places on the foundation programme is through an open, fair and transparent competitive application process across the UK. All entrants to the foundation programme must demonstrate that they meet the person specification and eligibility criteria for each recruiting year as published on the UK Foundation Programme Office (UKFPO) website.

3.12 Those eligible for full registration with the GMC can only participate in the second year of the foundation programme via the national F2 stand-alone application process.

3.13 Before applying for a two-year foundation programme, applicants must confirm that they are eligible to apply. UK medical schools confirm that their final year medical students meet the eligibility criteria on their students' behalf. Applicants from non-UK medical schools and applicants who qualified more than two years prior to the start of the foundation programme to which they are applying must comply with the eligibility checking process and timeframe determined for each recruiting year by the UKFPO. Details of the eligibility checking process and timeframe are published each year on the UKFPO website.

3.14 The process for applying to the two-year foundation programme (including the specialised foundation programme) will be published on the UKFPO website a minimum of six weeks before the application process begins.

3.15 If applicants believe that the published process was not followed in relation to their application, they may appeal against decisions made as part of the process of allocating foundation doctors. The UKFPO is responsible for publishing and managing the appeals process.

[11] Equality Act 2010 (applicable to England, Wales and Scotland, and equivalent Anti-Discrimination Legislation in Northern Ireland)

Supporting Trainees Entering Practice (STEP) in foundation training

3.16 The national Supporting Trainees Entering Practice (STEP) process is a means of supporting medical students during the transition from medical school to foundation training and during F1, and it includes the transfer of information process.

3.17 Under the Medical Act 1983, universities have formal responsibility for confirming that doctors at the end of F1 are eligible for full registration. It is therefore essential that there is a two-way transfer of information between the university/ medical school and HEE/NES/HEIW/NIMDTA/the foundation school until the point of full registration with the GMC.

3.18 The national STEP process is managed by the Medical Schools Council and supported by the UKFPO. The STEP process is facilitated by completion of a STEP form. Every applicant, including eligibility applicants, applying for the foundation programme (via the national application process) is required to comply with the STEP process and complete a STEP form.

3.19 The student completes the STEP form. The medical school endorses the information on the STEP form and may provide further information where appropriate. STEP forms should be shared only with relevant individuals at the applicant's allocated foundation school. There are three key components to STEP:

1. information concerning health and welfare
2. information concerning educational progress
3. information concerning professional performance

3.20 The STEP form and full details of the relevant STEP processes are available on the UKFPO website.

3.21 Completion of the STEP form does not replace the need to report any fitness to practise issues to the GMC or to inform the local education provider's human resources/ occupational health departments of any health issues.

Recruitment into specialty training

3.22 Theme 2 of the GMC standards Promoting Excellence requires that organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.

3.23 Guidance on recruitment is available through the following links:

England	Specialty Training
Scotland	Medical Training
Wales	Recruitment in HEIW
Northern Ireland	Medical and Dental Training Agency

Offers of training (foundation and specialty)

3.24 Trainees will have an educational agreement with HEE, NES, HEIW or NIMDTA that enables them to continue in a training programme subject to satisfactory progress.

3.25 An allocation offer for a training programme following the selection process is not an offer of employment. This can only be made by an employer, who will need to ensure that the candidate who has been allocated to that employer meets the requirements of employability.

3.26 Trainees will be offered an employment contract for the placement(s) they will be working in. Some trainees will be employed by one employer throughout their period of training. This employer is known as the lead employer for that programme. Other trainees will have more than one employer so trainees may have a series of contracts of employment throughout a training programme.

3.27 The trainee's employment is separate from their training and their training number/contract will be maintained throughout their training (paragraphs 3.30–3.37).

3.28 Once a programme allocation and offer has been made by HEE, NES, HEIW or NIMDTA and the applicant has accepted it:

i. the employing organisation will be informed of the applicant's details by HEE, NES, HEIW or NIMDTA. Offers of training and employment will be subject to the applicant being able to demonstrate GMC registration (provisional registration for F1 doctors and full registration for F2 doctors) with a licence to practise at the advertised start date of the programme, and criminal record and barring checks carried out by the employer at the appropriate level as well as having completed all other pre-employment requirements (including references) according to current government legislation.

ii. the employing organisation should contact the applicant to confirm the pre-employment process and set out the requirements for completion of satisfactory pre-employment checks. Contracts of employment remain the responsibility of the employing organisation or lead employer.

3.29 An offer of a place on a training placement is not an offer of employment. If an applicant is selected and offered a placement on a training programme by HEE, NES, HEIW or NIMDTA, these offers are subject to satisfactory pre-employment checks carried out by the relevant employing organisation. It ultimately has the right to refuse employment, although it should have valid reasons for doing so. If the employing organisation is unwilling to offer employment and no other employment with an alternative employing organisation is feasible in the relevant training authority (the locality in HEE, NES, HEIW or NIMDTA) that would allow the trainee to commence the

training placement, then the offer of place on a training programme to the applicant is likely to be withdrawn[12]

Training numbers (core and specialty)

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

3.31 NTNs will only be awarded to doctors in specialty training programmes that have an end point of the award of a CCT (including CCT via CESR(CP)/CEGPR(CP)).

3.32 Core trainees will not be awarded NTNs but will be awarded DRNs. These training numbers are for administrative purposes and do not confer any entitlement to entry to further specialty training.

3.33 The NTN/DRN is unique to the trainee for the period the trainee holds the number in that specialty training programme. The NTN/DRN may be changed for a given trainee if that trainee is subsequently appointed competitively to a different specialty or academic programme.

3.34 A trainee should not hold more than one training number (NTN or DRN) at the same time. Trainees on dual or triple CCT programmes must only hold one NTN.

3.35 Where a NTN/DRN has been issued, it will be held so long as the trainee is in specialty training or is out of programme on statutory grounds, or for out of programme activity that has been agreed with the Postgraduate Dean.

3.36 The NTN or DRN is a numeric code that identifies the location of training, the specialty and the GMC number of the holder with a single letter suffix (for example identifying whether the trainee is on a programme aimed at delivering a CCT or CCT via the combined programme) and whether they are an academic trainee). Detail on the configuration of the NTN/DRN and a table of permitted specialty and sub-specialty combinations can be found in the GMC NTN Appendix available on the GMC website.

3.37 The specialty component of a NTN/DRN will consist of a concatenation of specialty/sub-specialty codes to reflect all the curricula a trainee is undertaking as part of their training programme.

Deferring the start of a foundation or specialty training programme

3.38 The start of training for foundation, core and specialty training may normally only be deferred on statutory grounds (e.g. maternity/paternity/adoption leave, ill health). For the Defence Medical Academy only, training may also be deferred to meet Defence Medical Services operational requirements.

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[12] Where the employing organisation withdraws the offer of employment, in line with paragraph 4.170 below, there is no right of appeal against any decision of HEE, NES, HEIW or NIMDTA to withdraw the training offer.

3.39 Deferral of the start of training applies equally to trainees who have returned to programme following a prior period of statutory leave as well as to applicants for whom the period of statutory leave coincides with the proposed start date of the programme. One such example would be if an applicant has had a period of statutory leave for six months during the final year of core training and thus requires an additional six months to complete the training, providing they otherwise meet the eligibility requirements for specialty recruitment, they can apply for and be appointed to a specialty post and defer the specialty training start date by six months. The period of deferral would not normally exceed one year. However, in exceptional circumstances and with the Postgraduate Dean's approval, it could be extended to a maximum of two years before the doctor would need to reapply for a training post (paragraph 1.15).

3.40 Wherever possible, applicants are asked to give as much notice as possible of the need to defer the start date. This may allow the placement to be offered to someone else.

Registering with the Postgraduate Dean

3.41 All trainees (including those in a locum appointment for training (LAT) post) must register with the appropriate Postgraduate Dean at the time that they commence their training programme by obtaining and returning Form R (GG9 Appendix 1) or the Scottish Online Appraisal Resource (SOAR).

3.42 Foundation doctors (F1) must register with the appropriate Postgraduate Dean at the time that they commence their training programme by completing the Conditions of Taking Up a Training Post form. Additionally, F2 doctors must complete Form R or SOAR. F1 doctors are also expected to complete Form R. F1 doctors are limited to provisional GMC registration and are therefore not subject to the GMC revalidation requirement.

3.43 At this point (for F2 doctors and specialty trainees), their Postgraduate Dean will become their Responsible Officer for revalidation purposes. (*The references to Form R in relation to registration with the Postgraduate Dean in paragraph 3.44* ***do not apply to NES****, where SOAR replaces this form.*) This registration comes with responsibilities for the trainee.

3.44 Engagement with the Postgraduate Dean's processes is an important aspect of professionalism and is viewed alongside all other aspects of competence progression. Failure to comply with requirements such as Form R return, completion of the GMC national training survey and of other required 'local' surveys may result in an Annual Review of Competence Progression (ARCP) Outcome 2 or 3.

3.45 Trainees will also need to send to the Postgraduate Dean a signed copy of the conditions for taking up a training post (GG9 Appendix 2) which reminds them of their professional responsibilities, including the need to participate actively in the assessment and revalidation processes. These obligations relate to professional and training requirements, and do not form any part of the contract of employment.

3.46 Return of Form R (or SOAR) initiates the ARCP process (paragraph 4.36 onwards) and triggers the allocation of a training number/contract where appropriate.

3.47 Registration with the Postgraduate Dean for training is maintained by submitting Form R (or SOAR) on an annual basis, usually integrated with the ARCP process. This form should identify any updates to personal contact details, professional qualifications etc. It reaffirms the trainee's commitment to training and also declarations required for revalidation (including full scope of work, probity, health, involvement in significant events, complaints and compliments).

3.48 It is the responsibility of the trainee to inform the Postgraduate Dean of any changes to their contact details in a timely way. Trainees **must** ensure that HEE, NES, HEIW or NIMDTA has an up-to-date email address at all times and that it is one that the trainee checks regularly.[13] Accurate information is needed not only for the training organisation but also to support the requirements of the Colleges/Faculties and the GMC.

3.49 The Postgraduate Dean will issue a training number to each doctor appointed to a specialty training programme on registering with a completed Form R (or SOAR). This will be a NTN for each doctor appointed to a run-through programme or higher specialty training programme culminating in a CCT or CCT via the combined programme, and a DRN for each doctor appointed to a core programme or LAT. This procedure should be completed within one month of the start date. This will:

i. ensure that the doctor is registered on the Postgraduate Dean's database

ii. initiate the ARCP process, through which progress in training is monitored

iii. enable the Postgraduate Dean to put in place revalidation arrangements

iv. record the date of entry to the programme or post

v. For those trainees with a NTN or DRN, the Postgraduate Dean will forward a copy of the registration form to the relevant College/Faculty. This is to advise that a new trainee has been registered in HEE, NES, HEIW or NIMDTA, and provide the training number and GMC programme approval number.

vi. Foundation doctors are not issued with a NTN or DRN as outlined herein.

3.50 Before a training number/contract is issued, trainees will also be required to indicate formally that they accept the conditions for taking up a training post (GG9 Appendix 2). In addition, trainees awarded a training number/contract must agree to:

i. engage in activities approved by and agreed with the Postgraduate Dean that are compatible with their training programme. (This includes trainees taking agreed time out of training for research, leave of absence for a career break etc.)

[13] This should normally be a professional email address (e.g. NHS.net, nhs.scot).

ii. If time out of the training programme is agreed, the trainee must ensure that the Postgraduate Dean/TPD is informed of their proposed plans/timescale to return to the training programme.

iii. ensure that employer, Postgraduate Dean and College/Faculty processes are followed in relation to the reporting of absences

iv. engage in the training and assessment process (e.g. participate in setting educational objectives; participate in appraisal; attend training sessions; ensure that documentation required for the assessment process, revalidation and maintenance of the GMC licence to practise is submitted on time and in the appropriate format)

v. ensure that all activity undertaken that requires a licence to practise is included in the annual full scope of practice declaration for appraisal/ ARCP

vi. not undertake medical locum or other work activities that compromise their training or make them non-compliant with UK Working Time Regulations. Any locum activities or other medical activities must be documented and reported in the revalidation scope of practice declaration. Foundation doctors should note that locum work is only possible with full GMC registration.

vii. be aware that if they are employed outside of the NHS and cease to pursue (for any reason) the research or other activity that the Postgraduate Dean has agreed is compatible with the retention of the training number/contract, they must inform the Postgraduate Dean, who will then decide whether it is appropriate for them to retain their training number/contract

viii. be aware that if they hold a training number/contract, are employed outside of the NHS in a post that is not part of a training programme and wish to begin or return to a training programme in the NHS, they will need to discuss their return with the relevant TPD and give appropriate notice. They cannot be guaranteed a particular placement but their needs will be taken into account with the rest of the trainees in the programme.

3.51 Failure to comply with these requirements may result in the removal from foundation training or the withdrawal of the training number/contract by the Postgraduate Dean (paragraphs 3.99 iii and iv). The arrangements for appealing against the withdrawal of a training number/contract are described in paragraphs 4.169–4.175.

Maintaining a NTN/DRN/training contract: Continuing registration and remaining in foundation training

3.52 Trainees in foundation and specialty training programmes will remain in foundation training/retain their training number/contract through satisfactory progress and performance. They must also continue to comply with the conditions for taking up a training post (GG9 Appendix 2)

3.53 Trainees can maintain their training number/contract and therefore continue registration with HEE, NES, HEIW or NIMDTA even when they take time out for research (and may no longer be employed by the NHS) or when they take an agreed career break as long as they adhere to the protocol set out in paragraph 3.54.

3.54 In advance of leaving a training programme for a period of time, in accordance with the guidance for time out of programme (paragraphs 3.143–3.176), trainees must agree:

i. with the Postgraduate Dean the period of the time out of programme

ii. to complete the appropriate out of programme document, which sets down the agreed terms of leave from the programme

iii. that where research is concerned, they will continue to pursue the research for which agreement was reached unless a change to the research programme has been agreed with the named academic and educational supervisor

iv. that they intend to return to complete their training to FPCC, CCT or CCT via the combined programme

v. to provide the Postgraduate Dean with an up-to-date email address and to respond to any communication from the Dean

vi. to maintain their GMC registration with a licence to practise

3.55 Foundation doctors must check with the GMC regulations regarding provisional and full registration. When taking time out of training before gaining full registration, foundation doctors should seek advice from the GMC regarding the time limit on provisional registration. Taking time out of training while provisionally registered with the GMC will only be supported in exceptional circumstances.

Filling gaps in training programmes: Locum appointments

3.56 It is inevitable that there may be gaps in training programmes as a result of incomplete fill at recruitment, trainees taking time out of programme, trainees leaving programmes at variable rates after completion of training and variations in when appointments to programmes may occur.

3.57 Vacancies or gaps in training programmes can be filled by locums where there is a service/workforce requirement to do so.

3.58 These will be specified as LATs, stand-alone foundation posts or locum appointments for service (LASs), depending on whether training is offered through the placement or whether the locum is employed solely for service purposes.

3.59 The employer and HEE, NES, HEIW or NIMDTA should consult on the filling of locum posts in order to fill gaps or vacancies in training programmes/posts where these are required for service provision.

3.60 Where posts are required for service, employers should appoint but only after HEE, NES, HEIW or NIMDTA has identified how long a post is going to be left vacant.

3.61 Appointment to a LAT or a LAS post carries no future entitlement to appointment to a specialty training programme leading to a CCT.

Locum appointments for foundation training/stand-alone foundation posts

3.62 Any F1 or F2 vacancies that arise outside of the national application process will be filled using local recruitment processes agreed between the foundation school and the local employer(s). These will be advertised on the relevant websites.

3.63 Doctors appointed to LATs/stand-alone F2 programmes and LAS/non-training service posts must have appropriate workplace supervision.

3.64 Only LATs/stand-alone F2 programmes offer approved training. By definition, locally appointed posts are time limited (i.e. fixed term) unless the employer decides to make a permanent appointment.

3.65 Foundation LATs/stand-alone foundation programmes are usually one-year fixed-term appointments. Appointments will be by the same recruitment processes as for foundation training, adhering to the same national person specifications and in open competition. Where LATs/stand-alone foundation appointments are made outside of the national recruitment windows, there will be representation on the appointments panel from the Postgraduate Dean/Deputy.

3.66 The foundation school must be involved in the recruitment of doctors to LATs/ stand-alone F2 programmes.

3.67 Doctors appointed to LATs/stand-alone F2 programmes must follow the curriculum, have an educational supervisor/named clinical supervisor and, subject to satisfactory performance including ARCP, will be eligible for the FPCC/ARCP Outcome 6. However, LATs/stand-alone F2 programmes will not necessarily be extended if the foundation doctor does not meet the requirements for satisfactory completion of the foundation programme within the fixed-term appointment. Further information regarding LATs/stand-alone F2 programmes is available via the national F2 recruitment framework.

3.68 LATs/stand-alone foundation appointments offer formal, approved training and can be used by doctors:

i. in completing the requirements of the foundation programme

ii. as an employment opportunity with the potential to gain further experience and capabilities where it is appropriate and possible to do so

3.69 A record of capabilities achieved by LAT/stand-alone foundation doctors will also be retained by HEE, NES, HEIW and NIMDTA through the ARCP process.

Locum appointments for specialty training

3.70 LAT posts are usually fixed-term appointments of six months to one year but must be for a minimum of three months. Appointments will be by similar recruitment processes as for specialty training, adhering to the same national person specifications and in open competition. Where LAT appointments are made outside of the national

recruitment process, there will be representation on the appointments panel from the Postgraduate Dean/Deputy.

3.71 LAT appointments are undertaken only in posts that have been approved for specialty training by the GMC. They are managed within specific specialty training programmes approved by the GMC, under the auspices of a specialty TPD.

3.72 LAT posts offer formal, approved specialty training, usually in the early years of a specialty curriculum, and can be used by doctors:

i. in preparation for further specialty training

ii. as a means of considering alternative specialty careers

iii. to prepare them to work in career grade posts

iv. as an employment opportunity with the potential to gain further experience and capabilities where it is appropriate and possible to do so

3.73 LATs are not usually available to provide formal training in advanced elements of the specialty curriculum. The four UK health departments with the advice of their Postgraduate Deans will each determine the extent of the availability of (and access to) such curricular elements. LAT posts do not confer a right of entry to core, higher or run-through specialty training.

3.74 As for trainees in core, higher and run-through training, LAT appointees are required to register with the appropriate College/Faculty in order to access the educational portfolio and assessment documentation for the specialty, and for the post to count towards specialty training.

3.75 LAT trainees must have an educational supervisor with whom educational objectives are set, with regular appraisal, and a programme of workplace-based assessments relevant to the curriculum being followed as well as full clinical supervision. Training and assessment must be provided on an equivalent basis to that provided in specialty training programmes.

3.76 At the end of each post, LAT trainees should participate in the ARCP (section 4) and receive the appropriate annual assessment outcome documentation. LAT trainees are responsible for retaining copies of their ARCP outcomes as evidence of the capabilities they have obtained. A record of capabilities achieved by LAT trainees will also be retained by HEE, NES, HEIW and NIMDTA through the ARCP process.

3.77 A LAT trainee should acquire additional experience, skills and capabilities beyond those specified at that level of the LAT post, which should be recorded and documented in the doctor's educational portfolio. If the doctor subsequently competitively enters a relevant specialty training programme, this information/record will be shared with the receiving locality in HEE, NES, HEIW or NIMDTA and may be taken into account when considering the overall competence level of the doctor in the training programme.

3.78 LATs are undertaken in approved training posts, which can contribute towards a CCT once a trainee has been competitively selected for a relevant training programme. Evidence from these posts can also be used by doctors in submitting their CESR application.

3.79 Enrolled LAT appointments of three months' whole time equivalent or more should automatically count towards training where satisfactory progress is confirmed through the demonstration of achievement of capabilities (usually by ARCP), or unless otherwise notified by the host locality in HEE, NES, HEIW or NIMDTA.

3.80 By definition, a LAT must be for a minimum of three months. On occasions, a trainee working in a LAT post may not complete this time before acquiring a numbered post or further LAT appointment. Under these circumstances, a period of less than three months worked in a LAT post will not count towards training unless it is linked seamlessly (i.e. no delay between exiting LAT and commencing new post) to an appointment to a ST3 post with a NTN, or to another LAT post in the same locality in HEE, NES, HEIW or NIMDTA, and the same programme.

3.81 The number of LAT posts undertaken by a trainee has no GMC limits except that they can only count towards a CCT if the doctor subsequently enters an approved specialty training programme via open competition. HEE, NES, HEIW and NIMDTA should keep a careful record of these appointments on the trainee's file. Those capabilities will be assessed at the first ARCP in the specialty training programme and the CCT date adjusted accordingly. Doctors **cannot** obtain a CCT with only LAT appointments. They can, however, use evidence of capabilities gained in LATs towards a full CESR application.

Locum appointments for service (foundation and specialty)

3.82 Doctors undertaking a LAS post may be appointed by employers in consultation with HEE, NES, HEIW or NIMDTA and these are usually short-term service appointments.

3.83 Discussion with HEE, NES, HEIW or NIMDTA is required to ensure that the responsibility for filling the short-term gap is clear between the employer and HEE, NES, HEIW or NIMDTA. Since these appointments are for service delivery and will not enable appointees to be assessed for capabilities required in a GMC-approved curriculum, employers may use local person specifications. Doctors in these posts will not be able to have the capabilities assessed and credited towards educational progression in a foundation or specialty training programme.

3.84 Doctors undertaking a LAS post must have appropriate clinical supervision but do not require an educational supervisor since they will not normally be able to gain documented relevant training capabilities through the appointment. However, capabilities attained from undertaking a LAS post may count towards progressing to a Certificate of Readiness to Enter Specialty Training or entry onto a combined programme. Whether these capabilities can be taken into account would usually be assessed early after entry to a training programme and at the latest by the first ARCP.

3.85 LAS/non-training service posts are used for service delivery and will not enable appointees to meet the requirements for satisfactory completion of F1 or the foundation programme. LAS/non-training service posts must not be undertaken by provisionally registered doctors.

Dual and triple training

3.86 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 here.[14]

3.87 In most cases, trainees are competitively appointed to dual training specialties through a single recruitment process. Trainees are expected to complete the programmes in full and obtain the capabilities set out in all curricula. Application to the GMC for a CCT should only take place when all programmes are complete. The certificates should be applied for and awarded on the same date, and the expected end of training date for both specialties therefore becomes the same date.

3.88 Where a trainee wishes to curtail the programme leading to dual specialist registration and to apply to the GMC for a single CCT the trainee must apply to the Postgraduate Dean for agreement to do so. If the Postgraduate Dean agrees, the dual specialist registration programme will terminate and the trainee will continue training in the remaining single specialty. Similarly, if the trainee has received an ARCP Outcome 4 in one of the limbs of a dual training programme (paragraph 4.89), the trainee can only continue with the second limb of that programme with the approval of the Postgraduate Dean.

3.89 Dual training is not available for those training in general practice; however, trainees can apply for and be appointed a second specialty on completion of the general practice training programme.

Sub-specialty certification during training and post-specialist registration

3.90 In certain specialties, it is possible to be awarded a sub-specialty certificate and have this sub-specialty indicated on the specialist register against a doctor's name.

3.91 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.

3.92 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 at GMC | Sub-specialties.

3.93 Where sub-specialty training is undertaken within the envelope of a specialty training programme, trainees should apply for a sub-specialty certificate at the same time as they apply for their CCT. The College/Faculty CCT recommendations to the GMC should include details of any sub-specialty training programmes successfully completed

[14] Triple accreditation is not normally supported but Intensive Care Medicine and certain group 1 physician specialties (e.g. Internal Medicine and Acute Internal Medicine, Respiratory Medicine or Renal Medicine) is approved as an exception by the GMC.

by a trainee. 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. Guidance and an application form can be obtained from GMC | Sub-specialty Recognition Application.

Applying for consultant posts

3.94 UK SEBs and training organisations must comply with and implement relevant Department of Health guidance; therefore, trainees must ensure that they are eligible to apply for a consultant post before submitting the application. Trainees must not be interviewed more than six calendar months prior to their anticipated CCT date. Trainees must only apply if progress has been satisfactory (Outcome 1 at last ARCP) and if it is anticipated that the final ARCP outcome will recommend that training is completed by the time the suggested CCT date is reached.

3.95 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 trainee is eligible for the consultant post.

3.96 Once a doctor has been entered on the specialist register, they are able to take up a substantive, fixed-term or honorary consultant or general practitioner post in the NHS. There are different arrangements for Foundation Trusts, which can be found at GMC | The Specialist Register.

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

3.98 There may be exceptional circumstances where there is a requirement for tailored training within the approved curriculum towards a specific post. The rural track in the general surgery curriculum is a good example, where the GMC has approved the tailored training. 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. Such circumstances would require authorisation by the appropriate health department, and must be outlined in the recruitment documentation and agreed by the Postgraduate Dean. As an alternative approach, consideration could be given to achieving these capabilities in a post-CCT fellowship.

Removal from foundation training and withdrawal of training number/ contract – when is the training number/contract withdrawn?

This section sets out the Gold and Purple Guides' directive to the Postgraduate Dean for withdrawal of the training number/contract or removal from foundation training if the criteria in paragraphs 3.99 i–viii are met.

3.99 The training number/contract will be withdrawn when a trainee:

i. has completed their training programme and has received an ARCP Outcome 6 (including a period of grace where relevant)

ii. has received an Outcome 4 from the ARCP panel, and the appeals process (where relevant) has been concluded and the appeal rejected

iii. is assessed by the Postgraduate Dean as not being suitable for returning to or continuing training in the specialty/foundation programme in HEE, NES, HEIW or NIMDTA

iv. does not comply with the requirements for registering or maintaining their registration with the Postgraduate Dean, as set out in GG9 Appendix 2

v. does not hold GMC registration with a licence to practise

vi. has their name erased or suspended from the medical register, or where restrictions are applied to their registration and where such measures are incompatible with continuing in a medical training programme at their level of training

vii. is dismissed by an employer, which may be an individual employer or the lead employer, and the appeal against the dismissal (where relevant) has been concluded and the appeal rejected

viii. resigns their place in a training programme

3.100 In all cases where a training number/contract is withdrawn or a trainee is removed from foundation training, the Postgraduate Dean will inform the trainee in writing of the reasons for this decision and (where necessary) their right of appeal.

3.101 Should a training number/contract be withdrawn, or a trainee be removed from foundation training under paragraphs 3.99 iii, iv, vi or vii, then the trainee will have the right of appeal (paragraphs 4.169–4.175). If the training number/contract is removed under paragraph 3.99 vii, while this is subject to appeal, the appeal is restricted to the educational process under the governance of the Gold Guide. The appeal panel does not have authority to overturn employment/contractual decisions.

3.102 In relation to paragraphs 3.99 ii–vi, the relevant employing organisations need to be informed of any decision for withdrawal of a training number/contract as this will normally also mean that their employment contract will be terminated but the decision for the training number/contract to be withdrawn on educational grounds rests with the Postgraduate Dean.

3.103 If a foundation doctor resigns from their employment, they should also inform HEE/NES/HEIW/NIMDTA/the foundation school, which will normally terminate the training contract and notify the medical school. HEE/NES/HEIW/NIMDTA/the foundation school must inform the foundation doctor's current and any known future employer as part of the foundation programme when terminating a training contract.

3.104 If a trainee is dismissed by an employer, other than at the end of their fixed term, HEE/NES/HEIW/NIMDTA/the foundation school will normally remove the training number/contract. The employer is responsible for publishing and managing the appeals process against dismissal. Removals under paragraph 3.99 vii are therefore not subject to further appeal against the dismissal but focus on the educational grounds for removal of the training number/contract (paragraph 3.101).

3.105 For foundation doctors, HEE/NES/HEIW/NIMDTA/the foundation school should discuss with the GMC's Fitness to Practise Directorate if it thinks there may be fitness to practise concerns unless a referral has already been made by the employer or representative of the employer responsible for the dismissal.

3.106 The provision in paragraph 3.99 vi relates to decisions of the Medical Practitioners Tribunal Service (MPTS) after their full and formal Medical Practitioners Tribunal (MPT) process. This may also relate to decisions of MPTS Interim Orders Tribunals (which are temporary arrangements pending the decision of a full MPT) where such measures are assessed by the Postgraduate Dean as being incompatible with continuing in a training programme for a period likely to be in excess of two years (in accordance with paragraph 1.15).

3.106 i If a doctor has their training number/contract withdrawn following an Interim Orders Tribunal decision, and this decision is subsequently revoked and registration reinstated (within the two-year period defined in paragraph 1.15), the trainee may request that the Postgraduate Dean restores their training number/contract; and

3.106 ii providing that there are no outstanding fitness to practise issues or unresolved concerns (paragraph 3.108), the Postgraduate Dean will make a decision taking into account all the relevant factors, including any outstanding fitness to practise issues or other unresolved concerns that affect suitability to continue in or return to a training programme.

3.107 In some circumstances, a trainee will neither be currently employed in the NHS nor hold an honorary contract with an NHS organisation (e.g. they will be working overseas or taking a break from employment). Where the Postgraduate Dean believes that the conditions under which such a trainee holds the training number/contract have been breached and that the training number/contract should be withdrawn, the Postgraduate Dean will write to the training number/contract holder to tell them of their decision. The trainee will have the right of appeal through the process, as set out in paragraphs 4.169–4.175.

3.108 Foundation and specialty training posts and programmes are not normally available to trainees who have previously relinquished or been released/removed from a training post/programme in that specialty or in foundation training. However, provided that there are no outstanding fitness to practise issues, unresolved concerns or factors that affect suitability for foundation or specialty training, it is open to those who have

had their training number/contract/foundation programme place withdrawn or have given their training number/contract up voluntarily to reapply to specialty/foundation training at a later date.

3.108 i **In order to reapply for training in the same specialty**, where a trainee has previously been removed or resigned, they must have the support of the Postgraduate Dean in the locality in HEE, NES, HEIW or NIMDTA where training in this specialty was previously undertaken. Applications will only be considered if a trainee provides a 'Support for Reapplication to a Specialty Training Programme' form. No other evidence will be accepted. Re-entry in such cases will be by competitive process with other applicants.

3.108 ii **In order to reapply for foundation training**, where a trainee has previously been removed or resigned, they must have the support of the Postgraduate Dean/Deputy in the locality in HEE, NES, HEIW or NIMDTA where foundation training was previously undertaken. Applications will only be considered if a trainee provides a 'Reapplication to Foundation Training' form. No other evidence will be accepted. Re-entry in such cases will be by competitive process with other applicants. **Where the applicant has not practised medicine for more than two years, they will have to undergo an approved assessment of their clinical skills.**

Doctors in specialty training employed permanently outside of the NHS

3.109 In some specialties (e.g. occupational medicine and pharmaceutical medicine), it is anticipated that most specialty trainees will enter and complete their training with employers outside of the NHS. In such circumstances, trainees will not hold either substantive or honorary NHS contracts. They must, however, hold a NTN(I) (I for Industry). The programme should comply with the GMC's standards in Promoting Excellence (paragraph 2.29).

3.110 Before a NTN(I) is issued, the Postgraduate Dean must be satisfied that these specialty trainees have a contract with an approved education provider.

3.111 Receipt of a NTN issued in these circumstances confers no right to a placement in the NHS or to a place in any particular rotation with a non-NHS employer.

Less than full-time training

3.112 HEE, NES, HEIW and NIMDTA have a strong commitment to help all trainees reach their full potential. All doctors in training including academic trainees can apply for LTFT training.

3.113 This guidance is drawn from the NHS Employers document *Principles Underpinning the New arrangements for Flexible Training* (2005)[15] and is supported by the GMC's 2017 position statement on LTFT training.

3.114 Those in LTFT training must meet the same requirements as those who train on a full-time basis to achieve a CCT.

3.115 The aims of LTFT training are to:

i. retain doctors in the workforce who are unable to continue their training on a full-time basis for a well-founded individual reason

ii. promote career and personal development as well as work/life balance and wellbeing

iii. ensure continued training in programmes on a time equivalence (pro rata) basis

3.116 LTFT trainees will:

i. reflect the same balance of work as their full-time colleagues. Daytime working, on-call and out-of-hours duties will normally be undertaken pro rata to those worked by full-time trainees at the same training grade in that specialty.[16] The educational and legal requirements of training must always be met.

ii. normally move between placements within rotations on the same basis as full-time trainees

3.117 LTFT trainees are not precluded from undertaking additional work although they should ensure that in undertaking this work, they practise according to the GMC's standards in Good Medical Practice and that there is not a negative impact on their training. They should ensure that the Postgraduate Dean, as their designated Responsible Officer, is aware of all additional work undertaken by use of their annual Form R or SOAR submission. Further information is available on the Conference of Postgraduate Medical Deans website (COPMeD | Guidance on Undertaking Additional Work).

3.118 A balance needs to be maintained between the LTFT training arrangements, the educational needs of both full-time and LTFT trainees, and the needs of the service.

3.119 Decisions made by HEE, NES, HEIW and NIMDTA only relate to educational support for a LTFT training application. Employers/host training organisations must make

[15] NHS Employers guidance and policy is only applicable in England; devolved nations may have similar guidance.

[16] There is extra guidance in the NHS Employers (England only) Good Rostering Guide (2018) if a pro rata arrangement is not practicable in the employing organisation.

a separate decision about the employment aspects of any proposal including the placement and any associated out-of-hours work.[17]

Eligibility for LTFT training

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

3.121 Building on the NHS Employers document *Principles Underpinning the New Arrangements for Flexible Training* (2005), the Gold Guide should be considered as providing separate guidance to this legislation, reflecting the tripartite nature of supporting a LTFT trainee between the trainee, the four UK statutory education bodies and the employer/host training organisation.

Managing requests for LTFT training

3.122 All doctors in training can apply for LTFT training, the only requirement being a well-founded individual reason. A list of illustrative examples of reasons for requesting LTFT training is included in paragraph 3.123.

3.123 **Reasons for requesting LTFT training – illustrative list:**

i. Trainees with a disability or ill health – This may include ongoing medical procedures such as fertility treatment.

ii. Trainees with caring responsibilities (e.g. for children, or for an ill/disabled partner, relative or other dependant)

iii. Welfare and wellbeing – There may be reasons not directly related to disability or ill health where trainees may benefit from a reduced working pattern. This could have a beneficial effect on their health and wellbeing (e.g. reducing potential burnout).

iv. Unique opportunities – A trainee is offered a unique opportunity for their own personal/professional development and this will affect their ability to train full time (e.g. training for national/international sporting events, or a short-term extraordinary responsibility such as membership of a national committee or continuing medical research as a bridge to progression in integrated academic training).

v. Religious commitment – A trainee has a religious commitment that involves training for a particular role and requires a specific time commitment resulting in the need to work less than full time.

vi. Non-medical development – A trainee is offered non-medical professional development (e.g. management courses, law courses or

[17] Contractual provisions are set out by NHS Employers in Equitable Pay for Flexible Medical Training (2005) and the 2018 junior doctor contract refresh.

fine arts courses) that requires a specific time commitment resulting in the need to work less than full time.

vii. Flexibility for training and career development with the option to train less than full time with flexibility that might enable development of a broad career portfolio

3.124 All well-founded reasons will be considered. However, support to progress the application may be dependent on the capacity of the programme and available resources as well as compliance with relevant legislation relating to CCT requirements (paragraphs 3.118 and 3.119).

3.125 Trainees appointed to LAT posts may apply for LTFT training and must complete the process in the usual way. However, a placement may not be immediately available. Owing to the fixed-term nature of such appointments, if the LAT post is undertaken less than full time, it will be recognised on a whole-time equivalent basis as a proportion of the duration of the post. There is no entitlement to an extension of the fixed-term period of training on a pro rata basis.

Applying for LTFT training

3.126 The normal process for acceptance to LTFT training will include the following stages:

i. All trainees can apply for LTFT training either at the point of application for entry into training or at any time once they have been accepted into training. As for all other applicants wishing to enter foundation or specialty training, competitive appointment to training is required but must not be affected or influenced by the applicant's wish to be considered for LTFT training.

ii. Trainees will need to first submit their application for LTFT training to HEE, NES, HEIW or NIMDTA, which will be assessed and (where necessary) prioritised according to the provisions of the Equality Act relating to protected characteristics. HEE, NES, HEIW or NIMDTA will consider the application in the context of its effect on the training available to other trainees in the programme.

iii. Trainees must inform their College/Faculty of their arrangements for LTFT training and ensure their TPD or Head of School is aware.

iv. Approval of the training plan will normally be given for the duration of the placement and be subject to annual review around renewal. The LTFT placement and funding will also be subject to agreement with the employer/host training organisation before the placement can be approved.

3.127 LTFT trainees will require the approval of the Postgraduate Dean if they wish to increase or decrease their working hours (subject to the minimum requirements for recognition of training set by the GMC's 2017 position statement on LTFT training).

3.128 If a LTFT trainee moves to a different placement other than the planned movement on rotation or moves by inter-deanery transfer, a new request to continue training on a LTFT basis will be required.

3.129 LTFT trainees who wish to revert to full-time training must first inform the Postgraduate Dean. A suitable full-time placement may not be immediately available, and will depend on the current LTFT arrangements for that trainee and post availability in the training programme. HEE, NES, HEIW or NIMDTA must be informed of the planned start date for a return to full-time training.

3.130 The administration of an application will normally take three months and applicants should not expect to be placed immediately. The inability of HEE, NES, HEIW or NIMDTA to find a post at short notice should not be taken as a refusal of LTFT training; an individual's needs and expectations must be considered in the context of educational standards and service capacity, and as a result, LTFT training cannot always be guaranteed.

3.131 Further details of the application and appeals processes can be found on the individual websites of HEE, NES, HEIW and NIMDTA.[18]

Progression in training as a LTFT trainee

3.132 All trainees, full-time or LTFT, need to meet the requirements for progression in training as set out in the relevant GMC-approved curriculum. LTFT trainees will be assessed in accordance with the ARCP process as described in paragraphs 4.36–4.157.

3.133 Key points relating to LTFT trainees are:

i. LTFT trainees should have an ARCP not less than annually but at intervals of no more than 15 months (to comply with the revalidation requirement) but may need an ARCP at a critical progression point in training.

ii. LTFT trainees will be expected to demonstrate the capabilities relevant to their stage of training as described in their relevant curriculum on a pro rata basis. Any workplace-based assessments should be spread evenly across a training placement.

iii. Should a training extension be required after the award of an ARCP Outcome 3/10.2, this extension will be on a pro rata basis. There is the option of a fixed-term time extension should there be sound educational reasons for this.

iv. LTFT trainees can apply and be interviewed for a consultant post six months prior to their anticipated CCT date; this is on a fixed-term time basis and not pro rata.

[18] LTFT training appeals to HEE, HEIW, NES or NIMDTA will only relate to educational decisions, not employment.

v. LTFT trainees can apply for a period of acting up as a consultant in their final year of training. The period of acting up is normally three months and can be extended pro rata to reflect the LTFT training percentage. It can be extended for longer periods with the agreement of all parties, including the employer.

Academic training, research and higher degrees

3.134 All of the specialty training curricula require trainees to understand the important value and purpose of medical research, and to develop the skills and attributes needed to critically assess research evidence. In addition, some trainees 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)

HEIW | Academic Medicine

NIMDTA | Academic Training

Academy of Medical Sciences

3.135 Such opportunities are available through two main routes.

Option 1: Trainees can compete for opportunities to enter integrated combined academic and clinical programmes.[19] 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.

Option 2: Trainees can take time out of their specialty training programme for a period entirely focused on research leading to either an MD or PhD degree (time out of programme for research (OOPR), paragraphs 3.170–3.178), with the agreement of the TPD and Postgraduate Dean. Trainees will continue to hold their training number/contract during this time out of their clinical programme. (Other routes may be available to trainees in certain specialties such as public health.)

Option 1: Integrated academic and clinical programmes

3.136 Each of the four UK countries has developed its own arrangements for these integrated academic and clinical posts. Further details are available from the relevant websites. It is vital for those considering entry to an academic pathway to be aware of the specific training requirements in each of the four countries.

[19] Examples of integrated academic training include specialised foundation programmes.

3.137 Trainees in integrated academic programmes will be assessed through a joint academic and clinical annual assessment process as described in paragraphs 4.141–4.145.

3.138 If it is recommended at any point through the ARCP process that an integrated academic programme trainee should leave the academic programme but should still continue with their clinical training, then the trainee will be facilitated back into the clinical training programme by the Postgraduate Dean, given due notice.

3.139 Where a trainee is undertaking an academic programme within an uncoupled programme that confers the right to automatic access to higher specialty training (currently only in England), if they leave the academic programme during core training, they will forfeit their access to automatic run-through training.

3.140 In these programmes, the period of academic research is integrated with the clinical component and the appropriate proportion of these periods would normally be designated prospectively. It is accepted practice to count periods of research in an integrated academic programme towards any time-based requirement for the associated clinical CCT.

Option 2: Taking time out of programme to undertake research

3.141 Trainees will need to seek the prospective agreement of the Postgraduate Dean to take time out of programme to undertake research or an appropriate higher degree. Those taking time out of programme for research purposes will retain their NTN as long as they have the agreement of the Postgraduate Dean to do so. The process for this is described in paragraphs 3.170–3.179.

3.142 Trainees undertaking research with no clinical care component should also note paragraph 4.155 regarding maintaining clinical skills.

Taking time out of programme (OOP)

3.143 There are a number of circumstances when a trainee may seek to spend some time out of the training programme to which they have been appointed. All such requests need to be agreed by the Postgraduate Dean or nominated deputy in advance so trainees are advised to discuss their proposals as early as possible. Trainees may be approved for more than one OOP per training programme (including dual and triple CCT programmes). Postgraduate Deans will oversee and manage OOPs to ensure that the period of time out does not compromise clinical skills and currency (paragraph 1.15), and there should be adequate planning for the return to training and a programme supporting restoration of clinical skills where they may have been skills fade due to the time out of clinical practice. Normally, OOPs that run consecutively would not be approved. However, the Postgraduate Dean has discretion to consider exceptional circumstances and approve OOPs where there are sound educational reasons to do so.

(For example, academic trainees may be required to undertake time out of programme for clinical experience (OOPE) in preparation for OOPR to undertake a PhD degree.)[20]

3.144 The purpose of taking OOP is to support the trainee in:

i. undertaking clinical training that is not a part of the trainee's training programme (OOPT)

ii. gaining professional skills that would enhance their future practice (OOPE) – This could include enhancing skills in medical leadership, academia, medical education or patient safety, or enhancing clinical skills related to but not part of the curriculum. Such experience may benefit the doctor (e.g. working in a different health environment/ country) or may help support the health needs of other countries (e.g. with Médecins Sans Frontières, Voluntary Service Overseas, global health partnerships). OOPE is not applicable in foundation training.

iii. undertaking a period of research (e.g. leading to an MD or PhD degree) (OOPR)

iv. taking a planned career break (OOPC)

3.145 OOP can only be agreed if it has the formal approval of the Postgraduate Dean. Guidance for the processes for application for OOP can be found on the websites of HEE, NES, HEIW and NIMDTA. The trainee should give their Postgraduate Dean and their employer (current and/or next) as much notice as possible, and this would normally be six months so that the needs of patients are addressed appropriately.

3.146 Trainees will also need to ensure that they keep in touch with HEE, NES, HEIW or NIMDTA, and renew their commitment and registration to the training programme with the Postgraduate Dean on an annual basis. This process also requests permission for the trainee to retain their training number/contract and provides information about the trainee's likely date of return to the programme as well as the estimated date for completion of training and revalidation documentation. For trainees undertaking approved training out of programme, it should be part of the return for the annual review process. It is the trainee's responsibility to make this annual return, with any supporting documentation that is required.

3.147 Trainees must maintain their licence to practise while on OOP as well as their connection with HEE, NES, HEIW or NIMDTA for the purposes of revalidation and might be at risk of training number/contract withdrawal (paragraph 3.99 v) if they do not.

3.148 Trainees undertaking LAT posts cannot request time out of their post. Where time needs to be taken away from work (e.g. following bereavement or for illness), the service gap may be filled but the trainee's fixed-term appointment contract will not be extended.

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[20] OOP is normally fixed term for the maximum defined periods outlined in the Gold Guide; exceptions might include but are not limited to OOPT trainees acting up as a consultant (paragraph 3.160).

3.149 The Postgraduate Dean cannot guarantee the date or the location of the trainee's return placement. It is therefore important that both the Postgraduate Dean and the TPD are advised well in advance of a trainee's wish to return to clinical training. Postgraduate Deans will attempt to identify a placement as soon as possible but trainees should indicate their intention and preferred time of return as soon as they are able to do so.

3.150 The return of the trainee into the programme should be taken into account by the TPD when planning placements. If a trainee, having indicated that they are returning to the training programme, subsequently declines the place offered, then there is no guarantee that another place can be identified although every effort will be made to do so. Under these circumstances (but following discussion with the relevant TPD and the Postgraduate Dean), the trainee may need to relinquish their training number/contract. Employing organisations need to be party to any decisions by trainees to relinquish their training number/contract so that they can manage their service needs, and so that the process is timely and fair.

OOP in foundation training

3.151 Occasions where OOP is granted to foundation doctors are likely to be exceptional given the length and nature of their training. The duration of time out of the foundation programme will usually be 12 months to avoid foundation doctors becoming out of phase with the foundation programme. Foundation schools will typically only approve OOP at the end of F1 so that the time out is taken between the end of F1 and the beginning of F2. Time out during F1 or F2 placements will only be considered in exceptional circumstances.

3.152 **Foundation doctors** who want to take OOP should first discuss this with their educational supervisor and Foundation Programme Training Director.

3.153 **F1 doctors** should be aware that the GMC has made an important change to the way doctors can use their provisional registration. From 1 April 2015, the length of time doctors are allowed to hold provisional registration is limited to a maximum of 3 years and 30 days. Further information can be found at GMC | Provisional Registration.

3.154 **Foundation doctors** who take time out of the foundation programme during F1 to undertake training outside of the UK will require a Certificate of Experience from their medical school confirming that they have successfully completed the requirements of F1 in order to apply for full GMC registration. No other evidence will be accepted. If the foundation doctor cannot provide the evidence for the Certificate of Experience, they are not eligible for full registration and will be limited to applying for provisional registration on their return to the UK. Further guidance can be found at GMC | Provisional Registration.

3.155 If the **foundation doctor** does not contact the Foundation School Director (FSD) as agreed, the foundation school is no longer required to hold a F2 programme and the foundation doctor would need to apply for a vacant F2 appointment in open competition.

OOP in specialty training

3.156 OOP will not normally be agreed until a trainee has been in a training programme for at least one year of specialty training (unless at the time of appointment, deferral of the start of the programme has been agreed for leave on statutory grounds). Occasions where OOP is granted to trainees in core training programmes are likely to be exceptional given the length and nature of their training.

Time out of programme for approved clinical training (OOPT)

3.157 The GMC must prospectively approve clinical training out of programme if it is to be used towards a FPCC, CCT award (GMC | Out of Programme (OOP)). This could include overseas posts or posts in the UK that are not already part of a GMC-approved programme in the same specialty. Further approval from the GMC is not required if the OOPT is already part of a GMC-approved programme in the same specialty. If OOPT is being taken in a programme managed by another UK region, trainees must ensure that the programme is already approved for training. (See GMC | Programme and Site Approvals.)

3.158 The Postgraduate Dean is required to submit an application for prospective GMC approval for any OOP that is to count towards a FPCC or CCT on behalf of the trainee and this application is required to include support from the relevant College/Faculty. If prospective approval for OOP is not sought from the GMC, then it cannot count towards a FPCC or CCT. Where the OOPT is in a GMC-approved programme in the same specialty, an application for further GMC approval is not required.

3.159 Trainees will retain their training number/contract while undertaking an approved clinical training opportunity as long as the OOPT has been agreed in advance by the Postgraduate Dean and trainees continue to satisfy the requirement for annual review, including revalidation. OOPT will normally be for a period of up to one year.

3.160 Trainees may be able to take OOP to act up as a consultant and may be able to credit this time towards a CCT if it is explicitly allowed by the College/Faculty. This would normally be undertaken in the final year of training. Trainees acting up as consultants will need to have appropriate supervision in place. If the experience afforded by this post is in a location already approved for training in the relevant specialty by the GMC, additional prospective approval for OOPT is not required from the GMC. If acting up as a consultant is undertaken in another location, prospective approval will only be necessary if the acting up placement is relevant and contributes to gaining the capabilities, knowledge, skills and behaviours required by the curriculum. In these circumstances, OOPT will normally be for a period of three months or pro rata for LTFT trainees. However, length of periods approved for acting up as a consultant may be specified in the relevant College/Faculty guidance. Specific provisions around acting up roles need to be adhered to.

3.161 Trainees who undertake OOPT must continue to participate in the ARCP process of their home locality in HEE, NES, HEIW or NIMDTA. This is necessary to confirm the provisional period of OOPT permitted to count towards the FPCC or CCT. The period of recognition may be reduced if the training placement did not provide the expected capabilities.

Time out of programme for clinical experience (OOPE) – not applicable in foundation

3.162 Trainees may seek agreement for OOP to undertake clinical experience that has not been approved by the GMC and that will not contribute to award of a CCT or CCT via CESR(CP)/CEGPR(CP). In these circumstances, it is likely that the CCT date will need to be extended. The purpose of such OOPE could be to:

i. gain professional skills that would enhance a trainee's future practice. This could include enhancing skills in medical leadership, academia, medical education or patient safety.

ii. enhance clinical experience and skills related to but not part of the curriculum for the individual so that they may experience different working practices or gain specific experience in an area of practice

iii. support the recommendations in *Global Health Partnerships: The UK Contribution to Health in Developing Countries* (2007), which recommends:

'*An NHS framework for international development should explicitly recognise the value of overseas experience and training for UK health workers and encourage educators, employers and regulators to make it easier to gain this experience and training.* […] *Postgraduate Medical Education and Training Board (PMETB) should work with the Department of Health, Royal Colleges, medical schools and others to facilitate overseas training and work experience.*'

3.163 The request to take OOPE must be agreed by the Postgraduate Dean following the same rules as outlined above for OOPT (other than the requirement for prospective approval from the GMC). The OOP document must be used to make the request, and this should detail the rationale for the application and the specific capabilities to be acquired during the period of OOPE. This document must be returned on an annual basis to HEE, NES, HEIW or NIMDTA while the trainee is out of programme. OOPE will normally be for up to one year.

Time out of programme for research (OOPR)

3.164 Trainees should be encouraged and facilitated to undertake research where they have an interest and aptitude for doing so. Options are limited for foundation doctors because of the short programme duration. Owing to the nature and duration of foundation training, OOPR will be approved only in exceptional cases. It will usually be restricted to one year and will generally only be taken between F1 and F2.

3.165 Trainees who undertake OOPR must continue to participate in the ARCP process of their home locality in HEE, NES, the HEIW or NIMDTA and would be expected to return at the end of the period of OOPR.

3.166 Time spent out of a specialty training programme for research purposes will be recognised towards the award of a CCT when the relevant curriculum includes such research as an optional element. Under such circumstances, the GMC is not approving the research but is approving any training (including research) that is deemed to be

appropriate and relevant to the curriculum in question. Both the College/Faculty and HEE, NES, HEIW or NIMDTA need to support the application for prospective approval.

3.167 Once prospective approval of the posts and programmes has been obtained, it is still for the College/Faculty to confirm whether the training (including relevant research) has been completed satisfactorily and satisfies the requirements of the curriculum when the College/Faculty makes recommendations to the GMC for the award of a CCT.

3.168 Time taken out for research purposes is normally for a higher degree (e.g. PhD, MD or master's degree) and will not normally exceed three years. The Postgraduate Dean has discretion to consider exceptional circumstances and give specific prospective approval to extend the OOPR normally to a maximum of four years in total.

3.169 When OOPR does not count towards CCT requirements, GMC approval is not required.

3.170 If there is prospective approval from the GMC for the OOPR to contribute to the CCT, then formal assessment documentation must be submitted annually to the ARCP panel.

3.171 Many individuals undertaking such research retain a clinical element, which will allow them to maintain their existing capabilities while on OOP. The extent of this clinical element will guide HEE, NES, HEIW or NIMDTA and the relevant College/Faculty in making a recommendation to the GMC on whether the clinical and research capabilities attained during OOPR should be used to contribute towards the award of a CCT. The trainee should seek advice from their TPD and named academic supervisor to ensure that the proposed clinical element is appropriate.

3.172 Trainees in their final training year will not normally be granted OOPR.

Time out of programme for a career break (OOPC)

3.173 Planned OOPC will permit a trainee to step out of the training programme for a designated and agreed period of time to pursue other interests (e.g. domestic responsibilities, work in industry, developing talents in other areas or entrepreneurship).

3.174 Periods of ill health should in the first instance be managed under the guidance of the employer's occupational health services, as for other staff. OOPC is an inappropriate way of managing health issues.

Who is eligible to apply for OOPC?

3.175 OOPC can be taken with the agreement of the Postgraduate Dean, who will consult as necessary with those involved in managing the training programme. Limiting factors will include:

i. the ability of the programme to fill the resulting gap in the interests of patient care and others on the training programme

ii. the capacity of the programme to accommodate the trainee's return at the end of the planned break

iii. evidence of the trainee's ongoing commitment to and suitability for training

iv. the impact of a gap in training on deskilling and any subsequent need for remedial training

Planning and managing OOPC

3.176 The following apply to the planning and management of career breaks during training:

i. OOPC may be taken after a training programme has been started.

ii. OOPC is not an acceptable reason for deferring the start of a programme. In such cases, the trainee should defer making an application until ready to begin training.

iii. The needs of the service must be considered in agreeing a start date.

iv. The duration of OOPC will normally be a period of up to one year. There are good educational and training reasons why an overall period out of training should be no longer than two years (paragraph 1.15). Consequently, the Postgraduate Dean has discretion to consider a second year of OOPC in exceptional circumstances. The Postgraduate Dean may take into account prior OOPs for other reasons. Any further extension beyond a two-year period out of training would not normally be approved.

v. Trainees wishing to take longer OOPC will normally need to relinquish their training number/contract and reapply in open competition for re-entry to the training programme. Trainees should be aware of the GMC's expectations about the currency of examinations when relinquishing their training number/contract.

vi. The trainee should plan their return to work with their Postgraduate Dean. Although the returning trainee will be accommodated in the next available suitable vacancy, there is no guarantee of return date and it may take time for a suitable vacancy to arise.

vii. Trainees will normally need to participate in a 'return to work' package at the end of OOPC. After a prolonged absence from clinical practice, a period of additional support may be beneficial on return. Employers may not have been aware or have considered the implications of prolonged absence and this may have implications for patient safety. Trainees returning to clinical practice should access support by way of an appraisal of their needs to ensure a safe and timely return to training, whether this is full-time, LTFT or a phased re-introduction to clinical practice.

viii. Although trainees on a career break will be encouraged to keep up to date through attending educational events, there is no entitlement to study leave funding for this. Arrangements will be subject to local agreement. Since this is not prospectively approved training, it cannot

be counted towards a FPCC or CCT, but it may be used as part of an application for a full CESR/CEGPR.

ix. Trainees on OOPC must maintain their licence to practise throughout their period away from a training programme.

x. Trainees on OOPC must keep their Postgraduate Dean (as their Responsible Officer) updated on any activity or work that they undertake within their remit of holding a licence to practise, and they must also complete Form R (or SOAR) on an annual basis and submit this to the ARCP panel in order to continue to register their interest in staying in the programme. The information provided should include their intended date of return to the programme to facilitate the planning process.

xi. Trainees undertaking a period of time on a career break should consider any impact that this would have on their continuous NHS service.

xii. Trainees must ensure that they are able to respond to any requests for updates from the Postgraduate Dean.

Training: health and disability

3.177 Postgraduate Deans, programme directors and FSDs are encouraged to tailor individual foundation and 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.

3.178 Employers must make reasonable adjustments if appointees with disabilities 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 the individual appointee's educational needs wherever possible.[21]

3.179 Applicants should inform their programme director/FSD and employer at an early stage so that a suitable rotation can be identified.

3.180 All trainees 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.

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

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[21] Equality Act 2010 (applicable to England, Wales and Scotland, and equivalent Anti-Discrimination Legislation in Northern Ireland)

3.182 All trainees 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 (or SOAR) annually.

Absences from training and impact on certification (or completion) date

3.183 Absences from training (including OOP not approved towards training), other than for study leave or annual leave, may affect a doctor's ability to demonstrate capability and progression through the curriculum. The GMC has therefore determined that within each 12-month period where a trainee has been absent for a total of 14 days or more (when a trainee would normally be at work), a review will be triggered of whether the trainee needs to have their core training programme end date or their CCT date extended. This review would normally occur at the ARCP.

3.184 Where trainees returning from statutory leave (e.g. maternity/paternity/ 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 have an impact on the core training programme end date, or CCT date when this is reviewed at the ARCP.

3.185 For foundation doctors, where a trainee has been absent for **both statutory (e.g. maternity/paternity/adoption) and non-statutory reasons** for a total of 20 working days or more within each 12-month period, an early review will be triggered with regard to whether the trainee needs to have their F1 or F2 year extended.

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

Movement between HEE, NES, HEIW and NIMDTA (foundation doctors)

3.187 Foundation doctors can change from one foundation school to another through the **inter-foundation school transfer** (IFST) process.

3.188 The specific criteria for IFSTs are aligned to the criteria set for pre-allocation to a particular foundation school on the grounds of special circumstances. Foundation doctors who believe they meet the nationally agreed criteria for transferring to a different foundation school once they have been accepted on to the foundation programme should discuss the matter with the FSD of their allocated foundation school if they have not yet taken up their appointment or with their Foundation Programme Training Director if they are already in the training programme.

3.189 Apart from exceptional circumstances, transfers will only take place either at the start of foundation training (F1) or at the start of the F2 year. Arrangements for IFSTs must meet the requirements of the national process and in the case of exceptional circumstances, can only can be agreed between the two FSDs involved. All IFSTs must satisfy both of the following criteria:

i. There are places available in the receiving foundation school.

ii. Both foundation schools agree that the foundation doctor needs to transfer because of a relevant change in their circumstances since they originally applied to the foundation programme.

3.190 National guidance regarding the IFST process and copies of the relevant form(s) are available on the UKFPO website.

3.191 The UKFPO will consider appeals relating to the national process and in the case of exceptional circumstances, the originating foundation school is responsible for managing any appeals against decisions to reject IFSTs. The appeal will consider whether the agreed national process was followed. It is not possible to appeal against the unavailability of places in the receiving school. Both schools must abide by the decision of the appeal panel.

Movement between HEE, NES, HEIW and NIMDTA (specialty trainees)

3.192 The national **inter-deanery transfer** (IDT) process has been put in place to support medical trainees 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. Trainees are able to submit an application and required supporting documents in the transfer windows available each year.

3.193 The national IDT eligibility criteria, application guides, supporting document templates and FAQs can be found at Inter Deanery Transfers. Trainees 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.

3.194 While it is possible for trainees to move between HEE, NES, HEIW and NIMDTA (via IDTs), there is no automatic entitlement or right for this to take place. Trainees 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.

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

3.196 Transfers will only be considered during defined time period windows each year agreed by the UK statutory education bodies, which will be advertised in advance. Start dates will normally coincide with recognised rotation/change-over dates. It is the trainee's responsibility to apply in the relevant window so that they can comply with the agreed notice period.

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

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

i. Educational or training reasons

HEE, 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).

ii. Secondment to a different locality in HEE, 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. Trainees would keep their original training number/contract.

iii. Rotation between HEE, NES, HEIW and NIMDTA as part of a planned training programme

This arrangement applies in some specialties and across placements in HEE, NES, HEIW and NIMDTA because of local arrangements or to support access to appropriate training in some specialties.

iv. Undertaking research in a different locality in HEE, NES, HEIW or NIMDTA

Trainees 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 HEE, NES, HEIW or NIMDTA. Trainees will have no entitlement to transfer subsequently to the locality in HEE, 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.

v. Undertaking sub-specialty training in a different locality in HEE, NES, HEIW or NIMDTA

Trainees who are successful in being appointed to a sub-specialty training programme in a different locality in HEE, NES, HEIW or NIMDTA will usually have no entitlement to transfer. They will remain under the management of the home locality in HEE, NES, HEIW or NIMDTA and return there after completion of the sub-specialty training. Appointment to a grid training programme in paediatrics may, however, result in a transfer to a different locality in HEE, NES, HEIW or NIMDTA.

3.199 Where trainees wish to move to another locality in HEE, NES, HEIW or NIMDTA for any other reason, or if their request to transfer is not supported and they still wish to move, they will have to apply in open competition for a place in a specialty training programme in the receiving locality in HEE, NES, HEIW or NIMDTA through the normal application process.

3.200 Where trainees wish to pursue a CCT in a different specialty (i.e. transfer to a different training programme whether in the same or a different location in HEE, NES, HEIW or NIMDTA), they will have to apply for a place in the different specialty training programme through the normal competitive application process.

Section 4: Progressing as a specialty trainee or foundation doctor

Capabilities, experience and performance

4.1 The curricula approved by the General Medical Council (GMC) for foundation and specialty training programmes define the standards of capabilities, knowledge, skills and behaviours that must be demonstrated to achieve progressive development towards the award of the Foundation Programme Certificate of Completion (FPCC), the Certificate of Completion of Training (CCT), and the CEGPR approved programme (CEGPR(AP)). The outcomes for provisionally registered doctors determined by the GMC have been mapped to the curriculum. Curricula are mapped to the GMC's standards in Good Medical Practice and to the GMC's Generic Professional Capabilities Framework, which forms the basis of all medical practice.

4.2 Capabilities, knowledge, skills and behaviours take time and systematic practice to acquire and to become embedded as part of regular performance. Implicit therefore in a capability-based programme of training must be an understanding of the minimum frequency of practice, level of experience and time required to acquire competence and to confirm performance in the specialty.

4.3 The foundation programme (including the specialised foundation programme (SFP)) is time and outcome-based. Provisionally registered doctors with a licence to practise must complete one year (full-time equivalent) in an approved foundation programme to be eligible to apply for full registration with the GMC. A complete foundation programme takes two years (full-time equivalent) to complete.

4.4 The assessment frameworks should deliver a coherent approach that supports the trainee in developing their capabilities in a sustainable way through a combination of workplace-based assessments/supervised learning events, both formative and summative. This approach is designed programmatically so that the clinical and professional performance of trainees in everyday practice is assessed.

4.5 The emphasis on workplace-based assessments aims to address this through assessing performance and demonstration of the standards and capabilities in clinical practice. It means that trainers and trainees must be realistic about undertaking these assessments, and that educational supervisors must ensure that appropriate opportunities are provided to enable this to happen effectively.

4.6 Trainees develop their capabilities at different rates, depending on their own abilities, their determination and their exposure to situations that enable them to develop their skills. The expected rate of progress in acquisition of the required capabilities is defined in the curricula. This is important so that in Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW), and the Northern Ireland Medical and Dental Training Agency (NIMDTA), trainers, trainees and employers are clear as to what is acceptable progress in training. This will enable reasonable timeframes and resources for support and remediation to be set so that trainees are aware of the boundaries within which remediation can and will be offered.

4.7 Curricula and programmes of assessment evolve and develop over time. In order to ensure that trainees receive the most relevant and up-to-date training, and so that they are assessed appropriately, they will be required to move to the most recent foundation or specialty curriculum and use the most recent forms of assessment. As part of any developments, implementation plans for the transition of trainees to new curricula will be published. (See the GMC's 2021 position statement on moving to the new curriculum).

4.8 While GMC-approved curricula are capability-based, some curricula have time and outcome-based objectives contained within them, and there might be specific periods of training defined and required within a curriculum.

4.9 All postgraduate medical training curricula developed in the UK and approved by the GMC may reference indicative training time to experience the learning opportunities that will enable the required capabilities defined in the curriculum or the time that the training programme is normally expected to take.

4.10 This is important for two reasons:

1. to define a 'full' programme of prospectively approved training that entitles an individual who successfully completes it to the award of the CCT

2. to make sense of a capability-defined programme of educational progression within a framework of 'time required' to enable breadth of experience and practice to ensure that the capabilities gained are sustainable and part of everyday practice

4.11 There will be occasions when a trainee progresses more rapidly than the expected rate of progress and in such cases, the award of an Annual Review of Competence Progression (ARCP) Outcome 6 can be brought forwards. However, this can only occur if:

i. the trainee has gained all the relevant capabilities required in the curriculum

ii. the trainee has completed all the necessary examinations and assessments

4.12 Early achievement of the CCT needs to be planned via the ARCP process and would not normally be advanced by more than one year.

4.13 There are occasions where progress in training cannot be achieved because of events external to training and even though the trainee has remained in the workplace. This would result in a shorter period of time than expected having been available for training since the previous ARCP. In this situation, consideration would need to be given to training time being paused and the prospective FPCC date, core training programme end date, or CCT date being extended following review at the ARCP (paragraph 4.114). The decision to pause training time is an important one and needs to be formalised with written agreement from the Postgraduate Dean. Reference should also be made to the GMC's 2012 position statement on time out of training and foundation doctors should also refer to the GMC's information on registration.

Assessment of progression

4.14 Structured postgraduate medical training is dependent on having curricula that are mapped to the GMC's standards in Good Medical Practice and the Generic Professional Capabilities Framework. These curricula clearly set out the capabilities of practice, an assessment framework to know whether those capabilities have been achieved and an infrastructure that supports a training environment in the context of service delivery.

4.15 The three key elements that support trainees in this process are formative assessments and interactions (e.g. supervised learning events and other supervisor discussions), summative assessments (e.g. foundation supervisor reports, assessments of performance and examinations) and triangulated judgement made by an educational supervisor. These three elements are individual but integrated components of the training process. While the formative elements are for use between trainee and educational supervisor, engagement with them will aid the supervisor in making their informed judgement so that together with the other elements they contribute to the global assessment of progression (ARCP).

4.16 Assessment is a formally defined and approved process that supports the curriculum. A trainee's progress in their training programme is assessed using a range of defined and validated assessment tools, along with professional and triangulated judgements about the trainee's rate of progress.

4.17 An ARCP results in an 'Outcome' following evaluation of the documented evidence of progress (normally captured in the training portfolio) and determines the next steps for the trainee. An outcome that reflects satisfactory progress confirms that the required capabilities, together with ongoing conformance with the GMC's standards in Good Medical Practice, have been achieved.

Educational agreement

4.18 Each trainee should have an educational agreement for each training placement, which sets out their specific aims and learning outcomes for the next stage of their training, based on the requirements of the curriculum for the foundation or specialty training programme and on their most recent ARCP outcome. This should be the basis of all educational review discussions throughout all stages of training. The educational agreement will need regular review and updating.

4.19 The trainee's educational supervisor must ensure that the trainee is aware of and understands the trainee's obligations as laid down in the educational agreement, including (but not exclusively):

i. awareness of the trainee's responsibility to initiate workplace-based assessments

ii. awareness of the requirement to maintain an up-to-date educational portfolio

iii. understanding of the need to address areas identified in the trainee's educational portfolio including undertaking and succeeding in all

assessments of knowledge (usually examinations) and performance in a timely fashion based on the recommended timescale set out in the foundation or specialty curriculum

iv. awareness of the need to engage in processes to support revalidation

The educational supervisor and educational review

4.20 All trainees must have an educational supervisor who should provide, through constructive and regular dialogue, feedback on performance and assistance in career progression.

4.21 Educational review is mainly a developmental, formative process that is trainee focused. It should enable the training for individual trainees to be optimised, taking into account the available resources and the needs of other trainees in the programme. Training opportunities must meet the GMC standards.

4.22 Appraisal is a continuous process. As a minimum, the educational section of appraisal should take place at the beginning, middle and end of each phase of training, and should be documented in the educational portfolio. However, educational review can be undertaken more frequently, directed by curricula and where there are specific educational objectives that require enhanced supervision.

4.23 The educational supervisor is the crucial link between the educational review and workplace-based assessment processes since the educational supervisor's report provides the summary of the assessment evidence for the ARCP process. The outcome from the educational review underpins and informs the ARCP and revalidation processes, and provides evidence to employers about the performance of doctors in postgraduate training. The revalidation process is further supported by self-declaration evidence from the trainee as an employee about any relevant conduct or performance information.

4.24 The trainee's educational supervisor may also be their named clinical supervisor (particularly in GP specialty training, small specialties and small training units). In such a case, the educational supervisor could be responsible for some of the workplace-based assessments and producing appropriate structured reports as well as providing the educational review for the trainee.

4.25 Great care needs to be taken to ensure that these roles are not confused. Indeed, under such circumstances, the trainee's educational supervisor should discuss with the Training Programme Director (TPD) (and where appropriate the Postgraduate Dean) a strategy for ensuring that there is no conflict of interest in undertaking educational review and assessment for an individual trainee.

4.26 The purpose of educational review is to:

i. help identify educational needs at an early stage and agree educational objectives that are **SMART** (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**ime bound)

ii. provide a mechanism for reviewing progress, and implementing and monitoring any remedial requirements

iii. assist in the development in postgraduate trainees of the skills of self-reflection and self-appraisal that will be needed throughout a professional career

iv. enable learning opportunities to be identified in order to facilitate a trainee's access to these

v. provide a mechanism for giving feedback on the quality of the training provided

vi. make training more efficient and effective for a trainee

vii. consider matters around fitness to practise and revalidation

viii. document the judgement about whether a trainee has met the requirements and has provided documentary support for the satisfactory progress

ix. document recommendations about further training and support where the requirements have not been met

4.27 During their educational review discussion with their educational supervisor, trainees must be able to raise concerns without fear of being penalised.

4.28 Patient safety issues would normally be identified utilising clinical incident reporting mechanisms as well as being reported through organisational procedures.

4.29 Demonstrating reflection: GMC | The Reflective Practitioner

i. Trainees should discuss the experiences they are planning to reflect on (or have already reflected on) with their named clinical and educational supervisors. Discussion assists with the learning aspect of the reflective process to make it more meaningful. It also helps to demonstrate engagement in reflective thinking as an educational and professional tool.

ii. Trainees should include insights gained and any changes made to practice in their learning portfolio. Supervisors should confirm in the learning portfolio that the experience has been discussed, and agree appropriate learning outcomes and what actions are planned.

iii. Sharing original, non-anonymised information with supervisors is important but factual details should not be recorded in the learning portfolio.

4.30 Medical professionals have ethical and professional responsibilities to raise concerns about matters that may harm patients or colleagues. In the NHS and social care sector, these issues have the potential to undermine public confidence in these vital services and patient safety. Whistle blowing is the popular term applied to reporting such concerns about malpractice, wrongdoing or fraud. Such concerns should usually be raised by the trainee to their employer or an appropriate regulator. However, HEE, NES, HEIW and NIMDTA recognise that a trainee may feel it is not appropriate for them to raise a concern with their employer, or may be concerned that they will suffer detriment

from their employer or others as a result of raising such concerns. In these circumstances, HEE, NES, HEIW or NIMDTA will offer appropriate guidance and signposting to support any trainee wishing to raise concerns.

4.31 Where it is in the interests of patient or trainee safety, the trainee must be informed that the relevant element of the educational review discussion will be raised through appropriate clinical governance/risk management reporting systems. This will usually be with the Director/Lead of Medical Education in the local education provider (LEP) and the Postgraduate Dean/Responsible Officer (RO) (and employer where this is not the LEP). Trainees also need to be aware that any such discussions should be reported as part of the required self-declaration for revalidation.

4.32 The educational supervisor and trainee should discuss and be clear about the use of an educational portfolio. Regular help and advice should be available to the trainee to ensure that the portfolio is developed to support professional learning.

4.33 Records should be made on the trainee's educational portfolio of these regular educational review meetings, and these must be shared between trainee and educational supervisor.

4.34 The educational review process is the principal mechanism whereby there is an opportunity to identify concerns about progress at the earliest opportunity. (Further guidance on identification and management of concerns is available on individual HEE, NES, HEIW and NIMDTA websites.)

4.35 Concerns should be brought to the attention of the trainee during educational review meetings. Account should be taken of all relevant factors that might affect performance (e.g. health or domestic circumstances) and these should be recorded in writing. An action plan to address the concerns should be agreed and documented between the educational supervisor and trainee. If concerns are considered serious at the outset, persist or increase, further action should be taken and this should not be left to the ARCP process. Direct contact should be considered with the TPD, the lead for professional support, trainee support groups (if appropriate), the employer and the Director of Medical Education for the LEP, alerting them to these concerns. As the RO, the Postgraduate Dean will need any information that may affect future revalidation. The trainee should be informed of any such action taken following an educational review.

ARCP: Assessment

4.36 This section deals with how ARCP panels review supporting evidence enabling them to arrive at a judgement of progress (known as an 'Outcome') (paragraph 4.43).

4.37 A detailed summary of the assessments that should be undertaken is included in paragraphs 4.44, 4.46 and 4.58.

ARCP: What is its purpose?

4.38 The ARCP provides a formal process that reviews the evidence presented by the trainee and their educational supervisor relating to the trainee's progress against the objectives defined in the curriculum. It enables the trainee, the Postgraduate Dean and

employers to document that the capabilities required are being gained at an appropriate rate and through appropriate experience.

4.39 It should normally be undertaken on at least an annual basis for all trainees 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.

4.40 The ARCP fulfils the following functions:

i. It provides an effective mechanism for reviewing and recording the evidence related to a trainee's performance in the training programme or in a recognised training post (e.g. locum appointment for training (LAT)).

ii. At a minimum, it must incorporate a review of the trainee's educational portfolio including a structured report from the educational supervisor(s), documented assessments (as required by the foundation/ specialty curriculum) and achievements.

iii. 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 trainee's progress.

iv. It provides an effective mechanism for the review of out of programme experience and recording its contribution (where approved) to progress.

v. It considers any time out of training during the assessment period and from entry to the programme (see the GMC's 2012 position statement on time out of training), and determines whether the training duration needs to be extended.

vi. As long as adequate documentation has been presented, it makes judgements about the capabilities acquired by trainees and their suitability to progress to the next stage of training.

vii. As long as adequate documentation has been presented, it makes judgements about the capabilities acquired by trainees in a LAT post and documents these accordingly.

viii. It provides advice to the RO about revalidation of the trainee across their full scope of work to enable the RO to make a recommendation to the GMC when required and it ensures that any unresolved concerns about fitness to practise are acted on.

ix. It provides a final statement of the trainee'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.

x. It enables the Postgraduate Dean to present evidence to the relevant College/Faculty so that it can recommend the trainee to the GMC for award of the CCT.

xi. It enables the Postgraduate Dean to present evidence to the GMC for full registration at the end of F1 and for the recommendation of award of the FPCC at the end of F2.

xii. Where applicable, it provides comment and feedback on the quality of the structured educational supervisor's report.

4.41 **The ARCP process is applicable to:**

i. all trainees (including foundation, core and specialty trainees, those in less than full-time (LTFT) training and trainees in academic programmes)

ii. trainees who are out of programme with the agreement of the Postgraduate Dean

iii. LAT trainees

iv. Where a trainee has resigned from a training programme (and dependent on the timing of this resignation), they should be informed that an ARCP panel will review their progress between their last ARCP and the point of resignation (unless the effective exit from the programme occurred within three months of the last ARCP).[22] The trainee will need to complete Form R (GG9 Appendix 1) or the Scottish Online Appraisal Resource (SOAR) for the purposes of informing the revalidation process. The ARCP panel should document any relevant capabilities that have been achieved by the trainee; however, no outcome will be awarded, and the N21 and N22 codes should be utilised (GG9 Appendix 3 i) It is expected that trainees will engage in this process.

4.42 **ARCP: Assessment** – In accordance with GMC requirements, the Academy of Medical Royal Colleges, Colleges and Faculties have developed assessment strategies that are blueprinted against the curricula approved by the GMC and the requirements of the GMC's standards in Good Medical Practice. Further information about these requirements is available at GMC | Excellence by Design.

4.43 This section deals with the elements of the ARCP that are designed to review evidence and arrive at a judgement (known as an 'Outcome') of progress. It does not address the important processes of educational review and programme planning, which should respectively precede and follow from the ARCP process.

[22] This is to comply with appraisal and revalidation requirements where the ARCP is equivalent to the full scope of practice appraisal.

4.44 Assessment strategies will vary between curricula but will contain a variety of elements. These include (but are not limited to) items from the following illustrative list:

i. well-constructed and fit-for-purpose professional examinations that explicitly map back to the curriculum

ii. direct observation of procedural skills (DOPS)/clinical examination and procedural skills (CEPS)

iii. case note reviews

iv. case-based discussion (CBD)

v. multi-source feedback (MSF)

vi. team assessment of behaviour (TAB)

vii. observed video assessments

viii. assessments in clinical skills facilities

ix. clinical evaluation exercises (mini-CEX)

x. direct observation of non-clinical skills (DONCS)

4.45 Workplace-based assessments are increasingly being grouped into **formative** supervised learning events as assessments **for** learning and **summative** assessments **of** performance/learning.

4.46 A summary of the assessments undertaken along with a summary of the outcomes of these assessments should be collated for each period of training. It would be expected that assessments are spread throughout the time period under review. These summaries will be provided as part of the educational supervisor's report to the ARCP panel (paragraph 4.56).

4.47 Logbooks, audit or quality improvement reports/projects, research activity and publications document other sorts of experience and attainment of skills that trainees may need to demonstrate. They are not in and of themselves assessment tools but are a valid record to demonstrate progress. Information about these areas should be retained in an educational portfolio, which all trainees must maintain to record their evidence about training and performance in training. The portfolio will also form the basis of the educational and workplace-based assessment process as well as of the annual planning process. These documents also provide important evidence in support of revalidation.

4.48 Trainees must familiarise themselves with the relevant training curriculum, assessment arrangements and other documentation requirements needed for the assessment of their progress (and the supporting educational review and planning processes) at the start of the training programme. When changes are made to the programme of assessment or expectations for trainees, it is the responsibility of the Academy of Medical Royal Colleges through the UK Foundation Programme Office/ College/Faculty to notify HEE, NES, HEIW, NIMDTA, trainees and trainers of the new requirements so that the changes can be implemented.

4.49 Trainees must also familiarise themselves with the requirements of the GMC's standards in Good Medical Practice. Trainees need to undertake ARCP as it is the vehicle for revalidation as well as for educational progression. Trainees must:

i. maintain a portfolio of information and evidence, drawn from the scope of their medical practice

ii. reflect regularly on their standards of medical practice in accordance with GMC guidance on licensing and revalidation

iii. take part in regular and systematic clinical audit and/or quality improvement

iv. respond constructively to the outcome of audit, appraisals and the ARCP process

v. undertake further training where required by the Postgraduate Dean

vi. engage with systems of quality management and quality improvement in their clinical work and training (e.g. by responding to requests for feedback on the quality of training, such as the national training survey (GMC | National Training Survey))

vii. participate in discussion and any investigation around serious incidents in the workplace, discuss these experiences with their named clinical and educational supervisors, and include insights gained and any changes made to practice in their educational portfolio

viii. inform the GMC of their RO for revalidation

ix. inform their Postgraduate Dean/RO if they self-report to the GMC and if they receive a criminal or civil conviction or a police caution, or if they are bailed, they must inform the RO, including any bail conditions applied.

4.50 The minimum requirements for satisfactory completion of F1 and F2, with guidance notes, are set out in the Foundation Operational Guide. HEE/NES/HEIW/ NIMDTA should make the requirements clear at the beginning of the F1 and F2 years.

4.51 If genuine and reasonable attempts have been made by the trainee to arrange for workplace-based assessments to be undertaken but there have been logistic difficulties in achieving this, the trainee must raise this with their educational supervisor immediately since the workplace-based assessments must be available for the ARCP panel. The educational supervisor should raise these difficulties with the TPD. Between them, they must facilitate appropriate assessment arrangements within the timescales required by the assessment process.

ARCP: The educational supervisor's report

4.52 A structured report should be prepared by the trainee's educational supervisor. This should include the evidence that the trainee and supervisor agreed should be collected to reflect the educational agreement for the period of training under review.

The purpose of the report is to provide a summary of progress including collation of the results of the required workplace-based assessments, examinations and other experiential activities required by the curriculum (e.g. logbooks, evidence of research activity, publications, quality improvement activities and audits). Educational supervisors and trainees should familiarise themselves with the GMC's guidance as well as with the relevant curriculum and assessment framework (GMC | Approved Postgraduate Curricula).

4.53 Through triangulation of evidence of progression in training and professional judgement, the educational supervisor will contribute a structured report to the ARCP. This report must:

i. reflect the educational agreement and objectives developed between the educational supervisor and the trainee

ii. be supported by evidence from the workplace-based assessments planned in the educational agreements

iii. take into account any modifications to the educational agreement or remedial action taken during the training period for whatever reason

iv. provide a summary comment regarding overall progress during the period of training under review, including (where possible) an indication of the recommended outcome supported by the views of the training faculty

4.54 The educational supervisor is the crucial link between the trainee's educational progress, workplace-based formative assessment processes (e.g. supervised learning events) and summative assessment processes since the educational supervisor's report provides the summary of the assessment evidence for the ARCP process. The revalidation process is further supported by self-declaration evidence from the trainee as an employee about any relevant conduct or performance information.

4.55 At the end of each placement in foundation training, the educational supervisor should complete the educational supervisor's end of placement report and towards the end of the year, the educational supervisor's end of year report. The educational supervisor must only confirm satisfactory performance if the foundation doctor has participated in the educational process and met the required foundation professional capabilities.

4.56 The educational supervisor's report should be discussed with the trainee prior to submission to the ARCP panel. The report and any discussion that takes place following its compilation must be evidence-based, timely, open and honest. If such a discussion cannot take place, it is the duty of the educational supervisor to report the reasons to the ARCP panel in advance of the panel meeting.

4.57 Trainees are entitled to a transparent process in which they are assessed against agreed published standards, told the outcome of assessments and given the opportunity to address any developmental needs. If there are concerns about a trainee's performance, based on the available evidence, the trainee must be made aware of these concerns, and they must be documented in their educational portfolio and discussed with the trainee (paragraph 4.56) prior to the ARCP so that they are aware of any

implications and likelihood of additional training time (Outcome 3/10.2). This discussion must also be documented in the portfolio and referenced in the educational supervisor's report.

4.58 Trainees are responsible for listening, raising concerns or issues promptly and taking the agreed action. The discussion and actions arising from it should be documented. The educational supervisor and trainee should each retain a copy of the documented discussion (on portfolio).

ARCP: Collecting the evidence

4.59 HEE, NES, HEIW and NIMDTA will make local arrangements to receive the educational portfolio from trainees, and they will give them and their trainers at least six weeks' notice of the date by which it is required so that trainees can obtain all necessary components. The educational portfolio must be made available to HEE, NES, HEIW or NIMDTA at least two weeks before the date of the ARCP panel meeting.

4.60 The foundation school should publish its timeline for the review of progress. The Foundation Programme Training Director (FPTD), acting on behalf of HEE/NES/HEIW/ NIMDTA/the foundation school, should make clear the local arrangements to receive the necessary documentation from foundation doctors.

4.61 It is up to the trainee to ensure that the documentary evidence that is submitted, including their educational portfolio, is complete. This must incorporate all required evidence (including that which the trainee may view as negative). All assessments of performance should be included in the evidence available to the ARCP panel and retained in the trainee's educational portfolio.

4.62 The FPTD will not chase foundation doctors who have not updated their e-portfolios by the specified date. Foundation doctors should be aware that if they fail to complete their e-portfolio and submit any additional evidence on time, the ARCP panel will consider what has been submitted but with no satisfactory outcome at that time.

4.63 As part of their documentary evidence for each ARCP, trainees must submit an updated documentation form giving accurate demographic details for use in the HEE, NES, HEIW or NIMDTA database. This would be via Form R or SOAR.

4.64 It is important to ensure that all relevant supporting evidence around revalidation is provided to the ARCP panel (in England and Northern Ireland) or in the relevant reports in Scotland and Wales. This includes details of all areas in which the trainee has worked as a doctor (including voluntary) across their full scope of practice, which should include all activities that require GMC registration with a licence to practise as well as details of any investigations that have yet to be completed. This evidence assists the Postgraduate Dean/RO in making a recommendation to the GMC about revalidation (when required). Should a FPCC/CCT date need to be extended such that the date is significantly extended, it has the potential to affect the revalidation date, which is normally aligned to the FPCC/CCT date.

4.65 Trainees may submit as part of their evidence to the ARCP panel a response to their trainer's report or to any other element of the assessment documentation for the panel to take into account in its deliberations. While it is understood that for timing

reasons, such a document will only be seen by the ARCP panel in the first instance, it should be expected that the contents of any document will be followed up appropriately. This may involve further consideration by the TPD/FPTD, HEE/NES/HEIW/NIMDTA and/or the employer.

4.66 The ARCP panel is constructed to look at matters of educational performance, to assess progression in training and to provide an opinion to the RO in relation to revalidation. However, the evidence provided to the panel may relate to other issues and concerns such as clinical safety or perceived undermining within the LEP. While the ARCP panel is not in a position to investigate or deal with allegations of this nature, it will bring such matters to the immediate attention of the Postgraduate Dean for further consideration and investigation as necessary. HEE, NES, HEIW, NIMDTA and employers of trainees will have policies on managing allegations of inappropriate learning and working environments. Trainees must ensure they are familiar with these educational and clinical governance/risk management arrangements, and must follow these policies, including reporting their concerns. LEPs must make such policies known to trainees as part of their induction.

The ARCP panel

4.67 The ARCP panel is convened to deliver the requirements of an ARCP as set out in paragraphs 4.36 and 4.37.

Composition of the ARCP panel

4.68 **Composition of the ARCP panel for foundation training:** The ARCP panel has an important role, which its composition should reflect. It should consist of at least three panel members, which should typically comprise the FPTD (or equivalent) and two others. The additional members could include a postgraduate centre manager or other senior administrator, a specialty training doctor (ST4 or above), a named clinical supervisor/educational supervisor, a lay representative, an external trainer, an employer representative or an external HEE/NES/HEIW/NIMDTA/foundation school representative.

4.69 **Composition of the ARCP panel for core and specialty training:** The ARCP panel has an important role, which its composition should reflect. It should consist of at least three panel members appointed by the training committee or an equivalent group of which one must be either the Postgraduate Dean (or their nominated deputy), the Head of School or a TPD. The Chair of the Specialty Training Committee, TPDs, College/Faculty representatives (e.g. from the Specialty Advisory Committee), educational supervisors and Associate Deans/Directors are all appropriate panel members. Where more than one specialty is being assessed in the same ARCP panel (e.g. dual training or sub-specialty training in parallel with main specialty training) or where the trainee is on an integrated academic programme, the panel will include relevant specialist/sub-specialist/academic input. The panel could also have a representative from an employing organisation to enable employers to be assured that the trainees they employ are robustly assessed and are safe to deliver care in their service.

4.70 The Chair of the ARCP panel must ensure that there is no declared conflict of interest between any member of the panel and the trainee being assessed.

4.71 It is good practice for the Postgraduate Dean to nominate a deputy to be present at any panel meeting involving cases where it is possible that a trainee could have an ARCP Outcome 3/10.2 or 4.

4.72 The panel should normally have input from a lay advisor (foundation, core and specialty ARCP panels) and an external advisor (core and specialty ARCP panels). They should review a random sample (indicative minimum 10%) of the outcomes and evidence supporting these, and any recommendations from the panel about concerns over performance (paragraph 4.129).[23]

4.73 The lay advisor will primarily review the process followed by the ARCP panel and the conduct of the panel, as measured against accepted general good practice for ARCP panels and the standards that are set in the Gold Guide. The lay advisor should not be asked to judge whether the ARCP outcome awarded to the trainee is appropriate or whether the trainee has made satisfactory progress. The lay advisor may be asked on occasion to contribute a lay perspective to inform elements of the ARCP panel's activities but the role is to ensure the process is followed correctly, not to give an opinion on the outcome or the trainee's progress.

4.74 The external advisor may be a College/Faculty representative who is external to the programme and who has expertise in the relevant curriculum being assessed. This is not applicable in foundation training.

4.75 If either the lay advisor or the external advisor have concerns about the outcomes from the ARCP panel, these will be raised with the Postgraduate Dean for further consideration.

4.76 In that event (paragraph 4.75), the Postgraduate Dean may decide to establish a different panel to consider further the evidence that has been presented and the recommended outcomes.

4.77 Where an ARCP panel meeting is being held for an individual undertaking a SFP, clinical fellowship or lectureship, or for a clinical scientist, the panel should be in receipt of the named academic supervisor's report (paragraphs 4.137–4.140). If unsatisfactory progress is anticipated (either clinical or academic), then the panel should include at least one academic representative.

4.78 All members of the ARCP panel (including the lay advisor and those acting as an external advisor) must be trained for their role. This training should be kept up to date and refreshed, normally every three years.

4.79 Educational and named clinical supervisors should declare an interest if their own trainees are being considered by a panel of which they are a member. Where there are any concerns about satisfactory educational progress, they should withdraw temporarily from the process while their trainee is being considered and the panel should be constituted such that in that situation it remains quorate in accordance with panel composition as set out in paragraphs 4.67–4.79. If this occurs in foundation training, there will need to be an alternative panel member involved.

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[23] Arrangements may change in exceptional circumstances (e.g. global pandemic).

How the ARCP panel works

4.80 **The purpose of the ARCP** is to review the evidence and to assess competence and acquisition of required capabilities that inform a judgement of progress, which is captured as an outcome (defined in paragraph 4.94). Following an ARCP, there is a requirement to have a post-ARCP discussion for feedback between the trainee and the TPD/educational supervisor, to discuss and agree the learning plans for the next period of training (paragraph 4.85).

4.81 Supporting information is used for two distinct and separate processes:

1. **The formative process** of educational reviews, learning needs assessments, setting educational objectives and planning the personal development plan, and identifying and optimising learning opportunities to meet the required objectives defined in the curriculum

2. **The summative process** of making a global judgement of progression (using supporting information and assessments in the portfolio)

4.82 The ARCP panel will be convened by HEE, NES, HEIW or NIMDTA. The panel will normally be chaired by the Head of School, the Chair of the Specialty Training Committee, or one of the TPDs or Associate Deans/Directors.

4.83 The process is a review of the documented and submitted evidence, supporting information and assessments that are presented by the trainee. The trainee must not be present at the panel considering the outcome (paragraph 4.86). However, following the ARCP, there will be a meeting with the trainee to inform them of and explain the outcome, and to agree the objectives and learning plan (paragraph 4.85).

4.84 Any concerns that emerge about a trainee's fitness to practise must be reported to the Postgraduate Dean/Medical Director, as RO, for further advice and guidance.

4.85 Where the TPD, educational supervisor or named academic supervisor has indicated that there may be an Outcome 2/10.1, 3/10.2 or 4, the trainee must be informed of the possible outcome prior to the ARCP panel meeting, which may be included in the pre-ARCP feedback from the educational supervisor (paragraphs 4.56 and 4.57). After the panel has considered the evidence and made its judgement, if Outcomes 2/10.1, 3/10.2 or 4 are recommended, the trainee must meet with either the ARCP panel or a senior educator involved in their training programme at the earliest opportunity. The purpose of this meeting is to discuss the recommendations for focused or additional remedial training if this is required.

4.86 For practical and administrative reasons, HEE, NES, HEIW or NIMDTA may wish to discuss other issues (e.g. the trainee's views on their training or planning of future placements) on the same occasion as the annual panel meeting. However, the review of evidence and the judgement arising from the ARCP panel must be kept separate from these other issues. Trainees must not be present at the panel considering the outcomes.

4.87 At the ARCP, the FPCC end date, the core training programme end date or provisional CCT date should be reviewed and adjusted if necessary, taking into account such factors as:

i. statutory leave or other absence of more than 20 (normal working) days in any year for foundation doctors

ii. clinical statutory leave, sickness or other absence of more than 14 (normal working) days in any year for core and specialty trainees

iii. prior agreement with the Postgraduate Dean for training time to be paused

iv. a change to or from LTFT training

v. time out of programme for experience (OOPE), time out of programme for research (OOPR) or time out of programme for a career break (OOPC)

vi. rate of acquisition of capabilities that might bring forwards the CCT date

vii. for dual trainees or trainees undertaking sub-specialty training alongside main specialty training, whether both should continue to be pursued

viii. the academic component of joint clinical/academic core or specialty programmes

ix. failure to demonstrate achievement of capabilities (Outcome 3/10.2) as set out in the GMC-approved curriculum

x. where there have been significant deficits in the training environment beyond the control of the trainee

xi. where a change in the curriculum results in a trainee requiring additional training time to complete a programme

4.88 The adjusted date should be entered in the supplementary documentation section of the ARCP outcome form (GG9 Appendix 3 i) The expected date for the successful completion of training at whatever level is important information since it is required for planning subsequent recruitment into the specialty training programme and for keeping an overview of the available workforce in the specialty.

Outcomes from the ARCP

4.89 ARCP outcomes are defined in paragraph 4.94.

4.89 i **Outcomes 1 and 6** reflect satisfactory progress in achieving the required capabilities for the stage of training as defined in the curriculum.

4.89 ii **Outcomes 2/10.1 and 3/10.2** reflect that development of capabilities is required.

Outcome 2 is used where development is required without additional training time.

Outcome 3 is used where development and additional training time are required.

Outcome 10.1 is the 'no fault' equivalent to an Outcome 2.

Outcome 10.2 is the 'no fault' equivalent to an Outcome 3.

4.89 iii **Outcome 4** is used when there has been insufficient progress over a defined period in meeting previously identified educational objectives when additional support (which may include additional training time) has been provided and the trainee is released from the training programme.

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

4.91 For dual training or main specialty and sub-specialty training, the GMC requires a separate outcome per specialty and sub-specialty._Trainees in dual programmes can be permitted to progress at different rates and be at different phases in training programmes at the discretion of the Postgraduate Dean

4.92 It should be noted that there is no Outcome 2, 6 or 7 for F1 and no Outcome 1, 2 or 7 for F2. It is recommended that members of the ARCP panel use a checklist to confirm that they have considered all the requirements and add any comments to explain the judgement.

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

4.94 When an Outcome 3/10.2 or 4 recommendation is made by the ARCP panel, the Postgraduate Dean will confirm this in writing to the trainee, including where relevant their right to review or appeal the decision (paragraphs 4.158–4.175). Outcomes should be referenced by their number as defined in this Guide.

Outcome 1

Satisfactory progress – Achieving progress and the development of capabilities at the expected rate

Satisfactory progress is defined as achieving the capabilities in the curriculum approved by the GMC at the rate required.

In foundation training, satisfactory progress is defined as achieving the foundation professional capabilities for F1, leading to award of the Foundation Year 1 Certificate of Completion (F1CC). In foundation training, if less than full time or out of synchronisation and progressing as expected, the trainee will be given the outcome 'Other'.

The rate of progress should be defined in the specialty curriculum (e.g. with respect to assessments, experiential opportunities, examinations etc). It is possible for trainees to achieve capabilities at a more rapid rate than defined and this may affect their CCT date (paragraph 4.13).

Outcome 2 (not applicable in foundation)

Development of specific capabilities required – Additional training time not required

The trainee's progress has been acceptable overall but there are some capabilities that have not been fully achieved and need to be further developed. It is not expected that the rate of overall progress will be delayed or that the prospective date for completion of training will need to be extended or that a period of additional remedial training will be required.

Outcome 3

Insufficient progress – Additional training time required

The ARCP panel has identified that a formal additional period of training is required that will extend the duration of the training programme (e.g. FPCC end date, core training programme end date or anticipated CCT date).

Outcome 4

Released from training programme – With or without specified capabilities

The ARCP panel will recommend that the trainee is released from the training programme if there is still insufficient and sustained lack of progress despite having had additional training to address concerns over progress. The panel should document relevant capabilities that have been achieved by the trainee and those that remain outstanding. The trainee will have their training number/contract withdrawn and may wish to seek further advice from the Postgraduate Dean or their current employer about future career options, including pursuing a non-training, service-focused career pathway.

Where an Outcome 2, 3 or 4 has been recommended, the panel should record the supplementary information required for the GMC in these circumstances (U codes, GG9 Appendix 3 i).

Outcome 5

Incomplete evidence presented – An assessment of progression cannot be made

The ARCP panel can make no statement about progress or otherwise where either no information or incomplete information has been supplied and/or is available to the panel.

The panel should agree what outstanding evidence is required from the trainee and the timescale in which it must be provided to be able to issue an outcome.[24]

If the panel considers that an Outcome 1 is likely based on the evidence available and satisfactory outstanding evidence is received, the panel can give authority to the Chair to issue an Outcome 1. However, if the Chair does not receive the agreed evidence to support an Outcome 1, or if the panel considers that an Outcome 2, 3 or 4 is likely based on the evidence available, then a panel will be reconvened. This reconvened panel could be undertaken 'virtually'.

An Outcome 5 should also be recommended because of failure to submit Form R or SOAR (paragraphs 4.129 and 4.130).

Recommendation for completion of training:

Outcome 6

Gained all required capabilities – Will be recommended as having completed the training programme (foundation, core or specialty). If in foundation training, will be recommended for award of a FPCC. If in a run-through training programme or higher training programme, will be recommended for award of a CCT.

The ARCP panel will need to consider the overall progress of the trainee and ensure that all the capabilities of the curriculum have been achieved prior to recommending the trainee for completion of the training programme to the relevant foundation school/College/Faculty.

Outcomes for trainees in fixed-term training posts and OOP:

Outcome 7 (not applicable in foundation)

Fixed-term posts (e.g. LATs)

Trainees in fixed-term training posts will undertake regular in-work assessments and maintain documentary evidence of progress during their fixed-term appointment. This evidence will be considered by the ARCP panel and will result in one of the following outcomes:

[24] An Outcome 5 might be viewed as a 'holding position' to allow the missing evidence to be provided for the ARCP panel to review; that review would normally be **no more than eight weeks from the date of the ARCP Outcome 5 and must never cross a progression point**.

Outcome 7.1	**Satisfactory progress in or completion of the post** The trainee has demonstrated that they have acquired the capabilities expected of a trainee undertaking a placement of this type and duration at the level specified.
Outcome 7.2	**Development of specific capabilities required – Additional training time not required** The trainee's progress has been acceptable overall; however, there are some capabilities not fully achieved, which the trainee needs to develop either before the end of their current placement or in a further post to achieve the full capabilities for this period/year of training. The ARCP panel will need to specifically identify in writing the further development required. The rate of overall progress is not expected to be delayed, nor will the prospective date for completion of this period of training be extended as this is a fixed-term post. At the next review of progression, it will be essential to identify and document that these capabilities have been met.
Outcome 7.3	**Insufficient progress by the trainee** The trainee has not made sufficient progress for this period of training for it to be formally recognised towards either the CCT or the full CESR/CEGPR. If the trainee wishes to attain the described capabilities, they will be required to repeat this period of training (not necessarily in the same post, with the same employer, or in the same locality in HEE, NES, HEIW or NIMDTA). If trainees move to a new post, employer or locality in HEE, NES, HEIW or NIMDTA, they must declare their previous ARCP outcome.
Outcome 7.4	**Incomplete evidence presented** The ARCP panel can make no statement about progress or otherwise since the trainee has supplied either no information or incomplete information to the panel. The panel should agree what outstanding evidence is required from the trainee and the timescale in which it must be provided to be able to issue an outcome. If the panel considers that an Outcome 7.1 is likely based on the evidence available and satisfactory outstanding evidence is received, the panel can give authority to the Chair to issue an Outcome 7.1. However, if the Chair does not receive the agreed evidence to support an Outcome 7.1 or if the panel considers that an Outcome 7.2, 7.3 or 4 is likely based on the evidence available, then a panel will be reconvened. This reconvened panel could be undertaken 'virtually'. An Outcome 7.4 should also be recommended because of failure to submit Form R or SOAR (paragraphs 4.129 and 4.130).

Outcome 8

Out of programme for clinical experience, research or a career break (OOPE/OOPR/OOPC)

The ARCP panel should receive documentation from the trainee on the required form (GG9 Appendix 4) indicating what they are doing during their OOP time if the OOP is not recognised for training.

i. **OOPE**: If the OOP is to gain clinical experience that will not contribute towards the capabilities required by the training programme (OOPE), then an annual OOP report form should be submitted, including an indicative intended date of return.

ii. **OOPR**: If the purpose of the OOP is research, the trainee must produce a research supervisor's report together with the annual OOP report form indicating that appropriate progress in research is being made, along with achievement of the relevant degree (if appropriate). If there is prospective approval by the GMC for the OOPR to contribute to the CCT, then formal assessment documentation must be submitted annually to the ARCP panel.

iii. **OOPC**: If a doctor is undertaking a career break, a yearly OOPC request should be sent to the ARCP panel, indicating that the trainee is still on a career break and including an indicative intended date of return.

iv. **OOPT**: If the trainee is out of programme on a training placement (OOPT) or on OOPR that has been prospectively approved by the GMC and that will contribute to the capabilities of the trainee's programme, then an Outcome 8 should not be used. Instead, a routine assessment of progression should be made and an Outcome 1, 2, 3, 4 or 5 should be awarded.

When an outcome is not issued

There are circumstances when the ARCP panel would not issue an outcome, such as when the trainee is absent on statutory leave (e.g. maternity/paternity/adoption or sick leave) or where training has been paused. In these cases, the panel will record the reasons for this. (Refer to N codes, GG9 Appendix 3 i.)

Force majeure outcomes

The Outcome 10 derogations introduced as 'no fault' outcomes to enable progression or additional time where training was disrupted by the COVID-19 pandemic in 2020–2021 will be retained in subsequent versions of the Gold Guide as outcomes that may be applied in circumstances of 'force majeure'.

Outcome 10s must only be used following a directive from the UK statutory education bodies, which may be triggered in response to national emergencies/force majeure such as a global pandemic. When the use of Outcome 10 is directed by the UK statutory education bodies, this may include the use of specific additional C codes for

clarification
(GG9 Appendix 3 ii)

Outcome 10

Achieving progress and the development of capabilities at the expected rate but acquisition of some capabilities delayed by the impact of a national emergency

> **Outcome 10.1: Progress is satisfactory but the acquisition of capabilities by the trainee has been delayed by national emergency/force majeure disruption. The trainee is not at a critical progression point in their programme and can progress to the next stage of their training. Any subsequent additional training time will be reviewed at the next ARCP.**
>
> **Outcome 10.2: Progress is satisfactory but the acquisition of capabilities by the trainee has been delayed by national emergency/force majeure disruption. The trainee is at a critical progression point in their programme and additional training time is required in accordance with paragraph 4.108.**

Satisfactory progress is defined as achieving the capabilities in the curriculum approved by the GMC at the rate required.

In foundation training, satisfactory progress is defined as achieving the foundation professional capabilities for F1, leading to award of the F1CC. In foundation training, if less than full time or out of synchronisation and progressing as expected, the trainee will be given the outcome 'Other'.

The rate of progress should be defined in the specialty curriculum (e.g. with respect to assessments, experiential opportunities, examinations etc).

Where acquisition of required capabilities has been delayed solely owing to the impact of a national emergency/force majeure (e.g. due to cancellation or postponement of a required examination, or reduced exposure to required training opportunities), trainees should be enabled to progress to the next stage of training except those who are at a critical progression point in their programme. An action plan, the portfolio and personal development plan should capture and set out the required capabilities that will be expected at the next scheduled ARCP, and the time point for this review should be defined.

Outcome 10.1 acknowledges potential satisfactory progress but recognises additional training time may subsequently be required (which will be reviewed at the next ARCP).

Satisfactory completion of F1 (Outcome 1)

4.95 The Foundation School Director (FSD) (or any other authorised signatory) should only complete a F1CC if satisfied that the foundation doctor has met the requirements for satisfactory completion of F1, subject to any quality management process. An electronic signature is acceptable.

4.96 Universities/medical schools or their designated representative in HEE/NES/HEIW/NIMDTA/the foundation school will use the F1CC when completing the Certificate

of Experience to certify that a provisionally registered doctor has satisfactorily completed a programme for provisionally registered doctors.

4.97 For foundation doctors who graduated outside of the UK, the Postgraduate Dean/Deputy with responsibility for the foundation school where the doctor is currently training is responsible for completing the Certificate of Experience.

Satisfactory completion of F2 (Outcome 6)

4.98 The FSD (or any other authorised signatory) should only complete a FPCC if satisfied that the foundation doctor has met the requirements for satisfactory completion of F2, subject to any quality management process. An electronic signature is acceptable. A copy of the FPCC may be printed by HEE/NES/HEIW/NIMDTA/the foundation school.

Additional or remedial training

4.99 If the foundation ARCP panel decides that a foundation doctor has not met the requirements for satisfactory completion, it should award an Outcome 3 as an Outcome 2 does not exist for foundation training. Owing to the need to satisfactorily complete F1 to move from provisional to full registration, it is not possible to allow a trainee who has further training requirements to proceed to F2. In this situation, a trainee requires additional training time to complete F1 requirements and hence an Outcome 3 is issued.

4.100 The core or specialty ARCP panel may identify the need for additional or focused training (Outcome 2), or for remedial training (Outcome 3), which may extend the indicative core training programme end date, or CCT date.

4.101 If the panel recommends focused training towards the acquisition of specific capabilities (Outcome 2), then the timescale for this should be agreed with the trainee.

4.102 If additional remedial training time is required (Outcome 3/10.2), the panel should indicate the intended objectives and proposed timescale. The framework of how a remedial programme will be delivered will be determined by the Postgraduate Dean. The remedial placement will be planned by the TPD, taking into account the needs of other trainees in the programmes, and it must be arranged with the full knowledge of the employer to ensure that clinical governance aspects are addressed.

4.103 This additional training must be agreed with the trainee, trainers and employer. Full information about the circumstances leading to the additional training requirement must be transmitted by HEE, NES, HEIW or NIMDTA to the employer and LEP(s) for that period of training, including the reason for the remediation. The information transmission will be shared with the trainee. Agreement to it being shared with the new employer/LEP and trainers is a requisite of joining and continuing in the training programme.

4.104 Remedial training may be required as a result of a recommendation from the GMC or other body (e.g. NHS Resolution, formerly the National Clinical Assessment Service). When such remedial training is requested, the supporting Postgraduate Dean will establish a specific educational agreement with the relevant LEP, which will cover all aspects of the placements, including detailing the training required, clinical limitations on practice and any measures in place from the regulator. This will ensure that the doctor

receives the training that has been identified as well as respecting the clinical governance/risk management arrangements of the LEP.

4.105 The educational progress of the trainee during any additional or remedial training will be reviewed by the ARCP panel, which may seek to take further and external advice from other senior clinicians. The panel will decide whether the outcome of the additional training is that the trainee can continue in their training programme, requires further additional training, or has not met or cannot meet the standards required. If it is decided that the trainee is unable to meet the standards, this will lead to the recommendation that the trainee leaves the programme. Trainees will be provided with documentary evidence of the capabilities that they have achieved.

4.106 If the trainee fails to comply in a timely manner with the educational plan for the additional training, they may be required to leave the training programme before the additional training has been completed (paragraph 3.99 ii). This would normally be by means of issuing an Outcome 4.

4.107 The maximum total duration of any extension to F1 training should normally be for one year (or pro rata for LTFT training). In situations where a foundation doctor is deemed not to have satisfactorily completed F1 after the first 12 months (or pro rata for LTFT training) and is awarded an Outcome 3, HEE/NES/HEIW/NIMDTA/the foundation school should inform the medical school of graduation.

4.108 The length of time that training can be extended depends on the type of programme the trainee is following (e.g. foundation, core or run-through training). Trainees may be offered extensions to training up to the maximum limits detailed below. However, trainees should not anticipate that they will be offered the exceptional additional training time as it is dependent on the approval of the Postgraduate Dean and such approval will only be granted in exceptional circumstances. Two years is the maximum permitted additional training time for both run-through training and the combined core plus higher specialty training programmes. This does not include additional time that might be required because of statutory leave such as ill health or maternity/paternity/adoption leave.

Duration of extension to training – additional training time (ATT)

Programme	Extension to training time	Exceptional ATT[1]	Total ATT incl exceptional ATT
Foundation training	As in paragraph 4.105, normally limited to 1 year	Not normally extended owing to short duration of programme	1 year
Core training	6 months	6 months	12 months
Higher training	1 year (includes any ATT in core training in uncoupled training programmes)[2]	1 year	2 years[3]

Run-through training	1 year	1 year	2 years
General practice training	1 year	6 months	18 months

1. Exceptional ATT must be approved by the Postgraduate Dean.
2. ATT would normally include 1 year across both core and higher specialty training where the programme is uncoupled, and may include 6 months' additional training time in the core training programme. However, in exceptional circumstances such as a 3-year uncoupled core programme, the Postgraduate Dean has discretion (paragraph 1.12) to give more ATT in core, provided the total time across the combined programme (core plus higher) does not exceed 2 years.
3. Total ATT (including exceptional ATT) would include 2 years across both core and higher specialty training where the programme is uncoupled, and may normally include up to 12 months for the core training programme.

4.109 For core and specialty training, the extension does not have to be continuous (as a block of one year) but may be divided over the course of the training programme as necessary. For foundation training, the extension must be continuous. It must be undertaken in a GMC-approved training post. For LTFT trainees, should an extension to training be required following the award of an ARCP Outcome 3, this will be on a pro rata basis if training requirements for progression have not been met.

4.110 While not exclusive, examples of exceptional circumstances for extension to training beyond a normal period that may have a significant impact on the ability to train or on training opportunities may include significant unforeseen changes to personal circumstances, service reorganisation, a major epidemic or catastrophe, or the unforeseen absence of a trainer. (See also paragraph 4.87.)

4.111 During a period of additional training time, there is an expectation that the trainee will show continuing engagement with their portfolio to demonstrate maintenance of capabilities that have already been acquired.

4.112 If the ARCP panel decides that the foundation doctor should be released from the training programme, it should award an Outcome 4. For F1 doctors, HEE/NES/HEIW/NIMDTA/the foundation school and the medical school of graduation must jointly inform the GMC's Registration Directorate and discuss this with the GMC's Fitness to Practise Directorate, irrespective of whether there was an extension to F1.

4.113 In addition, the graduating UK medical school should write to the F1 doctor, setting out the process for an appeal, which will typically be heard by the graduating medical school. HEE/NES/HEIW/NIMDTA/the foundation school, in partnership with the university/medical school, should offer the F1 doctor career counselling.

4.114 However, if a F1 doctor graduated outside of the UK, HEE/NES/HEIW/NIMDTA/the foundation school where the doctor undertook the extended training should hear the appeal. The FSD should write to the doctor, setting out the process to appeal.

4.115 For F2 doctors, the medical school of graduation does not need to be informed.

Pausing training for reasons other than statutory leave – not applicable in foundation

4.116 Pausing training is a decision that should normally be taken outside of the ARCP process. It is a neutral action that should be agreed with the trainee, as early as reasonably practical, and then approved by the Postgraduate Dean and documented. Pausing training should not be assumed and must be supported with suitable evidence of need. HEE, NES, HEIW and NIMDTA should ensure that they have a process for obtaining suitable evidence around such circumstances (e.g. occupational health advice) and for deciding whether to temporarily pause training. Such pausing of training time will also require an adjustment to the expected core training programme end date, or CCT date (paragraph 4.87).

4.117 The ARCP panel will also need to consider any period when the training time has been paused. This may mean that a shorter period of time than expected has been available in which to make progress and the panel decision should take this into consideration. The panel may need to issue an N code for the period being assessed owing to a training pause. Pausing training is not a decision that is taken in foundation training because of the regulations regarding moving from provisional to full registration and the shortness of training of the F2 year.

4.118 In determining its specific recommendations with respect to any additional time that may be required, the ARCP panel should also consider aspects in the training environment such as service configuration or the supervision available, or a change to curricular requirements. This includes considering whether any training time should be discounted and the date for completion of training adjusted to reflect this.

Notification of ARCP outcome

4.119 The initial outcome from the ARCP may be provisional until quality management checks have been completed. The outcome(s) recommended by the panel (GG9 Appendix 3 i) for all trainees will be made available by the Postgraduate Dean to:

a) the trainee
They must sign it to demonstrate that they have been informed of the outcome, not that they agree with the outcome. Signature of the outcome does not change the trainee's right to request a review or appeal.

b) the TPD/FPTD
The TPD/FPTD (and/or the trainee's educational supervisor) should meet with the trainee to discuss the outcome and plan the next part of their training, documenting the plan fully.

c) the trainee's educational supervisor
This should be used to form the basis of the further educational review and workplace-based assessments that the educational supervisor undertakes on behalf of the employing organisation. For LAT trainees, the ARCP outcome should be made available to the trainee's educational supervisor for that year of training, who should arrange a follow-up

meeting even if the end of the appointment period/year has been reached.

d) the Medical Director (or their nominated officer)
ARCP outcomes should be sent to the Medical Director (or nominated officer) of the current employer (and of the LEP if different). For trainees working in general practice, communication should also be sent to the Medical Director of the relevant Local Area Team. This may be undertaken by exception (i.e. for Outcomes 2, 3 and 4). It is the educational supervisor's responsibility to raise any areas of concern about the trainee's performance that link to clinical governance as documented by the ARCP process with the Medical Director (or their nominated officer). If the review has been undertaken shortly before rotation to a new placement has occurred, the documentation should be forwarded by the TPD to the Medical Director where the trainee is due to start.

e) the relevant College/Faculty (not applicable in foundation)
These outcome documents are part of the minimum dataset that will need to be maintained by the College/Faculty to substantiate its recommendation to the GMC for award of the CCT.

4.120 HEE, NES, HEIW and NIMDTA submit ARCP outcomes to the GMC, which reports on the progression of doctors through key stages in their training. (See GMC | Progression Reports.)

4.121 All trainees should receive standard written guidance relevant to their outcome, which as appropriate should detail the duration of any extension to training, requirements for remedial action or focused training, and reference to the review and appeals processes.

4.122 Trainees with Outcome 1 and 6 will receive the standard written guidance through the e-portfolio.

Form R and the Scottish Online Appraisal Resource

4.123 The references to Form R in relation to revalidation described in paragraphs 3.41–3.49 do not apply to NES, where SOAR replaces this form.

4.124 Each trainee will need to update Form R or SOAR annually (except F1 doctors). This holds the up-to-date demographic data on the trainee.

4.125 The annual return of Form R or SOAR before the ARCP with any corrections and updates (along with the self-declaration details for revalidation purposes where appropriate) to HEE, NES, HEIW or NIMDTA together with the signed ARCP outcome(s) will enable the trainee to renew their registration on an annual basis with HEE, NES, HEIW or NIMDTA and the relevant College/Faculty (if appropriate).

4.126 When a trainee fails to submit a completed Form R or SOAR that reflects their full scope of practice since their last review, they are issued with an Outcome 5 and given two weeks to remedy the situation. In addition, the trainee should normally be

called to a support meeting with their Postgraduate Dean/RO or their nominated deputy to discuss the reasons for non-submission and to clarify next steps if the situation is not rectified.

4.127 If a trainee submits or resubmits a completed Form R or SOAR within the two-week timeframe, they receive an ARCP outcome appropriate for their educational progression and alignment with the GMC's standards in Good Medical Practice.

4.128 If the trainee still fails to submit a satisfactorily completed Form R or SOAR after two weeks and this is the first time that this situation has arisen in the training programme, for foundation, core, specialty and general practice trainees, an Outcome 2 (not applicable in foundation), 3 or 4 will be issued (according to training progression). A note is made on the trainee's record that they did not submit a completed Form R or SOAR. An Outcome 1 or 6 is not awarded, even if there are no training progression concerns.

4.129 For trainees who fail to submit a completed Form R or SOAR after an Outcome 5 is issued and a support meeting offered, and for whom this is a repeated situation, the process of referral to the GMC for non-engagement with revalidation should be commenced.

4.130 Should the trainee subsequently provide the completed Form R or SOAR, then the appropriate ARCP outcome for trainee progression can be awarded.

Quality assurance of the ARCP

4.131 Since decisions from the ARCP panel have important implications for both patient safety and individual trainees, there should also be external scrutiny of its decisions from two sources:

1. a lay advisor to ensure consistent, transparent and robust decision-making on behalf of both the public and trainees – The lay advisor should review the process and evidence supporting decisions as well as any recommendations from the ARCP panel about concerns over performance and training progression.

2. an external advisor from the same specialty but from outside of the local specialty training programme/specialty school (not applicable in foundation) – The external advisor should review a minimum random 10% of the outcomes and evidence supporting these as well as any recommendations from the ARCP panel about concerns over performance and training progression. All external advisors must be trained to undertake this role. The external advisor may be a College/Faculty representative if not otherwise represented on the panel. HEE, NES, HEIW and NIMDTA should work with the relevant Colleges/Faculties to help identify senior members of the profession to support this work.

The role of the Postgraduate Dean in the ARCP

4.132 The Postgraduate Dean has responsibility for the management of the ARCP process, including the provisions for further review and appeals (paragraphs 4.158–4.175).

4.133 With the collective agreement of the Conference of Postgraduate Medical Deans, the ARCP process for smaller specialties may be coordinated nationally although it must remain the overall responsibility of a designated dean (usually the UK lead dean for the specialty).

4.134 The Postgraduate Dean is also the statutory RO for revalidation in relation to doctors in GMC-approved postgraduate training programmes.[25] In order to discharge this function, they must make a revalidation recommendation to the GMC at intervals determined by the GMC. Information to inform this decision will come from the ARCP.

4.135 The Postgraduate Dean should maintain as part of the database a training record for each trainee, in which completed ARCP outcome forms are stored. For security purposes, a photograph of the trainee should be incorporated in this record. The training record may be physical or stored electronically with suitable measures to maintain its integrity. The supporting documentation for training progression may be held on the trainee's e-portfolio. The record of training progression of each trainee (including previous outcome forms and supporting documentation) must be available to the ARCP panel whenever the trainee is reviewed. The Postgraduate Dean's staff will provide administrative support for the panel.

4.136 Where concerns about a trainee have been raised with the Postgraduate Dean – either following an outcome from the ARCP process or through some other mechanism – the Postgraduate Dean (or their nominated deputy) should liaise directly with the Medical Director and the educational lead (e.g. Director of Medical Education) or the general practice trainer and TPD where the trainee is employed/working (depending on local arrangements) to investigate and consider whether further action is required.

The ARCP for specialised foundation programmes

4.137 Some doctors will undertake SFPs. There are important differences in the structure of SFPs in the different foundation schools. Trainees in such programmes will have to both successfully complete the full training programme and meet the requirements of the academic programme.

4.138 Individuals undertaking SFP training must have a named academic supervisor, who will normally be different from the trainee's named clinical supervisor.

4.139 On entry to the SFP, the named academic supervisor should devise a research plan with the trainee as the context against which to assess their academic progress. The educational supervisor and named academic supervisor should work together to

[25] For trainees in Northern Ireland (NIMDTA) and Wales (HEIW), the Medical Director has the RO function.

ensure that clinical and academic objectives are complementary. Both supervisors and the trainee should be aware of the trainee's overall clinical and academic requirements.

4.140 The named academic supervisor should submit a report to the educational supervisor at the end of the academic placement, highlighting the SFP trainee's achievements, strengths and areas for development. The educational supervisor should use this report as evidence for their end of year report about the trainee, which will be used by the ARCP panel to recommend an outcome.

The ARCP for integrated clinical and academic training programmes

4.141 Some doctors will undertake integrated clinical and academic training programmes (paragraphs 3.135–3.140). There are important differences in the structure of academic programmes in the four UK countries. Trainees in such programmes will have to both successfully complete the full training programme and meet the requirements of the academic programme.

4.142 Individuals undertaking academic training must have a named academic supervisor, who will normally be different from the trainee's named clinical supervisor.

4.143 The named academic supervisor is responsible for drawing up an academic training programme with the trainee and their named clinical and/or educational supervisor so that there is a realistic/achievable timetable with clear milestones for delivery, covering both academic and clinical aspects of the programme. Research plans should be drawn up to include specific training (where required), together with plans for research experience and outputs. These targets will be summarised in the overall personal development plan for the trainee, which should be agreed within a month of commencing work and annually thereafter.

4.144 On entry to specialty training, the named academic supervisor should devise a research plan with the trainee as the context against which to assess their academic progress. This should be within the framework of a general statement about the standards expected of the trainee if they are to make satisfactory progress throughout the programme and should reflect the fixed time period of the combined programme. A joint meeting with both named clinical and named academic supervisors should be held to ensure that both aspects of the programme are realistic. In addition, the educational supervisor and named academic supervisor should work together to ensure that clinical and academic objectives are complementary. Both supervisors and the trainee should be aware of the trainee's overall clinical and academic requirements.

4.145 Assessment of clinical progress of academic trainees should be capability-based, rather than time-based. Setting a target CCT date should be determined flexibly and tailored to the needs of the individual academic trainee. The target date for achieving a CCT for an academic trainee who continues beyond a doctorate degree (MD or PhD) should be determined at the first annual ARCP for clinical lecturers, when stock can be taken of initial progress at this more advanced post-doctoral academic training stage and of capabilities attained during their academic programme, after which time it can only be adjusted through the usual ARCP processes.

Recording academic and clinical progress – academic assessment

4.146 At the start of the academic placement and annually thereafter, academic trainees must meet with both their named clinical and named academic supervisors to agree objectives for the coming year. There is considerable advantage in coordinating this meeting so that the trainee is able to meet both named clinical and named academic supervisors together at least annually (although there may be a need for separate meetings on other occasions). Regular meetings with the named academic and named clinical or educational supervisors should take place throughout the year to review progress, and decisions taken should be agreed and documented for later presentation to the annual assessment of academic progress.

4.147 An annual assessment of academic progress must be undertaken and should take place at least one month before the joint academic/clinical ARCP panel convenes. Those present at this assessment should include the trainee and educational supervisor, together with the director of the academic programme and other members of the academic unit as appropriate. This does this does not apply to the SFP as the academic performance is considered as part of overall foundation programme ARCP.

4.148 Since the assessment process jointly assesses academic and clinical progress, the trainee must also submit evidence of clinical achievement.

4.149 The named academic supervisor is required to complete the 'Report on Academic Trainees' Progress' form (GG9 Appendix 5), which needs to be signed by the trainee for submission to the annual joint academic/clinical ARCP panel. The form must include details of academic placements, academic training modules and other relevant academic experience, together with an assessment of the academic capabilities achieved.

4.150 The report and any supporting documentation should be submitted to the joint academic/clinical ARCP panel as part of the evidence it receives.

4.151 The trainee should not attend the panel meeting. Plans for academic trainees to meet with members of the panel should only be made if the TPD or the named academic supervisor/lead for academic training indicates that Outcomes 2, 3 or 4, for either clinical or academic components (or both), are a potential outcome from the panel. The ARCP outcome is a global assessment of progress, dependent on both clinical and academic reports to assess achievement.

4.152 Standard ARCP outcomes of this joint process should be recorded as described above. The academic report should be attached to the outcome document.

The ARCP for trainees undertaking OOPR

4.153 Trainees who wish to undertake full-time research out of programme must have their research programme agreed with their named academic supervisor. This should form part of the documentation sent to the Postgraduate Dean when requesting OOPR.

4.154 Trainees must submit an annual OOPR return to the ARCP panel of their base locality in HEE, NES, HEIW or NIMDTA along with a report from their named academic supervisor. All academic trainees on OOPR should have a formal assessment of academic

progress, which is submitted as part of the documentation for the ARCP panel as described above for joint clinical and academic programmes. The report must indicate whether appropriate progress in the research has taken place during the previous year and also whether the planned date of completion of the research has changed. Any request for a potential extension to the OOPR will need to be considered separately by the Postgraduate Dean.

4.155 Both the trainee and the named academic supervisor must remain aware that normally a maximum of three years is agreed for OOPR. If a request to exceed this is to be made, such a request must be made to the Postgraduate Dean at least six months prior to the extension commencing. The request must come from the named academic supervisor, who must set out clear reasons for the extension request. Adequate governance structures must be in place to allow for discussion between the academic institution and HEE, NES, HEIW or NIMDTA on such requests.

4.156 OOPR can provide credit towards a CCT only if it has been prospectively approved by the GMC and demonstrates achievement of capabilities defined in the relevant specialty curriculum. The purpose of documenting performance during OOPR is therefore both to assess progress towards meeting the approved academic programme requirements and to ensure that progress is made so that return to the clinical training programme is within the agreed timescale.

4.157 Trainees undertaking research with no clinical care component that is for longer than three months should participate in a 'return to work' package. This should include consideration of returning to clinical learning as well as to clinical practice and may include 'keep in touch' arrangements.

Appeals of the ARCP outcomes

4.158 While the principles for managing appeals against ARCP outcomes in foundation training are consistent with the Gold Guide and standard operating procedures in training organisations across the UK (HEE, NES, HEIW and NIMDTA), the governance arrangements differ because F1 doctors come under the governance of the UK university of primary medical qualification. For F2 doctors, the governance is with the foundation school.

4.159 It should not come as a surprise to trainees that action through the ARCP process is under consideration since any performance and/or conduct shortcomings should be identified on the educational portfolio and discussed with the trainee during the educational review process (paragraphs 4.57 and 4.85).

4.160 As identified in paragraph 4.80, either the ARCP panel (wherever reasonably practicable) or a senior educator in the training programme with delegated responsibility will meet with all trainees, who are judged on the evidence submitted to:

i. require further development on identified specific capabilities (Outcome 2/10.1 or 7.2)

ii. require additional training time for all reasons other than associated with a 'training pause' (Outcome 3/10.2 or 7.3)

iii. be required to leave the training programme before completion, with identified capabilities achieved or with an identified and specified level of training attained (Outcome 4)

4.161 The purpose of the post-ARCP meeting identified in paragraphs 4.85 and 4.86 is to inform the trainee of the decision of the panel. The meeting should also plan the further action that is required to address issues of progress (in relation to Outcomes 2 and 3) or make clear to the trainee the capabilities with which they will leave the programme (in relation to an Outcome 4).

4.162 However, a trainee has the right to request a review and (in some circumstances) an appeal (paragraphs 4.158–4.182) if one of these outcomes is recommended by the ARCP panel.

4.163 If the trainee requests a review or appeal, the outcome documentation from the original ARCP panel should not be signed off by the Postgraduate Dean and the training number/contract is not removed until all review or appeal procedures have been completed. Only at this stage should the Postgraduate Dean sign off the ARCP panel's outcome.

Reviews and appeals

4.164 A review is a process where an individual or a group who originally made a decision returns to it to reconsider whether it was appropriate. This does not require the panel to be formally reconvened and can be undertaken virtually. The review must take into account the representations of the trainee asking for the review and any other relevant information, including additional relevant evidence, whether it formed part of the original considerations or has been freshly submitted. New information would not normally include capabilities or evidence from assessments acquired after the date of the ARCP outcome subject to review.

4.165 An appeal is a procedure whereby the decision of one individual or a group is considered by another (different) individual or group. An appeal can take into account information available at the time the original decision was made, newly submitted information relevant to the appeal and the representations of the appellant. New information for an appeal might include new evidence of mitigating circumstances not available to the ARCP panel. New information would not normally include capabilities or evidence from assessments acquired after the date of the ARCP subject to appeal. Those involved in an appeal panel must not have played a part in the original decision or the review.

4.166 Through the process of review or appeal, it may be decided that the decision to withdraw a training number/contract or issue ARCP Outcomes 2, 3 or 4 is not justified. Where this occurs for ARCP outcomes, the facts of the case will be recorded and retained but the outcome should be amended to indicate only the agreed position following review or appeal. This revised documentation should be forwarded to those indicated in paragraph 4.179.

Review of Outcomes 2/10.1 and 7.2

4.167 If the trainee requests a review of an Outcome 2 recommendation, this must be made in writing and with supporting evidence to the Chair of the ARCP panel or a nominated alternative within ten working days of being notified of the panel's decision. Trainees may provide additional evidence at this stage (e.g. evidence of mitigating circumstances or other evidence relevant to the original panel's decision) and this must be received as part of the request for the review so that the panel is able to consider it in detail. The original ARCP panel will review its decision where practical within 15 working days of receipt of such a request from a trainee. This may be undertaken virtually and the Chair will endeavour to include as many panel members as possible. After the review, the panel will ensure that the trainee receives its decision with reasons in writing. If the panel considers it appropriate, it may invite the trainee to meet with a senior representative to discuss the decision of the review.

4.168 The decision of the review of Outcomes 2/10.1 and 7.2 is final and there is no further appeals process.

Appeal against Outcomes 3/10.2 and 4 or withdrawal of a training number/ contract

4.169 Trainees have the right of appeal if their training number/contract is withdrawn under paragraphs 3.99 iii–vii or if they receive an ARCP outcome that results in a recommendation for:

i. an extension of the indicative time to complete the training programme (Outcome 3/10.2)

ii. release of the trainee from the training programme with or without identified capabilities having been achieved and without completion of the programme (Outcome 4)

4.170 Appeal requests should be made in writing to the Postgraduate Dean within ten working days of the trainee being notified of the decision. The request must specifically state the grounds for appeal.

4.171 Where the training number/contract withdrawal decision relates to an external body's decision that cannot be changed (e.g. erasure from the register by the GMC, imprisonment, examination failure where the trainee has exhausted the permitted number of attempts and any related complaints process), then an appeal would normally be refused. The same principles may be applied where the maximum permitted additional training time (ATT) has been reached (paragraph 4.108) including where exceptional discretion by the Postgraduate Dean has been exhausted and where an appeal might be considered futile.

4.172 Where the appeal is being made against a decision to withdraw a training number/contract as defined in paragraphs 3.99 iii–vii, the Postgraduate Dean will review the decision in the light of the information contained in the trainee's appeal request. If the Postgraduate Dean decides to reverse the original decision, then the trainee will not have their number withdrawn but if the Postgraduate Dean determines that there is insufficient reason to reverse the decision, the Postgraduate Dean will confirm with the trainee that they wish to proceed to an appeal hearing and this will then be arranged.

4.173 On receipt of an appeal request, the Postgraduate Dean will first arrange for a review of the original recommendation.[26] This review will follow the process outlined in paragraphs 4.167 and 4.168. The decision of the review panel will be communicated to the trainee.

4.174 Where the review panel has modified the decision of the original ARCP panel to an Outcome 1 or 2, this completes any appeals process.

4.175 Where the review panel does not alter the decision of the original ARCP panel or where an Outcome 4 is converted to an Outcome 3, the Postgraduate Dean will confirm with the trainee that they wish to proceed to an appeal hearing and this will then be arranged.

Appeal hearing

4.176 A formal appeal hearing should normally take place as soon as practical, without unreasonable delay and normally within 30 working days of the appeal request.[27] In exceptional circumstances (e.g. outstanding disciplinary, GMC or legal proceedings that might affect the appeal outcome), the appeal hearing might be delayed beyond the 30-day limit. However, where it has not been possible to hear an appeal within the 30-day period, appeals should normally be heard within 1 year of the decision that is subject to appeal.[28] Where there have been reasonable endeavours to progress the appeal and the appeal has not taken place within one year of the decision date, then the original decision is final. The Postgraduate Dean has discretion to consider requests for a reasonable postponement of the appeal beyond a year from the decision date in exceptional circumstances.

4.177 If the trainee agrees, it is not always necessary for an appeal hearing to be undertaken face to face and an appeal can be dealt with on written submissions. Members of the original ARCP panel must not take part as members of the appeal panel. Trainees may support their appeals with further written evidence relevant to the grounds of the appeal. All documentation presented to the appeal panel must also be made available to the trainee.

4.178 HEE, NES, HEIW and NIMDTA have agreed standard operating procedures that will define how appeals will be managed and that will take into account:

i. the timing of the notification by the trainee of their intention to appeal, the timing at which all additional evidence will be presented and the

[26] This is commonly referred to as a 'step 1' review as it is the first stage of the appeals process. It is without prejudice and does not affect the right to proceed to a full 'step 2' appeal hearing.

[27] Appeals should normally be heard within 30 working days consistent with timescales for similar processes – NHS Employers.

[28] In accordance with recommendations from NHS Improvement – Learning lessons to improve our people practices, May 2019

timing for the outcome of any appeal hearing to be notified to the trainee

ii. the membership of the panel and permitted attendees

iii. the standard format for an appeal hearing

Notification of appeal outcome

4.179 Trainees will be notified in writing of the panel's decision with reasons within five working days (where possible) of the appeal hearing. The decision of the appeal panel is final and there is no further right of appeal.

4.180 If the appeal is in relation to an ARCP outcome, the appeal panel should not impose an increased sanction on the trainee (e.g. an Outcome 3 should not be changed to an Outcome 4). In circumstances where new information has come to light that may inform such a decision, these issues will be brought to the attention of the Postgraduate Dean.

4.181 In appeals relating to Outcomes 3 and 4 or to a decision to withdraw a training number/contract, the employer should be kept informed of progress at each step in the appeals process.

4.182 When an Outcome 4 recommendation is upheld by the appeal panel or it upholds the decision to withdraw a training number/contract under paragraph 3.99 ii, the Postgraduate Dean will be notified. The Postgraduate Dean or their nominated deputy will write to the trainee to confirm the decision and the withdrawal of the training number/contract. This will be done either ten working days after the original recommendation is made when the trainee has not requested an appeal or at the completion of the appeals process, whichever is later. The effective date for the cessation of the training programme is the date of the letter confirming the decision by the Postgraduate Dean. This will also be the date of removal of the training number/contract. For trainees working in general practice, from the date of actual removal of the training number, they are not eligible for inclusion on the Medical Performers List (in NHS England) and normally, this triggers the process for removal from the Medical Performers List.

Appeal against a decision not to award a CCT/CESR/CEGPR

4.183 The decision regarding the award of the CCT, or full CESR/CEGPR is the responsibility of the GMC and all appeals against decisions not to award such a certificate should therefore be directed to the GMC.

Section 5: Being a trainee and an employee

Postgraduate trainees (foundation and specialty)

5.1 Foundation and specialty trainees are expected to take control of their own learning and become fully involved in the educational, supervised learning and assessment processes of their training programme.

5.2 Their responsibilities include:

i. abiding by the conditions of taking up a training post

ii. demonstrating professional behaviour in line with Good Medical Practice

iii. working within the human resources policies and procedures as outlined by the local education provider

iv. becoming familiar with the requirements for satisfactory completion of a training programme

v. becoming fully involved in the educational, supervised learning and assessment processes, including attending core generic training sessions, meeting regularly with their educational and named clinical supervisor, and maintaining an up-to-date e-portfolio

vi. taking part in the career management process to help them match their skills, interests and ambitions with the available opportunities

vii. taking part in systems of quality assurance and quality improvement in their clinical work and training. In particular, doctors should complete the General Medical Council's (GMC's) national training survey and other surveys required by Health Education England (HEE)/NHS Education for Scotland (NES)/Health Education and Improvement Wales (HEIW)/the Northern Ireland Medical and Dental Training Agency (NIMDTA).

5.3 All trainees should be assigned an educational supervisor for their programme and a named clinical supervisor for each placement. Trainees must make arrangements to see their educational supervisor and named clinical supervisor as regularly as is required by their training programme.

5.4 Wherever possible, trainees should raise any difficulties with their educational supervisor and/or named clinical supervisor and keep them informed of their progress. Trainees who have difficulties arranging appointments with their educational supervisor or named clinical supervisor and/or who have concerns about the quality of their training should contact their Training Programme Director.

5.5 If a trainee has concerns about poor quality care, harassment, criminal offences, fraud or corruption, they should follow their employer's whistle blowing policy or that of HEE/NES/HEIW/NIMDTA.

Accountability issues for employers, Postgraduate Deans and trainees

5.6 The Postgraduate Dean is responsible for commissioning and managing the delivery of good quality training and education to postgraduate trainees. In most cases, trainees in foundation and specialty training are employed by separate healthcare organisations. There are different employment models across the UK statutory education bodies. HEE and HEIW do not employ doctors in training. NES and NIMDTA have elected to take a lead employer role.[29] The guidance below relates to doctors who are not employed by HEE, NES, HEIW or NIMDTA. Where trainees are employed by NES or NIMDTA, separate guidance will be provided.

5.7 Trainees have an employment relationship with their employer, and issues such as misconduct and ill heath are subject to their employing organisation's policies, procedures and nationally agreed standards such as Maintaining High Professional Standards in the Modern NHS (in England) or the equivalent documents/processes in the other jurisdictions of the UK.

5.8 In the first instance where there are concerns around conduct, performance and professional competence, employers and host organisations should advise the Postgraduate Dean of any trainee who is experiencing difficulties as well as the action being taken, including steps to support and remedy any deficiencies. Where appropriate, the Postgraduate Dean, employers and host organisations will work closely together to identify the most effective means of helping/supporting the trainee while ensuring that patient safety is maintained at all times. There may also be a need for early involvement of services such as the Professional Support Unit provision in HEE, NES, HEIW and NIMDTA or NHS Resolution (formerly the National Clinical Assessment Service) to provide advice about how best to support the process.

5.9 Employers must ensure that mechanisms are in place to support the training of trainees, and to manage employment-related issues in an open and supportive way. Where personal misconduct is identified, employers may need to take action. In such cases, the Postgraduate Dean should be notified from the outset. Any decision by the employer to dismiss a trainee should be communicated to the Postgraduate Dean and considered in line with paragraph 3.99 vii of this Guide.

5.10 Payment in respect of ill health, jury service, maternity/paternity/adoption absence remains the responsibility of the employing organisation.

5.11 Trainees should participate in an employer's 'return to work' package at the end of any prolonged absence from work, including maternity/paternity/adoption leave. This should include consideration of returning to clinical learning as well as to clinical practice and may include 'keep in touch' arrangements organised by the healthcare organisation.

5.12 Under the Responsible Officers Regulations, every doctor with a full licence to practise must have a 'designated body' and relate to a named Responsible Officer (RO). ROs are responsible for ensuring the fitness to practise of their doctors, and that

[29] NIMDTA was asked by the DoH in January 2019 to take on the function of being the single lead employer for doctors and dentists in training in Northern Ireland. This began in a phased fashion from August 2019.

appropriate systems are in place to allow effective identification, remediation and monitoring of the doctor in difficulty. For doctors in postgraduate training, their RO is their Postgraduate Dean (or Medical Director in HEIW and NIMDTA) and their designated body is the locality in HEE, NES, HEIW or NIMDTA responsible for the management of their training programme. Further guidance on the role of the RO is available at GMC | Revalidation for Responsible Officers.[30]

5.13 On occasion, the concerns about performance of a doctor may be enough to warrant referral to the GMC's fitness to practise process. Trainees, in common with all doctors, may be subject to fitness to practise investigation by the GMC and adjudication by the Medical Practitioners Tribunal Service. Significant fitness to practise concerns may include misconduct, health concerns (mental or physical), sustained concerns about performance, difficulties with English language communication, determination by another regulatory body and receipt of conviction or caution. Concerns in any of these areas may create a risk to public protection, which includes health, safety and well-being of the public; public confidence in the profession; and/or maintaining proper professional standards and conduct for the profession. Where there are concerns, ensuring that doctors are referred to the GMC is a key part of the role of the RO. Guidance on referring a doctor is available at GMC | Raise a Concern or Refer Yourself to Us and support is provided by the Employer Liaison Service. Where such serious issues arise, advice should be sought from the relevant regional Employer Liaison Advisor about whether the doctor is likely to meet the GMC's fitness to practise threshold.

5.14 The Postgraduate Dean (or other HEE, NES, HEIW or NIMDTA staff) must not be involved as a member of a disciplinary or appeal panel in any disciplinary procedures taken by an employer against a trainee but may provide evidence to the panel, and may advise on training and education matters if required.

5.15 Medical professionals have ethical and professional responsibilities to raise concerns about matters that may harm patients or colleagues. In the NHS and social care sector, these issues have the potential to undermine public confidence in these vital services and patient safety. Whistle blowing is the popular term applied to reporting such concerns about malpractice, wrongdoing or fraud. Such concerns should usually be raised by the trainee with their employer or an appropriate regulator. However, HEE, NES, HEIW and NIMDTA recognise that a trainee may feel it is not appropriate for them to raise a concern with their employer or may be concerned that they will suffer detriment from their employer or others as a result of raising such concerns. In these circumstances, HEE, NES, HEIW or NIMDTA will offer appropriate guidance and signposting to support any trainee wishing to raise concerns.

Transfer of information

5.16 Trainees must maintain an educational portfolio that is programme specific and covers all aspects of their training. They must share this with their educational supervisors as they move through their rotational programme, as part of the ongoing training process. The transfer of educational information from placement to placement in

[30] Medical Profession (Responsible Officers) Regulations 2010 + 2013 amendments

the training programme is fundamental to the training process and is applicable to every trainee.

5.17 The Annual Review of Competence Progression process (which incorporates educational and named clinical supervisor reports) will also be shared with employers to ensure that they are aware of the progress and performance of all their doctors in postgraduate training.

5.18 Trainees in general practice who need to be included on the Medical Performers List (MPL) must comply with the provision of information that is necessary for their inclusion and continuation on the List. If trainees are not included on the Medical Performers List (outside of the initial period of grace), they must discontinue clinical activity in general practice. (This does not apply to foundation doctors in general practice in England, Wales and Northern Ireland.)

5.19 In situations where an employer has taken action because of concerns about a trainee's conduct or performance, it will be essential for the educational supervisor and Director of Medical Education at the trainee's placement to be made aware of the ongoing training and/or pastoral needs to ensure that these issues are addressed.

5.20 Where a trainee has significant health issues that may affect their training, the trainee must engage with the healthcare organisation's and/or the Postgraduate Dean's requests for health assessment and information. For example, a trainee must not unreasonably refuse to engage with an employer's request for a trainee to attend an occupational health appointment. If a trainee fails to engage with the process, it may not be possible to safely continue training and removal of the training number/contract will be considered in line with paragraph 3.99 of this Guide.

5.21 It may also be essential (for the sake of patient safety and to support the trainee) that relevant information regarding any completed or outstanding disciplinary or competence issue is transferred to the next placement provider. This may make reference to any educational or supervisory needs that must be addressed, and any formal action taken against the trainee, including the nature of the incident triggering such action. Information about any completed disciplinary procedure that exonerated the trainee will not be shared unless issues relevant to the trainee's progression or training are identified.

5.22 In addition, where there are potential fitness to practise concerns or information relating to a doctor's revalidation, the Postgraduate Dean or Medical Director in NIMDTA (as the trainee's RO) and the RO for the employing organisation may have a statutory responsibility to share relevant information with the GMC, the Medical Performers List and/or other external agencies.

5.23 In all of these circumstances, any information shared will comply with the principles set out in the General Data Protection Regulation, implemented in May 2018, and with the Gold Guide Privacy Notice set out in GG9 Appendix 6.

Managing absence from training other than annual leave

5.24 Sections 34J and 34K of the Medical Act 1983 outline the minimum training times for general practice and specialty training respectively, and section 34L outlines

that for the GMC to be able to award a Certificate of Completion of Training, it must be satisfied that the trainee has satisfactorily completed the approved course of training. The course of training is based on meeting required capabilities. All trainees must complete the GMC prospectively approved full course of training to be eligible for the award of a Certificate of Completion of Training. The following applies to trainees absent from training when they would be expected to be training:

i. The trainee must advise the employing organisation and the Postgraduate Dean if they are absent owing to ill health, if they are going to be taking maternity/paternity/adoption leave or if they have to attend jury service.

ii. If the trainee is taking time off from the training programme for sickness, maternity/paternity/adoption leave or jury service and the sum of these absences exceeds 14 days in any 12-month period, then a review of training should be undertaken and the expected date for end of training adjusted if required.

Gold Guide 9 Appendices

The Gold Guide

9th edition

incorporating the Purple Guide

Version: GG9 – 3rd August 2022

POLICY DOCUMENT

Failure to Comply with the Requirements of the Training Programme (NI Deanery Policy)

2015 (Version 1.4)
CS>ROG

Policy Review Schedule

Date first Approved by ROG: February 2015

Last Approved by ROG:

Date of Next Review: February 2017

Policy Owner: Administrative Director

Amendment Overview

Version	Date	Pages	Comments	Actioned
2014 – 1.0	01/04/2014		Policy created.	Margot Roberts
2014 – 1.1	01/11/2014	Page 9	Policy renamed and revised and submitted to ROG for approval	Margot Roberts
2014 – 1.2	04/2/2015	Pages 8 & 9	Policy further revised and submitted to ROG for approval. **Approved subject to minor revision.**	Margot Roberts
2015 – 1.3	04/2/2015	Cover page and Page 8	Minor revisions made for circulation to trainees and publication on website	Margot Roberts
2015 – 1.4	10/03/2016	9	Incorporated guidance on non-completion of Form R	Denise Hughes

Contents

Policy Influences

This policy has been influenced by the following:

- Management of Trainees Requiring Support (NI Deanery)
- ARCP Policy for Hospital Specialty Training
- GP ARCP Guidance
- GMC Protocol for Making Revalidation Recommendations
- A Reference Guide for Postgraduate Specialty Training in the UK (Gold Guide 2014)

Policies Impacted

This policy may have an impact on the following:

- Educational Agreement for Doctors in Training in the NI Deanery
- Learning and Development Agreement for the Provision of Postgraduate Medical and Dental Training and Education

Role of 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, Social Services and Public Safety (DHSSPS) to train postgraduate medical and dental professionals for Northern Ireland. NIMDTA seeks to serve the government, public and patients of Northern Ireland by providing specialist advice, listening to local needs and having the agility to respond to regional requirements.

NIMDTA commissions, promotes and oversees postgraduate medical and dental education and training throughout Northern Ireland. Its role is to attract and appoint individuals of the highest calibre to recognised training posts and programmes to ensure the provision of a highly competent medical and dental workforce with the essential skills to meet the changing needs of the population and health and social care in Northern Ireland.

NIMDTA organises and delivers the recruitment, selection and allocation of doctors and dentists to foundation, core and specialty training programmes and rigorously assesses their performance through annual review and appraisal. NIMDTA manages the quality of postgraduate medical and dental education in HSC Trusts and in general medical and dental practices through learning and development agreements, the receipt of reports, regular meetings, trainee surveys and inspection visits. It works in close partnership with local education providers to ensure that the training and supervision of trainees support the delivery of high quality safe patient care.

NIMDTA recognises and trains clinical and educational supervisors and selects, appoints, trains and develops educational leaders for foundation, core and specialty medical and dental training programmes throughout NI.

NIMDTA is accountable to the General Medical Council (GMC) for ensuring that the standards set by the GMC for medical training, educational structures and processes are achieved. The Postgraduate Medical Dean, as the 'Responsible Officer' for doctors in training, has a statutory role in making recommendations to the GMC to support the revalidation of trainees. Revalidation is the process by which the GMC confirms that doctors are up to date and fit to practice. NIMDTA also works to the standards in the COPDEND framework for the quality development of postgraduate Dental training in the UK.

NIMDTA enhances the standard and safety of patient care through the organisation and delivery of relevant and valued career development for general medical and dental practitioners and dental care professionals. It also supports the career development of general medical practitioners and the requirements for revalidation through the management and delivery of GP appraisal.

NIMDTA aims to use the resources provided to it efficiently, effectively and innovatively. NIMDTA's approach to training is that trainees, trainers and educators should put patients first, should strive for excellence and should be strongly supported in their roles.

1. Introduction

The GMC in its guidance for Responsible Officers (ROs) requires the RO to inform the General Medical Council (GMC) if a doctor has failed to engage with any of the local systems or processes (such as appraisal) that support revalidation. For trainees the Annual Review of Competence Progression (ARCP) is used to assess progress of trainees towards a Certificate of Completion of Training (CCT) and a recommendation by the RO for revalidation.

On joining a foundation or specialty training programme each trainee is required to sign an educational agreement which sets out the conditions of their appointment. These include participating proactively in the assessment, appraisal and programme planning processes, maintaining regular contact with the Head of School and Specialty/Foundation Programme Director and regularly taking part in educational activities:

Trainees are required to comply with these conditions with the understanding that failure to do so may result in a non-engagement outcome for revalidation and/or an unsatisfactory ARCP outcome.

This paper sets out a process to be applied when trainees show persistent inadequate participation in the requirements of their training programme.

2. Identification of non-participation

Some trainees do not engage with what is required of them to progress in their training programme.

This may become manifest by:

- Failure to comply with regulatory requirements eg inclusion on the GMC register; inclusion on the Primary Medical Performers List (PMPL)
- Poor record keeping on e-portfolio
- Poor attendance at formal education events
- Unexplained absences
- Non-attendance at meetings with Trainer (clinical or educational supervisor), Training Programme Director or Head of School
- Taking study leave without approval
- Non-completion of workplace based assessments
- Non-attendance at ARCP where required

A separate process is followed (appendix 2) if a trainee fails to submit a completed Form R on commencement of training or at ARCP.

3. Process

Once a concern about inadequate participation is expressed or identified by the clinical or educational supervisor the trainee should be referred to the relevant lead educator (Head of

School, Specialty or Foundation Training Programme Director). It is important to ascertain at the outset whether there are any mitigating circumstances as to why the trainee is not participating, for example the trainee might be ill or in need of additional support. Failure to attend a meeting with the lead educator will result in automatic referral to the relevant senior educator within NIMDTA ie the Associate Dean for Foundation/Specialty Training or the GP Director.

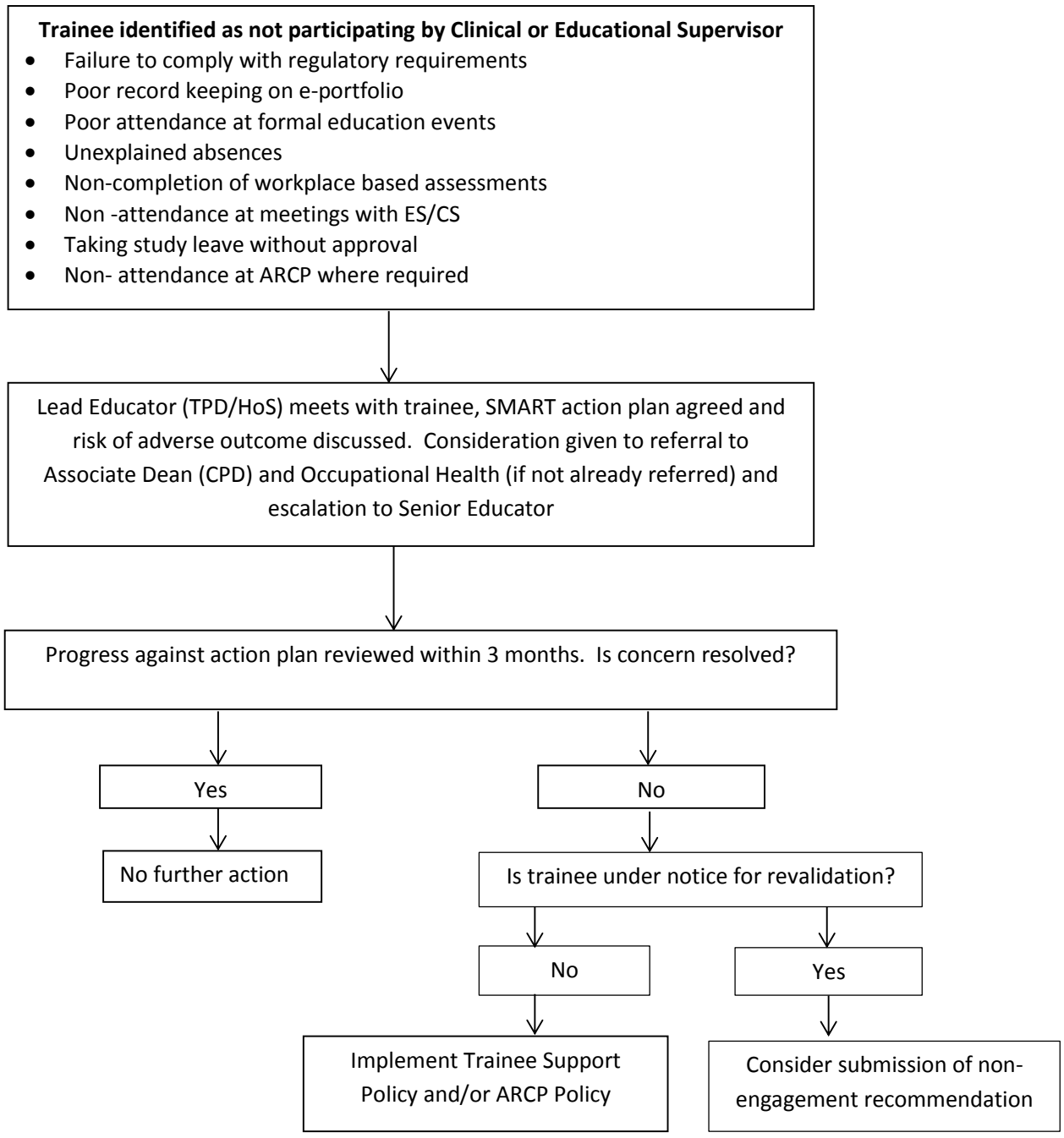
On referral, the lead educator should meet with the trainee and a written record of the meeting taken, shared with the trainee and retained on file. The risk of receiving an adverse ARCP outcome should be clearly explained to the trainee and documented and an action plan agreed for review within three months. The action plan should have clearly stated objectives and identify any additional educational support required by the trainee. Consideration should also be given at this stage as to whether the trainee should be brought to the attention of the relevant senior educator within NIMDTA, particularly if there is a likely risk of the trainee receiving an adverse outcome at the next ARCP.

If the trainee is ill or requires additional support he/she should be referred to Occupational Health (if this has not already occurred), the Associate Dean for Career and Personal Development for support and referral to the Trainee Support Review Group. The concerns should also be escalated to the senior educator within NIMDTA.

Progress against the action plan will be reviewed within the timeframe set and if the concerns have not been resolved the Trainee Support Policy and/or ARCP Policy will be invoked and the Postgraduate Dean informed.

The Postgraduate Dean, as the Responsible Officer (RO), may contact the GMC's Employer Liaison Adviser at any time if a doctor is not engaging with the revalidation processes. As a result, the RO may be required to submit a REV6 form to the GMC to alert the GMC that the doctor is not engaging. The GMC will write to the doctor to remind them that they are obliged to participate in the ongoing processes that support revalidation in order to maintain their licence to practise. An exception to this would be if a doctor is under their period of notice for revalidation in which case the RO may make a revalidation recommendation of non-engagement.

Appendix 1 - Flow chart for Trainees not participating



Appendix 2

Guidance on actions to be taken if a trainee fails to submit a Completed Form

All trainees are required to complete a Form R upon commencement of training and then annually as part of the ARCP process. This is to ensure that the 'trainee re-affirms his/her commitment to training and thereby remains registered for their training programme'.

A complete Form R must be received 4 weeks in advance of ARCP to allow consideration of the revalidation recommendation. Failure to provide a Form R in advance of ARCP will result in an Outcome 5. If the trainee submits an updated Form R within the agreed timeframe the appropriate outcome for progression can be awarded.

If the completed Form R is not received within the initial 2 week period, the trainee will be written to and required to meet with their Lead Educator (Head of School or Training Programme Director or Associate Dean), This correspondence will inform them they have a further 4 weeks from the date of this letter or are at risk of receiving an Outcome 4. A template letter is provided below.

If a trainee is being considered released from the training programme as a result of non-engagement, this will be discussed with the GMC Employer Liaison Advisor.

Dear Trainee

Re: Non Submission of Form R (Part B)

Despite the additional 2 week deadline following your Outcome 5 at ARCP, you have still not submitted your Form R.

By not submitting your Form R (Part B) within the specified timescales you are failing to engage with revalidation. There is now a risk that a recommendation of non-engagement will be made to the GMC which can ultimately result in you losing your Licence to Practise.

A meeting has been arranged with your (Lead Educator) at (**Time, Date, Venue)** as my designated representative to discuss the reasons behind your failure to submit your Form R.

If a completed Form R is not received by (4 weeks from date of letter) you are at risk of receiving an Outcome 4 and will be released from the training programme and this will be discussed with the GMC Employer Liaison Advisor.

Please confirm your attendance to (Specialty Administrator)

Yours sincerely

Professor Keith Gardiner
Postgraduate Dean, Responsible Officer

POLICY DOCUMENT

NIMDTA Engagement with Trainees

2015 (Version 1.1)
QMG

Policy Review Schedule

Date first Approved by QMG: 1 June 2015

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Amendment Overview

Version	Date	Pages	Comments	Actioned
2015 – 1.0	10.05.15	7	Created	D Hughes
2015 – 1.1	26.05.15	8	Amended by PGD	D Hughes
2015 – 1.1	01.06.15		Approved by QMG	D Hughes

Role of 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, Social Services and Public Safety (DHSSPS) to train postgraduate medical and dental professionals for Northern Ireland. NIMDTA seeks to serve the government, public and patients of Northern Ireland by providing specialist advice, listening to local needs and having the agility to respond to regional requirements.

NIMDTA commissions, promotes and oversees postgraduate medical and dental education and training throughout Northern Ireland. Its role is to attract and appoint individuals of the highest calibre to recognised training posts and programmes to ensure the provision of a highly competent medical and dental workforce with the essential skills to meet the changing needs of the population and health and social care in Northern Ireland.

NIMDTA organises and delivers the recruitment, selection and allocation of doctors and dentists to foundation, core and specialty training programmes and rigorously assesses their performance through annual review and appraisal. NIMDTA manages the quality of postgraduate medical and dental education in HSC Trusts and in general medical and dental practices through learning and development agreements, the receipt of reports, regular meetings, trainee surveys and inspection visits. It works in close partnership with local education providers to ensure that the training and supervision of trainees support the delivery of high quality safe patient care.

NIMDTA recognises and trains clinical and educational supervisors and selects, appoints, trains and develops educational leaders for foundation, core and specialty medical and dental training programmes throughout NI.

NIMDTA is accountable to the General Medical Council (GMC) for ensuring that the standards set by the GMC for medical training, educational structures and processes are achieved. The Postgraduate Medical Dean, as the 'Responsible Officer' for doctors in training, has a statutory role in making recommendations to the GMC to support the revalidation of trainees. Revalidation is the process by which the GMC confirms that doctors are up to date and fit to practice. NIMDTA also works to the standards in the COPDEND framework for the quality development of postgraduate Dental training in the UK.

NIMDTA enhances the standard and safety of patient care through the organisation and delivery of relevant and valued career development for general medical and dental practitioners and dental care professionals. It also supports the career development of general medical practitioners and the requirements for revalidation through the management and delivery of GP appraisal.

NIMDTA aims to use the resources provided to it efficiently, effectively and innovatively. NIMDTA's approach to training is that trainees, trainers and educators should put patients first, should strive for excellence and should be strongly supported in their roles.

Introduction

The Northern Ireland Medical and Dental Training Agency is committed to engaging with trainees and encouraging trainees to suggest ways in which training and training programmes can be improved. Trainees have an important role in providing feedback and in suggesting improvements to the quality of education and training available.

Greater engagement between NIMDTA trainee representatives and NIMDTA Educators and Senior Educators will be of benefit to NIMDTA's commissioning and quality management roles and thereby improve the quality of training.

NIMDTA educators are defined as foundation programme directors, specialty or GP training programme directors, deputy head and heads of Specialty Schools.

NIMDTA senior educators are the Foundation School Director, Associate Deans, Associate Directors and Director of GP Education and the Postgraduate Medical and Dental Deans

Trainee Communication

Many NIMDTA educators and senior educators will meet trainees as part of their clinical work on a one-to-one basis. In addition to this, there are a number of ways in which NIMDTA communicates and engages with trainees:

1. Induction Meetings

The Annual Medical Foundation Programme Induction day provides an opportunity for trainees to receive information about their programme and Health and Social Care in NI as well as an opportunity to meet with the Director of the Foundation School, Associate Dean for Careers and Personal Development and the Postgraduate Dean

Each Specialty Programme will have an induction for the new trainees commencing in that programme and these events will usually be led and facilitated by the lead educator (Training Programme Director of Head/Deputy Head of School).

2. Formal Education Events

The Foundation Programme runs a series of eight full day generic and professional skills training sessions. NIMDTA educators and senior educators participate in these sessions.

In Specialty Training, there are both specialty-specific and generic, professional and leadership skills events. The lead educators for the specialty will often be involved in the delivery of some of the specialty-specific events. Lead and Senior Educators are involved in the generic skills session.

3. Deanery Visits

NIMDTA visits to HSC Trusts, GP practices and training programmes are part of the continuous process of Quality Management of Postgraduate Medical and Dental Education and Training. The purpose of these visits is to assess the quality of training delivered in the training unit or programme. The Trainee Doctor (GMC, 2011) mandates that: "Training must be quality managed, monitored, reviewed, evaluated and improved. The quality management of programmes and posts must take account of the views of those involved, including trainees, local faculty and, where appropriate, patients and employers". "Trainees must have a means of feeding back, in confidence, their concerns and views about their training and education experience to an appropriate member of local faculty or the deanery, without fear of disadvantage and in the knowledge that privacy and confidentiality will be respected".

In advance of each visit trainees in the unit being visits are invited to complete a survey on their experiences during their training placement within the hospital and specialty being visited. This information is collated and shared with the visiting team in advance of the visit t the unit.

Trainee feedback from visits forms an essential element of NIMDTA's quality management processes and enables NIMDTA to obtain primary, independent, qualitative data to triangulate with information obtained from LEP self-assessment reports and from NIMDTA and GMC Trainee surveys. All specialties will be visited within a 5 year cycle. Trainees have signed an *Educational agreement for doctors in training in the Northern Ireland Deanery*, which includes the commitment to attend, if present in the workplace on the day of a NIMDTA visit, the scheduled session with the visiting team.

4. ARCP Panels

All trainees should have an Interim Review using a process defined by their Specialty School. This would normally involve the Head of School, Training Programme Director or Educational Supervisor meeting the trainee to consider the trainee's evidence and progress. This may be particularly relevant for specialties which do not currently use e-Portfolio where it will be more difficult to review evidence without the trainee present.

All trainees at risk of receiving unsatisfactory outcome (Outcome 2, 3 or 4) will be invited to attend the ARCP panel.

Some specialties will schedule all trainees to meet with the ARCP panel (after the evidence has been considered and the outcome decided on). This would be regarded as good practice and allows the panel to inform the trainee about the outcome, review their training to date and consider their future training needs.

5. One to one Meetings

Trainees may meet with lead or senior educators on a one-to-one basis for advice, to discuss career decisions, progress or difficulties that they are encountering.

6. Email Correspondence

The primary route for communication with trainees is electronically. Trainees sign an educational agreement on commencement to training and agree *to maintain regular contact with my Head of Specialty School/Foundation School Director, Specialty or Foundation Training Programme Director (TPD) and the Deanery by responding promptly to communications from them, usually through email correspondence.*

Information specific to individual training programme is communicated directly from the relevant School administrative team.

Circulations to trainees are limited to essential areas such as GMC surveys, information about revalidation or safety alert letters.

A Foundation Weekly Update is circulated to all F1 doctors, F2 doctors and Foundation contacts. The objective of the NIFS Foundation Weekly Update is to streamline communication to all Northern Ireland Foundation doctors, trainers in contact with Foundation doctors and all in health and medical education in Northern Ireland who are in contact with Foundation doctors. This contains the key weekly messages relevant to all involved in Foundation Programme training in Northern Ireland.

7. Website Correspondence

Trainee guidance and policies are published on the NIMDTA website www.nimdta.gov.uk/trainee-policies-and-guidance/ and trainees are signposted to this regularly with reference to updated policies and new information relevant to their training.

Courses, events and other relevant news items are also published on the NIMDTA website. Additional training opportunities (eg Research, Clinical Leadership) and safety alerts will also be highlighted on the website

8. School Boards and Training Committees

The **Foundation School Board** is responsible for ensuring foundation training is delivered in accordance with the national standards set by the GMC and guidance developed by the UK Foundation Programme Office. Membership of the School Board includes a medical student, F1 trainee and F2 trainee.

Specialty School Boards support the Head and Deputy Head of School in the planning, delivery and assessment of postgraduate medical education and training within the Specialty School. Each School Board has trainee representation at core (or ST1-3) and higher level. These trainees are democratically elected by their peer group,

Specialty Training Committees (STC) are responsible for providing advice and guidance to national and local bodies on all matters relating to the education, training and professional development of general practitioners and potential general practitioners including undergraduate medical students. There are trainee representatives on each STC.

The **General Practice Specialty Training Committees (GPSTC)** is responsible for providing advice and guidance to national and local bodies on all matters relating to the education, training and professional development of general practitioners and potential general practitioners including undergraduate medical students. There are 2 trainee representatives on the GPSTC.

9. Trainee Forum

The Northern Ireland **Trainee Forum** has been established to provide a better opportunity for trainee views and feedback to be heard, and to ensure that training in the region is delivered to the highest standard in order to deliver excellent and safe clinical care to patients.

The forum meets 2-3 times per year and involves trainees from foundation, hospital specialty, dentistry and GP programmes, with the aim of listening to trainee perspectives on current issues and future developments.

The trainee forum aims:

- To provide trainee input into key strategic and management issues pertaining to NIMDTA's educational governance and quality management functions
- To consider policies and procedures which apply to training including, where appropriate, to challenge proposals and processes which impact adversely on the quality or delivery of training
- To monitor and report on consistency of standards in quality of training and delivery of patient care including identifying pertinent issues within training locations
- To work collaboratively in identifying, developing and implementing innovation in education, training and engagement of trainees and trainers throughout the region
- To share examples of good practice in all aspects of training
- To identify challenges to the quality or delivery of training and make recommendations to contribute to the formation of future strategy
- To provide an additional forum for communication, updates and dissemination of information between trainees and NIMDTA. This will include issues relating to workforce development, organisational change and national policy
- To nominate members to assist NIMDTA in processes requiring trainee representation (e.g. ARCP appeals, School Boards, Specialty Training committees, NIMDTA committees including Revalidation Steering Group)
- To work with NIMDTA to consider best means of appropriately involving trainee representation in Deanery processes (e.g. trainee engagement and participation in NIMDTA Visits and Specialty Reviews; trainee engagement and participation in GMC visits)

10. GMC National Training Survey

The GMC annual National Training Survey is a core part of the GMC's role in monitoring the quality of medical education and training in the UK. It provided the opportunity for trainees to have their voice heard.

All trainees are required to complete this mandatory survey which provides feedback and benchmarking of Trusts and programmes throughout the UK. NIMDTA uses the results from this survey to monitor and improve the quality of training.

11. Other Committees

NIMDTA Revalidation Operational Group is responsible for overseeing NIMDTA's processes to support trainees preparing for revalidation. Membership includes a trainee representative and deputy, elected from the trainee forum.

Joint NIMDTA/BMA Northern Ireland Junior Doctor Committee (NIJDC) Liaison meetings take place 3 times per year and aim to improve communication and information sharing between NIMDTA and the NIJDC. Information from the meetings is cascaded by the BMA to their members.

12. Trainee Presentations

Trainees may also meet NIMDTA educators and senior educators at other educational events or conferences (such as the joint Ulster Medical Society/NIMDTA/QUB Research Prize evening and the Faculty Medical Leadership and Management Regional Conference) which NIMDTA supports.

POLICY DOCUMENT

Allocation of Placements Policy

Foundation, Core and Specialty Trainees (including Hospital Dentistry)

2020 (Version 7.3)
QMG

Policy Review Schedule

Last Approved by HSTC: May 2019
Date first Approved by QMG: October 2020
Date of Next Review: October 2022

Policy Owner: Senior Education Manager

Amendment Overview

Version	Date	Pages	Comments	Actioned
2010 – 1.0	August 2010	2	Document created and **approved**.	D Hughes
2012 – 2.0	August 2012	4	Merged specialty into one document. Document **approved**.	D Hughes
2014 – 3.0	7 May 2014	9	Amended policy at HSTC sub-meeting. Document **approved**.	D Hughes/K Moore
2014 – 3.1	4 Nov 2014	12	Amended at sub-meeting HSTC.	D Hughes / G Carlisle
2015 – 4.0	20 April 2015	12	Amendments agreed at HSTC. Document **approved**.	D Hughes
2015 – 4.1	5 May 2015	13	Minor amendments to School of Paediatrics ST1 allocation arrangements.	G Carlisle
2017 – 5.0	10 May 2017	12-14	Amendments to School of Paediatrics and School of Medicine allocation arrangements	E Dale
2017 – 5.1	5 July 2017	5, 8, 15, 16	Minor amendments to wording of sections	E Dale
2017 – 5.2	11 May 2018	Appendix 1	Appendix 1 added	E Dale
2019 – 6.0	1 May 2019		Minor amendments to Foundation, Specialty & addition of BBT and Hospital Dental Training.	E Dale
2020 – 7.1	6 Aug 2020	19	Reviewed to consider assessment of rural needs with regard to the impact and relevance on allocation processes	I Steele/D Hughes
2020 – 7.2	8 October 2020	18	Oversight changed to QMG to reflect cross-departmental policy. **Approved**.	D Hughes
2021 – 7.3	29 April 2021	10	Minor amendment to Emergency Medicine allocation process.	E Dale

Contents

Role of 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 (DoH) to train postgraduate medical and dental professionals for Northern Ireland. NIMDTA also seeks to serve the government, public and patients of Northern Ireland by providing specialist advice, listening to local needs and having the agility to respond to regional and national requirements.

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NIMDTA enhances the standard and safety of patient care through the organisation and delivery of relevant and valued career development for general medical and dental practitioners and dental care professionals. It also supports the career development of general medical practitioners and the requirements for revalidation through the management and delivery of GP appraisal.

NIMDTA carries out these roles on behalf of the DoH by focussing on the needs of people (population, trainees, trainers and NIMDTA staff), in partnership with key stakeholders and by paying attention to HSC Values - openness and honesty, compassion, excellence and working together.

1. Background

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for organising and delivering the recruitment, selection and allocation of doctors to foundation, core and specialty training programmes in the Northern Ireland Deanery. These trainee doctors contribute along with other medical and non-medical staff to deliver hospital and community services to patients in Northern Ireland.

NIMDTA acts on behalf of Local Education Providers (LEPs) consisting of HSC Trusts, the PHA, GP and GDPs to recruit and select doctors and dentists to training programmes in NI. NIMDTA works in close partnership with the LEPs to ensure that the training and supervision of trainees support the delivery of high quality safe patient care.

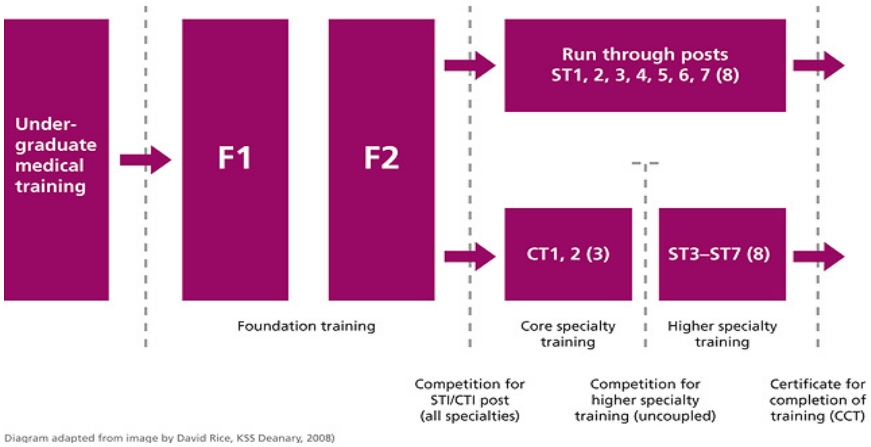
There are approximately 1800 hospital training posts across 5 HSC Trusts. The distribution of training posts is based on a combination of historical arrangements (including where responsibility for recruitment to posts transferred from Trusts and hospitals to NIMDTA) and expansion in the number of training posts funded by DoH, HSCB or Trusts. Approval of any new training post is now subject to final approval from the HSCB/PHA and DoH to ensure that workforce planning needs have been considered.

There are normally more posts available to be filled than doctors and dentists who apply for entry to training programmes, meet the nationally-determined person specifications for the posts and who accept offers on the programmes. This results in vacancies in a variety of training posts across the hospitals in Northern Ireland.

NIMDTA seeks to act openly and fairly with regards to allocation of trainees to the training posts. The purpose of this policy is to describe the process for allocating doctors in training to placements within Local Education Providers (LEPs) in Northern Ireland and not the management of vacancies which may subsequently arise. Vacancies may occur before or after trainees have been allocated to posts (e.g. resignations, statutory leave, out of programme). Funding associated with vacant posts remains with the Trust and is available to be used for other staff to support the service.

2. Introduction

2.1 Training Pathway



2.2 Specialty School Structure

Doctors in training are either recruited into posts which form part of a training programme or into a fixed term post for a period of 6 or 12 months. Those appointed to a programme of training, with the exception of a few specialties, are required to rotate across all five HSC Trusts throughout the duration of the programme and should expect to do so. The process of allocation to programmes and posts varies across specialties and grades of trainee as outlined below.

Less Than Full Time Trainees may be allocated to “slot share” arrangements in accordance with the LTFT Policy or reduced hours in a substantive post (e.g. 80%) or supernumerary in exceptional circumstances.

3. Foundation Trainees

The Northern Ireland Foundation School (NIFS) participates in the foundation national recruitment process and follows the guidance from the United Kingdom Foundation Programme Office (UKFPO).

NIFS Applicants are asked to rank foundation schools during the application process. They are allocated to their foundation school on the basis of their score from the national Situational Judgement Test (SJT) in addition to their Educational Performance Measure (EPM).

Medical students who wish to remain in a geographical area for specific family, caring or health reasons to undertake their F1 training can apply to the UKFPO to be considered for pre-allocation to a specific foundation school on the grounds of special circumstances. Further information is available from the Foundation Programme website via the following link: http://www.foundationprogramme.nhs.uk/content/applicant-guidance

Students allocated to NIFS are required to rank each of the foundation programmes in order of their preference online.

NIFS use the online 'auto match' facility to allocate successful applicants to programmes within the School. This is an automatic allocation to programme based on score obtained and applicants' ranked order of posts.

Where two or more applicants have the same score 'auto match' will use random selection to decide which applicant to take first.

Where 'auto match' runs out of preferences it will use random allocation. Applicants are asked to make their preferences and rank all programmes before the on line deadline. Within NIFS 243 preferences are available for ranking.

Since the commencement of foundation training in 2006, NIFS has offered all applicants a two year fixed programme.

Foundation doctors may be required to extend their F1 or F2 training for a variety of reasons to include sick leave, maternity leave or targeted training. In these cases a placement will be identified from available vacancies, tailored to meet individual training needs.

3.1 Academic Foundation Trainees

The NIFS participates in the national recruitment process for Foundation Academic Recruitment and follows the guidance from the UKFPO.

Applicants are appointed via an interview process and asked to rank the nine academic foundation programmes in order of preference.

Appointments are subject to applicants obtaining above the minimum national score for allocation to foundation training

If there are academic programmes remaining, on completion of the allocation process, these programmes are relocated to the main foundation recruitment process for preferencing by all successful applicants to Northern Ireland.

3.2 Standalone Foundation Trainees

Standalone F2 one year posts are normally advertised in Spring and the number of vacancies is variable. Further information can be found at
http://www.foundationprogramme.nhs.uk/content/applicant-guidance

4. Specialty Trainees

Postings will normally cover a period of six or twelve months at a time (August to February/August) depending on the Specialty School. Post allocation is managed by Head /

Deputy Head of School / Training Programme Directors in conjunction with the relevant School Board or Specialty Training Committee.

Allocations will be reviewed by the relevant School Board before the post start date.

4.1 Core Trainees / Trainees in early years of run through training:

Trainees will normally be posted to a Trust for at least 6 months. For some specialties it may be preferable to allocate to the same unit for the whole 12 months and this will be clearly defined in the relevant specialty section below.

At core level for Specialty Trainees (or run through trainees in the early years of training) all hospitals with approved training posts would be expected to meet the needs of trainees. Due to the range of posts available it may be necessary to design programmes that ensure there is the correct balance of posts (e.g. combining non acute and acute units during a training year).

For core trainees if there are fewer trainees than there are posts this will result in vacancies. The trainee postings will stand as determined by their preferences, but on occasion trainees may need to be reallocated due to exceptional circumstances for example, health issues, service reconfigurations or vacancies.

Where there is an agreed draft of postings available, these will be issued to Trusts by 31 May. Thereafter, updates will be shared with Trusts as changes occur, and as ongoing recruitment is completed and vacancies filled. Remaining vacancies will be notified to the LEPs following review at the relevant School Board.

4.2 Higher Trainees / Trainees in the later years of run through training:

Trainees will normally be posted to the same Trust for 12 months. For some specialties it may be preferable to allocate to two Trusts for each of 6 months.

Specialty trainees need to be able to achieve their curriculum competences during their programme of training. For most trainees it will be possible to achieve all of these requirements within the local training programme. For some very specialised areas of training there may be a need for some of this training to take place outside of Northern Ireland. This will normally be clear at the time of commencing the programme, but on occasions may become apparent during the course of training due to change in requirements, redesign in services or changes in the profile of approved training available in Northern Ireland.

Some trainees may wish to spend a period of time out of programme for research, training or experience, in line with the Out of Programme Policy www.nimdta.gov.uk/trainee-policies-and-guidance.

For Higher trainees if there are fewer trainees than there are posts this will result in vacancies. The trainee postings will normally stand as determined by the original postings process but on occasion trainees may need to be reallocated due to exceptional circumstances for example, health issues, service reconfigurations or vacancies.

Where vacancies are identified after trainees have been allocated to the most suitable posts for their training, if this is confirmed more than 4 months in advance it may be appropriate to carry out a recruitment process to fill these posts with LATs. If it is not felt to be appropriate for NIMDTA to carry out this process then the LEPs will be notified to allow them to recruit to these posts as LAS appointments.

Where a trainee is involved in an ongoing investigation, e.g. LEP or GMC, it may be necessary for the trainee to remain in their current post rather than move to their next post, in accordance with the Learning and Development Agreement and with advice from the Trainee Review Group.

Trainees who have completed their training and are in an approved six month Period of Grace placement will be distributed across Trusts.

The numbers of vacancies at Core or Higher level are reviewed at the Hospital Specialty Training Committee (HSTC).

5. Specialty Schools

5.1 School of Anaesthetics & Intensive Care Medicine

- Allocations are made annually, and trainees are given placements for 2 x 6 months or 1 x 12 months. The rotations are devised by the Head and Deputy Head of School and shared with the School Board to ensure a balance of specialties and locations.
- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs.
- All trainees are provided with a proforma asking for their training requirements. New trainees are allocated to their specialty based on their preferences and rank at interview.

5.2 School of Diagnostics

Radiology

- Allocations are made annually and are confirmed again at 6 months, particularly if there are any changes in the training requirements of a trainee.
- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs.

Pathology

- Allocations in Histopathology are made on an annual basis and are confirmed again at 6 months. Histopathology trainees are employed by the Belfast Trust. They will normally spend two 6 month attachments outside the Belfast Trust, in Craigavon, Antrim, Altnagelvin, but will remain employed by the Belfast Trust during this period.
- Placements outside the Belfast Trust are allocated primarily on trainee preference and training needs.
- Perinatal/Paediatric Pathology services for Northern Ireland are now provided by Alder Hey Children's Hospital and trainees will be required to complete a 2 week training attachment during either ST1 or ST2 to fulfil curricular requirements. Falling numbers of suitable autopsies locally have also necessitated training attachments in units in Wales and or in Kent for periods of 2-4 weeks. These are usually completed in ST1/ST2; training in Kent may also occur at the start of ST3.

5.3 School of Emergency Medicine

- Allocations are made annually, and trainees are given placements for 2 x 6 months or 1 x 12 months. The rotations are devised by the Head and Deputy Head of School and shared with the School Board to ensure a balance of specialties and locations.
- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs.
- All trainees are provided with a proforma asking for their training requirements. New trainees are allocated to their specialty based on their preferences and rank at interview.

5.4 School of Medicine

Internal Medical Training

- The rotations are devised by the TPD/Deputy Head of School to enable trainees to gain the competencies across the 2 or 3 year training programme.
- Applicants to Internal Medical Training are required to submit preferences for placement as part of the recruitment process. Successful applicants are advised of two years of their rotation at the time of receiving an offer.
- All trainees will be placed for 12 months within one of the five HSC Trust areas.
- All rotations will include 4 months of geriatric medicine during IMT1 and 3 months of ICU during IMT2.

- Trainees will be assessed as to whether they have met requirements to progress from IMT2 to IMT3 in keeping with national guidelines during their IMT2 year.

- IMT3 will be two 6 month rotations in the same trust where the trainees will gain experience in working at the level of a medical registrar out of hours.

Higher Medical Training – ST3+

- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director / Head of School, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs

- Trainees in immunology, haematology, medical microbiology and chemical pathology may spend periods of approximately 3 to 6 months outside the Belfast Trust and will remain employed by the Belfast Trust during this period.

- Trainees in Immunology are based in one Trust throughout the programme, however they may be seconded to other services in order to meet curricular requirements

- Where gaps occur in the rotation the Neurology Specialty Training Committee will review where they should be distributed to. In this situation the STC will need to consider how trainees are allocated to best protect and maximise training. This may require minimising gaps in the Belfast Health and Social Care Trust. Any further trainees appointed will be allocated to the remaining training units. This may need to be on a rotational basis.

Public Health Medicine

- Trainees are employed by and allocated to the four area offices of the Public Health Agency (PHA) but may spend periods of time outside of the PHA to include QUB, Northern Ireland Cancer Registry, Institute of Public Health Ireland, DHSSPS and RQIA.

- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs

- Placements are reviewed annually and the duration of the placement is dependent on the project undertaken by the trainee.

5.5 School of Obstetrics & Gynaecology

- Allocations are made annually, and trainees are given placements for 2 x 6 months or 1 x 12 months. There are designated training posts for core (ST1-2), intermediate (ST3-5) and higher level trainees (ST6-7). Trainees are expected to rotate through all 5 Trusts throughout the run through programme. Allocations are decided based on training requirements and previous allocations.

- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director / Head of School, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum.

- ST1 trainees are allocated to a Trust based on their preferences and final score at interview.

- All trainees are provided with a proforma requesting preferences and their training reasons for choosing these preferences.

5.6 School of Paediatrics

- All current trainees are provided with a “Posting Preference” proforma in February/ March of each year to state their post preferences for the ensuing training year and the training reasons for choosing those preferences. However trainees can discuss training needs with the Training Programme Director / Head of School, at any time.

- Trainees are expected to have read the Paediatric Training Prospectus in order to help them determine where best to meet their training needs. This is available at: http://www.nimdta.gov.uk/specialty-training/specialty-schools/paediatrics-and-child-health/

- Allocations are made for 6 months at a time, with the exception of incoming ST1s who are allocated for a period of 12 months. Trainees are allocated to specific posts based on their training needs, as reflected within the curriculum, but also in recognition of the service demands and patient safety needs of each training unit. Trainees will be placed in each of the five Trusts, at least once, during their training in Northern Ireland.

- Incoming ST1 trainees are provided with a “Posting Preference” proforma after successful appointment to the program. Trainees are allocated to a 6 month placement in one of Antrim, Altnagelvin, Craigavon or Ulster Hospitals and a 6 month placement in RBHSC, which includes a compulsory 3 month attachment in the Paediatric Emergency Department. The ST1 placements are allocated in order of ranking/final score at interview i.e. the highest ranked trainee will be given their first choice and the second highest ranked trainee will be given their first or second choice based on availability, etc.

- Trainees must spend at least 6 months in the Regional Neonatal Unit, RJMS during ST2 or ST3, in order to meet the compulsory clinical experience requirements of the Level 1 RCPCH curriculum. During ST2 and ST3, trainees will also have options to do general paediatrics in each of the five Trusts and limited opportunities for paediatric sub-specialties (including community paediatrics), in RBHSC/Belfast Trust.

- In ST4-5, trainees must complete 6 months of neonatology in the Regional Neonatal Unit at RJMS, 6 months in community paediatrics and a minimum of 6 months in general paediatrics, in order to meet the compulsory clinical experience requirements of the Level 2 RCPCH curriculum. There is limited availability of the compulsory Level 2 posts in neonatology and community child health. The Head of School/TPD may therefore have to allocate ST4-5 trainees to one of these compulsory posts at a time other than the trainee’s expressed preference, in order to maintain the overall Level 2 training program.

- ST6-8 trainees who are pursuing a General Paediatrics CCT, will be facilitated training according to their individual career choices. This would normally be a combination of general paediatrics and a number of sub-specialties, depending on availability. Those trainees who wish to follow an RCPCH SPIN module curriculum during Level 3 training period, must meet with the Head of School/TPD, before entry into Level 3 or soon thereafter, in order to determine whether delivery of the SPIN curriculum is possible or not.

- Those trainees who wish to follow one of the RCPCH National Grid subspecialty training programs, must meet with the Head of School/TPD, before entry into Level 3 or soon thereafter, in order to ensure eligibility for entry into the chosen National Grid program. The RCPCH National Grid subspecialty training programmes are recruited and managed by the RCPCH directly.

- Currently, Northern Ireland has RCPCH approved National Grid programs for Neonatology, Paediatric Emergency Medicine, Paediatric Respiratory Medicine and Community Child Health. If these posts are unfilled by National Grid trainees, they are absorbed into the Paediatric Training Programme and trainees may be allocated to these placements.

5.7 School of Psychiatry

- Allocations are made annually, core trainees are allocated to 2 x 6 month placements and higher trainees are allocated for 12 months. The rotations are devised by the Head and Deputy Head of School taking all trainees preferences into account.

- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs.

- All trainees are provided with a proforma requesting preferences.

5.8 School of Surgery

Core Surgical Training

- The rotations are devised by the CST TPD/Deputy Head of School to enable trainees to gain the competencies across the 2 year training programme. Hospitals are paired with specialty posts in the Belfast area where possible as it provides a spread of training opportunities.

- Applicants to Core Surgical Training are required to submit preferencing of placements as part of the recruitment process. Successful applicants are advised of their first year rotation (2 x 6 month posts) at the time of receiving an offer.

- Current trainees are provided with a proforma requesting preferences for their CT2 year.

Higher Surgical Training

- Higher surgical specialty allocations are made annually and normally consists of two six month placements in the following specialties: General Surgery, Trauma & Orthopaedics, Urology, ENT, OMFS, Vascular Surgery, Ophthalmology
- Allocations are reviewed twice per the year and trainees will normally rotate every 6 months, but may be based on one site for a year
- Current trainees within the training programme will have the opportunity to discuss training needs in advance with their Training Programme Director, at their ARCP panel and are allocated based on their training needs, as reflected within the curriculum. Trainees currently within the training programme will normally be placed in advance of newly appointed trainees to address their training needs
- Trainees in the following surgical specialties are based in one Trust throughout the programme: Paediatric Surgery, Cardiothoracic Surgery, Plastic Surgery (with internal rotation in year to a second site), Neurosurgery and Vascular Surgery.

5.9 Broad Based Training

- Trainees will rotate on a six monthly basis through General Practice, Internal Medical Training, Paediatrics and Psychiatry
- Trainees will spend the entirety of their two year Broad Based Training Programme within one of the five HSC Trust areas.
- On appointment to the programme, trainees will be asked to preference the five HSC Trust areas. Allocation will be based on preferences and final score at interview.

5.10 School of General Practice

Further information can be found at http://www.nimdta.gov.uk/trainee-policies-and-guidance/.

The GP director in conjunction with the Associate Directors for GP Specialty Training will confirm 3 year GP Specialty Training programmes on an annual basis. The content of the training programmes take account of the RCGP and GMC requirements for award of a Certificate of Completion of Training in General Practice.

Further information can be found at http://www.nimdta.gov.uk/trainee-policies-and-guidance/.

- Applicants to GP Specialty Training are required to submit preferences for placement as part of the online GP recruitment process. Successful applicants are advised of three years of their rotation at the time of receiving an offer.

- All trainees will be placed in either one of the following posts within their designated HSC Trust Areas:
    - GP ST1 – 3 x 4 monthly Hospital Training posts or 2 x 6 monthly Hospital Training posts
    - GP ST2 – 1 x 6 monthly Hospital Training post and 1 x 6 monthly General Practice Training post.
    - GP ST3 - 12 months in a General Practice Training post

5.11 Hospital Dentistry

- Trainees in the following dental specialties are based in one Trust throughout the programme: Oral Surgery (with rotation through High Street Specialist Oral Surgery practices), Restorative Dentistry/Academic Restorative Dentistry.

6. Special Circumstances

Trainees are given the opportunity to identify any special circumstances which may need to be considered when allocating placements.

Trainees should complete the appropriate special circumstances form and provide the required evidence.

Special Circumstances guidance can be downloaded from http://www.nimdta.gov.uk/trainee-policies-and-guidance/.

All trainees who are not subject to having their postings considered under special circumstances will be treated equally.

7. Opportunity to Review Allocation (for Hospital Specialty Training only)

If a trainee is unhappy with their allocation, they may contact the Head of School, Deputy Head of School or Training Programme Director, as appropriate, to discuss their individual case within 5 WORKING DAYS of receiving their allocation.

If this issue is not satisfactorily resolved following this, an appeal may be made to the Postgraduate Dean or Associate Dean for Hospital Specialty Training. The reason(s) for dissatisfaction must be clearly outlined in writing in advance. The Head/Deputy Head/Training Programme Director will be kept informed of progress as appropriate.

Foundation programme training is based on rank and choice of the applicants and changes without a re-ranking are not feasible.

Appendix 1

NIMDTA Allocation of Placements Template for Specialty Trainees

- Form **must** be completed and returned no later than **[insert date in May]**
- Allocations will be reviewed by lead educators at the School Board on **[insert date/venue]**
- **NIMDTA** is required to notify Trusts before 31 May 2019 and trainees will be informed at the same time
- **All trainees** including those out of programme (OOPC/R/T/E), Academic trainees, inter-deanery transfers, supernumerary, Periods of Grace, Acting-up and Statutory Leave (i.e. Maternity leave or sick leave) need to be included
- **Any** suggested alteration to postings must be communicated to the NIMDTA education management staff by the lead educator for the programme
- Lead Educators should consult the most recent *NIMDTA Allocation of Placements Policy* for details specific to each School and the requirement to discuss educational objectives with all trainees at interim ARCP prior to allocation decisions
- Include any anticipated periods of future leave greater than 2 weeks duration

To be completed by Lead Educator

Specialty: _____

Form completed by (Print):_____

Date:_____

Return to **[email address to be inserted]**

Trainee Name & Grade (ST)	7 Aug 19 – 4 Feb 20	5 Feb 20 - 4 Aug 20	LTFT (%)	Comments (e.g. Post sub-specialty, Supernumerary or Academic Trainee, etc.)	For office use only

Trainee Name & Grade (ST)	Dates of anticipated leave greater than 2 weeks duration	
	7 Aug 19 – 4 Feb 20	5 Feb 20 - 4 Aug 20

POLICY DOCUMENT

Professional Support Unit Policy

Version 3.0 February 2021

Policy Review Schedule

Date first Approved by the QMG: September 2017

Last Approved by the QMG: September 2017

Date of Next Review: March 2023

Policy Owner: Dr Camille Harron

Amendment Overview

Version	Date	Pages	Comments	Actioned
1.0	Sep 2017	24	New policy replacing Management of Trainees Requiring Support.	E Fugard
2.0	May 2018	15-16	PSU Committee ToR removed, separate document created	G Dennison
		18-20	TRG ToR removed, separate document created	G Dennison
		23-24	Trainee Support Meeting Proforma updated	G Dennison
		9	Addition of PSU Team Case Review Meeting	E Fugard
3.0	February 2021		Complete policy review	C Harron

Table of Contents

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Policy Influences

This policy has been influenced by the following:

- Department of Health, Social Services and Public Safety on *'Maintaining High Professional Standards (MHPS): A framework for the handling of concerns about doctors and dentists in the modern HPSS'*
- Reference Guide for Specialty Training in the UK *(The Gold Guide - 7th Edition)*
- UK Committee of Postgraduate Dental Deans and Directors (COPDEND) *(Dental Gold Guide)*
- GMC – Good Medical Practice
- GMC – Raising Concerns
- GDC – Standards for the Dental Team
- Data Protection Act: Schedules 1, 2 and 3
- Freedom of Information Act 2000
- Health Education Southwest Postgraduate Medical Education Peninsula & Severn Professional Support Unit. "Professional Support Unit Policy and Trainee Support Guide"

Policy Impact

This policy may have an impact on the following:

- Local Education Providers – Policies and Procedures in relation to 'Trainees requiring Support'
- Escalation of Concerns Process
- Learning and Development Agreement
- Bullying and Harassment Policy – Guidance for Doctors and Dentists in training
- Whistleblowing Policy

1. Aim of the Policy

The policy has been written with a view to defining consistent procedures for supporting Medical and Dental trainees where there may be challenges to training progression. The aims are to promote early identification of such trainees, provide a clear structure for addressing concerns, and ensure that trainees are provided with appropriate support.

This policy has been developed by the Northern Ireland Medical & Dental Training Agency (NIMDTA) Professional Support Unit (PSU) and should be referred to in combination with the **Guide for Educators: Trainees Requiring Additional Support**

2. Scope

This policy applies to all Medical and Dental Postgraduate trainees enrolled on a NIMDTA Training Programme .

This policy is designed to provide guidance and information for those who are involved in supporting trainees at various levels, including:

- NIMDTA Educators and Educational Management staff
- Directors of Medical Education
- Specialty (College) Tutors
- Training Programme Directors and Foundation Programme Directors
- Heads and Deputy Heads of School
- GP Educators and GP Trainers
- Dental Educational Supervisors
- All Recognised Trainers

3. Identification of Trainees Requiring Additional Support

- It is important to identify trainees needing specific help and support as early as possible. Early identification and intervention is in the best interests of patients, the trainee and the whole clinical team. (Further guidance can be found in the **Guide for Educators: Trainees Requiring Additional Support**) http://www.nimdta.gov.uk/professional-support/mgt-of-trainees-req-support/psu-policies-and-guidance-documents/
- Regular assessment of a trainee's performance by the Educational Supervisor (Recognised Trainer) is an important opportunity to identify and deal with the majority of problems in a timely fashion within the trainee's current educational setting.

4. Escalation of Concerns

- Most concerns can be managed at a local level within the practice setting (e.g. ward, department, GP practice etc.). If a problem is serious or remains unresolved it should

be escalated to NIMDTA by email professionalsupport.nimdta@hscni.net or telephone 028 9536 0224.

- If the problems have implications for progress in training, advice should be sought from an appropriate Lead Educator:
    - Medical Foundation Trainees: Foundation Programme Director
    - Specialty Trainees: Training Programme Director or Head/Deputy Head of School
    - General Practice Trainees: GP Programme Director or Associate Director
    - Dental Foundation Trainees: Dental Training Programme Director or Adviser
- Many problems will be resolved by intervention at this stage with the support of the appropriate individual within NIMDTA who will work with the Educational Supervisor to assess the training needs of the trainee, ensure that the trainee is appropriately supervised and agree a remedial educational plan.
- If the concerns remain unresolved, despite remedial action and with no evidence of improvement, the trainee should be further escalated to NIMDTA's Head of Department (Senior Educator):
    - Foundation Trainees: Director of Foundation Training
    - Specialty Trainees: Director of Hospital Specialty Training
    - General Practice Trainees: Director of GP Training
    - Dental Trainees: Postgraduate Dental Dean and Associate Postgraduate Dental Dean
- The Head of Department will determine whether the trainee needs to be referred to the Professional Support Unit (PSU).
- Where the trainee is the subject of a formal investigation and there is a serious or immediate risk to patients, or where there are concerns about the trainee's health or well-being the trainee should be automatically referred to the Professional Support Unit (PSU) for pastoral support (in addition to informing the Postgraduate Medical Dean).
- All trainees who have been referred to the PSU and who have been seen at a one-to-one meeting will be discussed at a monthly PSU Triage Meeting. This meeting will require the attendance of at least 2 PSU educators and will be chaired by the Associate Dean for Careers and Professional Support or their nominated deputy.
- Administration of the meeting will be serviced by a member of the PSU team. In addition to triage, trainees will be categorised as requiring discussion at the Trainee Review Group (TRG New Referral), PSU Active (receiving ongoing services from PSU), TOI (requiring a Transfer of Information when rotating post) or inactive. The PSU active list and TOI lists will also be reviewed for an update on trainee status at these meetings.
- Trainee Review Group (TRG) will meet at least 4 times each year. Trainees will be identified for discussion where there are complex or serious issues which would benefit from additional expertise. Trainees will be presented at TRG in a partially anonymised form using trainee initials. TRG will facilitate shared decision making regarding the risk to patient and/or trainee safety, ensure support is provided for the trainee and any appropriate adjustments are put in place. TRG will also decide if a trainee requires ongoing review at TRG (TRG active) or may move to another category on the PSU database (PSU Active, TOI, Inactive).
- If a trainee has been on sick leave for more than six months consideration will be given to arranging a case management meeting with representation from PSU, the training department, the employer and Occupational Health. It is expected that sick leave will be managed in accordance with the employer's policy.

5. Role of the Professional Support Unit in Providing Trainee Support

- The NIMDTA Professional Support Unit is led by the Associate Dean for Careers and Professional Support. Other team members include the
    - Professional Support Clinical Leads
    - Senior Professional Support Manager
    - Professional Support Manager
    - Professional Support Co-ordinator
    - Professional Support Officer
    - Professional Support Administrator
- The PSU provides advice and support to trainers and educators involved in supporting trainees through:
    - 1:1 discussions
    - Educational events
    - Written resources (**Guide for Educators: Trainees Requiring Additional Support**)
    - Web resources
- Trainees may be referred for 1:1 support by an Educational Supervisor or other educator or NHS self-refer. Any trainee who has been issued with an ARCP outcome 2, 3 or 4 should be provided with the contact details for PSU.
- The PSU will advise on types of support that may be helpful. These include:
    - Assessment and monitoring by Occupational Health
    - Workplace adjustments such as the provision of a supernumerary placement or less than full-time training post, a restriction on out of hours commitments or a phased return to work, application for Allocation of Placement for Special Circumstances (Policy available on NIMDTA website)
    - Discussion with educators regarding workplace support
    - Pastoral support
    - Coaching and mentoring
    - Support from the trainee's GP and specialist care
    - Appointment of a mentor
    - Confidential counselling
    - Referral for an Educational Assessment
    - Dyslexia coaching
    - Assessment by NHS Resolution
    - Financial support from charitable organisations such as the Royal Medical Benevolent Fund and the British Dental Association Benevolent Fund
    - Support from the trainee's medical/dental defence organisation
    - On-going monitoring and support from the Trainee Review Group
- The PSU will feedback to the referrer that a meeting has taken place. In addition:
    - For Dental Foundation Trainees, the NIMDTA Dental Adviser will be informed of the meeting.
    - For Medical Foundation trainees, NIMDTA's Foundation team will be informed a meeting has taken place.
    - For Specialty trainees, the referring educator will be encouraged to share the feedback with the relevant Training Programme Director.
    - For GP Trainees, the relevant GP Associate Director will be informed of the meeting.
    - For trainees who are employed by NIMDTA, the Single Lead Employer team will be informed that a meeting has taken place.

- The PSU will update the referrer and relevant training/employment team when a case has moved to TOI or inactive.
- The PSU will escalate for advice to the Postgraduate Medical Dean for doctors and Postgraduate Dental Dean for dentists should a concern be identified which could call into question the Doctor's or Dentist's fitness to practise.
- Acceptance of support from the PSU is voluntary.
- The PSU monitors and quality assures its services through evaluation from users and the training departments
- The PSU gathers demographic data from referrals to inform and direct future service development and for the purpose of equality monitoring.
- The PSU reports to the Senior Management Committee via the Professional Support Committee to ensure on-going service review and development (PSU Terms of Reference).

6. PSU Documentation and Review of Cases

- Each new referral will be logged in a confidential and secure database
- Each new referral will be allocated a member of the PSU team for a 1:1 initial support meeting, identification of actions and ongoing case management (Appendix 2).
- The allocated PSU team member will meet face to face with the trainee on a confidential one to one basis to provide rapid and responsive support for their concerns, analyse those concerns and agree a remedial action plan and follow up arrangements.
- It may be necessary for a Transfer of Information (TOI) to take place if a trainee receiving support is moving to a new practice setting (e.g. hospital Trust, practice etc.). The TOI will take place in line with NIMDTA Transfer of Information Process (see Transfer of Information Policy).

7. Confidentiality

- Data regarding referrals and self-referrals to the PSU will be stored confidentially in line with NIMDTA's Records Management policy.
- Records of trainee meetings, copies of OH reports and educational assessment reports will be password protected when shared by email and stored on the trainee support drive.
- PSU information will be stored separately from the trainee's main Deanery training file and will only be accessed via a secure access server. Access will be restricted to PSU staff.
- The Professional Support Meetings Information Sharing Policy will be applied in relation to any sharing of trainee information (Appendix 3).
- Data may be anonymised and used for audit or quality improvement purposes.
- Numerical data on service use will also be provided as part of an annual report.

8. Ethics and Valuing Diversity

- NIMDTA is committed to ensuring that trainees are treated fairly based on the principles of equality regardless of gender, disability, religious belief, political opinion, racial group, age, marital status or sexual orientation.
- Should a conflict of interest arise for example a member of the PSU knowing a trainee on a personal level, appropriate steps will be taken to ensure that the conflict does not impact on the support provided.

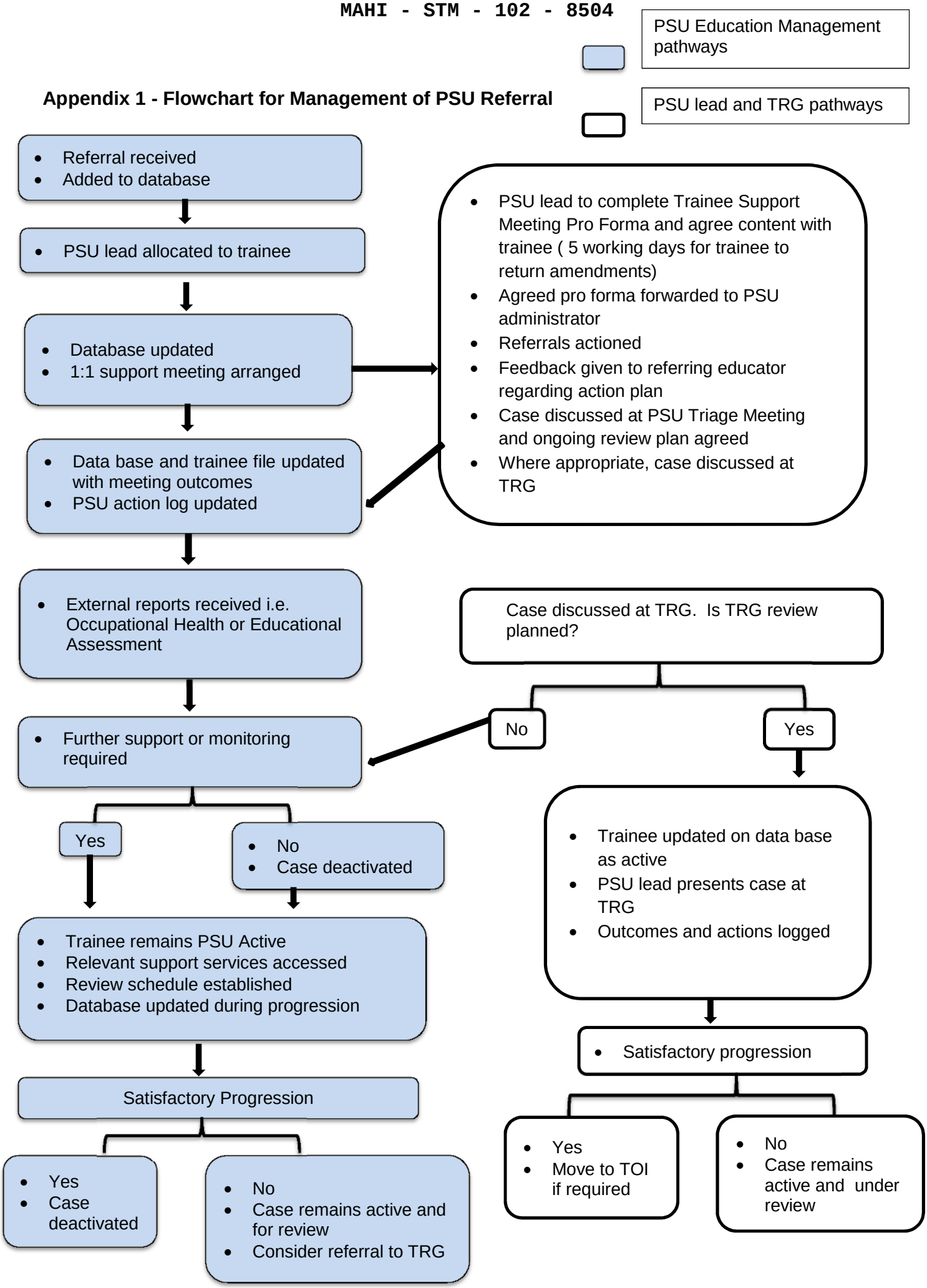
9. Review of policy

- This policy will be subject to review at least every three years by the Trainee Review Group and submitted to the Quality Management Group for approval.
- Any revisions to the policy will take account of changing legislation, best practice and experience gained from managing trainees who need additional help and support.
- All complaints received in relation to the operation of this policy will be reviewed on a regular basis by the Professional Support Committee to ensure that the policy remains fit for purpose and reflects best practice in this area. Complaints will also be reported to the Senior Management Committee by the Senior Professional Support Manager.

10. Dissemination of policy

- All educators and members of staff responsible for supporting trainees with concerns will be made aware of this policy.
- Policy content will be included in education on Trainee Support for trainers and potential trainers.
- Heads of Department will be responsible for keeping staff and educators up to date.
- The policy will be available on the Professional Support Unit pages of the NIMDTA website.

Appendix 1 - Flowchart for Management of PSU Referral



Appendix 2 - PSU Referral Form

An electronic referral template can be found by clicking the link below.
http://www.nimdta.gov.uk/professional-support/mgt-of-trainees-req-support/psu-policies-and-guidance-documents/

Please complete this form by TYPING IN your responses

1. PERSONAL DETAILS			
Trainee Name:			
Trainee Email:			
Level of Training	**FD/F1☐ F2☐ CT/ST/DCT1☐ CT/ST/DCT2☐ CT/ST/DCT3☐** **ST4☐ ST5☐ ST6☐ ST7☐ ST8☐**		
Specialty:		**Sub-specialty:**	

2. REFERRER DETAILS	
Name of Referrer	
Referrer Email:	
Referrer Telephone:	

3. REFERRAL DETAILS			
Reason for Referral:			
Summary of Action Taken to Date:			
Provisional PSU Matrix Code:		**Confirmation that referral has been discussed with the trainee:**	**Yes☐ NO☐**

Once completed, save this form and forward as an e-mail attachment to professionalsupport.nimdta@hscni.net.

Appendix 3 – Professional Support Meetings Information Sharing Policy

One of the aims of the Professional Support Unit at NIMDTA is to provide best practice in supporting postgraduate doctors and dentists in training. As part of the services available, trainees may self-refer or be referred by an Educational Supervisor (Recognised Trainer) for one-to-one support meetings.

These meetings are confidential. A record of the meeting will be taken by a NIMDTA staff member and a summary of the discussion and agreed actions prepared. This summary will be emailed to the trainee for review of the content. A trainee will then be given 5 working days to comment on the content. If no comment is received the summary will be accepted as accurate. The summary is kept in electronic form as part of a professional support file. All documentation is stored in keeping with the principles of the Data Protection Act 1998.

Trainees will be encouraged to share meeting summaries with relevant Educational Supervisor (Recognised Trainer) or NIMDTA Lead Educator. If a trainee does not agree to sharing the summary with a referring educator, the educator will still receive confirmation that a meeting has taken place. Issues which arise as part of a one-to-one support meeting will be discussed as part of a Trainee Review Meeting which takes place regularly at the Deanery. The terms of reference for this meeting may be accessed via the NIMDTA website at https://www.nimdta.gov.uk/professional-support/psrg/

Trainees should also be aware that the interests of patient safety and trainee support can, on occasion, necessitate the transfer of personal information to other health and social care organisations or statutory bodies. This is included in the Educational Agreement for Doctors in Training in the Northern Ireland Deanery.

Any questions about how information is stored or used may be directed towards the Professional Support Unit professionalsupport.nimdta@hscni.net

Appendix 4 – Professional Support Trainee Meeting Pro Forma

Trainee name:		**Specialty:**	
Level of training:		**PSU matrix code:**	
Date of meeting:	Click here to enter a date.	**Notes taken by:**	Choose an item.
Current placement:		**Referral source:**	**Self ☐** **Trainer / Educator ☐**
Name of PSU case lead:	Choose an item.		
In attendance:			

Reason for review / meeting:				
☐ Performance	**☐ Health**	**☐ Conduct**	**☐ Environment**	**☐ Careers**

Meeting Summary

Feedback for Referrer

Support Available (the following support mechanisms were signposted):

☐	Counselling available through Staff care via the Belfast Trust, further information can be accessed at: 0800 7313674 http://www.bwellbelfast.hscni.net/?page_id=1681	☐	Counselling available through Inspire Wellbeing (formerly Carecall) via the Trust, further information can be accessed at https://www.inspirewellbeing.org/workplaces
☐	The availability of potential financial support from the Royal Medical Benevolent Fund: http://www.rmbf.org/		

Referrals to be Actioned:

☐	Mentoring	Please provide details of preferred type of mentor:	
☐	Occupational Health Referral	Trust:	
☐	Educational Assessment	Please detail reason for EA, if exam please provide name of exam, no. of attempts & re-sit date:	
☐	NIMDTA Coaching Service	Please detail coaching topic & approx. date of exam re-sit if applicable:	

☐	Dyslexia Coaching Service	Approximate date for exam re-sit:	
☐	Further Pastoral Support Meeting	Please detail timescale for follow up appointment:	
☐	Careers Advice Meeting	Please detail timescale for appointment:	
☐	Cedar Foundation Referral		

Actions Identified

Belfast Health and Social Care Trust
caring supporting improving together

POSTGRADUATE MEDICAL AND DENTAL EDUCATION MANAGEMENT

Post: Specialty Tutor

Grade: Medical Consultant

Reports to: Director of Medical and Dental Education

Accountable to: Director of Medical and Dental Education
(Belfast Health and Social Care Trust ("the Trust") and Chair of Division)

Job Purpose:

The Specialty Tutor is responsible for the overall management and quality control of the specialty training programme within the Trust. The responsibilities of these posts will vary depending on the specialty area and may encompass some activities on behalf of the Trust and Deanery.

General Responsibilities:

1. To implement, monitor and improve the specialty training programme in the Trust in conjunction with the Director of Medical and Dental Education and NIMDTA.

2. To ensure the programme meets the requirements of the specialty curriculum and that it also complies with the GMC standards for training.

3. To inform and support Clinical and Educational Supervisors to ensure that the specialty placement fulfils the specific programme requirements.

4. To ensure that all trainees have a named Clinical and Education Supervisor who is recognised as a trainer and to forward this information to the Trainers' Administrator in the Postgraduate Education team. It is the responsibility of the Specialty Tutor to decide on the number of trainees allocated to each of the Educational Supervisors.

5. To oversee the progression of the trainees through the programme and to devise a mechanism for delivering co-ordinated specialty induction, educational supervision, pastoral support and career guidance, to enable the trainees to gain the relevant competencies and experience.

January 2023

6. To participate in the School or Specialty Training Committee arrangements as developed by NIMDTA.

7. To contribute to annual assessment outcome process in the specialty.

8. To help manage trainees who require extra support by assisting Educational Supervisors in their assessment process and in identifying remedial replacements where required, in line with Trust policy and in conjunction with Director of Medical and Dental Education and the Postgraduate Dean.

9. To participate in and assist in the preparation for external visits from the Deanery, GMC or any other regulatory or inspection body. To work with the directorate management to complete and implement action plans arising from inspection visits.

10. To assist the DME in the completion of the bi-annual Quality reports, as required. This involves liaising with service management e.g. Chair of Division, Co-Director etc to ensure a timely response to NIMDTA's areas of concern.

11. To promote the good practice and achievements of trainees and trainers in the specialty.

12. To act as a link between the specialty, the Trust's Medical and Dental Education Department and NIMDTA.

13. To participate in the trust Education Committee meetings.

14. To ensure that Clinical and Educational supervisors in their area have an Annual Educational Review to inform their Annual Appraisal.

15. Ensure compliance with the requirements regarding mandatory training for trainers, including Maintaining Recognition requirements, in line with GMC/Deanery guidance

KEY RESULT AREAS

1. Provision of clinical work base programme offering a varied experience appropriate to the Curriculum.

2. To ensure those involved in supervision and assessment are familiar with programme requirements.

3. Clear evidence of the delivery, uptake and effectiveness of learning for training in all aspects of the Curriculum.

January 2023

4. To organise and ensure delivery of the teaching programme based on the Curriculum covering clinical, specialty and generic topics.

5. Attendance at Trust and NIMDTA Education Meetings as appropriate.

6. To ensure Local Induction is provided for all trainees and that trainees comply with trust processes around Induction, including completion of mandatory e-programmes including Training Tracker.

7. Active involvement in recruitment and annual review processes for trainers.

7. Recording of information required by local, regional and national quality control processes and in the provision of a report, if necessary.

8. Support Clinical Supervisors and Educational Supervisors in dealing with the trainees requiring extra support.

January 2023

PERSONAL DEVELOPMENT

Annual review of the role will take place through appraisal and job planning processes. It will be essential to develop an appropriate educational personal development plan to be discussed and approved at the annual education review with the Director of Medical and Dental Education.

PERSONNEL SPECIFICATION

Essential Criteria

- A consultant in the specialty area.
- Possesses valid GMC Recognition of Trainers status.
- Has explicit time in their contract and job plan to allow for the fulfilment of the responsibilities outlined above.
- Experience of an educational role, for example clinical or educational supervisor.
- Demonstrate an understanding of the curriculum for their specialty area.
- Ability to deliver educational appraisal and feedback.
- Competent in trainee assessment methods, including the use of specific in-work assessment tools approved by the GMC for the specialty.
- Willingness to undertake additional training appropriate to role.

Desirable Criteria

- Good IT literacy skills.
- Experience of an educational role, which should be at the level of Education Supervisor or the equivalent.

The PA allocation for this post is approximately 0.5-2 PAs and is agreed in conjunction with service management.

January 2023

Belfast HSC Trust Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role:

RESPECT & DIGNITY

- Being respectful to others
- Showing compassion to those who are suffering
- Acting fairly and even-handed
- Acknowledging the good work of others
- Supporting others to achieve positive results

OPENNESS & TRUST

- Communicating openly and consistently
- Listening to the opinions of others and acting sensitively
- Being trustworthy & genuine
- Ensuring that appropriate information is shared honestly

ACCOUNTABILITY

- Taking responsibility for your own decisions and actions
- Openly admitting your mistakes and learning from them
- Using all available resources appropriately
- Challenging failures and poor practice courageously

LEADING EDGE

- Actively seeking out innovative practice
- Participate in new approaches & service development opportunities
- Share best practice with others
- Promote the Trust as a centre of excellence

MAXIMISING LEARNING & DEVELOPMENT

- Act as a role model for the development of others
- Continuing to challenge my own practice
- Fulfil my own statutory mandatory training requirements
- Actively support the development of others

January 2023

Clinical Supervisor Job Description

For every placement, the doctor in training must have a named clinical supervisor. In some instances, this will be the same person as the educational supervisor.

A **clinical supervisor** is a trainer who is responsible for overseeing a specified trainee's clinical work throughout their placement in a clinical environment and who is appropriately trained to do so. Their role is to lead on providing day-to-day supervision of trainees, reviewing a trainee's progress and providing constructive feedback.

Responsibilities of the Clinical Supervisor

In supporting the delivery of high quality educational supervision, the clinical supervisor has a responsibility to:

1. Be involved with teaching and training the trainee in the workplace
2. Help with both professional and personal development
3. Offer a level of supervision of clinical activity appropriate to the competence and experience of the individual trainee.
4. Support the trainee through direct supervision, close supervision and regular discussions, review of cases and feedback
5. Organise induction to the clinical department (covering duties of the post, particular responsibilities, departmental meetings, senior cover, cross-specialty induction when cross-cover is required, handover arrangements, bleep policies)
6. Agree specific and realistic programme-specific learning objectives appropriate to the level of the individual trainee
7. Meet the trainee within a week of starting the placement and establish a supportive relationship
8. Provide regular review during the placement both formally and informally to ensure that the trainee is obtaining the necessary experience, included supervised experience in practical procedures and give constructive feedback on performance
9. Perform and oversee the work-based assessments detailed in the portfolio
10. Encourage trainee attendance at formal education sessions
11. Ensure a suitable timetable to allow completion of the requirements of the specific curriculum
12. Ensure that relevant information about progress and performance is made available to the educational supervisor to inform the end of placement appraisal and the Educational Supervisor's report
13. Inform the Educational Supervisor should the performance of any individual trainee give rise to concern

Northern Ireland mdta Medical & Dental Training Agency

Educational Supervisor Job Description

For every placement, the doctor in training must have a named educational supervisor. In some instances, this will be the same person as the clinical supervisor.

An **educational supervisor** is defined as:

A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement or series of placements. Every trainee must have a named educational supervisor. The educational supervisor helps the trainee to plan their training and achieve agreed learning outcomes. He or she is responsible for the educational agreement and for bringing together all the relevant evidence to form a summative judgement at the end of the placement or series of placements.

All Educational Supervisors should be doctors who have a clear expressed interest in the training, assessment and development of postgraduate medical trainees.

Role of the Educational Supervisor

All trainees must have a named Educational Supervisor. An Educational Supervisor may be based in a different department and occasionally in a different organisation to the trainee.

Typically no more than 4 trainees may be supervised concurrently by an Educational Supervisor, subject to the provision of appropriate time in a job plan for the provision of educational supervision function as defined in this Agreement.

Responsibilities of the Educational Supervisor to the Trainee

1) Ensure the trainee receives appropriate training and experience
    a. Support the trainee in developing their learning portfolio and evidence of competency
    b. Ensure trainee understanding of and engagement with the assessment process
    c. Ensure trainee completion of workplace-based assessments
    d. Review trainee progress against the curriculum and decide whether placements have been completed successfully
    e. Agree the best use of Study Leave to achieve required competencies and experience
    f. Ensure that the trainee received appropriate career guidance and planning
2) Meet the trainee in private at agreed, protected times in a placement in accordance with curricula requirements to ensure he or she make the expected clinical and educational progress
    a. To conduct an induction interview within the first two weeks of a placement and develop a mutually agreed Learning Agreement and educational objectives and establish a supportive relationship
    b. At mid-point to carry out an appraisal based on the Learning Agreement
    c. At the end to carry out appraisal to inform the trainee's ARCP
    d. Give regular, honest and constructive feedback according to the stage and level of training, experience and competence of the trainee

e. Be approachable and available to a trainee to give advice and guidance on clinical, administrative, organisational and governance issues and to provide opportunity for the trainee to raise issues relating to training and support and manage in accordance with LEP and NIMDTA policies
f. Keep appropriate records of assessments
g. Document all meetings and associated outcomes/actions agreed in the portfolio and review development of the portfolio by the trainee
h. Liaise with others to share information over trainee progression

3) Attend meetings relevant to the education supervision role and disseminate information to a trainee's Clinical Supervisor and the trainee as appropriate
4) Arrange for an appropriate colleague to fulfil the educational supervision role during any period of absences and inform the TPD if a period of absences will extend beyond 4 weeks
5) Undertake a formal handover with the new Educational Supervisor.

Psychiatry Training

PLACEMENT QUALITY REVIEW 2020

Northern Ireland Medical and Dental Training Agency
REPORT COMPILED BY DR K. WALSH & DR S.A. PHILLIPS

Review members

Dr Sally Anne Phillips (Associate Dean for Placement Quality)

Dr Keira Walsh (ST6 Psychiatry, ADEPT Clinical Leadership Fellow 2019/20)

Mrs Gillian Carlisle (Quality & Revalidation Manager)

Dr Ian Steele (Associate Dean for Specialty Training and Quality Management)

Dr Damien Hughes (Head of School, Psychiatry)

Contents

Executive Summary

In Northern Ireland, the percentage of doctors entering directly into GP/specialty training post-Foundation has fallen from 70.9% in 2011 to 31.8% in 2018. (1) Despite this decline, psychiatry training in NI has remained a competitive and attractive specialty with over subscription to both core training and higher training specialties for the last 10 years. (2) This is in contrast to the recruitment and retention of psychiatry trainees in other parts of the UK where an average of 18% of training posts are unfilled. (3) Northern Ireland remains an attractive place to work as a consultant psychiatrist. This is reflected in the lower number of vacant consultant posts in NI in comparison to the rest of the UK, with the Royal College of Psychiatrists 2019 Census reporting a Northern Ireland consultant vacancy rate of 7.47% contrasting with 9.66% in Scotland, 9.91% in England and 12.74% in Wales.

Trainees working in Psychiatry in Northern Ireland work in all five Health and Social Care Trusts. They work across six psychiatry sub-specialties: Child & Adolescent, Forensic, General Adult, Intellectual Disability, Old Age and Psychotherapy. Trainees can work in a variety of settings such as inpatient units, outpatient teams, specialist teams or a combination. In addition to core and higher psychiatry trainees, Foundation Year 2 (FY2) and GP trainees also complete rotations in psychiatric specialties. Rotations are for a minimum of 4 months (usually FY2/GP trainees) and a maximum of 12 months (usually higher trainees).

The Placement Quality (PQ) Review of Specialty Training Programmes started in August 2018. The aim of this work is "*To optimise patient-centred care though quality improvement of medical training posts within Northern Ireland, involving rigorous review of current placements, active engagement with trainees, trainers and providers, and the development and implementation of strategies to improve current practice within medical training*." The PQ review adds to the existing information available from NIMDTA deanery visits and the GMC National Training Surveys (NTS), providing a more detailed specialty specific assessment of the quality of training posts in Northern Ireland.

A PQ Review of psychiatry training was completed in 2019/20. The first step in the process was to review the current psychiatry training curricula and educational framework to confirm the requirements for training in psychiatry. A group of psychiatry trainees met with the Placement Quality team to compile a detailed survey to assess the quality of training placements. This was approved by the Head of School for Psychiatry and the Specialty School Board at NIMDTA. The survey was circulated to all trainees working in a psychiatry placement between February and August 2019, including Foundation Year 2, GP and psychiatry trainees (core and higher). The survey was open for three weeks in July 2019. The response rate was 50% (74/149) which represented 36% core psychiatry trainees, 34% higher psychiatry trainees and 30% F2/GP trainees.

Section 1 of this report summarises the results of the survey under the following headings:

1. Post Preferences, Rota Allocations and Induction
2. Educational and Clinical Supervision
3. Clinical Workload
4. Formal Teaching and Educational Opportunities
5. Overall Opinions and Trainee Suggestions for Improvement

Section 2 highlights the identified good/transferrable practice and sets out the agreed local actions for improvement.

To ensure improvements are maintained and to assess the success of additional measures that have been introduced to further improve the training experience, the Placement Quality Team at NIMDTA will be conducting a further survey of all trainees in psychiatry training placements in late 2020.

Section 1: Analysis and Recommendations

1. Post Information, Rota Allocations and Induction

Post Information

Additional information about training posts prior to making placement preferences was requested by 61% of trainees. This included more information on rota patterns, banding, special interest sessions, opportunities for emergency assessments, ECT and tribunal experience and departmental teaching arrangements (Table 1).

Table 1: Information requested prior to making posting preferences (% of trainees)

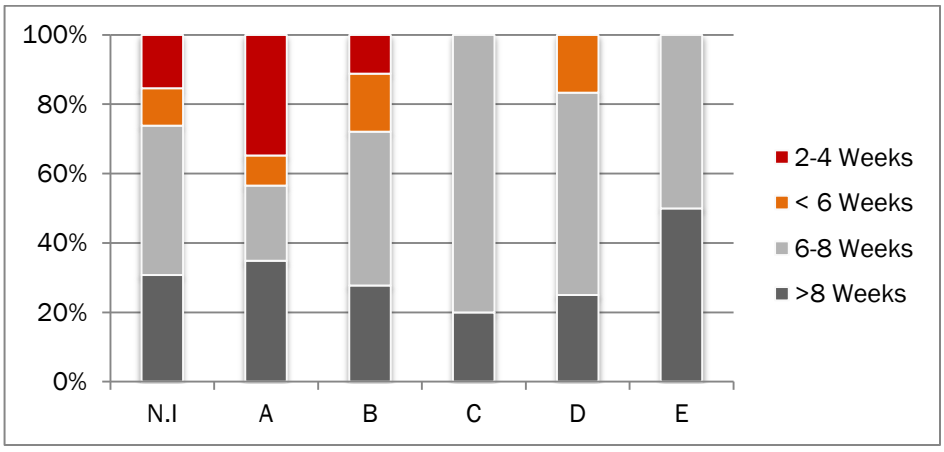
Rota Pattern	27%
Opportunities for Tribunal experience	21%
Opportunities for ECT experience	19%
Banding	19%
Departmental Teaching arrangements	19%
Special Interest Sessions available	15%
Opportunities for Emergency assessments	13%

Rota Allocations

It is a requirement of the Learning and Development Agreement between NIMDTA and Local Education Providers (LEPs) that information relating to the allocation of trainees within training programmes is provided to LEPs 8 weeks in advance of the changeover date. [5] Trainees are notified by NIMDTA of their post allocation at this time and Trusts are then required to inform trainees of their out of hours (OOH) rota allocation at least 6 weeks before the commencement of their post. [6]

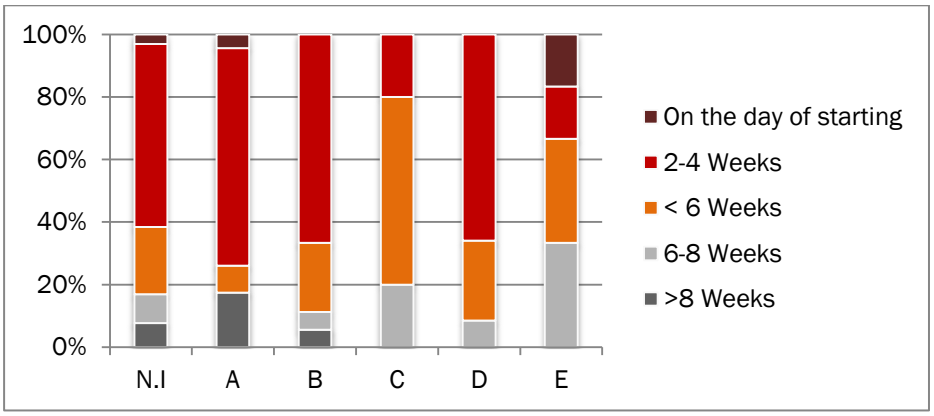
The majority of trainees (74%) reported receiving notification from NIMDTA of the Trust where they would be working at least 6 weeks prior to starting their post, with 31% getting more than 8 weeks' notice. Regionally however 15% had less than 4 weeks' notice. In Trust A, although 35% of trainees reported having less than 4 weeks' notice of their posting it has been confirmed that all trainees were emailed confirmation of their posting to the Trust more than 8 weeks prior to post commencement and the survey response to this question may reflect the later allocation of posts within the Trust.

Figure1: NIMDTA notification of training placement by Trust



Trainee feedback indicated that timely notification by Trusts of OOH rotas is a significant problem with only 17% of trainees receiving information about their OOH rotas at least 6 weeks prior to post commencement. The majority of trainees (72%) reported less than 4 weeks' notice of their OOH rota with 25% having less than 2 weeks' notice prior to starting their post. There was some variation across Trusts, with rota notification in Trusts A, B and D being significantly later, less than 4 weeks' notice of OOH arrangements being reported by 70%, 67% and 65% of trainees respectively. In comparison in Trusts C and E only 20% and 17% of trainees respectively had less than 4 weeks' notice of their OOH rota (Figure 2).

Figure 2: Trust notification of OOH rotas by Trust



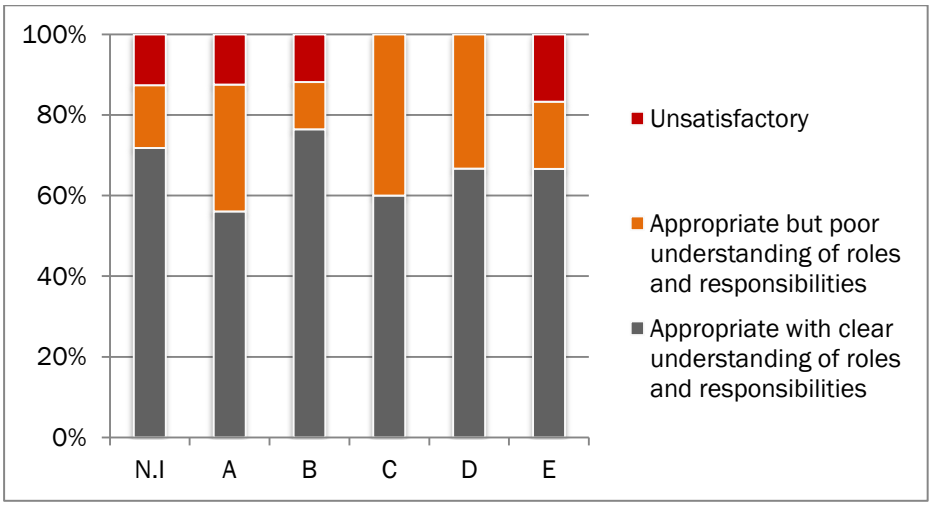
A number of factors were identified that appear to contribute to the delay in rota notification. Trainee post allocations are made by the School of Psychiatry to a Trust and not to a specific hospital site/training post. When Trust Human Resources (HR) are notified by NIMDTA of trainee allocations the Lead Educational Supervisor (ES) then has to assign each trainee to a specific site/post within the Trust. Delays can occur at this point due to the ES not being notified of trainee allocations at the same time as the Trust HR and a lack of provision to the ES of information relating to the specific training requirements of each trainee, needed to make appropriate post allocations.

Induction

The GMC's Promoting Excellence sets out the requirements for Trusts to provide an induction at the start of a placement with clearly defined aims. [6]

The majority of trainees (72%) reported that their induction to their placement was appropriate, providing a clear understanding of their roles and responsibilities. In Trusts A, B and E induction was reported as unsatisfactory or did not occur by 17%, 12% and 17% of trainees respectively (Figure 3). Further analysis indicated that 50% of those who felt that their induction did not provide them with a clear understanding of their roles and responsibilities were GP trainees.

Figure 3: Departmental/Unit Induction by Trust



Key Recommendations: Post Information, Rota Allocation and Induction

Development of a Unit Prospectus for all Psychiatry training sites

Trusts to review induction process for GP specialty trainees in psychiatry training posts

Trusts to provide all trainees with information of their OOH rota at least 6 weeks prior to start of post

2. Educational and Clinical Supervision

Educational Supervision

Both quality of and access to educational supervision was rated very highly with 77% of respondents rating the quality of supervision from their Education Supervisor (ES) as excellent/above average and 85% reporting excellent/above average access to their ES (Figures 4 and 5).

Figure 4: Quality of Education Supervision by Trust

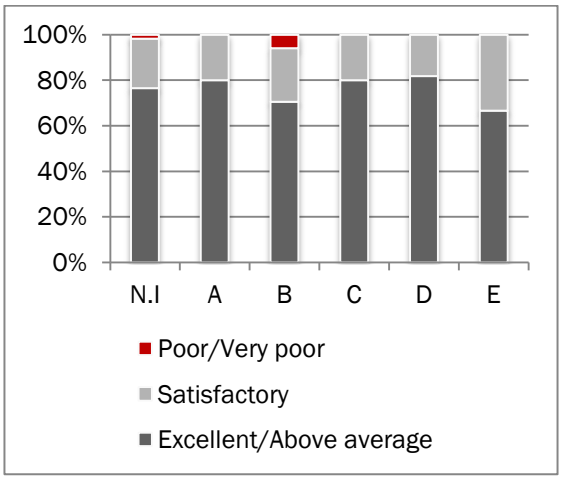
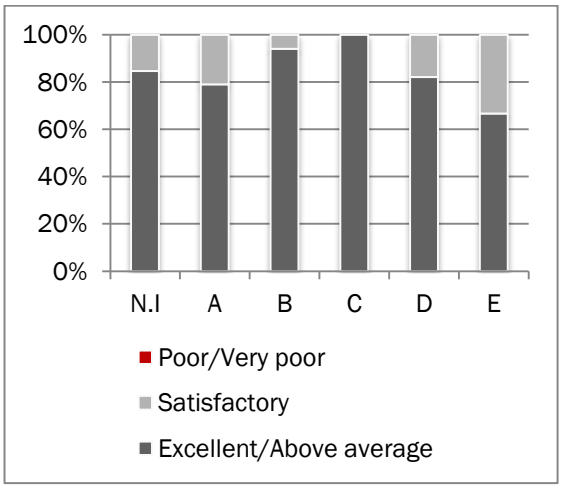


Figure 5: Access to Education Supervisor by Trust



In Trust B one trainee reported the quality of their education supervision as poor: further analysis showed this to be a GP specialty trainee, and this feedback related to an ES from general practice.

Trainee free text comments include:

"Always available and made time for me"

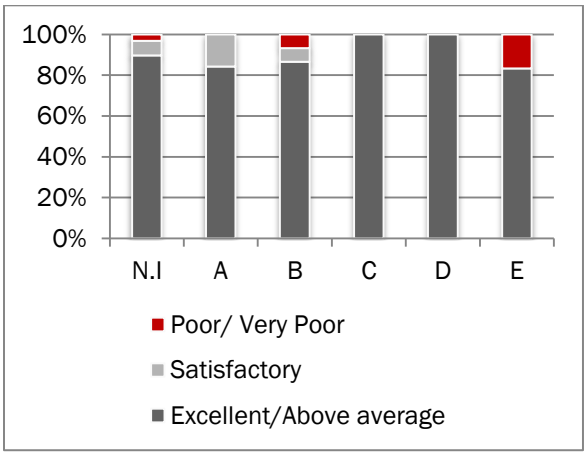
"Approachable at all times. Helpful. Provided scheduled supervision sessions where I had opportunities to discuss my progress and raise concerns."

Clinical Supervision

The majority of trainees rated the quality of their clinical supervision as excellent/above average (81%) with 81% also reporting access to their Clinical Supervisor (CS) as excellent and an additional 9% as above average(Figures 6 and 7).

Figure 6: Quality of Clinical Supervision by Trust

Figure 7: Access to Clinical Supervisor by Trust



When asked to rate the quality of senior clinical supervision during normal working hours the number of trainees reporting clinical supervision as excellent/good was 76% overall with this number falling to 53% for clinical supervision out of hours (Figures 8 and 9). In Trust A and Trust E the quality of senior clinical supervision remained high regardless of day time or out of hours working. Trust D however had the largest drop in the quality of clinical supervision decreasing from 82% excellent/good during normal working hours to 27% out of hours, although all respondents indicated that clinical supervision was at least satisfactory.

Figure 8: Quality of Clinical Supervision during normal working hours by Trust

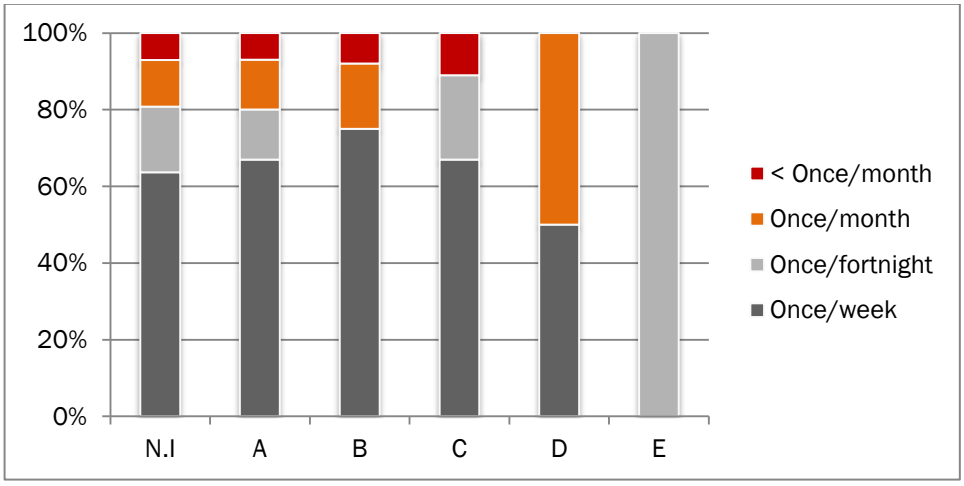
Figure 9: Quality of Clinical Supervision out of hours by Trust

Protected Clinical Supervision

One hour per week of 1:1 protected clinical supervision is mandated in the Psychiatry curriculum for all core and higher trainees as "a key to developing strategies for resilience, well-being, maintaining appropriate professional boundaries and understanding the dynamic issues of therapeutic relationships" and clinical supervisors are required to have protected time within their job plans to deliver this. [7]

Regionally only 63% of trainees reported receiving the mandated 1 hour per week of protected clinical supervision, with 17% receiving 1 hour every fortnight and 20% reporting that protected clinical supervision occurred only once a month or less (Figure 10). Of those reporting protected clinical supervision time of once a month or less, 75% were core specialty trainees.

Figure 10: Protected Clinical Supervision Time by Trust (Core and Higher Psychiatry trainees)



There was variation in results between Trusts, with Trust B delivering the mandated protected clinical supervision time to over 70% of trainees, while in Trusts D and E results were significantly below the regional figures. In Trust D only 50% achieved the mandated 1 hour per week of protected clinical supervision with 50% reporting this occurred only once a month. In Trust E no trainees received the mandated 1 hour per week of protected clinical supervision but all trainees reported that this occurred at least once a fortnight.

Key Recommendations: Educational and Clinical Supervision

An ongoing commitment to deliver high quality educational and clinical supervision is evidenced by trainee feedback across all training units in the School of Psychiatry. These high standards are to be commended. The need for attention to regular provision of the mandated one hour per week of protected clinical supervision is highlighted in some areas.

Ensure that all psychiatry specialty trainees receive 1 hour per week of protected clinical supervision

3. Clinical Workload

Regionally trainees reported a well-balanced workload during the day with 73% indicating that the workload was just right. In Trusts A, B and C the majority of trainees reported the workload at night was appropriate but in Trusts D and E, 36% and 50% respectively reported workload at night as very intense/excessive above the regional figure of 14% (Figures 11 and 12).

Figure 11: Daytime Workload by Trust

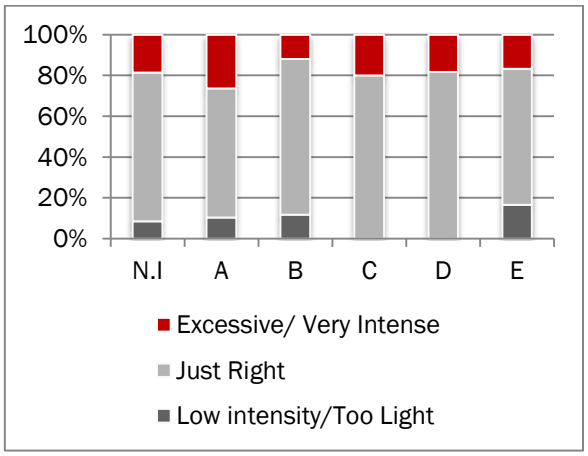
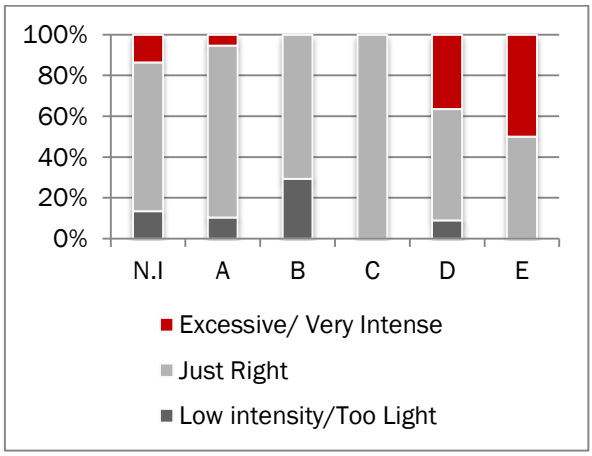
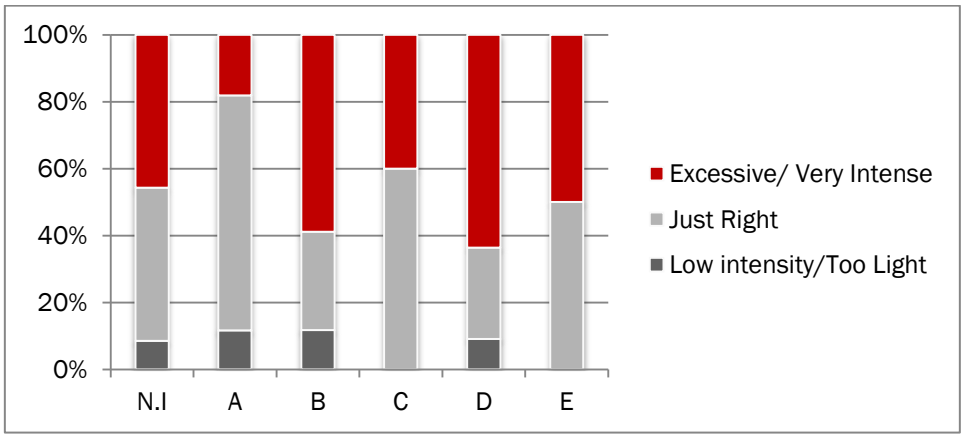


Figure 12: Workload at Night by Trust



At weekends workload intensity was higher with 46% of trainees regionally reporting workload as very intense /excessive. In Trusts B, D and E the figures were above the regional average with 59%, 64% and 50% of trainees respectively indicating that the workload at weekends was excessive (Figure 13).

Figure 13: Workload at Weekends by Trust



In Trust B there is a 1 in 15 on-call rota pattern covering two sites and 2 trainees from this Trust work OOH on the Belfast CAMHS rota covering multiple sites. In Trust D it was acknowledged that the OOH workload particularly at weekends can be busy with limited support from staff grades who do not work OOH or at weekends. As in Trust B, it was noted that one trainee does not work in the Trust OOH but works on the Belfast CAMHS rota. In Trust E there is a single 1 in 15, twenty four hour on-call rota. In Trusts B, D and E consideration had been given to changing the rotas to a 2 person 1 in 7 or 1 in 8 shift pattern to reduce workload intensity OOH and at weekends, but this option had been rejected by trainees who preferred to continue with the more onerous but less frequent current on call system.

Key Recommendations: Workload

Core Trainees: All OOH and weekend work should be in the Trust where the trainee works during normal working hours

Higher Trainees: When OOH and weekend work is outside the base Trust, appropriate induction to these sites, including provision of IT and security access must be in place

4. Formal Teaching and Educational Opportunities

Formal Teaching

Regionally, 60% of trainees reported receiving 3 hours of protected (bleep free) training time per week, with this figure reaching 75% in Trust A (Figure 14). A further 27% of respondents stated that they received 1 hour per week of protected training time. In Trust C however the results were significantly below the regional average with only 20% of trainees receiving the recommended 3 hours per week of protected training and a further 20% reporting receiving less than 3 hours per month.

Figure 14: Protected (bleep free) Teaching by Trust

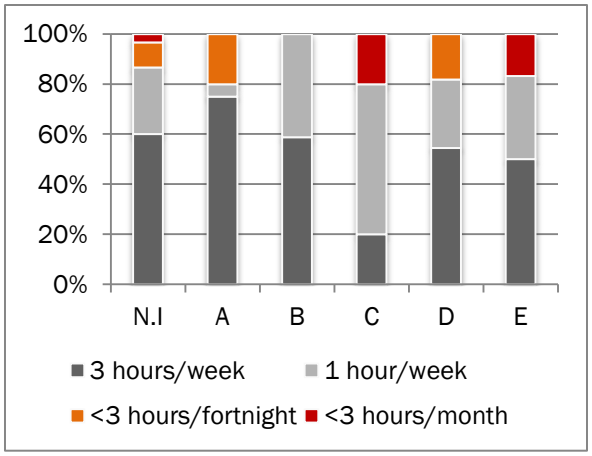
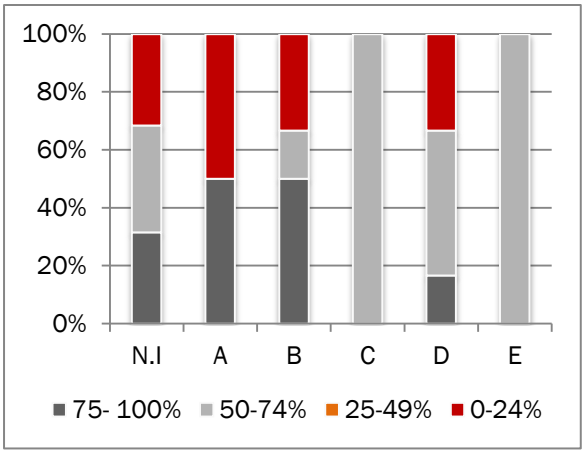


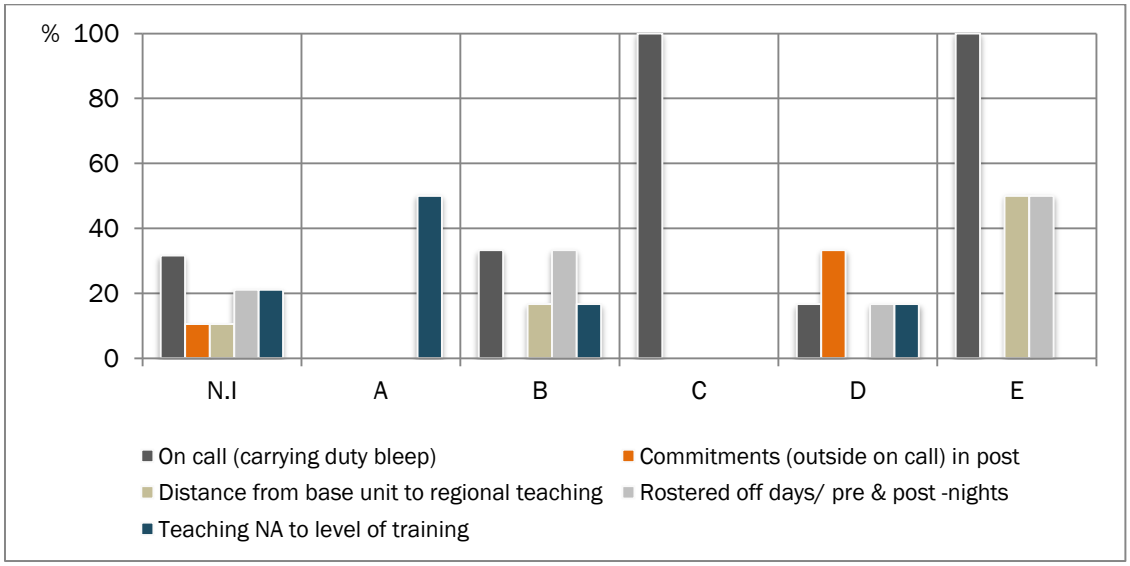
Figure 15: Regional Teaching sessions, annual attendance by Trust



Attendance at **regional teaching** was good with 68% of respondents being able to get to over half of all regional teaching sessions and 32% attending 75-100% of sessions (Figure 15). Around a third of trainees however reported that they had attended less than 25% of sessions. This figure corresponded to the number of trainees who indicated that attendance was not applicable to their level of training – identified as CT3 trainees, who having passed their MRCPsych examination did not need to attend.

For the remainder of trainees, the main barriers to attendance at regional teaching were reported as on call commitments, commitments in post, distance from the base unit to the site of teaching and being pre or post–nights. (Figure 16)

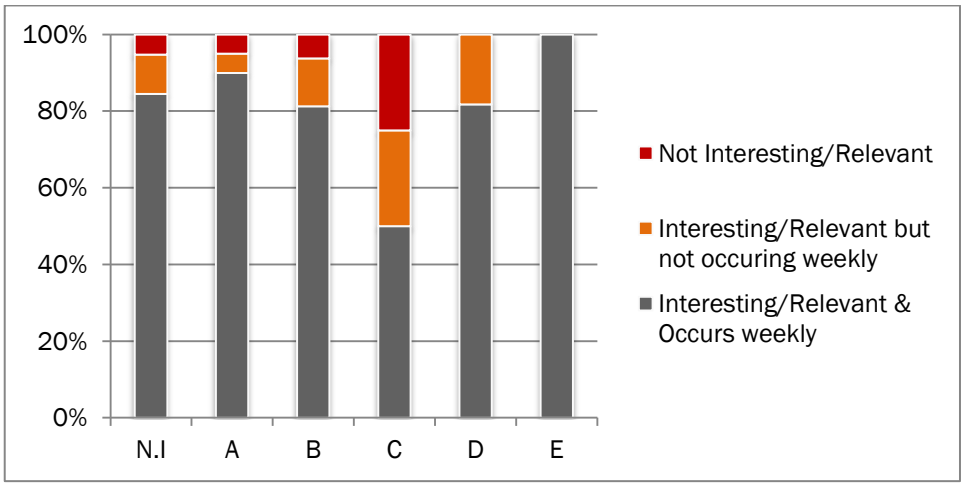
Figure 16: Barriers to attendance at Regional Teaching by Trust



Consultant attendance at regional teaching was high with 75% of trainees indicating that a consultant was always/usually present and 79% reporting that regional teaching was interesting /relevant and occurred weekly.

The quality of departmental teaching was also rated very highly, with 95% of respondents reporting it as interesting and relevant and 85% indicating that it occurred regularly on a weekly basis (Figure 17).

Figure 17: Quality of Local Departmental Teaching by Trust



As with regional teaching there was a notably high consultant attendance at departmental teaching, 96% of trainees indicating that a consultant was always/usually present.

Educational Opportunities

Access to and qualities of training opportunities (TOs) were rated highly by trainees across a number of key areas.

Access to training opportunities for the **acute care of serious mental illness (SMI)** and the **management of chronic mental health (MH) conditions** were rated as excellent/good by 78% and 84% of respondents respectively; the quality of training in these areas being reported as excellent/good by 94% and 97% of trainees (Figures 18 and 19). There was some variation between Trusts, with the quality of training in this area being rated as excellent/good by all respondents in Trust E while in Trust C, although all training was rated as good by respondents, 50% reported that training opportunities were often missed.

Figure 18: Quality of training received in Acute Care of SMI by Trust

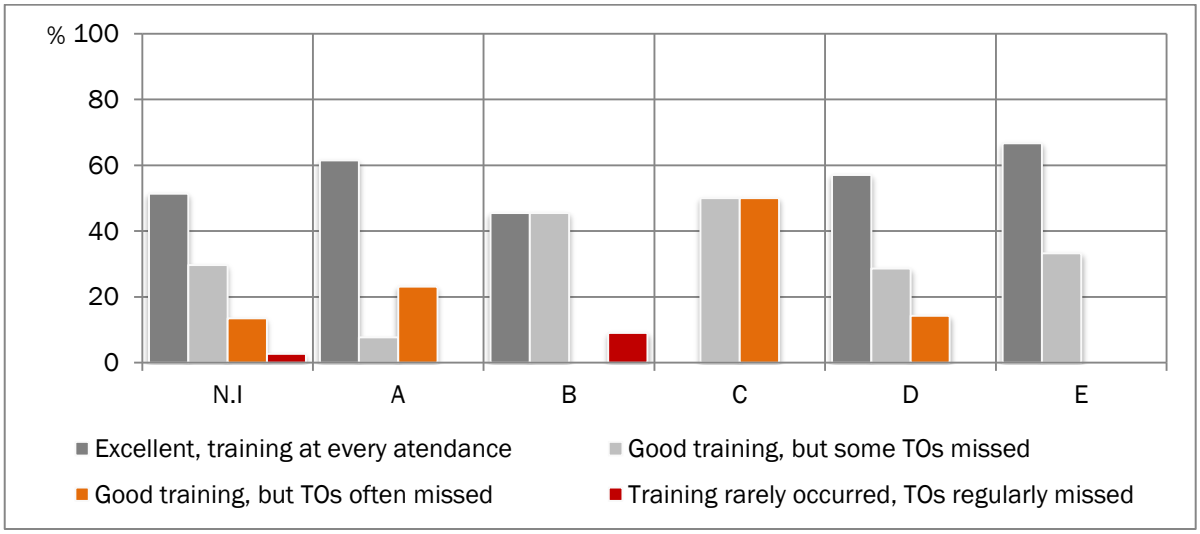
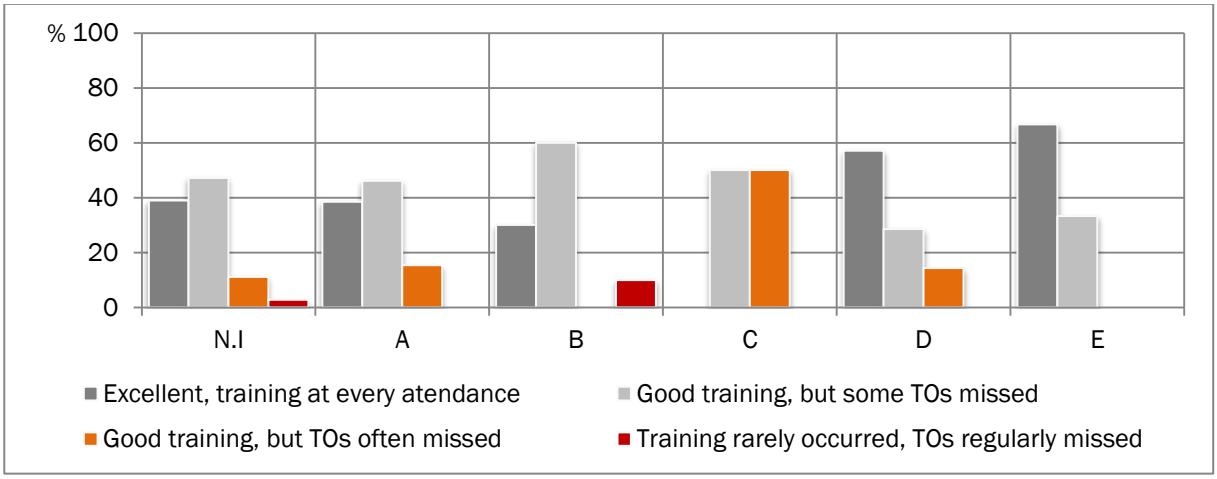
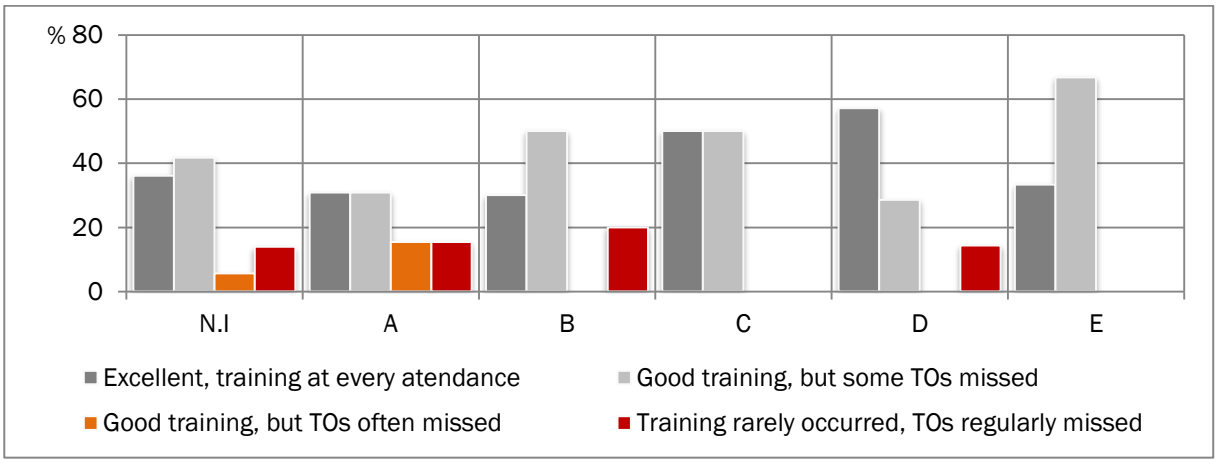


Figure 19: Quality of training received in Management of Chronic MH conditions by Trust



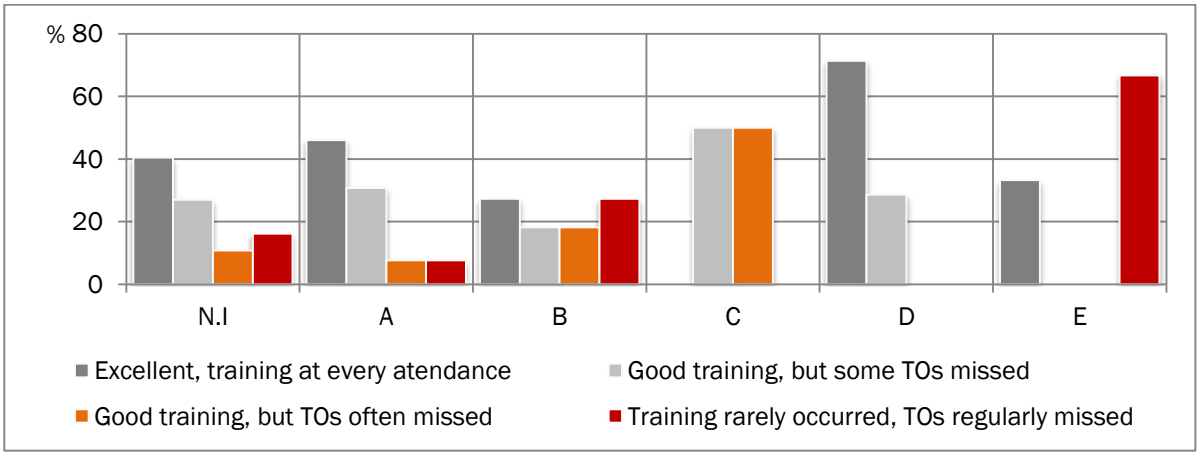
Access to **Mental Health order (MHO) experience** was rated as excellent/good/satisfactory by 92 % of trainees with the quality of training reported as excellent/good by 83% of respondents (Figure 20).

Figure 20: Quality of training received in MH Order Assessments by Trust



Training opportunities for **Emergency MH assessments** were also rated highly regionally with 78% of respondents reporting excellent/good training in this area (Figure 21). In Trust E however the survey results were significantly below the regional figures with 67% of respondents reporting that training opportunities were regularly missed or rarely occurred. This relates to the limited access to training opportunities in this area reported by 67% of respondents on this site.

Figure 21: Quality of training received in Emergency MH Assessments by Trust



The survey also highlighted high quality training regionally in areas including management and leadership and quality improvement and audit (Figures 22 and 23). In Trust C however, 50% of respondents reported that training opportunities were often missed/rarely occurred, twice the regional figure (25%).

Figure 22: Quality of Management & Leadership opportunities by Trust

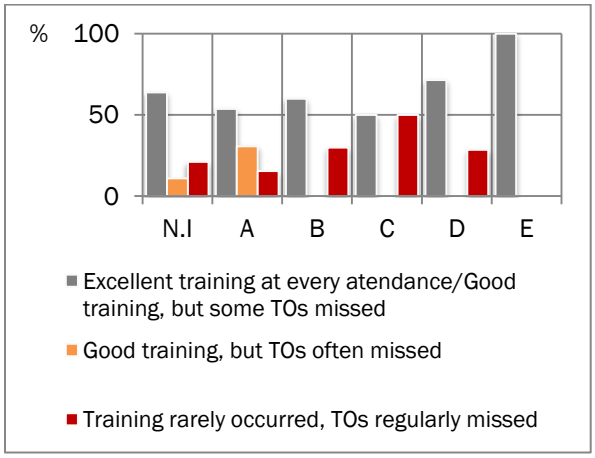
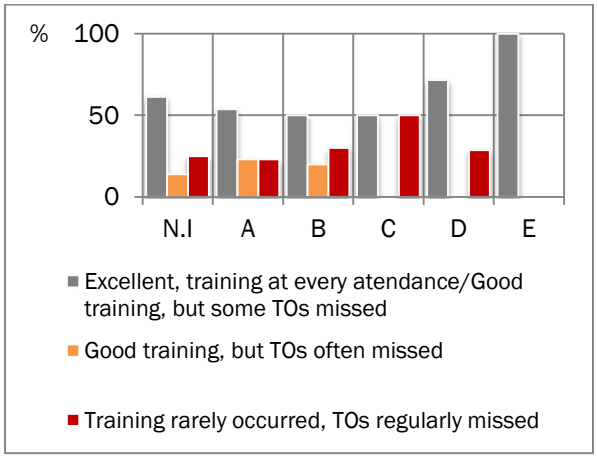


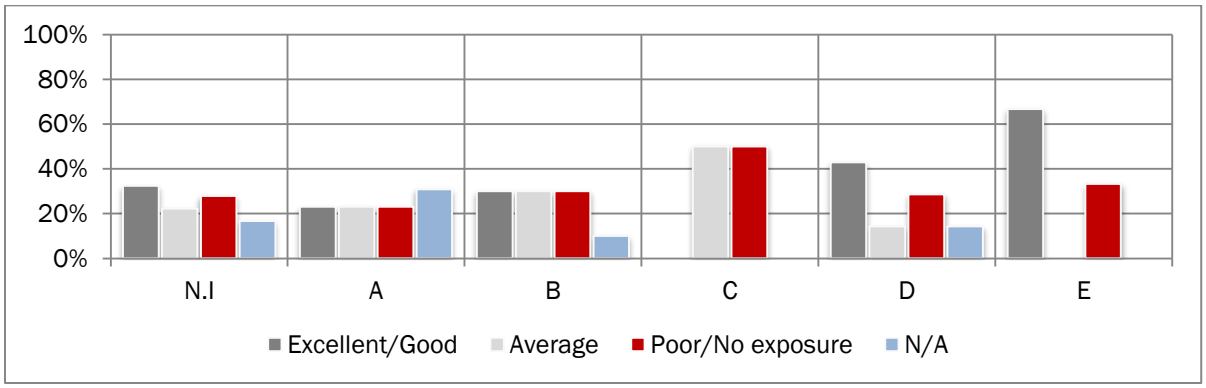
Figure 23: Quality of Quality Improvement/Audit opportunities by Trust



Psychotherapy Training

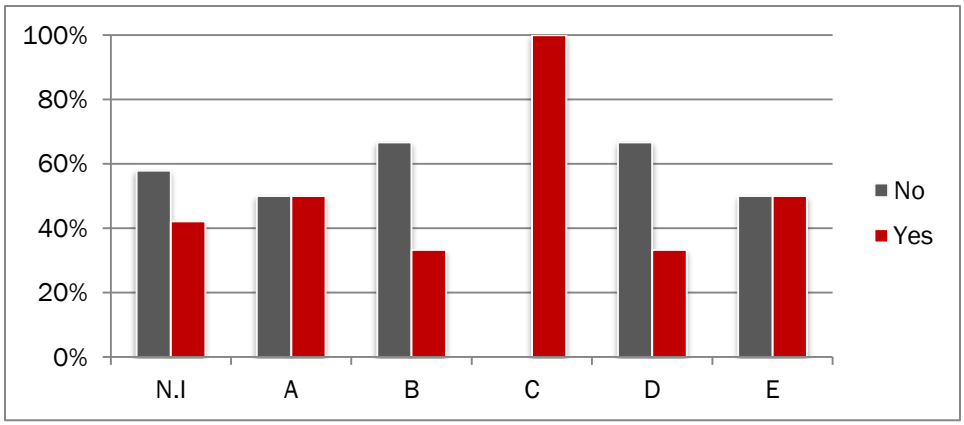
A regional issue identified by the current survey is access to opportunities for psychotherapy training, with only 34% of respondents reporting access to psychotherapy training opportunities as excellent/good and 28% reporting exposure as poor (Figure24).

Figure 24: Access to Psychotherapy Training by Trust



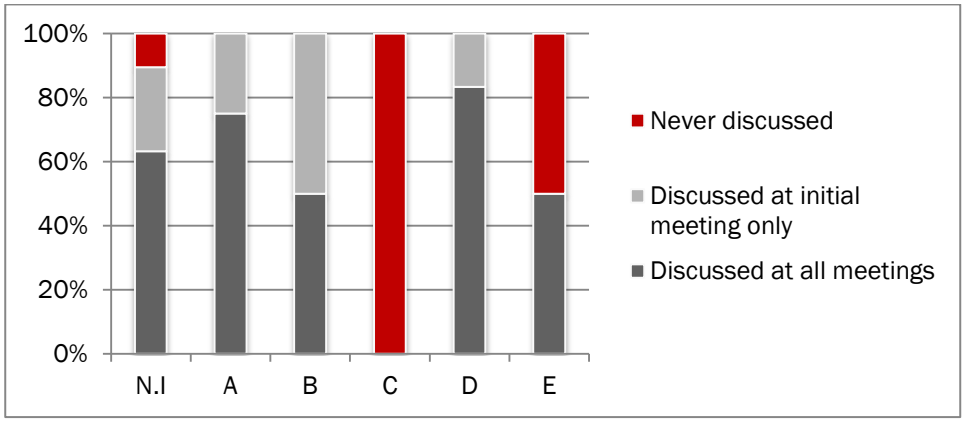
A significant factor contributing to this is difficulty accessing suitable cases for psychotherapy training, reported by 42% of trainees regionally, with figures ranging from 33% in Trusts B and D to 100% in Trust C (Figure25).

Figure 25: Difficulties accessing cases for Psychotherapy Training by Trust



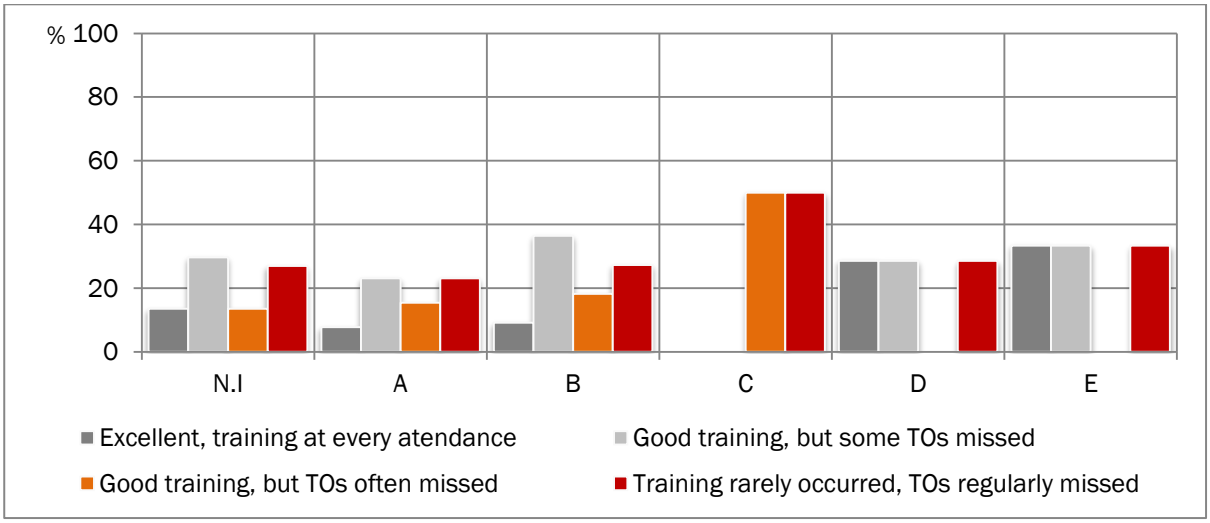
In the current survey 63% of core trainees reported that their Psychotherapy training needs were discussed with their ES at all meetings, but 11% of respondents reported that psychotherapy training needs were never discussed by their ES. In Trust C all core trainees indicated that psychotherapy training needs were never discussed (Figure 26).

Figure 26: Discussion of Psychotherapy Training needs with ES by Trust



The quality of psychotherapy training regionally was reported as excellent/good by only 43% of respondents with 27% reporting that training rarely occurred and training opportunities were regularly missed. In Trust C this figure exceeded the regional average with 50% of respondents indicating regularly missed/absent training opportunities (Figure 27).

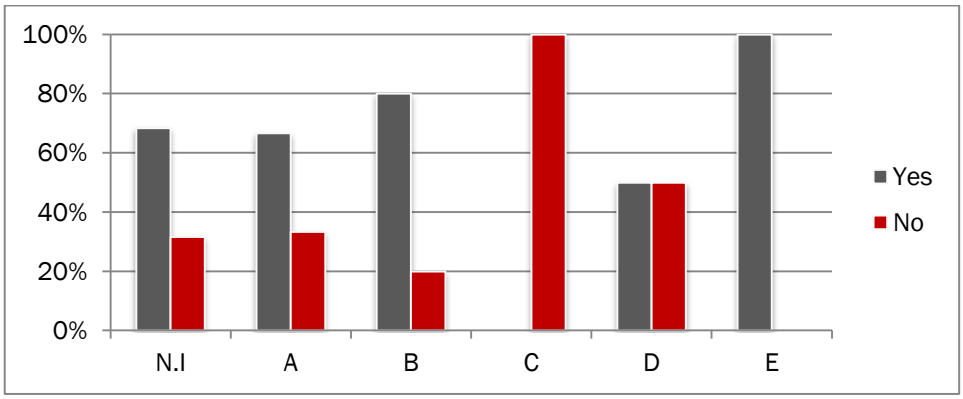
Figure 27: Quality of Psychotherapy training received by Trust



Higher Specialty Trainees

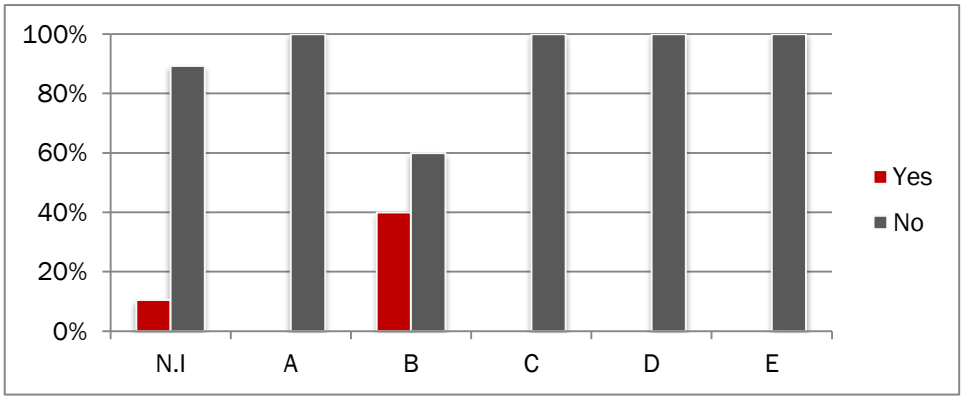
Regionally, 68% of higher trainees reported adequate access to peer group meetings (Figure 28). In Trust C however, access to peer group meetings was below the regional figure with all respondents indicating limited training opportunities.

Figure 28: Higher Trainees – Adequate access to Peer Group Meetings by Trust



In Trusts A, C, D and E, no higher trainees reported difficulties in arranging special interest sessions. In Trust B however, 40% of trainees reported difficulties in arranging these sessions (Figure 29).

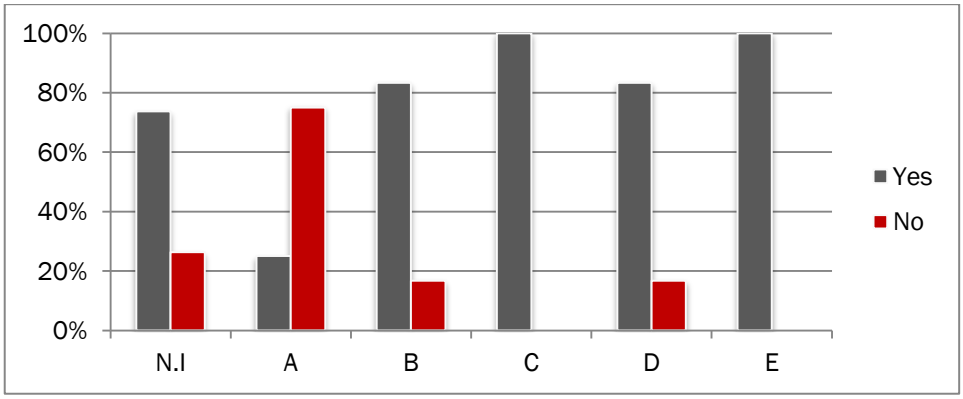
Figure 29: Difficulties arranging Special Interest Sessions (higher trainees) by Trust



Core Specialty Trainees

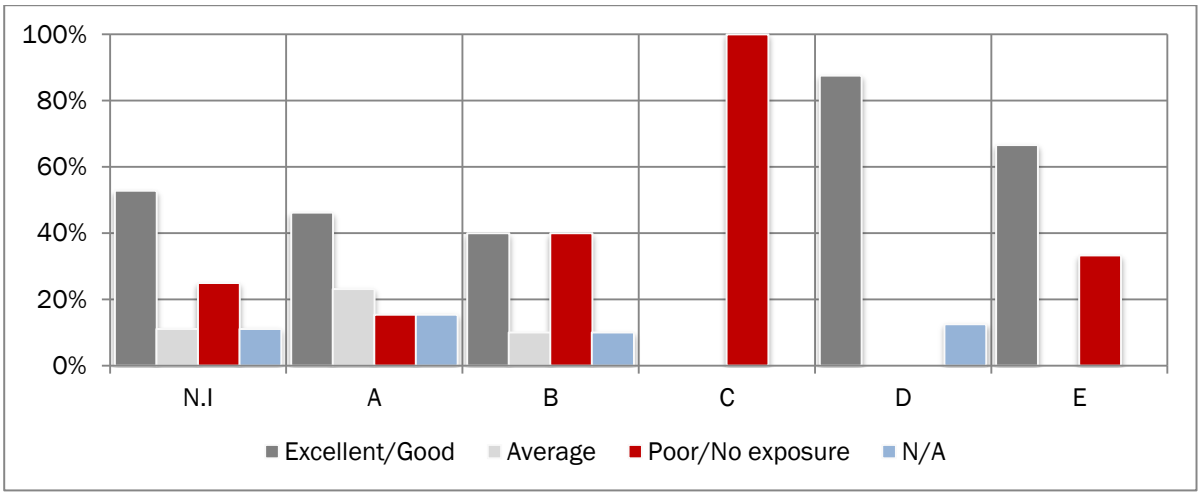
The majority of core trainees (74%) reported receiving ECT training/teaching over the past year. Access appeared best in Trusts C and E (100%), but was below the regional figure in Trust A where only 25% of core trainees reported receiving ECT training during the past year (Figure 30).

Figure 30: ECT training received by Core Trainees over the past year by Trust



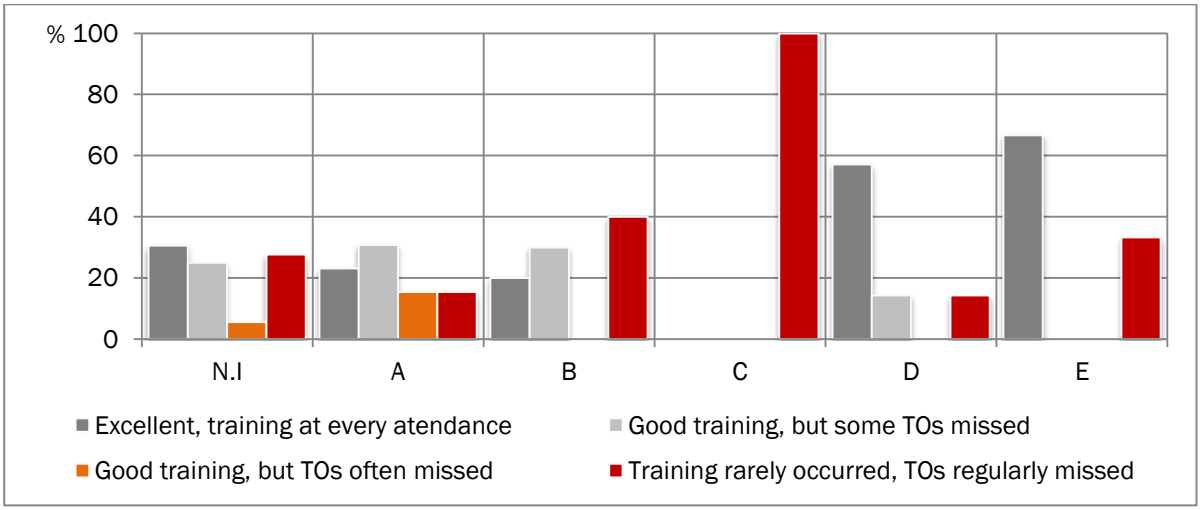
Regionally, 64% of trainees reported adequate access to reflective practice groups (Figure 31).

Figure 31: Access to Reflective Practice Groups by Trust



The quality of reflective practice training opportunities were reported as excellent/good by 61% of respondents however 28% indicated that training opportunities were regularly missed or didn't usually occur (Figure 32). In Trust C, the figures were below the regional average with all trainees reporting that training opportunities rarely occurred and this related to the poor/no access to reflective practice groups reported by trainees on this site.

Figure 32: Quality of Reflective Practice training opportunities by Trust



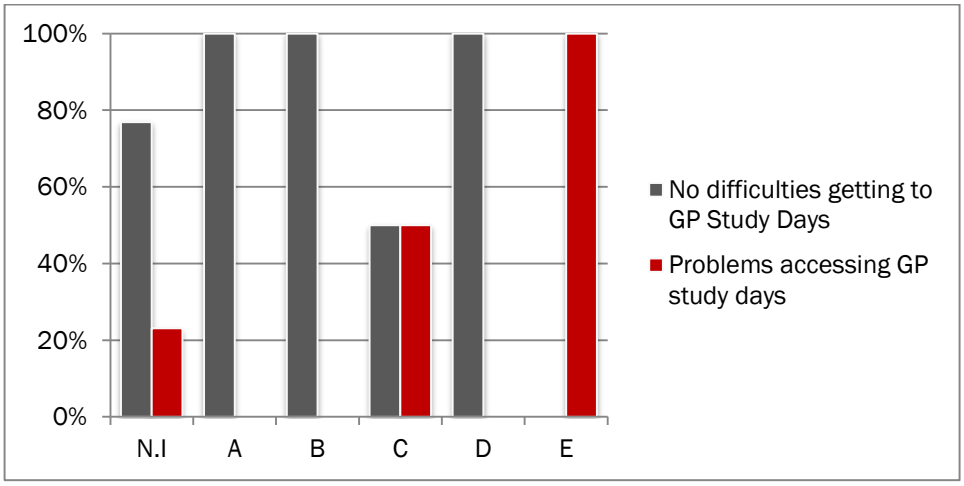
Good access to training opportunities for mental health assessments was reported with 95% of core trainees indicating that they were on track to achieve the curriculum mandated 50 emergency MH assessments. The majority of core trainees (79%) reported having had breakaway training within the past year and a further 16% indicated that they had not had training, but that it was available to them.

GP Specialty Trainees

For GP specialty trainees on a 6 month psychiatry placement, good access to training opportunities was documented in the survey, with all GP trainees reporting having met with their GP Clinical Supervisor within the first 4 weeks of their placement and 92% reporting being on track to achieve their required 3 formative meetings with their CS. In addition, 86% of the GP trainees who wanted to complete the PGDip in Mental Health (DMH) indicated that they had been supported to achieve this.

Overall, good access to regionally delivered GP training was reported, with 77% of GP trainees having no difficulties in getting to GP study days (Figure 33). There was however some variation between Trusts with all GP trainees in Trusts A, B and D able to access regional study days while in Trust C and E, 50% and 100% of GP trainees respectively reported difficulties attending these sessions.

Figure 33: GP trainees – Access to GP Study days by Trust



Foundation Year 2 Trainees

Similar positive results for training opportunities were reported by Foundation Year 2 (F2) trainees, with all F2 trainees reporting no difficulties in attending regional generic skills days, all being on track to achieve the required number of meetings with their Foundation CS and all those wanting to complete the PGDip in MH feeling supported to do so.

Key Recommendations: Formal Teaching and Educational Opportunities

All Trusts to have an identified consultant for psychotherapy training

5. Overall Opinions and Trainee Suggestions for Improvement

Overall Opinions

Feedback from trainees was very positive across a wide range of areas surveyed and this is reflected in the overall global score for placements, where regionally 71% of respondents rated the training opportunities provided by their current placement as either excellent/good and 21% as acceptable (Figure 34). For GP specialty trainees, placements were rated as excellent/good training opportunities by only 54% of respondents, with 23% reporting the placement as less than satisfactory (Figure 35). Further development in this area is required.

Figure 34: Global score of placement as a training opportunity, by Trust

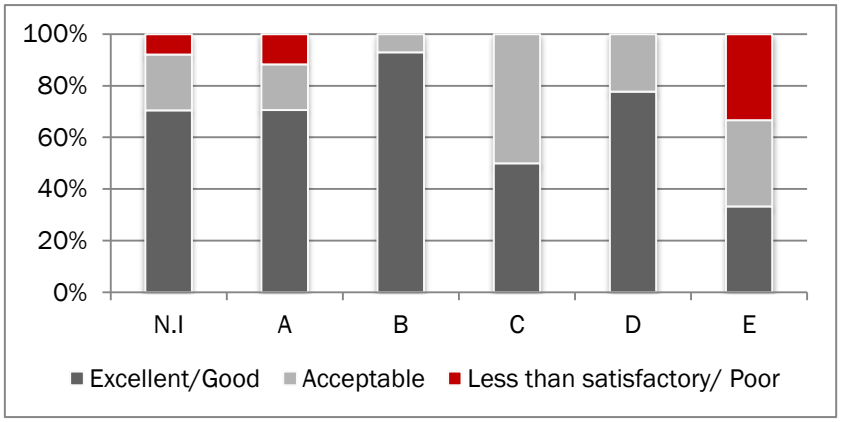
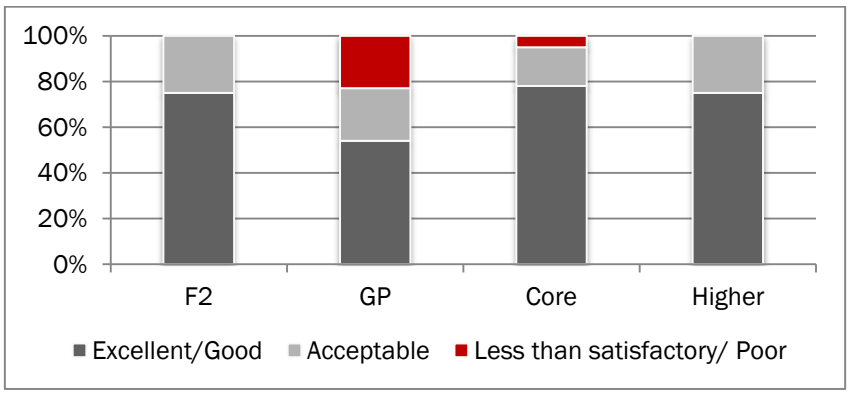


Figure 35: Global score for placement as a training opportunity by trainee grade



Summary of Trainee Suggestions for Improvement

1) More timely distribution of the OOH rota
2) Better access to psychotherapy cases
3) More access to reflective practice groups
4) Increased provision of regular protected time for structured clinical supervision
5) On call duties in same Trust as daytime responsibilities
6) More teaching on common psychiatric issues encountered in GP practice for GP specialty trainees
7) Increased focus on clinic attendance for GP specialty trainees
8) Departmental teaching to include targeted information specifically for core psychiatry trainees
9) More access to research opportunities
10) Formal opportunities 9-5pm for higher trainees to supervise more junior staff

Section 2: Good Practice and Actions Identified

Post Information

The need for improved information for trainees prior to making placement preferences and the suggested development of a prospectus for each Trust was discussed with each Trust at visits conducted in November-December 2019. The proposal for a Psychiatry prospectus, outlining details of training opportunities within all training units, was outlined and discussed at the Psychiatry School Board in January 2020.

Proposed Trust Actions:

1) Each Trust to work with Psychiatry Clinical Education Fellows to provide a draft prospectus in early 2020 for publication on the NIMDTA website by March 2020*.

Rota Allocation

There is a requirement for Trusts to inform trainees of their out of hours (OOH) rota allocation within 6 weeks of the commencement of their post.[(2)] One factor which appears to contribute to delay in trainees receiving notification of their rota allocation by Trusts is the current allocation policy of the School whereby trainee allocations are made by the School of Psychiatry to a Trust and not to a specific hospital site/training post. This coupled with a lack of information being received by Education Supervisors in regard to trainees' specific training requirements at the time of notification of trainee allocations adds to delays in making post allocations at Trust level.

Proposed Actions:

1) The School of Psychiatry will hold a postings meeting with Lead Education Supervisors from each Trust a week prior to HR notification of posts by NIMDTA in June and December each year**.
2) At the postings meeting:
    a. The Head of School will provide the ESs with the necessary information regarding trainees' specific training requirements to allow appropriate allocation of trainees to posts within their Trust for the next 6 months
    b. The Lead ES will, prior to the postings meeting have ascertained the posts to be filled within their hospital/unit for the next 6 months postings and at the meeting will allocate all trainees to specific posts within their Trust
    c. The School will give trainees' specific post allocations to NIMDTA so that hospital site/training unit post allocations are made to Trust HRs and trainees at least 8 weeks in advance of the changeover date
3) Lead ES will release rota information to trainees as soon as posting information is released to Trust HR
4) It was agreed that if there are any unfilled posts within a Trust, there should not be a delay in sending OOH rota information to the trainees already allocated to the Trust.
5) Trusts to inform NIMDTA of the names of individuals e.g. ESs, who need to receive details of trainee allocations to the Trusts to ensure efficiency and clarity in sharing of information going forward.

Induction

Good Practice

1) Provision of online resources and information, including unit policies and guidelines and specialty specific information (GPs and F2s)[(A)]
2) Provision of 2.5 day induction programme at start of all posts[(D)]
3) Provision of handbook in some sub-specialties e.g. Psychiatry of Learning Disability[(A)]

Proposed Trust Actions:

1) All trainees to be made aware at induction that discussion and clarification of their individual roles and responsibilities will be carried out by their Clinical Supervisor (CS) at their initial CS meeting (A,B.C,D,E)
2) Trusts will engage with current trainees to seek information on 'things they would have liked to have known' at the start of their placement with particular note of GP specialty trainees' requirements – so as to improve the information provided as part of the induction process.(A,C,D)
3) Development of a Trust handbook to cover practical issues.(A)
4) Inclusion of GP trainee input into the Trust psychiatry handbook (C)

Workload

Good Practice:

1) Trainees offered option of 2 person shift rota (1:7 or 1:8) to replace 1:15 twenty four hour on-call rota to reduce intensity of out of hours and weekend workload.(B, D, E)
2) Employment of staff grade to reduce day time medical calls(D)
3) Second on call on site at weekends to review voluntary admissions B)
4) Medical admission of voluntary patients after 9pm completed the next day by daytime medical staff (unless specific clinical concern from senior nursing staff) (D)
5) Senior (Band 7) nurse screens calls on CAMHS rota out of hours (A)
6) Introduction of morning conference call at weekends between consultant and trainees to distribute work to be done equitably (B)
7) Introduction of day off after on call shift(E)

Proposed Trust Actions:

1) Review and simplification of existing rota structure(A)
2) Review of CAMHS rota to allow trainees to do their OOH and weekend on call in the Trust to which they are posted during the day(A)

Education and Training Opportunities

Good Practice:

1) Facilitation of regular protected time for learning with the provision of a dedicated day a week for continued personal development (regional)
2) Delivery of a weekly regional teaching programme for MRCPsych exam preparation
3) Evidence of high quality departmental teaching programmes (A,B,D,E)
4) A high level of consultant involvement in both regional and local departmental teaching (regional)
5) Centrally co-ordinated teaching for Foundation and GP specialty trainees (C)
6) Provision of a named consultant for psychotherapy training (A,B,C,D)
7) Balint group re-established (C)

The GMC Promoting Excellence (R1.16) states that
"Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety."(3)

The survey feedback overall demonstrates evidence of well-motivated and dedicated educators delivering this key GMC training requirement and is to be commended.

Proposed Trust Actions:

1) Identification of a new 'named' consultant for psychotherapy training (C,E)
2) Psychotherapy training needs to be discussed at ES meetings (C)
3) Provide a contact to facilitate access to the psychiatry liaison service to improve access to emergency MH assessments (E)
4) ECT training needs to be identified as part of trainee PDP (A)
5) Information on QI/Audit opportunities to be included in induction material (C)
6) Review of duty bleep arrangements to facilitate attendance of GP specialty trainees at GP regional teaching (E)
7) ZOOM access to regional psychiatry teaching to be investigated (E)
8) Development of tailored teaching sessions for GP/F2 trainees in Psychiatry once a month after regular weekly journal club (B)
9) Establishment of Special Interest days in primary care liaison psychiatry (E)
10) Consideration to be given to appointment of a GP training liaison officer (E)

COVID-19 Amendments to implementation schedule

**Post Preferences: Prospectus Publication Date put back to August 2020*

**** Rota Notification: *Implementation of the new system for placement allocations delayed to December 2020.*

References

1) UKFPO F2 Career Destinations Report 2018
2) NIMDTA (2019) Specialty Recruitment Competition Ratios 2019, Northern Ireland
3) NHS HEE National Psychiatry Recruitment - Fill Rates & Competition Ratios, UK
4) Royal College of Psychiatrists 2019 Workforce Census Report
5) BMA Code of Practice Section 6.1: Employment Information
6) GMC Promoting Excellence: standards for medical education and training. (2016)
7) A Competency Based Curriculum for Specialist Core Training in Psychiatry, Royal College of Psychiatrists. (2013)

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Mandatory training from MS Teams (Psychology)

Core Mandatory Training	Frequency	E-Learning site	Comment
BHSCT Mandatory Training			
Trust Welcome Programme	Once		
Fire Safety Awareness	Annually	https://elearning.belfasttrust.hscni.net/login/index.php	Fire Training specifically evacuating patients/clients available to book through HRPTS or contacting FireSafetyTraining@belfasttrust.hscni.net
Health and Safety Awareness	Once	https://elearning.belfasttrust.hscni.net/login/index.php	
Adverse Incident Reporting	Once	https://view.pagetiger.com/budlacb/1	
Data Protection	3 Yearly	https://elearning.belfasttrust.hscni.net/login/index.php	
Equality for Staff/Managers	5 yearly	https://www.hsclearning.com	
Quality 2020: Level 1 Awarness	Once	https://www.hsclearning.com	
Safeguarding Adults and Children Awarness	Once	New Safeguarding Compliance - 1 (pagetiger.com)	
Infection Control Awareness	2 yearly	https://elearning.belfasttrust.hscni.net/login/index.php	
Manual Handling	2 yearly	https://www.hsclearning.com	
	Annually		
SDR's	Annually	Line Manager	
Service specific training (Leads to delete or add as appropriate for own service)			
Management of Attendence (All Leads/Managers	3 Yearly	HRPTS	
Infection Prevention &Control for Staff with Direct Patient Care	2 yearly	https://elearning.belfasttrust.hscni.net/login/index.php	
Infection Prevention &Control for Staff with Indirect Patient Care	2 yearly	https://elearning.belfasttrust.hscni.net/login/index.php	
Display Screen Equipment	Once	https://www.hsclearning.com	
Recruitment & Selection	3 Yearly	https://www.hsclearning.com	
Fire Warden	3 Yearly	HRPTS	
SDR Reviewee	Once	HRPTS	
SDR Reviewer All Supervisors	Once	HRPTS	
Mental Capacity Training	Once	https://www.health-ni.gov.uk/mental-capacity-act-training	
Personal Safety & Disengagement			
Safeguarding Vulnerable Adults	TBC	HRPTS	
Safeguarding Children	TBC		
Personal Safety at Work	TBC	https://www.hsclearning.com	

NHS Education for Scotland

Psychology Services Workforce in NHSScotland

QUARTER ENDING 31 MARCH 2020

An Official Statistics publication for Scotland

Publication date: 2 June 2020

NHS Education for Scotland

This is an Official Statistics Publication

As of 1st October 2019, NHS Education for Scotland (NES) has taken responsibility for some national workforce data, statistical & intelligence functions.

NHS Education for Scotland (NES) is NHSScotland's education and training body. It is the authoritative source of information on the people who work for NHSScotland. NES became an accredited provider of Official Statistics in December 2019 and as such this release is produced in accordance with the UK Statistics Authority's **Code of Practice for Statistics**. NES voluntarily applied the Code of Practice for the **publication** released on 3 December 2019.

Find out more about Official Statistics at:
https://www.statisticsauthority.gov.uk/national-statistician/types-of-official-statistics/

Contents

1. Introduction

This publication summarises national data on the workforce providing Psychology Services in NHSScotland, following the latest census on 31 March 2020. When describing the size of a particular staff group, figures are presented either as headcount (actual number of staff) or whole time equivalent (WTE), which adjusts the headcount to take account of part-time working.

This report summarises key aspects of the data including:

- The number and characteristics of clinical staff in post
- The number of trainees in Doctorate and MSc Courses

Please note, due to the Covid-19 pandemic, data on vacancies as at 31 March 2020 are not reported, due to the additional demands this would place on colleagues at NHS Boards.

The data are collected directly from Psychology services and held within the National Services Scotland (NSS) National Psychology Workforce Information Database. The data are verified by Psychology Heads of Service, who work closely with NES to ensure a high level of accuracy. The information collected and presented is used routinely by NES, the Scottish Government and NHS Boards to support local, regional and national workforce planning, and to support educational training and planning.

In recent years, NHSScotland has seen a steadily increasing demand for access to Applied Psychologists and Psychological Therapies due to the growing evidence base, recognised in Scottish Intercollegiate Guidelines Network (SIGN) and National Institute for Health and Clinical Excellence (NICE) guidelines, for the effectiveness of psychological interventions in delivering positive health change for people with a wide range of clinical conditions. The term ‘Psychological Therapies’ refers to a range of interventions based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships, in order to relieve distress and to improve functioning. The skills and competences required to deliver these interventions effectively are acquired through training and maintained through clinical supervision and practice.

The NHS Education for Scotland- Scottish Government Report **'The Matrix: A Guide to Delivering Evidence-Based Psychological Therapies in Scotland'** summarises and describes the most up-to-date evidence-based psychological therapies. The Matrix report also provides information and advice for NHS Boards on the delivery of effective and efficient therapies and the levels of training and supervision necessary for staff to deliver these safely and effectively.

In conjunction with this report, comprehensive workforce data at 31 March 2020 are shared across the following outputs:

Dashboards

- The **psychology workforce dashboard** presents quarterly data on staff in post in NHSScotland psychology services and information on staff in training.
- The dashboard presents a breadth of data including staff WTE and headcount, WTE per 100,000 population, age band, target age and area of work, gender and contract type, Agenda for Change (AfC) band, contract length, staff in training, and the retention of trainees in the workforce. Staff in post data are available as chart visuals or tables.

Data tables

- Supplementary long-term trend data for staff in post and trainees.
- Quarterly updates to staff in post tables. See the **list of tables** for the full breadth of information.
- Annual updates on:
  - Staff ethnicity and disability status
  - Psychology training course intakes
  - The retention of trainees within the NHSScotland psychology workforce
- Due to varying sources and frequency of bespoke data collections, not all published tables are updated at this time of year.

2. Main Points

At 31 March 2020:

- Within Psychology Services in NHSScotland as at 31 March 2020, there were a total of 1214.1 WTE (1,475 headcount) clinical staff in post. This is 91.4% (579.7 WTE) higher than in September 2006, 3.2% (37.8 WTE) higher than reported 12 months previously and less than 1.0% (0.3 WTE) lower than the December 2019 census.

- The number of female staff in post has dropped slightly compared to the previous quarter (9 headcount, 0.7%). However, female staff still comprise the majority of the NHSScotland psychology workforce (85.2%). The majority of female staff work part-time hours (58.3%), while the majority of male staff work whole-time (70.8%).

- The 2020 intake of trainees to both NHSScotland MSc programmes was relatively high this year compared to previous years. For the MSc Psychological Therapy in Primary Care, there was an intake of 35 students in 2020, compared to 30 in 2019 and an average intake of 24 between 2005 and 2020. The intake to the MSc Applied Psychology for Children and Young People was 29, compared to 30 in 2019 and an average intake of 18 between 2007 and 2020.

3. Staff in Post

3.1 Staff WTE and Headcount

At 31 March 2020, there were a total of 1214.1 WTE (1,475 headcount) clinical staff in post within Psychology Services across NHSScotland. Bespoke data collection for this workforce began with an initial pilot collection in 2001, with quarterly data collection commencing in 2010.

Figure 1 shows the WTE and headcount of psychology staff in post between March 2011 and March 2020 and the current distribution of staff WTE between NHS boards.

Figure 1. Staff in NHSScotland Psychology Services as at 31 March 2020

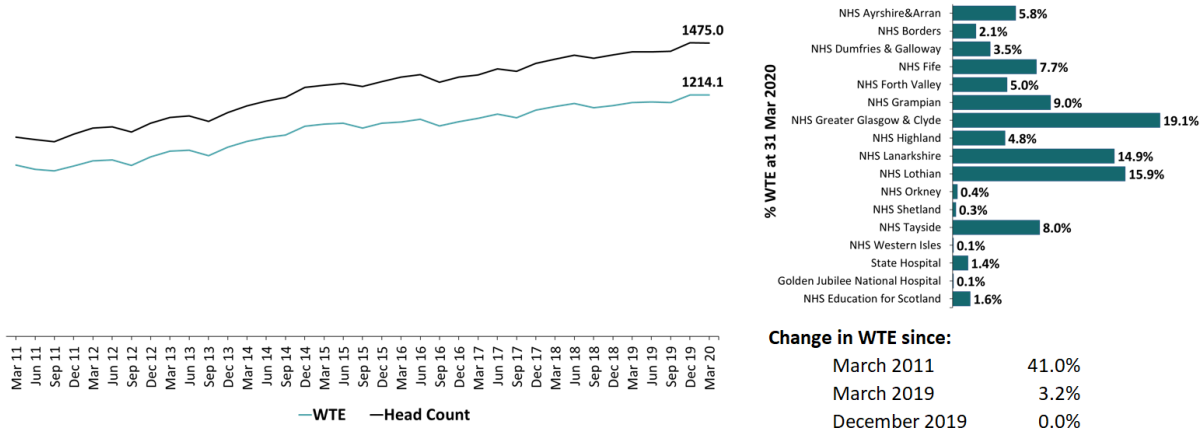
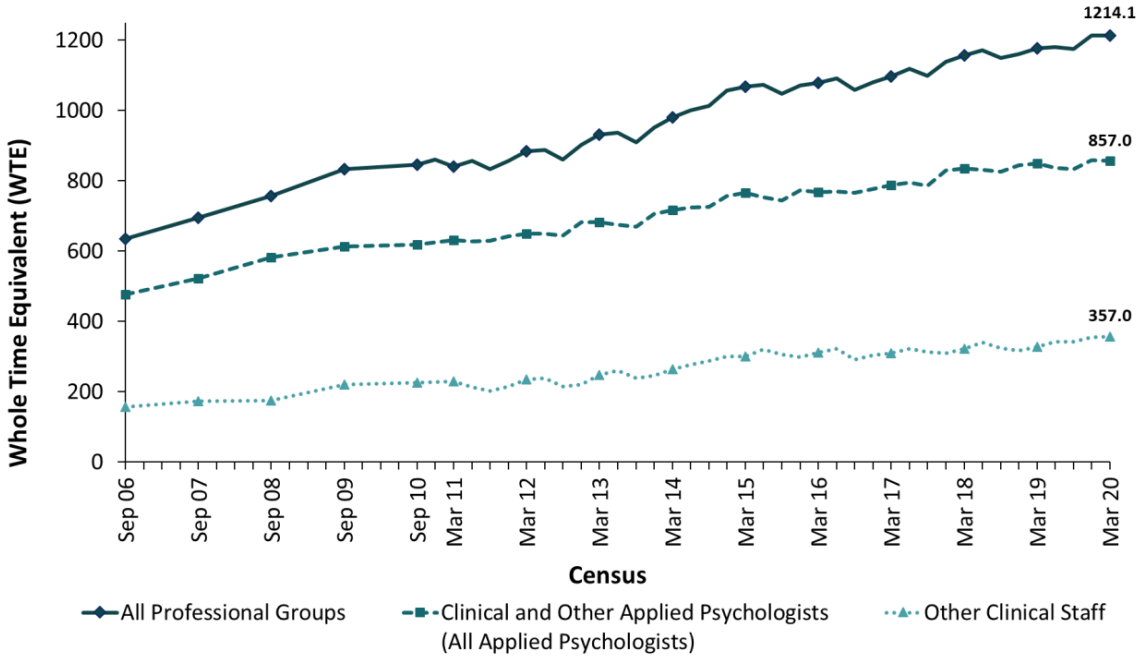


Figure 2 shows the increase in this workforce since the first annual census in 2006, overall and split by the professional groups All Applied Psychologists and Other Clinical Staff. Since 2006, the overall workforce has increased by 91.4% (579.7 WTE). In the past 12 months, there has been an overall increase of 3.2% (37.7 WTE), and since the last quarterly census, there has been a very slight decrease of less than 1.0% (0.3 WTE).

Figure 2: WTE of staff in NHSScotland Psychology Services between September 2006 and March 2020[1,2].

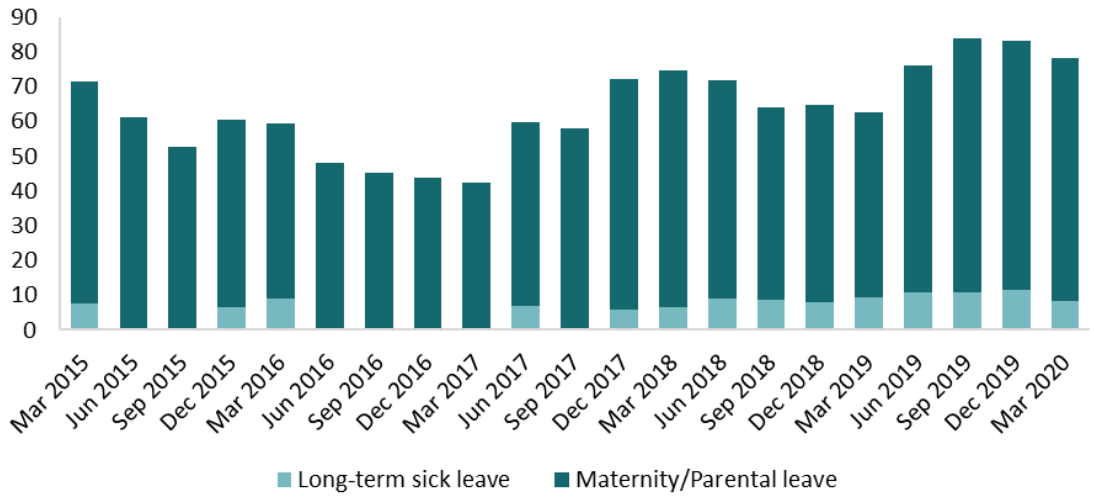


Notes:

1. Quarterly data collection began from March 2011. Prior to this there was only an annual census at 30 September.
2. Clinical and Other Applied Psychologists are also referred to as all Applied Psychologists. Further information can be found in the **Glossary** and **Summary of Professional Groups**.

As at 31 March 2020, there were 69.8 WTE staff on maternity leave and 8.3 WTE staff on long term sick leave. Figure 3 illustrates the WTE of staff on maternity/long-term sick leave, quarterly since March 2015.

Figure 3. WTE of Staff in NHSScotland Psychology Services on Maternity and Long-term Sickness Absence, Quarterly from March 2015 to March 2020.[1]



Notes:

1. Numbers under 5.0 have been suppressed.

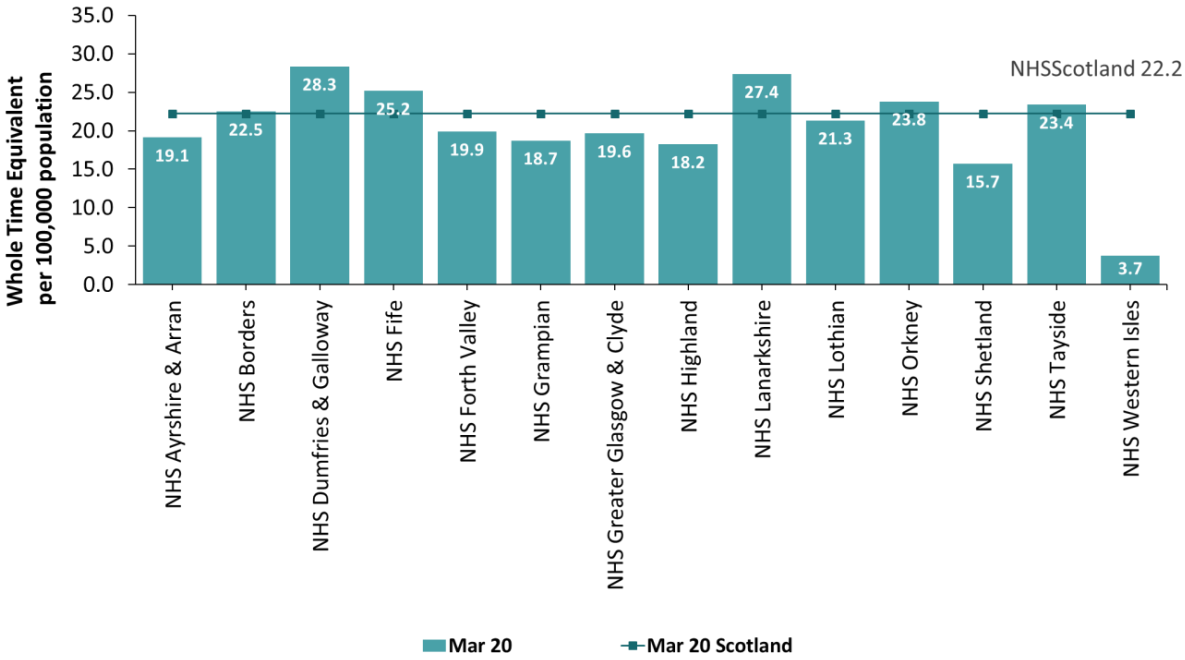
For further information on staff in post by WTE and headcount, please see the Psychology Workforce **Dashboard** and **Data Tables**.

3.2 Whole Time Equivalent (WTE) per 100,000 Population

Figure 4 shows the Whole Time Equivalent (WTE) of all clinical staff employed in NHSScotland Psychology Services per 100,000 population as at 31 March 2020. NHS Dumfries and Galloway and NHS Lanarkshire currently have the largest WTE per 100,000 population, with 28.3 WTE and 27.4 WTE respectively, compared to the overall Scotland rate of 22.2 WTE.

The higher rates in some boards are partly due to the provision of regional services, including referrals from other boards. In some instances, this may also involve specialist inpatient care where staffing requirements are higher. Health boards with higher levels of deprivation have a greater demand for services.

Figure 4. WTE of All Clinical Staff per 100,000 Population as at 31 March 2020.[1]

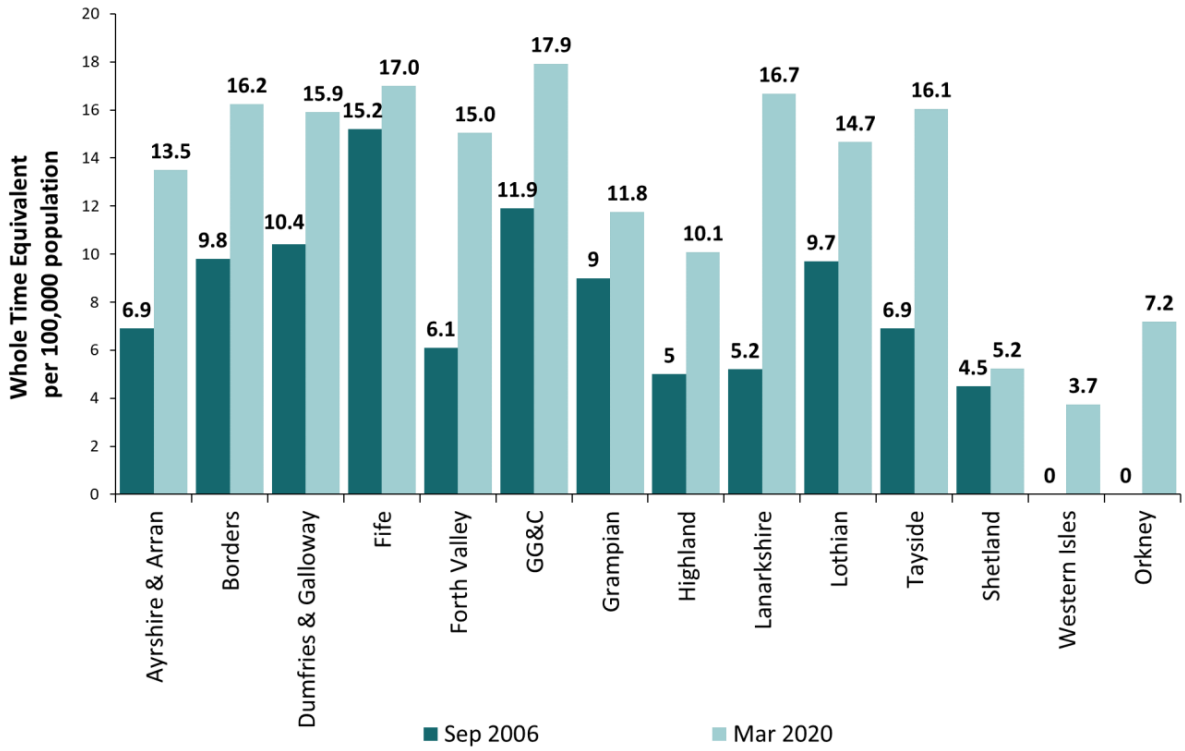


Notes:

1. The total NHSScotland figures also include staff working in Special Health Boards: NHS Education, NHS State Hospitals Board for Scotland and Golden Jubilee National Hospital.

Figure 5 compares the Whole Time Equivalent of all Applied Psychologists employed per 100,000 population in NHS Boards as at 30 September 2006 and 31 March 2020. NHS Greater Glasgow and Clyde has the highest number of Applied Psychologists employed per 100,000 population (17.9 WTE).

Figure 5. WTE per 100,000 Population of Applied Psychologists in NHSScotland Psychology Services as at 30 September 2006 and 31 March 2020.



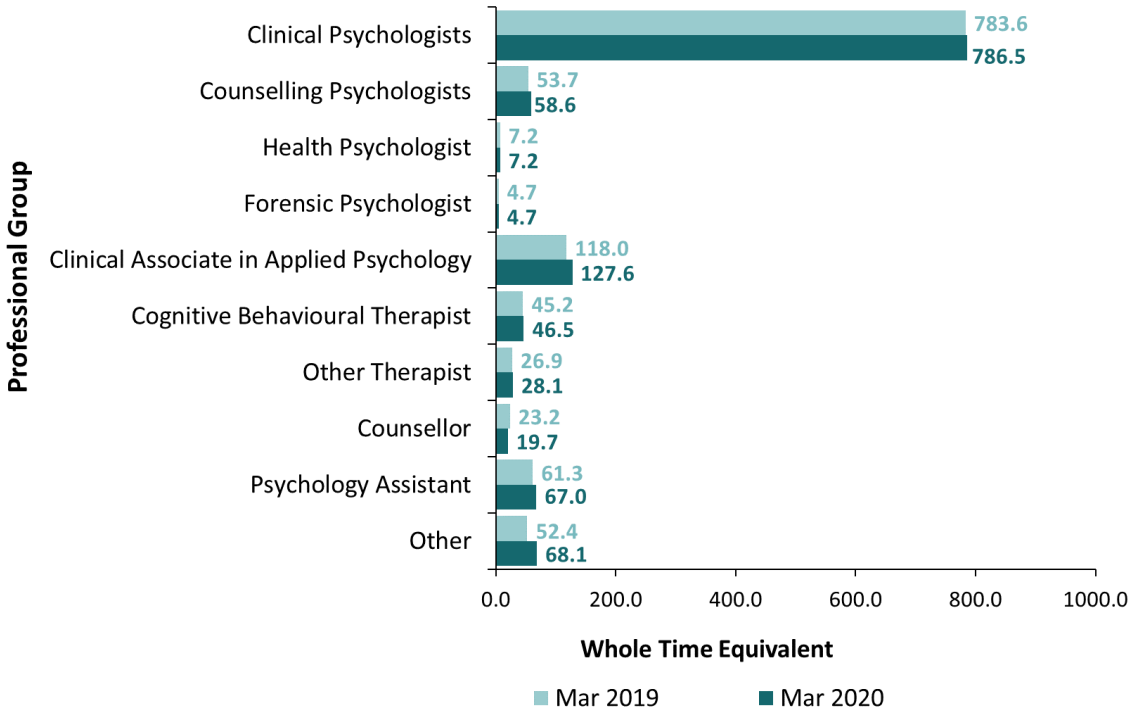
3.3 Staff by Professional Group

As at 31 March 2020, All Applied Psychologists comprised 70.6% of the workforce (857.0 WTE) and Other Clinical Staff 29.4% (357.0 WTE).

Figure 6 shows the WTE of the different Professional Groups in NHSScotland at 31 March 2020 and 31 March 2019. At the current census, Clinical Psychologists were the largest staff group, comprising 64.8% (786.5 WTE) of the workforce. This is 0.4% (2.9 WTE) higher than in March 2019 and 0.3% (2.4 WTE) lower than in December 2019. The WTE of Counselling Psychologists also increased, by 9.2% (4.9 WTE), while the WTE of Health and Forensic Psychologists did not change.

The WTE of most of the Other Clinical Staff groups also increased between March 2019 and March 2020, with the greatest changes being seen in the Other category (30.0%, 15.7 WTE) and Clinical Associates in Applied Psychology (8.1%, 9.6 WTE). Conversely, the WTE of the Counsellor Professional Group decreased by 15.2% (3.5 WTE).

Figure 6: WTE of Professional Groups in NHSScotland Psychology Services as at 31 March 2019 and 31 March 2020.[1]



Notes:

1. Other includes: Mental Health Clinicians, Self Help Workers, Peer Support Workers, Primary Mental Health Workers, Mental Health Nurses, Psychological Therapists and Child and Adolescent Therapists.

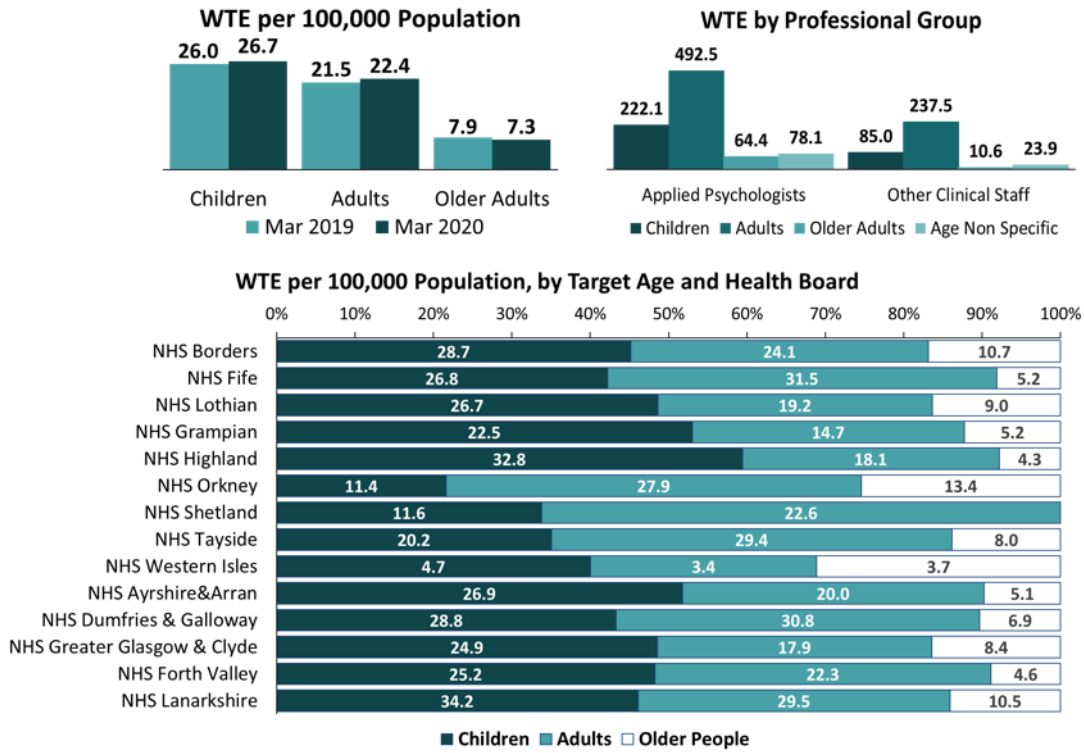
3.4 Staff by Target Age and Area of Work

This section provides further information on the specialty areas and patient groups cared for by the psychology workforce. For more detailed information, please refer to the **data tables**.

Within each professional group, individual staff members may work across several different Target Ages and Areas of Work. Target Age refers to the age group of patients being cared for. For Psychology Services, the distinct age groups are generally Child & Adolescent (0-18 years), Adult (19-64 years), or Older Adult (65+ years).

Area of Work refers to the broad specialty area that the clinician works in. For definitions of each Area of Work please refer to the **glossary**.

Figure 7. WTE of Staff in Post in NHSScotland Psychology Services by Target Age.



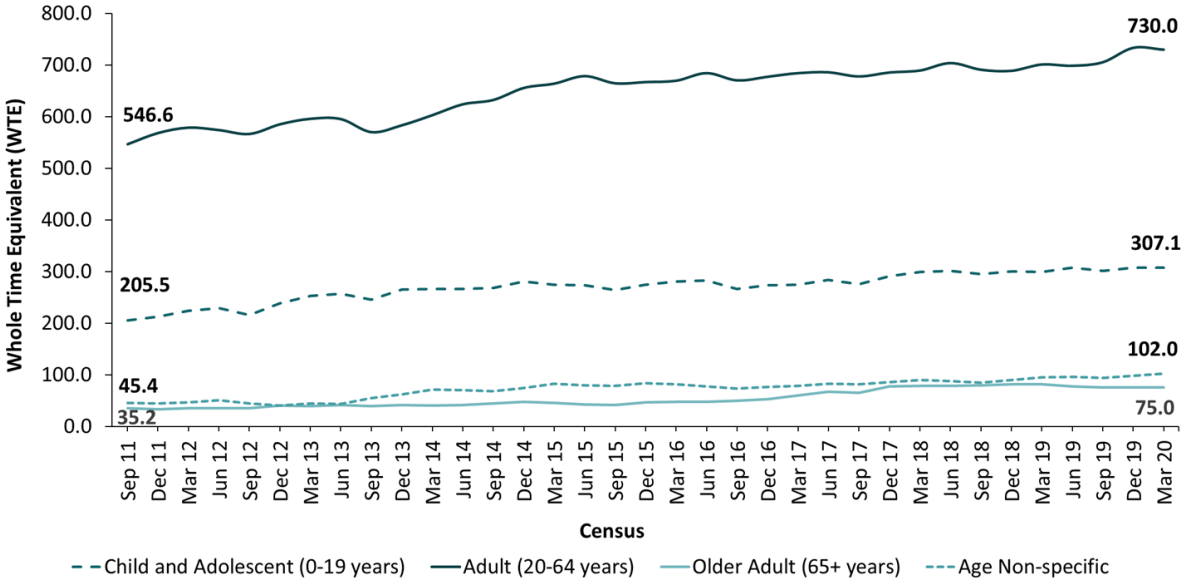
3.4.1. Target Age

Figure 8 displays the quarterly WTE of staff working across each Target Age, between September 2011 and March 2020. The largest Target Age group continues to be Adult, which accounts for 60.1% (730.0 WTE) of the Psychology workforce at 31 March 2020. The Child and Adolescent Target age accounts for 25.3% (307.1 WTE) of the workforce, Older Adults 6.2% (75.0 WTE) and Age Non-Specific 8.4% (102.0 WTE).

The Adult Target Age category has seen the largest growth of WTE since September 2011, an increase of 183.4 WTE (33.6%). The largest percentage increases were seen in the Age Non-Specific and Older Adult categories, with increases of 124.7% (56.6 WTE) and 113.1% (39.8 WTE) respectively. The increase within the Older Adult Target Age may partly be due to the introduction of trainees on the Doctorate in Clinical Psychology course having specific alignment to Older People's Services. The MSc Psychological Therapy in Primary Care course covers both adults and older adults. This has enabled more graduates to work in the Older Adult Target Age on completion, an age group for which historically there have been fewer staff.

The WTE of staff working within the Child and Adolescent Target Age has increased by 49.4% (101.6 WTE) over this time period, although the proportion of staff has remained similar, accounting for around a quarter of the total staff WTE.

Figure 8. WTE of all clinical staff in Psychology Services by Target Age between 31 September 2011 and 31 March 2020[1].



Notes:

1. There is a differing age range of service provision across the boards in child services. For more details, please see the Age of Service Provision table within the **CAMHS publication**.

3.4.2. Area of Work

Area of Work refers to the broad specialty area of the services that a clinician provides: Mental Health, Learning Disabilities, Physical Health, Neuropsychology, Forensic, Alcohol & Substance Misuse and Other specialty services.

Figure 9 shows the WTE for the Mental Health Area of Work, broken down into sub-specialties (General, Mild to Moderate, Severe and Enduring, Eating Disorders, and Early Intervention) at March census dates since 2013. Different speciality areas have different staffing requirements. For example, the subcategory Severe and Enduring Mental Health requires a more intensive level of staffing than Mild to Moderate services. For definitions of each Area of Work, including the subcategories for Mental Health, please see the **glossary**.

By far the largest area of work is General Mental Health, which accounted for 44.7% (542.2 WTE) of the workforce at 31 March 2020. Mild to Moderate Mental Health accounted for 9.7% (118.0 WTE) of the workforce, Severe and Enduring Mental Health for 2.9% (35.2 WTE), Early Intervention for 2.7% (32.7 WTE), and Eating Disorders for 1.8% (21.4 WTE).

Figure 9. WTE of Staff in Post in the Mental Health Area of Work, from 31 March 2014 to 31 March 2020.

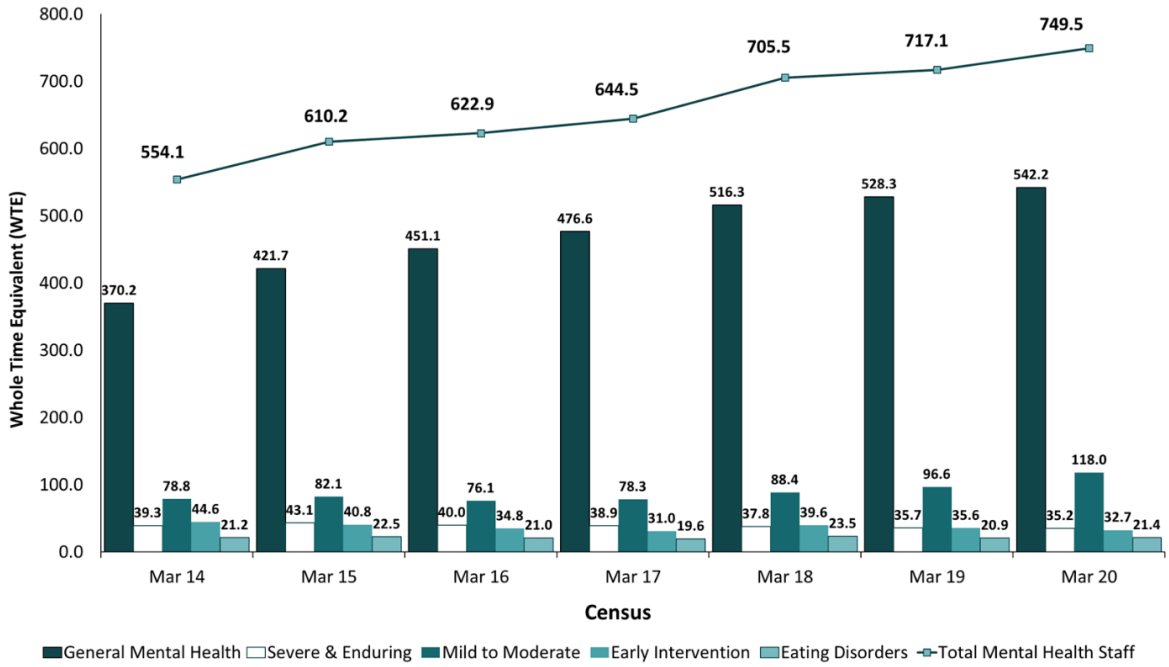
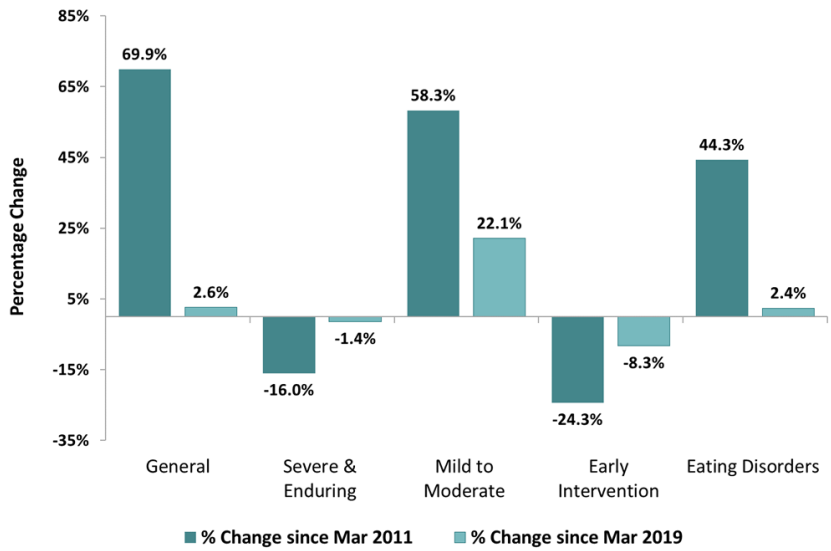


Figure 10 shows the percentage change in WTE in the subcategories in the Mental Health area of work, since March 2011 and March 2019. The WTE in General Mental Health, Mild to Moderate Mental Health and Eating Disorders has increased over both time periods, while the WTE of Severe and Enduring Mental Health and Early Intervention has decreased.

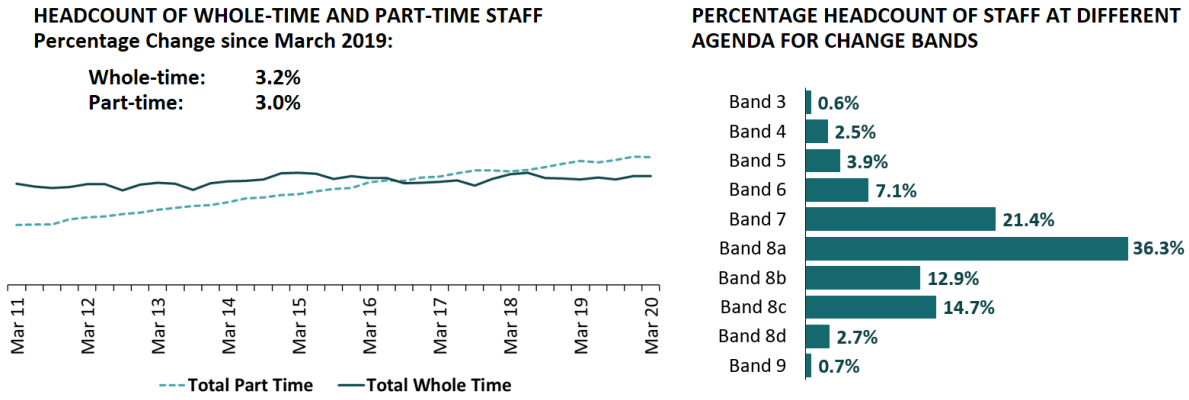
Figure 10. Percentage Change in WTE in Mental Health Subcategories since 31 March 2011 and 31 March 2019.



The Other category is currently the largest non-Mental Health area of work, accounting for 9.7% of the workforce (117.9 WTE). This group incorporates sub-categories such as Healthcare for the Elderly and Dementia, Academic, Teaching and Management, Trauma Services, Autistic Spectrum Disorder, Self-help Workers, Prison Services and Gender-based Violence. The second largest category is Physical Health (9.4% of the workforce, 113.8 WTE), followed by Learning Disabilities (6.9%, 83.6 WTE), Forensic (5.0%, 60.2 WTE), Neuropsychology (4.6%, 55.7 WTE), and Alcohol and Substance Misuse (2.8%, 33.5 WTE).

4. Characteristics of the Workforce

Figure 11. Characteristics of staff in NHSScotland Psychology Services by Contract Term and Agenda for Change Pay Band.

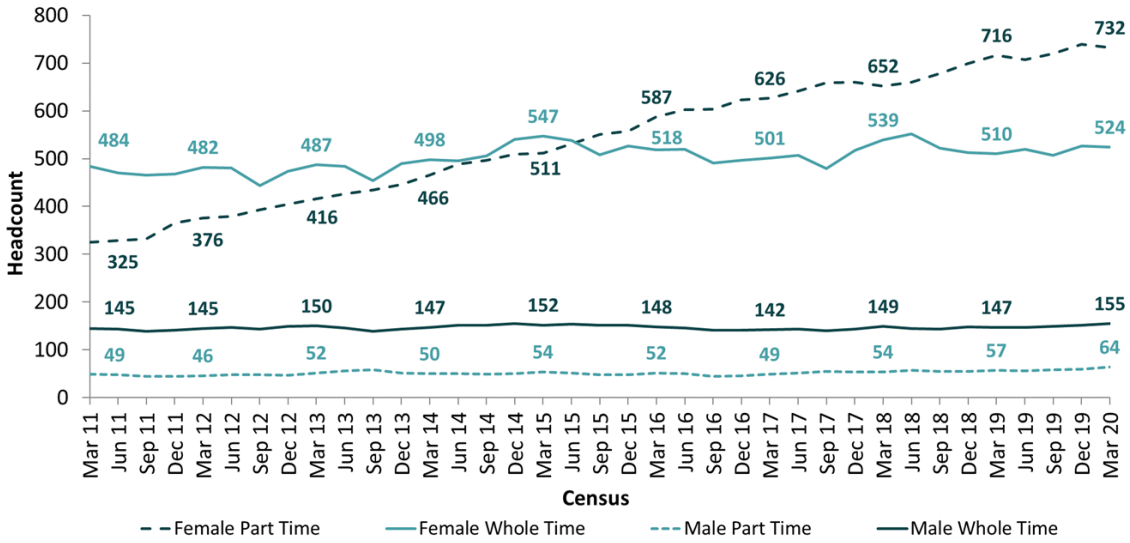


4.1 Gender and Contracted Hours

There has been a substantial increase in the number of female staff working part-time, from 325 headcount as at 31 March 2011 to 732 headcount at 31 March (+407 headcount, 125.2%). At 31 March 2020, 58.3% of contracts for female staff were part-time, compared to 29.2% for male staff. The number of male staff working part-time increased from 49 headcount in March 2011 to 64 headcount in March 2020 (+15 headcount, 30.6%), see Figure 12. For more detailed information on contract type and gender by professional group, please refer to Table 6.1 within the **data tables**.

A contract of 37.5 hours or 40 sessions is the standard working week for one whole-time equivalent staff member under NHS guidelines. While 29.2% of male staff and 58.3% of female staff work fewer than 37.5 hours, some practitioners may also hold part-time positions outside of NHSScotland.

Figure 12. Contract Type and Gender for Psychology Staff within NHSScotland from 31 March 2011 to 31 March 2020, by Headcount.



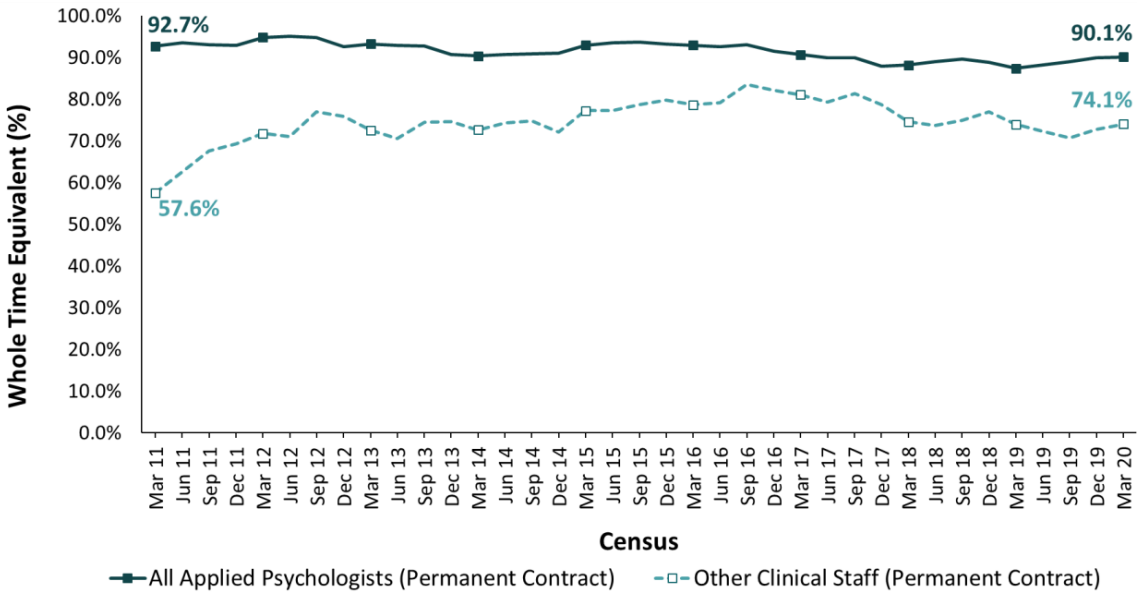
4.2 Contract Length

At 31 March 2020, 1036.9 WTE (85.4%) of staff in NHSScotland Psychology Services were employed on a permanent contract, 132.7 WTE (10.9%) were employed on a fixed term contract of less than two years' duration and 44.4 WTE (3.7%) were employed on a fixed term contract of longer than two years' duration.

The percentage of staff employed on a permanent contract varied by professional group. While 772.5 WTE (90.1%) of All Applied Psychologists held a permanent contract, this number was lower for Other Clinical Staff (264.5 WTE, 74.1%).

Figure 13 shows the trend in the percentage of all clinical staff holding permanent contracts between 31 March 2011 and 31 March 2019. The percentage of Applied Psychologists on permanent contracts declined from 92.7% (585.0 WTE) over that period, while the percentage of Other Clinical Staff holding permanent contracts increased from 57.6% (132.5 WTE). The percentage of Applied Psychologists working on fixed term contracts increased from 7.3% (46.1 WTE) in March 2011 to 9.9% (84.6 WTE) in March 2020, while the percentage of Other Clinical Staff working on fixed term contracts decreased from 42.4% (97.7 WTE) in March 2011 to 25.9% (92.6 WTE) at the current census.

Figure 13. Percentage of Applied Psychologists and Other Clinical Staff on Permanent Contracts, from 31 March 2011 to 31 March 2020.



4.3 Agenda for Change Pay Bands

The AfC Pay Band of a clinician reflects their level of training and expertise as well as the duties of the post, including the potential responsibilities in terms of the supervision and management of other staff. As a consequence, Clinical or Applied Psychologists are generally banded higher than other Clinical Professionals working in these services, with the majority of staff on Band 8a or higher (88.7%, 760.5 WTE as at 31 March 2020). Figure 14 shows the WTE of All Applied Psychologists and Other Clinical Staff, by band, as at 31 March 2020.

Figure 14. WTE of All Applied Psychologists and Other Clinical Staff at different Agenda for Change Pay Bands at 31 March 2020.

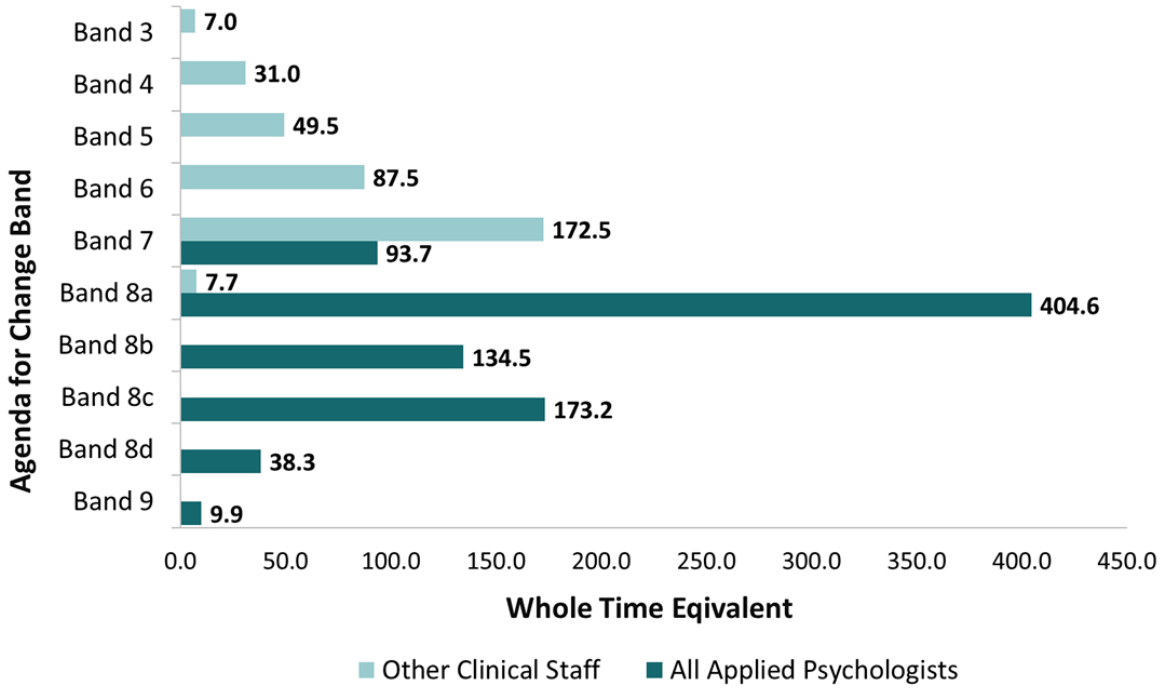
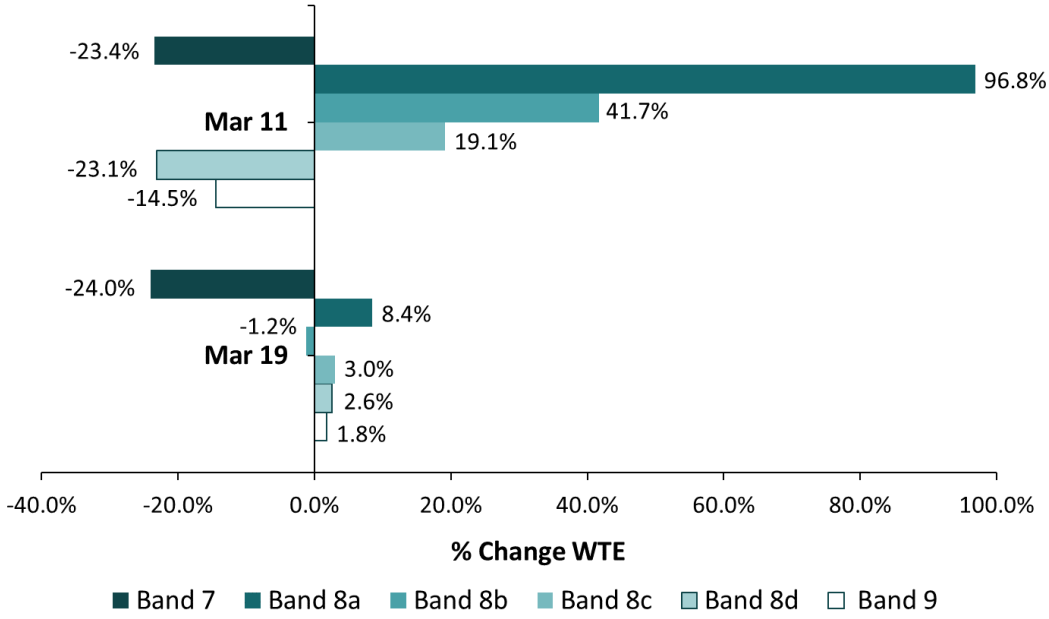


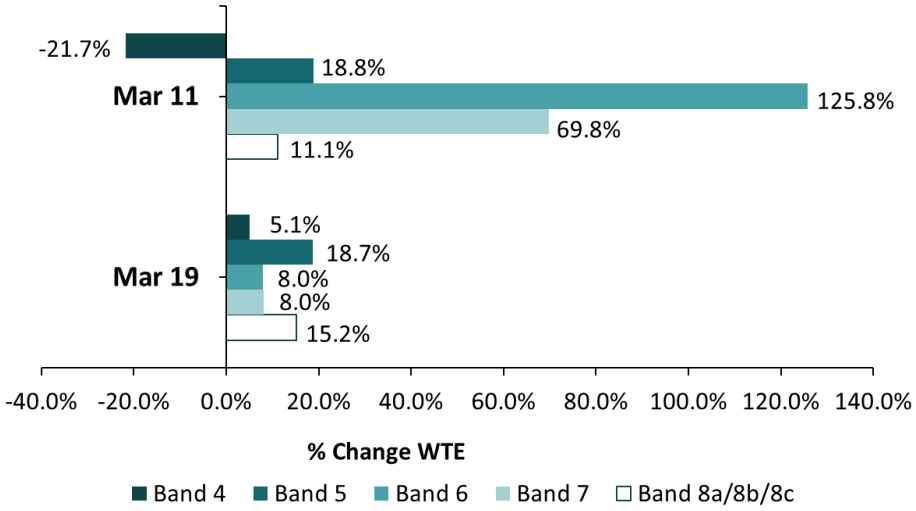
Figure 15 shows the percentage change in WTE of All Applied Psychologists at different AfC bands since 31 March 2011, when this information was first collected, and since 31 March 2019. Since March 2011, the WTE of Applied Psychologists at Bands 7, 8d and 9 has reduced, while the WTE of Applied Psychologists at bands 8a, 8b and 8c has increased. Since March 2019, there has been a slight reduction in the WTE of staff employed at band 8b and a more substantial reduction in staff employed at band 7. For more details, please refer to tables 7.1 and 7.2 in the **data tables**.

Figure 15. Percentage Change in WTE of Applied Psychologists between March 2011 and March 2020, and between March 2019 and March 2020, by Agenda for Change Pay Band.



The percentage change in WTE of Other Clinical Staff at different AfC bands, since March 2011 and March 2019, is shown in Figure 16. Since March 2011, the WTE of staff employed at bands 6 and 7 has grown substantially, which may reflect the increased number of roles for Clinical Associates, while the WTE of staff employed at band 4 has fallen.

Figure 16. Percentage Change in WTE of Other Clinical Staff between March 2011 and March 2020, and between March 2019 and March 2020, by Agenda for Change Pay Band.[1]



Notes:

1. As of March 2011, Band 3 posts for Other Clinical staff are not recorded.

5. Staff in training

NES has responsibility for commissioning the pre-registration training of Clinical Psychologists for NHSScotland, the main source of psychology workforce supply.

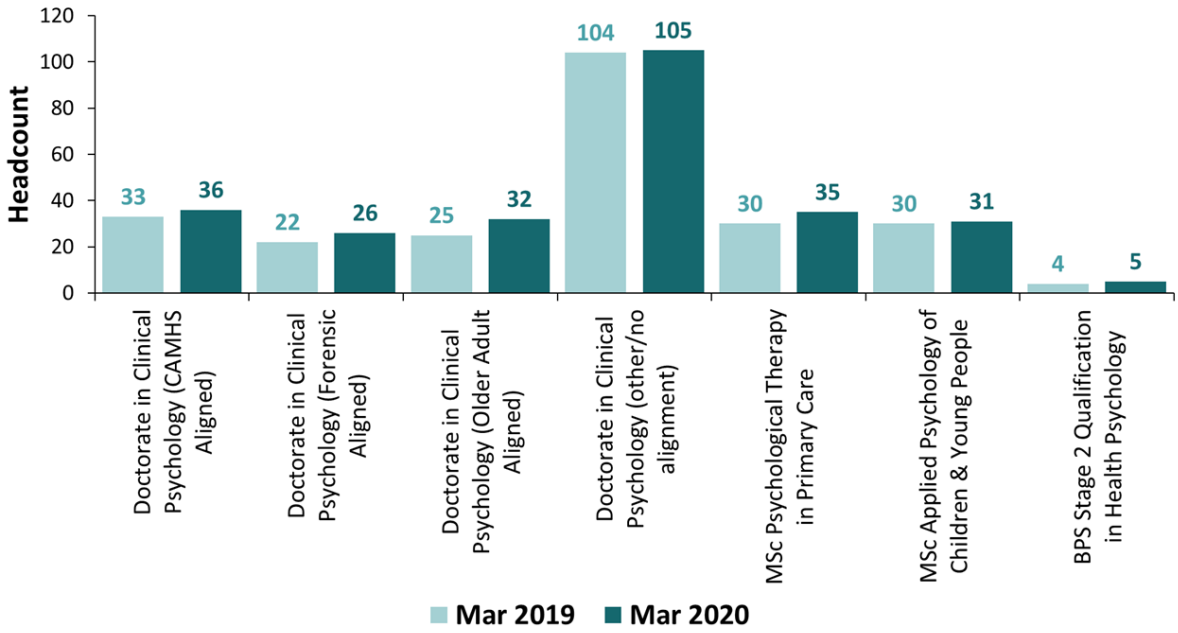
In addition to the Doctorate in Clinical Psychology (DClinPsych), MSc Psychological Therapy in Primary Care (MSc PTPC) and MSc in Applied Psychology for Children and Young People (MSc APCYP), NES works in partnership with NHS boards to provide the British Psychological Society's Stage 2 Training in Health Psychology. Trainees on each of these courses are employed by the NHS during training. For definitions of these training courses see the **Summary of Training Courses**.

5.1 Current Trainees

The latest reported numbers of individuals training towards Applied Psychology postgraduate qualifications are shown in Figure 17. The total number of doctorial trainees has increased by 15 (8.2%) since March 2019, the number of MSc Psychological Therapy in Primary trainees has increased by 5 (16.7%), and the number of trainees on the MSc Applied Psychology of Children & Young People and BPS Stage 2 Qualification in Health Psychology courses have both increased by 1.

Since 2009, aligned training pathways on the DClinPsych have been funded by the Scottish government, with the aim of increasing capacity in specific areas of the psychology workforce. At the current census, of the 199 trainees working towards Doctorate in Clinical Psychology, 36 were aligned to CAMHS, 26 to Forensic Psychology and 32 to Older Adults.

Figure 17. Current Trainees (Headcount) in NHSScotland as at 31 March 2019 and 31 March 2020[1]



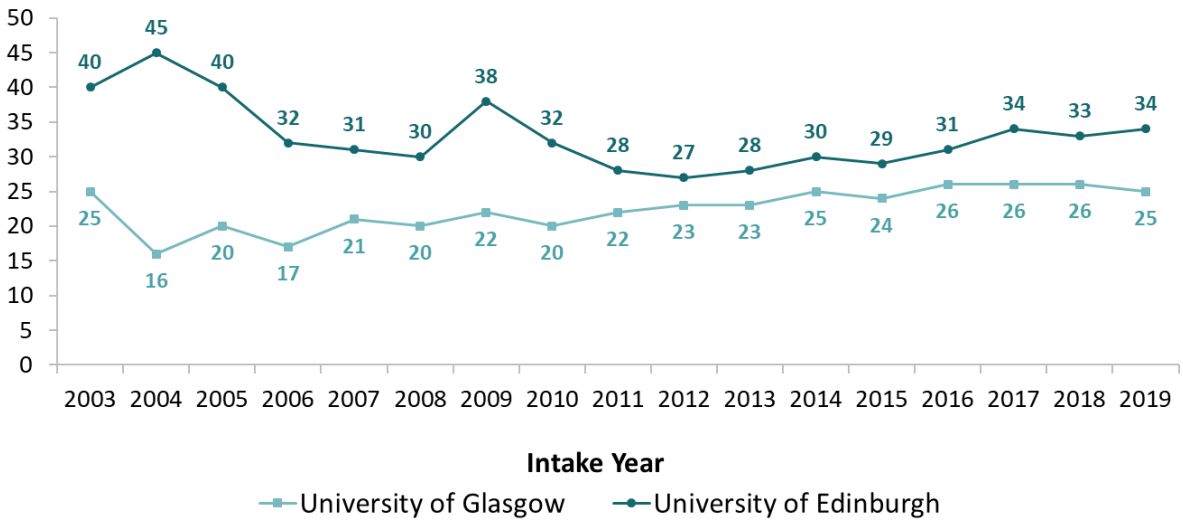
5.2 Course intakes and outputs

This section explores the number of trainees starting the course (intake) and the number completing the course (output).

5.2.1. Doctorate in Clinical Psychology

Figure 18 displays the intake of trainees on the DClinPsych courses in Scotland from 2003 to 2019. The average intake over this period was 55 trainees per year. There were 59 trainees at the latest intake in September 2019 (25 at the University of Glasgow and 34 at the University of Edinburgh).

Figure 18: Intake of Trainees on the Doctorate in Clinical Psychology Courses at the University of Edinburgh and University of Glasgow by headcount from 2003 to 2019[1,2].



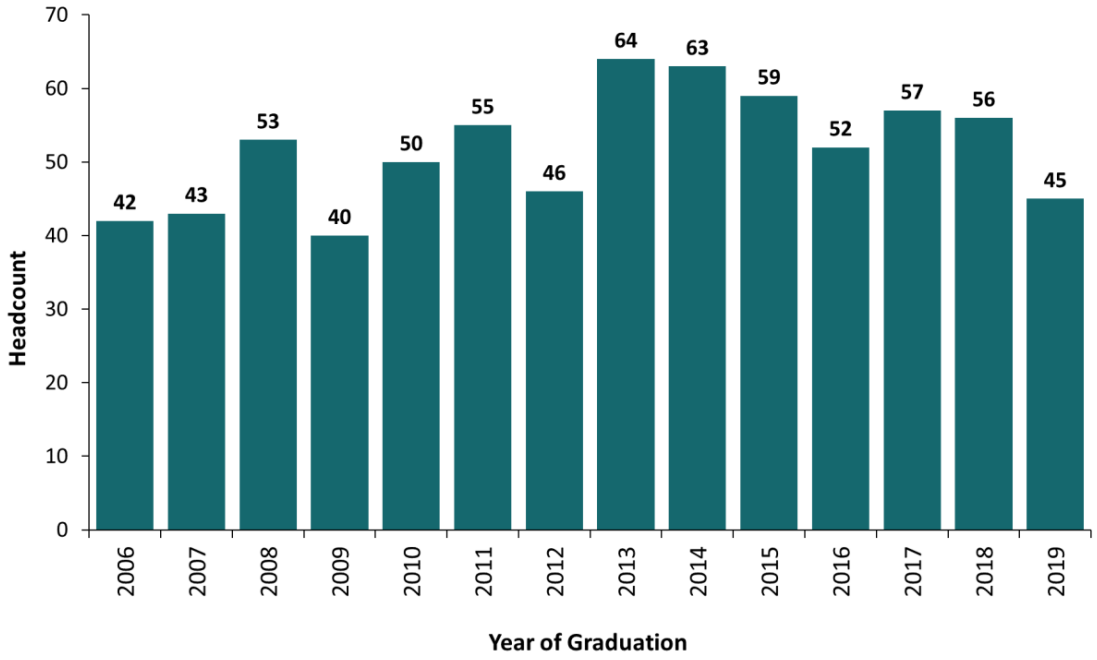
Notes

1. Data are only available from the 2003 intake onwards.
2. Data includes trainees in 2.5 years and 3 years Doctorate in Clinical Psychology Courses at University of Glasgow and trainees in 2.5 year, 3 years, 4 years and 5 years at University of Edinburgh

The last intake of trainees on either a four or five year course at the University of Edinburgh was in 2012. Since 2013, all trainees have therefore commenced a three-year course, unless they have previously completed either the MSc APCYP or the MSc PTPC. Graduates from these courses have now been given recognition for prior learning and are able to complete the DClinPsych course in 2.5 years. This came into effect from the 2014 intake at the University of Edinburgh and the 2017 intake at the University of Glasgow.

Figure 19 shows the number of graduates from the DClinPsych courses that achieved Health and Care Professions Council (HCPC) registration after completing the course. HCPC registration is required in order to undertake a post as a Clinical Psychologist within the UK.

Figure 19: Headcount of DClinPsych Trainees achieving HCPC Registration, by Graduation Year, from 2006 to 2019[1,2].

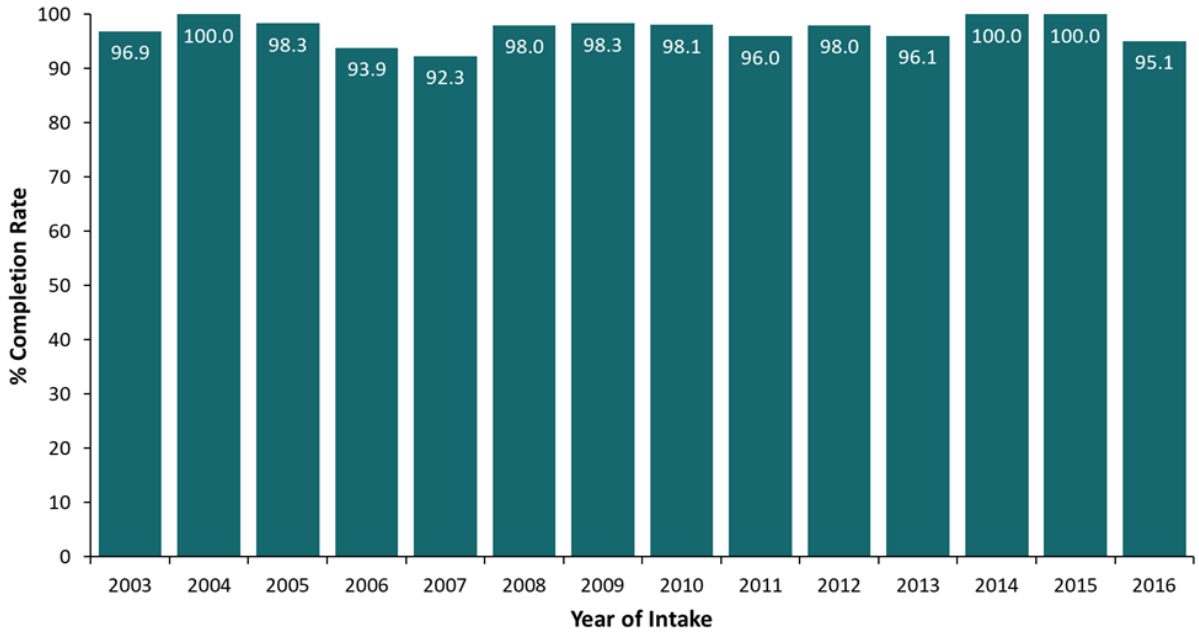


Notes

1. The data are only available for 2006 graduates onwards.
2. The completion rates are based on those that have already left the course and will exclude anyone that is currently on an extension as it is unknown whether they will achieve HCPC registration. Therefore, completion rates for some years are subject to change in future.

Figure 20 displays the completion rates for trainees who started on the DClinPsych course from 2003 to 2016. The completion rate for every cohort has been above 92%. Excluding trainees who are currently on an extension, the overall completion rate for the DClinPsych courses in Scotland is 97.3%. Further information on completion rates for each course is available in the **data tables**.

Figure 20: Completion Rates for DClinPsych Trainees by Intake Year, from 2003 to 2016[1].



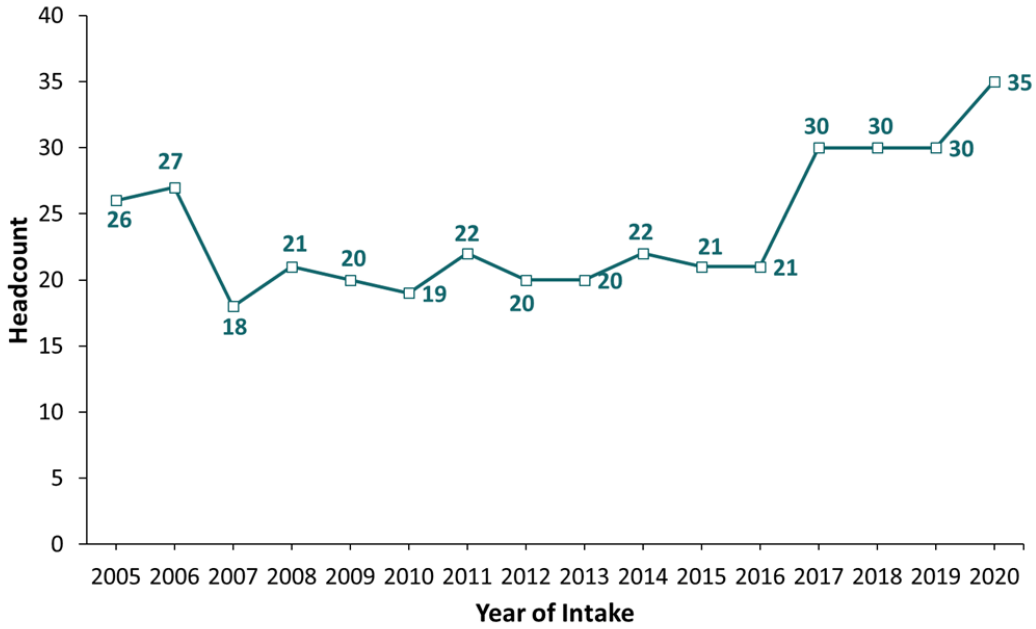
Notes

1. The completion rates are based on those that have already left the course and will exclude anyone that is currently on an extension as it is unknown whether they will achieve HCPC registration. Therefore, completion rates for some years are subject to change in future.

5.2.2. MSc Psychological Therapy in Primary Care

Figure 21 displays the intake of trainees on the MSc Psychological Therapy in Primary Care course. Since 2005 there has been an intake of 382 trainees in total, with an average intake of 24 trainees each year. Excluding the trainees from the 2020 intake who are due to complete in 2021, there have been 330 graduates from the course. This indicates a completion rate of 95.1%.

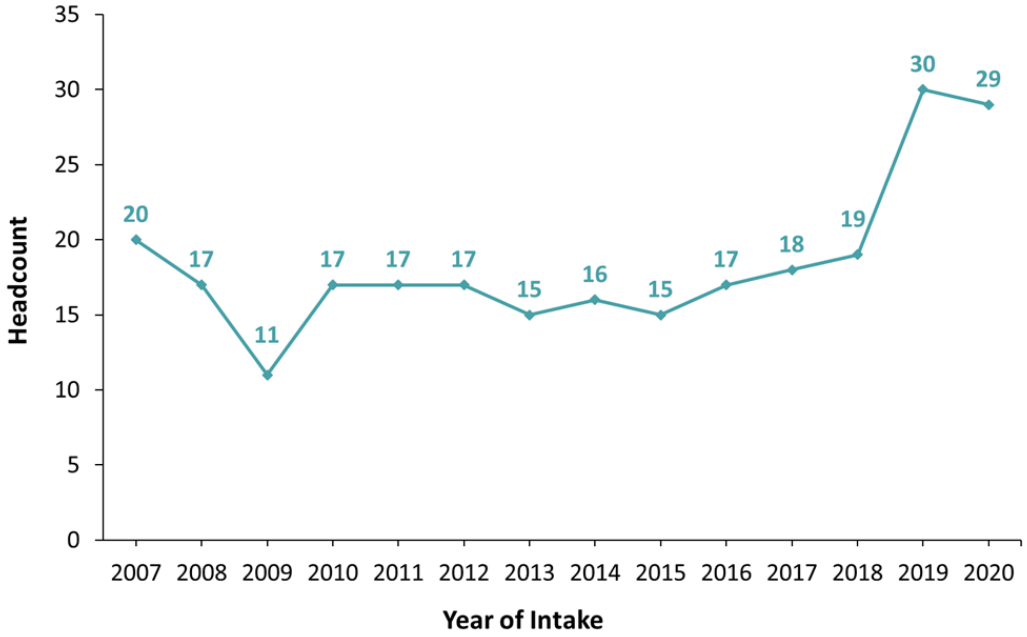
Figure 21: Intake of Trainees onto the MSc PTPC Course, from 2005 to 2020.



5.2.3. MSc Applied Psychology for Children and Young People

Figure 22 displays the intake of trainees on the MSc Applied Psychology for Children and Young People course. Since 2007 there has been an intake of 258 trainees in total, with an average intake of 18 trainees each year. Excluding the trainees from the 2020 intake who are due to complete in 2021, there have been 219 graduates from the course. This indicates a completion rate of 95.6%.

Figure 22: Intake of Trainees onto the MSc APCYP Course from 2007 to 2020.

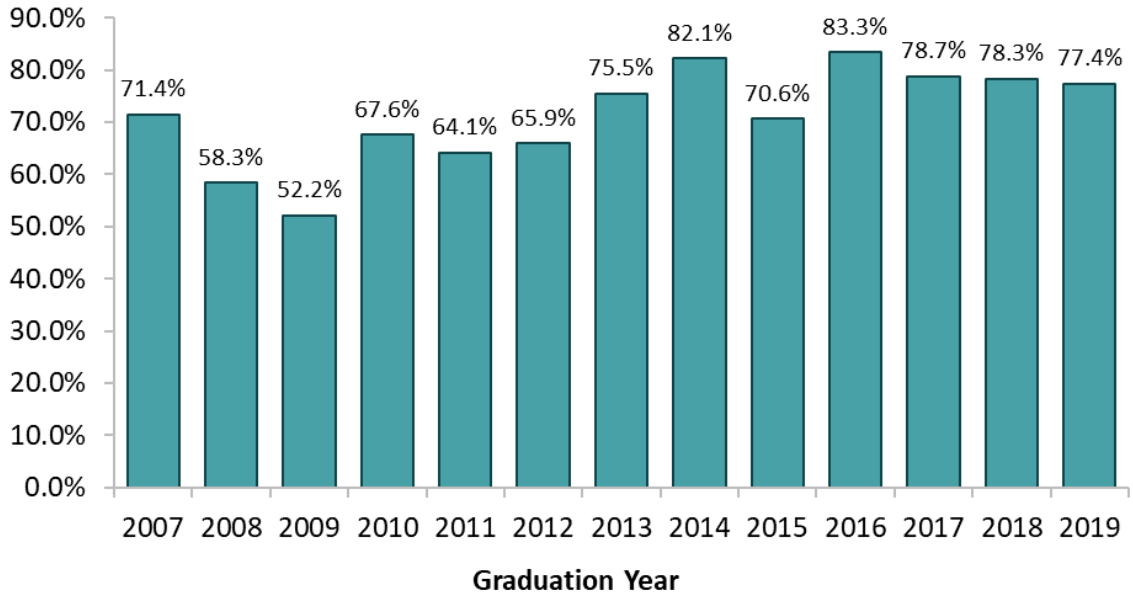


5.3 Graduate Retention- Doctorate in Clinical Psychology (D Clin Psych)

Between 2007 and 2019 there were 683 successful graduates of DClin Psych. Figure 23 illustrates the retention rate, showing the percentage of graduates employed in Psychology Services in NHSScotland for each graduation year since 2007. Of the 506 graduates for whom this information is available, 369 are currently employed in NHSScotland, an overall retention rate of 72.9%.

Due to data quality issues, some of the graduates who are currently in employment in NHSScotland might not be included in the data. Further work is being done to determine the accuracy of the data. Any reduction in retention could be due to a number of factors such as graduates taking a career break before beginning permanent employment in Scotland, taking up employment in NHSScotland outwith Psychology Services, moving to NHS England or further abroad, or choosing to work in the private sector. More information on graduate retention is available in the **data tables**.

Figure 23: Retention Rate of DClinPsych Graduates within NHSScotland Psychology Services, by Graduation Year since 2007[1].



Notes

1. National Insurance numbers are missing for 177 graduates between 2007 and 2019. These graduates are not included in the retention figures above, as we are unable to track their current employment. Further work is being done to determine the accuracy of the data.

6. Glossary

Agenda for Change (AfC): The national pay system for NHS Workforce excluding doctors, dentists and very senior managers.

Applied Psychologists: Includes clinical, counselling, forensic, health and neuropsychologists. See the **Summary of Professional Groups** for definitions of each.

Area of Work: The specialty area that a clinician works in. For a list of areas of work, see table 3.2 in the **data tables**. Below are definitions of the sub categories under 'Mental Health' and the other areas of work:

> ***Mental Health – mild to moderate****: A mild mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life. A moderate mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.*
>
> ***Mental Health – severe and enduring****: People with recurrent or severe and enduring mental illness, for example schizophrenia, bipolar affective disorder or organic mental disorder, severe anxiety disorders or severe eating disorders, have complex needs which may require the continuing care of specialist mental health services working effectively with other agencies. Many people with severe mental illness are treated in the community with the support of primary care staff. A range of services is needed in addition to primary care - specialist mental health services, employment, education and training, housing and social support. Needs will fluctuate over time, and services must be able to anticipate and respond to crisis.*
>
> ***Mental Health – early intervention****: A multidisciplinary, coordinated system of service provision to identify risk situations and/or likelihood of psychological ill health.*
>
> ***Mental Health – eating disorders****: Eating disorders are a group of disorders in which abnormal feeding habits are associated with psychological factors. Characteristics may include a distorted attitude toward eating, handling and hoarding food in unusual ways, loss of body weight, nutritional deficiencies, dental erosion, electrolyte imbalances, and denial of extreme thinness. The most common conditions include anorexia nervosa and bulimia nervosa. Persons with eating disorders of this kind characteristically misperceive themselves as either overweight or of normal weight.*
>
> *Treatment of eating disorders is often on an outpatient basis unless severe malnutrition and electrolyte imbalances are present, severe depression and suicidal tendencies endanger the patient, or there is evidence that the patient cannot cope with daily living without resorting to abnormal eating patterns. Additionally, the family and home environment may be creating unbearable tension because of a power struggle over the patient's abnormal eating pattern.*

Alcohol & Substance Misuse*: Treatment of individuals with a maladaptive pattern of a drug, alcohol or other chemical agent that leads to social, occupational, psychological or physical health problems.*

Forensic*: Forensic psychology deals with the psychological aspects of legal processes, including applying theory to criminal investigations, understanding psychological problems associated with criminal behaviour. Forensic Psychologists work in a range of NHS settings. They work in high and medium security hospitals in the assessment and treatment of those detained under the Mental Health Act. They also work within the community and in child and family settings where issues of risk assessment and offence related work may be critically important. In addition to the NHS, a significant number of forensic psychologists work in the prison service.*

Learning Disabilities*: A learning disability is a reduced intellectual ability and difficulty with everyday activities, e.g. delayed childhood development, socialising, or physical tasks, which affects someone for their whole life. The level of support someone needs depends on the individual; those with a severe learning disability or profound and multiple learning disability (PMLD) will need more care from a multi-disciplinary team and with areas such as mobility, personal care and communication.*

Neuropsychology*: Neuropsychology looks at the relationship between the physical brain and its various functions, dealing with topics such as sensory perception, memory, and the biological basis for conditions like depression. Psychologists within this field also help with the assessment and rehabilitation of people with brain injury or other neurological conditions, such as strokes, dementia, and degenerative brain disease.*

Physical Health*: Psychologists working in physical health deal with the psychological and emotional aspects of health and illness as well as supporting people who are chronically ill.*

Clinical Psychologists: Psychology staff with a Doctorate in Clinical Psychology and registered with the Health and Care Professions Council.

Clinical Staff: All staff working in psychology services within NHSScotland.

Establishment: Term used in calculating NHSScotland workforce information to describe total filled and vacant posts. Establishment is calculated by adding the number of staff in post to the number of vacant posts.

HCPC: Health and Care Professions Council. This is a Register for Health and Care Professionals within the UK who are required to meet certain standards of practice. For many professions, including several types of Psychologist, it is a legal requirement to be registered in order to practice in their field.

Headcount: The actual number of individuals working within NHSScotland. The Scotland figures eliminate any double counting that may exist as a result of an employee holding more than one post.

GG&C: NHS Greater Glasgow and Clyde

NES: NHS Education for Scotland

Other Clinical Staff: Includes posts often taken up by graduates of the MSc in Psychological Therapy in Primary Care and the MSc Applied Psychology for Children and Young People E.g. clinical associates in applied psychology, counsellors, assistant psychologists, cognitive behavioural therapists, other therapists and other professionals.

Target Age: The age group of patients seen by a clinician. For Psychology Services this can be child & adolescent (0-18/19 years), adult (20-64 years), or older adult (65+ years). Age non-specific refers to those clinicians who see patients from across the lifespan and can also include non-clinical work such as teaching.

Vacancy: A post which was vacant and being advertised for recruitment at the census date.

Whole time equivalent (WTE): The WTE adjusts headcount figures to take account of part-time working. For example, NHS Agenda for Change staff work 37.5 whole-time hours per week so a staff member working part-time at 30 hours per week would be calculated as 0.8 WTE.

7. Summary of Professional Groups within Psychology Services

All Applied Psychologists

This includes Clinical Psychologists, Counselling Psychologists, Health Psychologists, Forensic Psychologists and Neuropsychologists. These staff have completed specific post-graduate training and hold additional qualifications in their field.

Clinical Associate in Applied Psychology

(CAAP) Graduates of the MSc Applied Psychology for Children and Young People or the MSc Psychological Therapy in Primary Care are qualified to work as CAAPs. They are trained in the delivery of evidence-based psychological therapies for common mental health problems in primary care, or in the delivery of tier two psychology assessments in a range of services for children and young people.

Clinical Psychologist

Psychology staff with a Doctorate in Clinical Psychology (see **Summary of Training Courses**) and registered with the Health and Care Professions Council.

Counselling Psychologist

Psychologists who hold a British Psychological Society accredited post graduate qualification in Counselling Psychology and are registered with the Heath and Care Professions Council (HCPC).

Health Psychologist

Psychologists who hold a British Psychological Society accredited Masters in Health Psychology and as Stage II or Doctorate in Health Psychology.

Forensic Psychologist

Psychologists who hold a British Psychological Society accredited postgraduate qualification in Forensic Psychology.

Neuropsychologist

Clinical Psychologists who in addition to their Doctorate in Clinical Psychology qualification hold a Stage II British Psychological Society Neuropsychology qualification.

Cognitive Behavioural Therapist

Cognitive behavioural therapists use talking therapy to help patients change negative patterns of thinking or behaviour. They have completed accredited training programme in Cognitive Behavioural Therapy.

Other Therapist

Includes Psychotherapists, family and couple therapists

Counsellor

Counsellors provide talking therapies to clients and their families. They are trained to listen with empathy and can help people with a range of mental health conditions including: depression, anxiety, long term illnesses, eating disorders and drug misuse. Counsellors come from a range of backgrounds but will all have completed a recognised counselling qualification.

Psychology Assistant

Psychologists who have completed an undergraduate degree in Psychology and wish to gain experience in a clinical setting. Psychology Assistants often aspire to undertake further training in a specific area of Psychology e.g. Doctorate or MSc course.

8. Summary of Training Courses

Doctorate in Clinical Psychology

The Doctorate in Clinical Psychology is a 3-year full time course funded by NES which can be studied at either the University of Edinburgh or the University of Glasgow in Scotland. Entry to the course requires an Honours degree in Psychology (2:1 or above) which has the British Psychological Society (BPS) Graduate Basis for Chartered Membership, alongside relevant clinical or research experience. Specific CAMHS aligned trainee pathways on the Doctorate courses are government-funded places which give trainees greater experience working with CAMHS populations in addition to their main trainee workload. Aligned pathways have been introduced for several clinical populations with the aim of increasing workforce capacity within those areas. On completion, trainees will be fully qualified Clinical Psychologists and are still able to work in areas outwith CAMHS. Both of the Scottish courses are approved by the Health and Care Professions Council as well as the British Psychological Society and represent the highest level of training in Psychology. Further information on the Doctorate as well as links to the University Course websites for Scotland can be found at: **http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/training-psychologists/training-programmes.aspx**.

MSc Psychological Therapy in Primary Care

The MSc in Psychological Therapy in Primary Care is a one-year course that was introduced in 2005. The MSc is funded by NHS Education for Scotland and delivered jointly by the Universities of Stirling and Dundee. Entry to the course requires an Honours degree in Psychology (2:1 or above) which has the British Psychological Society (BPS) Graduate Basis for Chartered Membership, and during training,

trainees are employed in NHS Boards and provide clinical services as part of supervised practice. This course was designed to train people to deliver evidence-based psychological therapies to adults in Primary Care by developing knowledge of prevalence, diagnostic criteria, presentation and treatment of common mental health disorders within a Cognitive Behavioural Framework. The course is designed to extend the knowledge of the theoretical foundations of human behaviour and psychological disorders, and to develop the necessary competences to deliver evidence-based psychological therapies to treat common mental health disorders in adults in a primary care setting. Graduates of this course are able to work as Clinical Associates in Applied Psychology (CAAP) in the NHS, or within other clinically related posts in the private or public sector. This allows graduates to enter the workforce quickly and respond to pressing service demands (e.g. support the NHS Boards to meet Psychological Therapies Heat Targets)

Further information can be found online at: **https://www.dundee.ac.uk/study/pg/psychological-therapy-primary-care/**

Or **https://www.stir.ac.uk/postgraduate/programme-information/prospectus/psychology/psychological-therapy-in-primary-care/#intro**

MSc in Applied Psychology for Children and Young People

The MSc in Applied Psychology for Children and Young People is a one-year course that was introduced in 2007 and is funded by NHS Education for Scotland at the University of Edinburgh. Entry to the course requires an Honours degree in Psychology (2:1 or above) which has the British Psychological Society (BPS) Graduate Basis for Chartered Membership, and whilst training trainees are expected to complete a full year clinical placement within an NHSScotland CAMHS setting. The course was introduced to expand the professional skill mix working within CAMHS and other child services, with graduates of the course able to apply for employment as Clinical Associates in Applied Psychology, Child and Adolescent Therapists or Primary Mental Health Workers, for example. Further information can be found at: **http://www.ed.ac.uk/health/clinical-psychology/studying/msc-applied-psychology**

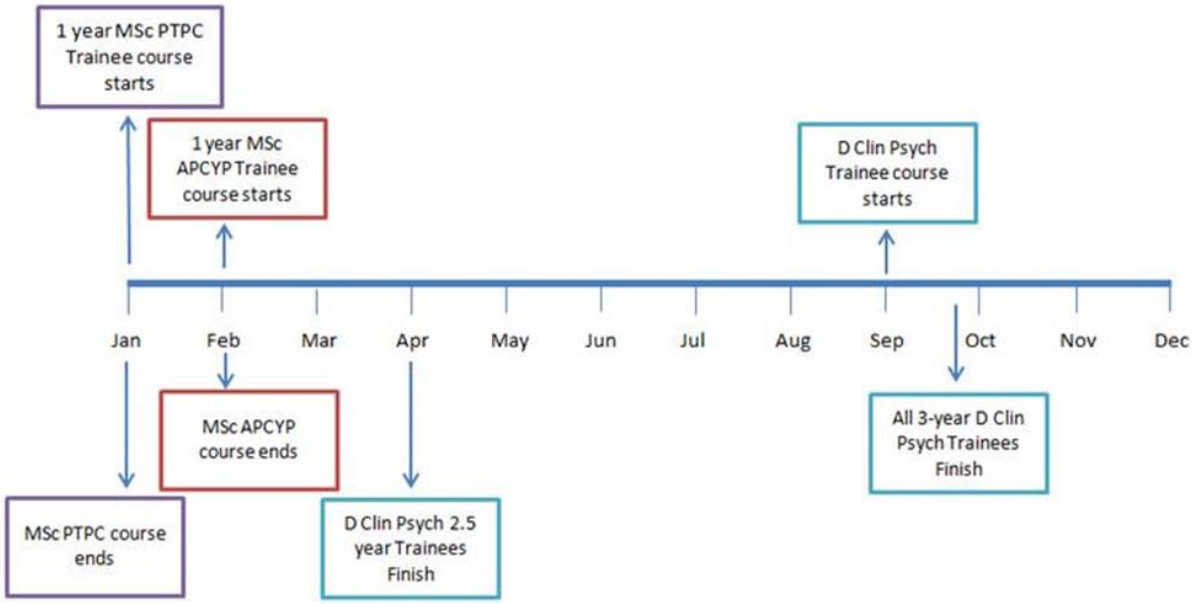
BPS Stage 2 Qualification in Health Psychology

BPS Stage 2 Qualification is a doctoral level qualification in Health Psychology. NHS Education for Scotland (NES) in partnership with Health Boards in Scotland funds Trainee Health Psychologists to explore the contribution health psychology can make in supporting NHSScotland to meet its Health Improvement Targets. This is a two-year programme designed to allow the Trainee Health Psychologists to successfully complete the British Psychological Society's Stage 2 Training while employed by NHS to undertake a programme of approved work. Entry to the course requires an Honours degree in Psychology (2:1 or above) which has the British Psychological Society (BPS) Graduate Basis for Chartered Membership and a BPS accredited Masters Degree in Health Psychology. NHS-funded Stage 2 training places may also require applicants to have a number of years' experience working in relevant areas such as working with people with physical health problems, supporting people to make lifestyle changes, population-based interventions or undertaking research and evaluation. Trainees work with the Public Health departments of their health boards on projects aimed at meeting specific HEAT Targets for health improvement and Trainees should receive supervision from an appropriately experienced Health

Psychologist during their training. Graduates of this course can work as Chartered Health Psychologists and are registered with the Health and Care Professions Council (HCPC).

Further information can be found at: **http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/training-psychologists/training-programmes/health-psychologist-in-training.aspx**

Figure 24: Start and End dates of Psychology Training Courses[1,2].



MSc PTPC – MSc Psychology Therapy in Primary Care

MSc APCYP – MSc Applied Psychology for Children and Young People

Notes

1. The stage 2 Health Psychology course usually takes 2 years to complete, however the start dates can vary from year to year.
2. Please note that some individuals take maternity leave or other periods of leave during training which can impact on the timing of the course completion.

9. List of Tables

Please note, due to the Covid-19 pandemic, data on vacancies as at 31 March 2020 are not reported, due to the additional demands this would place on colleagues at NHS Boards.

Table No.	File name	Time Period	File and size
1-12	2020-03-03-Psychology-Workforce-Tables	2001-2019	Excel 750 Kb
1.1	All Clinical Staff (WTE) employed in Psychology Services by NHS Board	2010-Mar 2020	"
1.2	All Clinical Staff (Headcount) employed in Psychology Services by NHS Board	"	"
1.3	All Clinical Staff (WTE per 100,000 population) employed in Psychology Services by NHS Board	"	"
2.1	All Clinical Staff (WTE) employed in Psychology Services by Age Group	"	"
2.2	All Clinical Staff (Headcount) employed in Psychology Services by Age Group	"	"
3.1	All Clinical Staff (WTE) employed in Psychology Services by Area of Work	2011-Mar 2020	"
3.2	All Clinical Staff (WTE) employed in Psychology Services by detailed Area of Work and Target Age	"	"
4.1	All Clinical Staff (WTE) employed in Psychology Services by Target Age	"	"
4.2	All Clinical Staff (WTE or Headcount) employed in Psychology Services by Target Age, Area of Work and Professional group	"	"
5.1	All Clinical Staff (Headcount and WTE) employed in Psychology Services by Gender	"	"
6.1	All Clinical Staff (Headcount and WTE) employed in Psychology Services by Contract Type and Gender	"	"

7.1	All Clinical Staff (WTE) employed in Psychology Services by Band	"	"
7.2	All Clinical Staff (Headcount) employed in Psychology Services by Band	"	"
8.1	All Clinical Staff (Headcount) employed in Psychology Services by Contract Length	"	"
8.2	All Clinical Staff (WTE) employed in Psychology Services by Contract Length	"	"
9.1	Ethnicity of All Psychology Services Staff	Sep 2011-Sep 2019	"
9.2	All Psychology Services Staff by Declared Disability	"	"
10.1	All Applied Psychologists (Headcount) in Training in NHSScotland	Mar 2020	"
11.1	Course Intakes, Outputs and Completion Rates for trainees on a Doctorate in Clinical Psychology Course in Scotland from the 2003 intake onwards	Sep 2003-Mar 2020	"
11.2	Graduates of Doctorate in Clinical Psychology (Headcount) in Workforce in NHSScotland Psychology Services	Sep 2003-Sep 2019	"
12.1	Course Intakes and Outputs for the MSc Applied Psychology for Children and Young People and MSc Psychological Therapy in Primary Care	Sep 2005-Mar 2020	"
12.2	Graduates of MSc Psychological Therapy in Primary Care and MSc Applied Psychology in Children and Young People (Headcount) in Workforce or Doctorate in Clinical Psychology Courses in Scotland	Sep 2003-Mar 2020	"

10. Psychology Workforce Contacts

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Appendices

Appendix 1 – Background information

Mental Health Policy and Targets

Developments in mental health care have been driven by a series of reports and policy recommendations:

The Scottish Government 10 year Mental Health Strategy 2017-2027 was published in March 2017 (**http://www.gov.scot/Publications/2017/03/1750**). The strategy highlights the need to increase the supply of the workforce and to ensure the skill mix across a wide range of services meets in the needs of the population.

The Scottish Government has set a standard for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014.

The Psychological Therapies 'Matrix' is a guide to planning and delivering evidence-based Psychological Therapies within NHS Boards in Scotland. It provides a summary of the information on the current evidence base for various therapeutic approaches, a template to aid in the identification of key gaps in service, and advice on important governance issues.

http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/the-matrix-(2015)-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland.aspx

Further information on Older People's Psychology Services can be found in the paper: 'The Challenge of Delivering Psychological Therapies for Older People in Scotland' (2011), a report of Older People's Psychological Therapies Working Group **https://www2.gov.scot/resource/0039/00392671.pdf**

For more details on psychology forensic services, please refer to the following paper:

'Psychological Care in the Context of Forensic Mental Health Services: New Responsibilities for Health Boards in Scotland (2011), Report by Heads of Psychological Services in NHSScotland.

For more information on Psychology Services in NHSScotland please see the 'Applied Psychologists and Psychology in NHSScotland: Working Group Discussion Paper' available at: **http://www.sehd.scot.nhs.uk/mels/CEL2011_10.pdf**

In June 2017 the Scottish Government published **Part 1 of the National Health and Social Care Workforce Plan**. The plan outlines measures that are designed to strengthen and harmonise NHSScotland workforce planning practice nationally, regionally and locally to ensure that NHSScotland has the workforce it will need to address future demand for safe, high quality services. These measures include the establishment of a National Workforce Planning Group.

Part 2 of the workforce plan was published in December 2017 and outlined a framework for improving workforce planning in social care. Part 3 was then published in April 2018 to cover the primary care setting. Together these will enable different health and social care systems to move together towards publication of a second full Health and Social Care Workforce Plan later in 2019 and beyond.

Links to Related Publications

There is a differing age range of service provision across the boards in child services, for more details of this please refer to the **CAMHS publication.**

For further information on training programmes within applied psychology in NHSScotland please see:

http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology.aspx

Appendix 2 – Early access details

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", HPS is obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

- Scottish Government Health Department
- NHS Board Chief Executives
- NHS Board Communication leads

Early Access for Management Information

These statistics will also have been made available to those who needed access to 'Management Information', i.e. as part of the delivery of health and care:

- Scottish Government Health Department – Mental Health Division
- Health Improvement Scotland – Improvement Advisor.

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **alformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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NHS
Health Education England

Psychological Professions Workforce Plan for England

2020/21 to 2023/24

Updated: December 2021

Executive Summary

The NHS Long Term Plan, alongside the growth of Mental Health Support Teams (MHST) for schools, requires an unprecedented growth in the 12 psychological professions. It is anticipated that this workforce of psychologists, psychotherapists, psychological therapists, counsellors and psychological practitioners needs to grow by over 60% from the 2019 baseline by 2024, contributing a third of the overall growth required in the mental health workforce.

This integrated workforce plan for the psychological professions has been developed by the National Psychological Professions Workforce Group to fulfil a commitment of the Interim People Plan[1]. This group brings together NHS England and Health Education England policy and delivery leads with stakeholders in the psychological professions, including service user and carer 'experts by experience' and 13 professional bodies.

Until recently there was no national or regional professional leadership of the psychological professions in NHS structures, meaning these groups have remained poorly understood in workforce planning, and their full potential remains to be realised.

The workforce plan sets out a direction of travel to maximise the impact of this workforce for the public to 2024. It highlights the role of the national NHS bodies, Integrated Care Systems (ICSs), employers and higher education institutes (HEIs) in working together to support this direction.

It lays out an ambitious but achievable programme to turn the NHS Long Term Plan ambitions into a lived reality for service users, families and carers. It is based around five strategic priorities:

1. **Grow:** Expanding the psychological professions workforce to improve access to psychological healthcare

2. **Develop:** Establishing clear career paths and development opportunities for all psychological professionals

3. **Diversify:** Attracting and retaining people of talent from all backgrounds

4. **Lead:** Developing the right local, regional and national leadership

5. **Transform:** Embracing new ways of working

Multiple stakeholders will need to play a role if we are to deliver on these priorities:

- Health Education England (HEE) with NHS England and NHS Improvement (NHSEI) can support delivery by ensuring the right level and type of education commissioning, alongside support to systems to deliver the required expansion in posts. This support will include both national and regional professional leadership for the psychological professions.

[1] Interim NHS People Plan: the future allied health professions and psychological professions workforce

- ICSs can contribute by ensuring that the required growth and development is part of their workforce planning, supported by professional and clinical leadership input from psychological professionals in their local and regional system.

- Employers will ultimately enable the change required by ensuring the recruitment of the expanded workforce, providing placements for the growing number of trainees, and supporting staff to manage the supervision requirements for this alongside the wider service needs.

- HEIs will play an important role in expanding, aligning and adapting their programmes to support the expansion, aligned to the NHS Long Term Plan strategic priorities.

By working together with focus across the system, we can achieve a step-change in psychological professions workforce, for the benefit of the public.

1. Introduction

This Psychological Professions Workforce Plan for England sets out the scale of the requirement for expansion of the psychological professions to 2023/24 to support delivery of the NHS Long Term Plan and the Mental Health Support Teams for schools. It shines a spotlight on the psychological professions specifically because of the massive growth required in these occupations and because the unique contribution of these diverse roles is not widely understood.

The Mental Health Implementation Plan 2019/20 – 2023/24 set out an ambitious roadmap for workforce growth to improve access to the range of quality, evidence-based psychological therapies and interventions at a faster pace than ever before. The exact numbers in the Mental Health Implementation Plan were indicative and were modelled pre-COVID-19. Demand for psychological interventions and mental health services may need to grow further over the coming years as a result of the COVID-19 pandemic.

This plan aims to support local systems to deliver the growth in psychological professions that their wider mental health plans require and to make the effective use of the diverse roles in this professional grouping. Delivering this transformation will require a 'step-change' in our psychological professions workforce – investing in and growing the workforce by at least 60 per cent from 2019/20 to 2023/24, as well as supporting staff to work differently.

The NHS Long Term Plan financial settlement to support the growth in the posts required is secure to 2023/24. However, the delivery of education and training to enable individuals to progress into these posts will be dependent on further education and training funding being identified from 2021/22 onwards. It is likely that systems will need to take a range of actions using all levers at all levels to secure the supply required by ICS plans, and this workforce plan sets out the different actions that different partners might take.

No one organisation holds all the levers needed to achieve this 'step-change'. Delivery will depend on all parts of the system working together to recruit, retrain and retain the staff we need. This integrated workforce plan for the psychological professions working in NHS commissioned services in England seeks to facilitate the required actions at local, regional and national levels.

It sets out the actions HEE, NHSEI, ICSs, providers, commissioners, regulators, Psychological Professions Networks (PPNs), HEIs, leaders in the professions and the professional bodies can take collectively to:

- Maximise the contribution of these professions to the delivery of the NHS Long Term Plan and Mental Health Support Teams
- Build on the far-reaching programme of development already underway
- Adapt in response to learning during the COVID-19 pandemic.

This plan is primarily focused on the mental health ambitions of the NHS Long Term Plan and on meeting people's mental health needs. However, we also recognise that increasing numbers of psychological professionals work across physical and integrated healthcare, where they have potential to make a very significant and growing impact.

The document therefore seeks to look beyond the NHS Long Term Plan to other areas where psychological professionals can make a significant difference to the lives of services

users, families and carers, whether in physical healthcare settings, drug and alcohol services, forensic services, implementing the Mental Health Act Reform or working to prevent mental ill health.

This plan forms part of a wider strategic workforce planning process being undertaken by HEE and feeds into the overarching mental health workforce strategy. It also aligns to We are the NHS: People Plan 2020/21 and the National Vision for the Psychological Professions, which builds on the priorities of the NHS Long Term Plan, but also looks beyond it, to imagine a health and care service in which psychological healthcare is fully integrated.

While this plan focuses on the actions the system needs to take collectively in the short and medium term, we will also continue to work with our partners and stakeholders to develop a longer-term strategy to plan sustainable improvements beyond 2023/24.

2. Who are the psychological professions?

The psychological professions are a diverse group of professions whose work is informed by the disciplines of psychology and psychological therapy. They work to prevent and alleviate psychological and emotional distress, manage mental health and wellbeing and empower individuals and communities to improve their lives.

These professions work across the lifespan - with children and young people, adults and older adults - as well as with communities and supporting the wider NHS workforce, and across a wide range of settings, including mental health services, hospitals, primary care services, prisons, local authorities and educational settings.

Although a wide range of professions in the NHS draw on psychological theory and practice within their work, the professions specified below (and associate and assistant roles linked to these disciplines) are those represented within the psychological professions leadership structure within the NHS in England.

This workforce plan focuses particularly on these disciplines, although it may have relevance to other practitioners across the extended psychological professions family. It will be imperative that we continue to foster and develop the ongoing relationships between the 12 psychological profession groups and other professions (including medical psychotherapists, art, drama and music therapists) who also have a specialist psychological knowledge in order to reduce any silo working and learn from their collective leadership and management skills. This will also help to decrease any inter-professional barriers and allow the delivery of the safest, highest quality and evidence-based patient care.

Fig. 1 The Psychological Professions professional group in the NHS in England.

Psychologists	Psychological therapists	Psychological practitioners
• Clinical psychologist • Counselling psychologist • Forensic psychologist • Health psychologist	• Adult psychotherapist • Child and adolescent psychotherapist • Family and systemic psychotherapist • CBT therapist • Counsellor	• Psychological wellbeing practitioner • Children's wellbeing practitioner • Education mental health practitioner

Notes:
1. Art, drama and music therapists are part of the national allied health professions professional grouping within the NHS in England.
2. Clinical, counselling, educational and occupational psychologists can undertake further training to become neuropsychologists.
3. Medical psychotherapists are psychiatrists on the General Medical Council specialist register, recognising their additional training and specialism in various modalities of psychotherapies. This group of doctors belongs to the Royal College of Psychiatrists and is part of the medical professional grouping within the NHS in England. Additional new

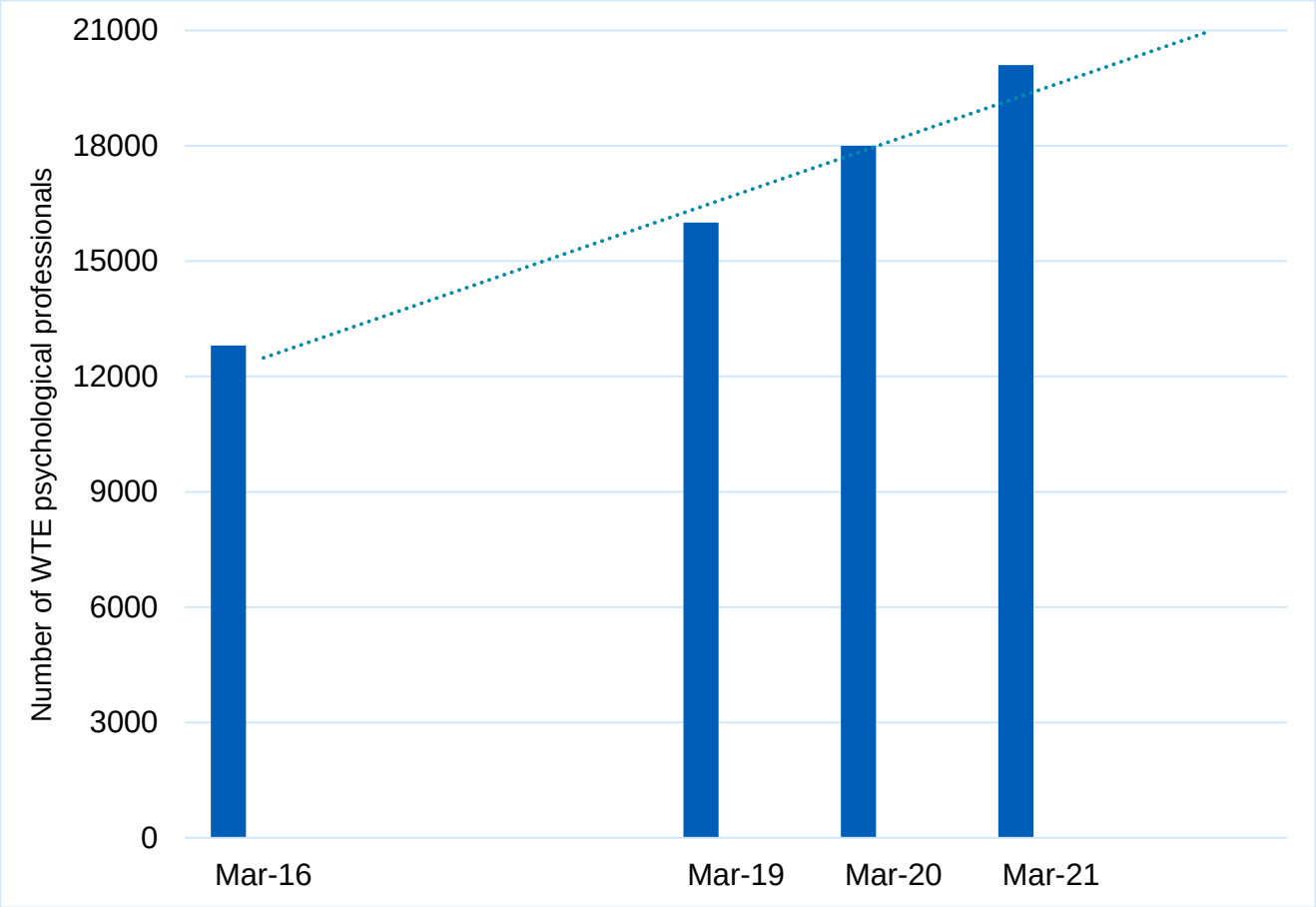
roles are being developed and deployed through national and regional programmes such as the mental health and wellbeing practitioner (MHWP), youth intensive psychological practitioner (YIPP), clinical associate psychologists (CAPs) and associate psychological practitioner (APP).

4. There are many different specific types of psychological practice, therapy and intervention which are delivered as part of NHS commissioned services by practitioners across this extended group. Some practitioners or approaches may not fit neatly into a single category represented here, but their work and impact is no less important for this.

3. Our current workforce: Where are we now?

Since the publication of Stepping Forward to 2020/21: The Mental Health Workforce Plan for England in 2017 the psychological professions workforce has grown rapidly. In 2016, there were around 13,000 (whole time equivalent [WTE]) psychological professionals providing psychological interventions and therapies in NHS commissioned mental health services, rising to about 16,000 in 2019. In March 2021, the workforce stood at around 20,100 WTE. While the workforce has expanded across all NHS commissioned mental health service pathways, there has been particularly significant growth in Children and Young People's (CYP) mental health[2] and Improving Access to Psychological Therapies (IAPT) services[3].

Fig. 2 Comparative growth of psychological professions workforce in NHS commissioned mental health services 2016-2021

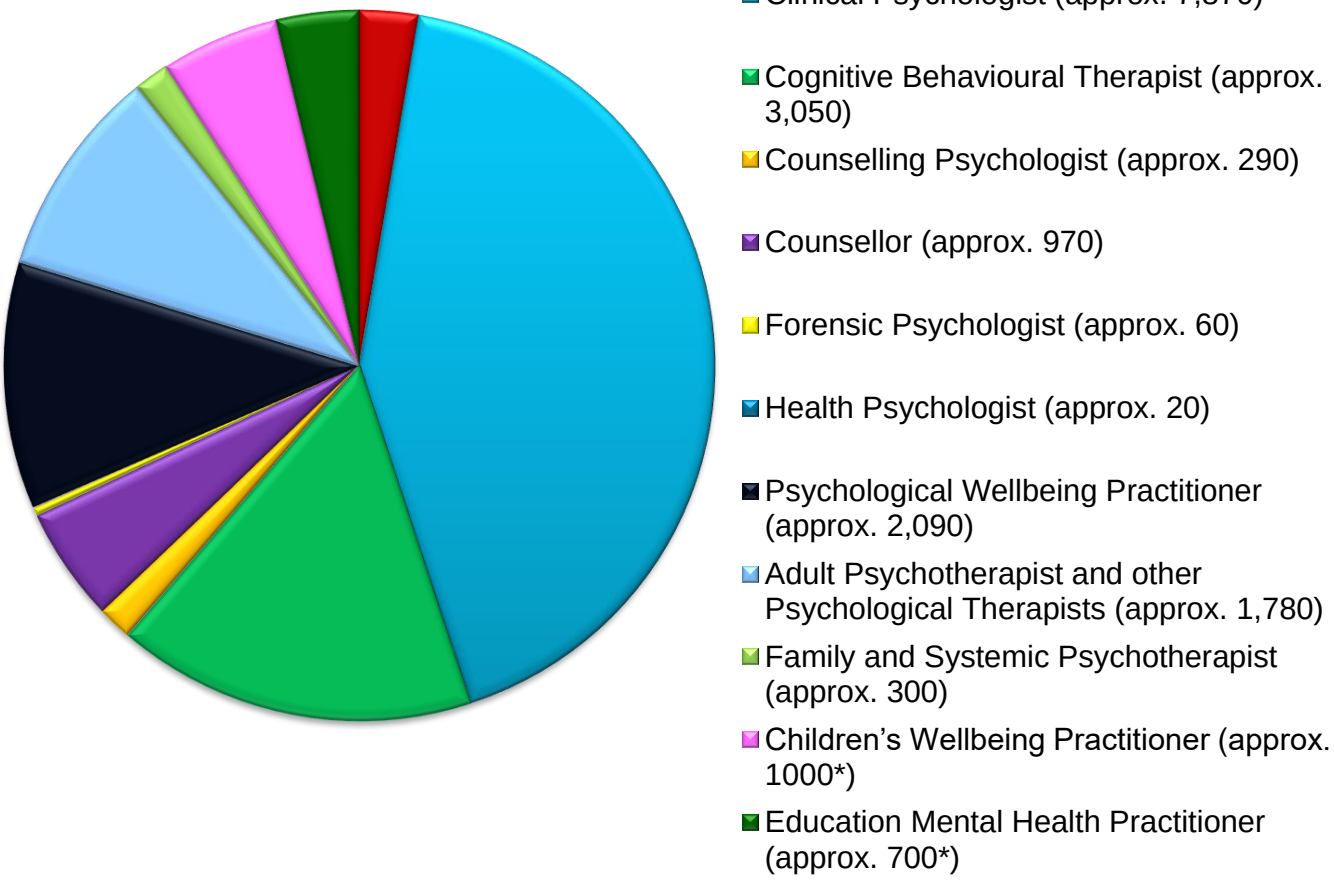


The largest professional groupings in NHS commissioned mental health services are clinical psychologists, cognitive behavioural therapists (CBT Therapists) and psychological wellbeing practitioners (PWPs), which together made up around three quarters of psychological professionals working in NHS commissioned mental health services.

[2] Children and young people's (CYP) mental health workforce benchmarking report
[3] Adult IAPT mental health workforce benchmarking report

This workforce has also seen significant innovation in the past few years, with the creation of a number of new roles, including education mental health practitioners (EMHPs), children's wellbeing practitioners (CWPs) and, more recently, MHWPs and YIPPs. These new roles are playing a key role in supporting the development and expansion of important new service pathways and numbers of staff in these roles are set to grow rapidly over the next few years.

Fig. 3 Estimated Psychological Professions in post (WTE) in NHS commissioned mental health services by profession, March 2020[4]



[4] Note: estimated workforce numbers do not include psychological professions working in physical healthcare settings, GP services or in non-NHS commissioned settings.
* Number of CWP and EMHP in training or completed training by March 2020. This does not account for those who may have left the role since completion of training.

4. The NHS Long Term Plan and beyond: Where do we need to be?

Building on the NHS Five Year Forward View, the NHS Long Term Plan set out ambitious proposals to expand access to psychological therapies and interventions at a faster pace than ever before. This includes specific commitments to expand access to evidence-based psychological therapies and interventions in perinatal mental health, children and young people's mental health, for adults with common mental health problems and for those with severe mental health problems, expanding access to high quality, evidence-based mental health services to an additional two million people.

Since the publication of the NHS Long Term Plan, we have seen an additional increase in need for mental health services across the lifespan arising from the COVID-19 pandemic. This includes a rise in prevalence of eating disorders, depression, anxiety disorders, post-traumatic stress disorder and complicated grief, as well as increased need for psychological rehabilitation following severe disease and long COVID-19. There is also a backlog of people who did not get help for their mental health needs during the COVID-19 pandemic. This need looks set to continue to rise over the coming months and years.

Delivering the transformation in access to mental health services required to meet these changing needs will require a 'step-change' in our workforce - expanding in numbers, but also investing in our staff and supporting them to work differently. Across NHS mental health services in England, an estimated 27,000 (WTE) new mental health posts will be needed to deliver the NHS Long Term Plan, in addition to the growth that was already being delivered under Stepping Forward to 2020/21.

This includes a significant and rapid expansion in the psychological professions workforce, growing not only established professions like clinical psychologists, but also embedding new roles, like EMHPs and MHWPs, across the system.

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 indicates an estimated 8,140 (WTE) additional psychological professionals will be needed in post between 2019/20 and 2023/24, including an additional 2,520 (WTE) practitioner psychologists and 2,860 (WTE) high intensity psychological therapists and PWPs in IAPT services. In addition, outside of NHS mental health services, an estimated 2,500 (WTE) EMHPs will also be needed in post by 2023/24 to support the national roll out of Mental Health Support Teams.

Taken together, both the Mental Health Implementation Plan and Mental Health Support Teams expectations amount to an indicative 10,640 (WTE) growth in psychological professions staff, representing an expansion in the workforce between 2019/20 and 2023/24 of over 60 per cent. This does not include any existing requirements specified in Stepping Forward to 2020/21 or additional need resulting from the COVID-19 pandemic.

Alongside delivering a net expansion of skilled staff to support growth and transformation in psychological care, it will be essential to retain the skilled staff we have, investing in their skills and supporting them to use their expertise where it is most needed. This includes up-skilling our workforce, establishing more coherent and integrated career paths for all psychological professions and developing and embedding new roles.

While the focus of this workforce plan is on the NHS Long Term Plan's commitments for meeting mental health needs, ignoring other areas of healthcare would risk missing significant opportunities to benefit service users, families and carers.

The system also needs to collectively consider other areas where, with the right support, psychological professions could make a real difference over coming years – such as in further extending psychological practice into physical healthcare settings and major health conditions, helping people to live well with dementia, working with communities to prevent ill-health, supporting NHS staff wellbeing and implementing the forthcoming Mental Health Act reforms.

Table 1: Indicative additional posts required by NHS Long Term Plan service area and staff group (according to Mental Health Implementation Plan 2019/20 – 2023/24)

Service area	Profession(s)	Staff (WTE)
Perinatal mental health	Psychologists	210
Children and young people's (CYP) services	Psychologists	1,360
	Psychotherapists and psychological professionals	2,550
Adult common mental illnesses (IAPT)	Psychotherapists and psychological professionals	2,860
Adult severe mental health problems (SMHP)	Psychologists	750
	Psychotherapists and psychological professionals	210
Therapeutic acute mental health inpatient care	Psychologists	160
Problem gambling mental health	Psychologists	40
	Total additional practitioner psychologists (WTE)	2,520
	Total additional psychotherapists and psychological professionals (WTE)	5,620
	Total staff (WTE)	**8,140**

Table 2. Indicative additional posts combining NHS Long term Plan growth and Education Mental Health Practitioners for Mental Health Support Teams

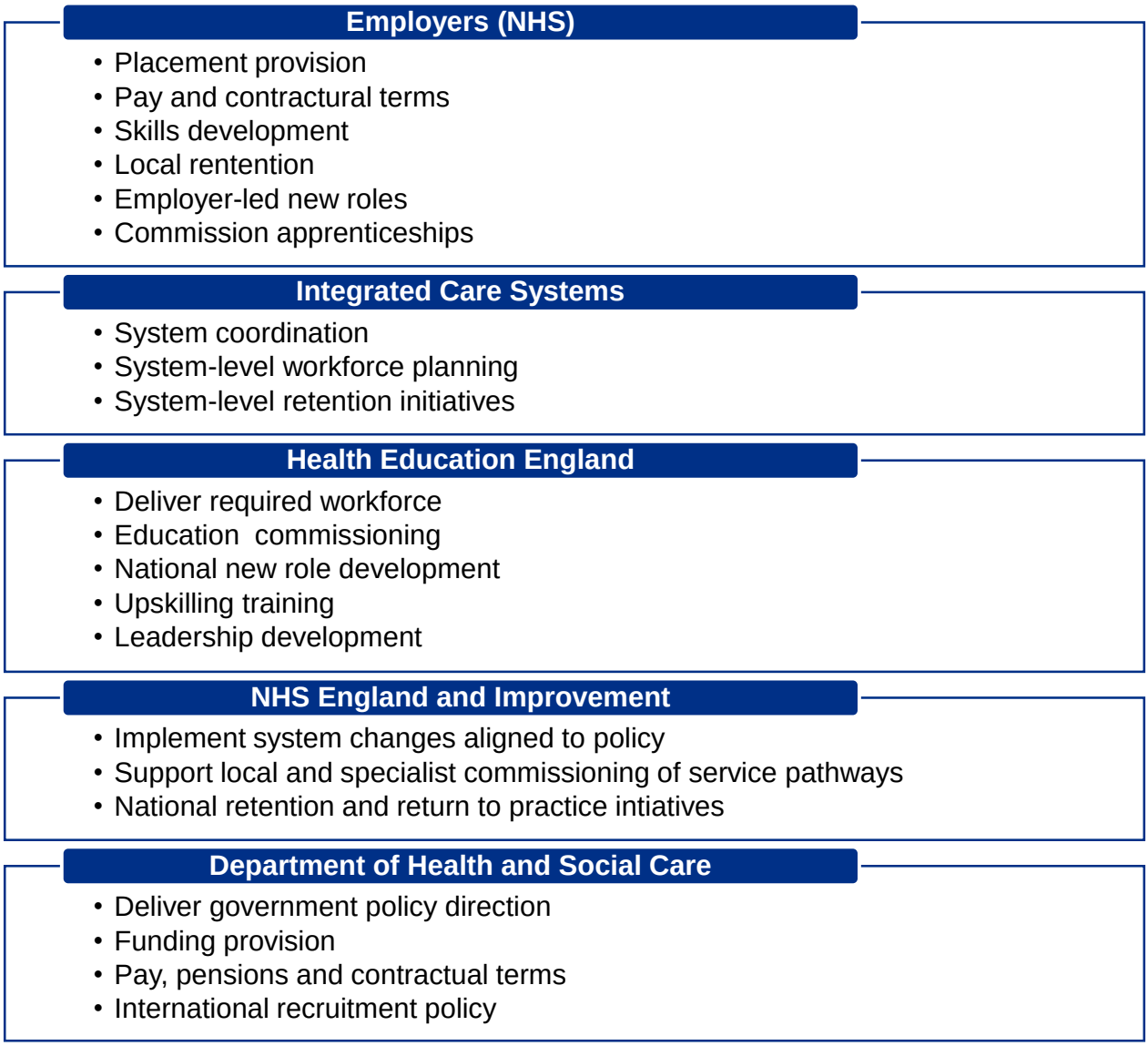
Profession(s)	Staff (WTE)
Total additional practitioner psychologists, psychotherapists and psychological professionals for NHS Long Term Plan Growth (WTE)	8,140
Total Education Mental Health Practitioners for Mental Health Support Teams (WTE)	2,500
Total staff (WTE)	**10,640**

5. How we will get there: A system-wide approach

Across the system, there are a range of levers that can help us achieve this transformation in the psychological professions workforce by 2023/24. Government, working with employers, make decisions on pay, pensions and contractual terms and conditions. NHSEI commissions service pathways, develops guidance and funds national Return to Practice (RtP), Recruit to Train and national recruitment initiatives.

Employers are responsible for the local recruitment, retention and skills development of their staff. HEE funds training and clinical placements for a number (but not all) of the psychological professions. ICSs determine the number of posts that are needed in each region, commission expansion posts and develop regional workforce plans.

Fig. 4 NHS system-wide levers for workforce transformation



No one organisation holds all the levers to achieve success. The scale of the challenge we face in securing not only the required expansion in funded posts, but also the trained people

to fill them, means the whole system – HEE, NHSEI, ICSs, providers, commissioners, regulators and professional bodies – must work together, using their respective levers in a concerted and collaborative effort to deliver the net growth of staff and skills.

ICSs have a particularly critical role to play in coordinating this effort in order to deliver the minimum 60 per cent expansion needed across the psychological professions workforce by 2023/24.

5.1 What does this mean for the psychological professions?

A competency-based approach to workforce design can help us challenge traditional thinking around who does what in order to ensure we have the right roles and skill mix in place. Focusing on competences, rather than professions or job titles, requires that we have service users, families and carers in mind from the outset, designing services and roles around the needs of people. It can also help us unlock knowledge, skills and experience already within our workforce, support staff retention and reduce barriers between professions.

To consider which levers to use to increase the supply of psychological professionals by 2023/24, it is important to understand the unique contribution and competences each occupation offers, the specific challenges each faces and the training 'pipeline' for each.

5.1.1 Clinical psychologists

Clinical psychologists work with service users, families and carers directly and make vital contributions at team and organisational level, as multi-disciplinary team members/leaders, supervisors, trainers, psychological therapists and clinical researchers. The profession offers important areas of expertise, including leadership and service redesign that will be particularly critical in this period as we expand access to psychological healthcare.

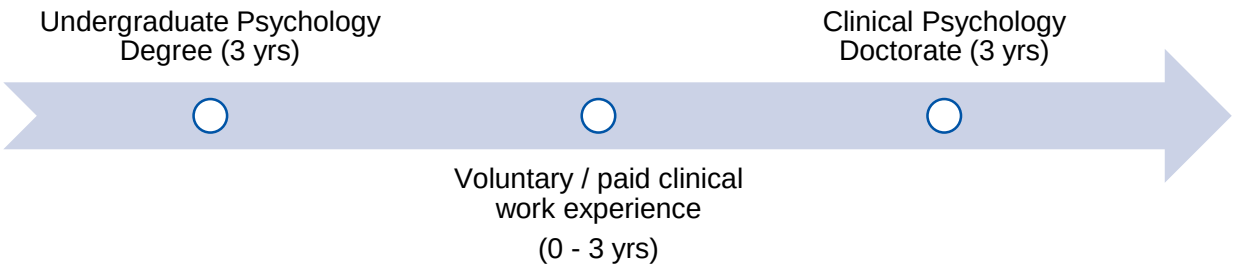
By 2023/24:

- An estimated additional 2,520 WTE practitioner psychologists will be needed in post nationally to deliver the NHS Long Term Plan
- A further indicative 366 WTE clinical psychologists are needed to provide interventions in IAPT, to staff wellbeing hubs and to backfill staff taking on Responsible Clinician roles
- Additional clinical psychologists will also be needed to provide leadership and supervision to the new Mental Health Support Teams and to fill vacancies across the NHS

Numbers of clinical psychologists have been rising in recent years but need for the profession continues to outstrip supply. In 2019, clinical psychologists were added to the Migration Advisory Committee's Shortage Occupation List (SOL) for the first time in a decade.

Clinical psychologists undertake specialist training with people of all ages (across the lifespan), including people who have learning disabilities, typically specialising and undertaking further training post-qualification. The training 'pipeline' for clinical psychologists from undergraduate to qualification is typically 6-9 years.

Fig. 5 Typical clinical psychology training pathway



While over 20,000 people graduate with a degree in psychology in the UK each year, there are limited opportunities for them to gain clinical work experience (particularly paid), with still fewer opportunities to undertake the Clinical Psychology Doctorate due to limited funded training places. To address this, in 2020/21 and 2021/22 HEE:

- Funded paid clinical experience opportunities for disadvantaged psychology graduates wishing to enter clinical psychology careers; and
- Increased clinical psychology training commissions for both 2020/21 and 2021/22 by 25 per cent each year.

The investment in additional Clinical Psychology Doctorate training places will have an immediate impact on service capacity as trainees hold caseloads on placement, as well as help to close the long-term gap in workforce supply. Subject to funding, further sustained investment in training places over a number of years, along with retention and return to practice measures, will be needed to safeguard the future supply of clinical psychologists.

5.1.2 Child and adolescent psychotherapists

In March 2020 there were approximately 500 WTE child and adolescent psychotherapists (CAPTs) working in NHS commissioned mental health services. Working across a range of NHS services, CAPTs provide specialist psychoanalytic psychotherapy to children and young people (up to age 25) with the most complex mental health difficulties, their families and carers. The profession also contributes to multi-disciplinary teams and networks to support complex casework, lead and supervise colleagues and make vital contributions at team and organisational levels.

As access to children and young people's mental health services is expanded, it will be important to ensure there are enough staff with the competences to support and treat those children and young people with the most severe or long-standing problems. In recognition that retention measures alone will not be sufficient to meet the need for CAPTs, in 2020/21 and 2021/22 HEE expanded CAPT clinical training programme places significantly each year, delivering a much-needed increase in the supply of CAPTs across the country.

Subject to funding, further sustained investment in CAPT training places in future years may be needed to meet rising needs, alongside targeted interventions to address the significant regional disparities in access to child and adolescent psychotherapy.

5.1.3 Children's wellbeing practitioners

A new role established in response to Implementing the Five Year Forward View for Mental Health, CWPs offer brief, focused evidence-based interventions in the form of low intensity support, guided self-help and psychoeducation to children and young people (and their parents/carers) with mild/moderate anxiety (primary and secondary school age), low mood (adolescents), and common behavioural difficulties (working with parents for under eights).

The CWP training is commissioned by HEE and delivered by HEIs that have been core to the CYP IAPT learning collaboratives. Since the roles' introduction in 2018, more than 1,700 CWPs will have completed training or qualified to work by January 2022. In some areas, they are being carefully supported into supervisory and mentoring roles for CWPs and EMHPs.

5.1.4 Cognitive behavioural therapists

CBT therapists work within a variety of key NHS mental health expansion areas, including IAPT services, adult community services and CYP mental health services. Professional training is specific to a population group and a set of problem types (e.g., anxiety and depression, or psychosis and bipolar). Interventions are delivered on a one-to-one basis (with or without parents/carers present), or in groups.

In adult IAPT services, High Intensity CBT Therapist trainees are increasingly being recruited from the PWP workforce, rather than from a broader multidisciplinary pool (mental health nurses, counsellors, social workers, clinical psychologists etc.). This is leading to a loss of professional diversity within the IAPT workforce, as well as of skills and experience in PWP teams.

To expand the adult IAPT workforce and improve access to services, HEE, NHSEI, employers, ICSs and commissioners will need to use every available lever to maximise the supply and retention of CBT therapists. This includes attracting more people from outside of IAPT into training and bringing back staff who have left the NHS.

In CYP mental health services and adult community mental health services Recruit to Train roles are helping to transform clinical practice in a range of evidence-based interventions. Over 1,100 clinical professional staff have been trained in CBT through CYP IAPT since 2012.

5.1.5 Counselling psychologists

Counselling psychologists work across NHS mental health settings, as well as in education, research, the third and independent sectors. In March 2020 there were an estimated 290 (WTE) counselling psychologists working in NHS commissioned mental health settings.

Taking a competency-based approach to workforce development, counselling psychologists may provide some of the 2,520 (WTE) additional practitioner psychologist posts required to meet the needs of the NHS Long Term Plan. Counselling psychology combines evidence-based specialist psychological therapeutic practice with research and wider psychological competences including psychometric assessments in the care of clients. Counselling psychology continues to offer the additional career route to bring practitioner psychologist competences into the NHS.

One strength of this route is that training can often be completed part-time, making it accessible to candidates with other responsibilities. At the same time, this route is currently self-funded. Training places are competitive but trainees and qualified counselling psychologists continue to contribute to the practitioner psychology workforce within NHS mental health settings.

5.1.6 Counsellors

In March 2020, there were approximately 970 (WTE) counsellors[5] working in NHS commissioned mental health services in England. 855 counsellors were employed within adult IAPT services as high intensity therapists, with the remaining working predominantly in CYP mental health services.

Until 2021 IAPT services have relied on an entirely self-funded training route to supply counsellors for high intensity roles. This differs to most other NHS psychological professions, which have funded and salaried core training. This anomaly also means the training path and content is has not been specifically aligned to the priorities of the NHS Long Term Plan.

In recognition of the scale and pace of expansion in adult IAPT posts required, in 2021/22 NHSEI and HEE launched a recruitment initiative to encourage people from outside of IAPT (including many accredited counsellors and psychotherapists) into IAPT posts to deliver the range of high intensity modalities.

Alongside this initiative, HEE is working to establish clear entry points and better training and career pathways, including piloting an NHS professional training for psychotherapeutic counsellors incorporating an IAPT therapy modality (i.e., Person-Centred Experiential Counselling for Depression, Interpersonal Therapy, Couple Therapy for Depression or Brief Dynamic Interpersonal Therapy) within the training. This training pathway will support the expansion of the IAPT High Intensity workforce in line with the modelled requirements for these modalities and increase access to these therapies and choice for service users, families and carers across the country.

5.1.7 Education mental health practitioners

The EMHP is a new role established in 2018. Based across education settings and working alongside other mental health and wellbeing support, EMHPs work within Mental Health Support Teams to promote resilience and wellbeing, support earlier intervention, enable appropriate signposting and deliver evidence-based interventions. They work with children and young people with mild to moderate mental health problems and their families, parents and carers.

EMHPs also support school/college mental health leads to develop their whole school approaches to promoting better mental health and liaise with external specialists to help children and young people stay in education.

EMHPs are one of the fastest growing psychological professions. The one-year EMHP training programme, which drew on the CWP and other CYP IAPT curricula, is funded by HEE. Since it commenced in January 2019, more than 1,500 EMHPs will have started training by January 2022 and will working alongside hundreds of senior practitioners. By

[5] Note, Counsellors who take up CBT high intensity training and work within IAPT services are categorised here as CBT therapists.

2023/24 around 2,500 EMHPs will be in post across the country. In some areas, further career progression training opportunities are in development to enable EMHPs to train and progress into more senior EMHP supervisor roles.

5.1.8 Health psychologists

Health psychologists support changes in population health behaviours, work to promote healthier lifestyles and support healthcare settings to provide better psychologically-informed care and treatment. Settings can vary from large-scale public health programmes to organisations and systems, group and individual work, academia, teaching and research.

Currently only a very small number of health psychologists are directly employed by NHS commissioned services. However, over the coming years numbers are likely to increase as psychological practice in physical healthcare is expanded and there is an increased focus on prevention.

HEE are presently funding a programme to employ seven trainee health psychologists to build capacity and capability for workforce redesign within the NHS, applying the psychology of system and health behaviour change. They will build capability within regions and systems through workforce projects and the training of others, as well as contribution to existing projects and service delivery. Trainees will achieve qualification with the British Psychological Society and register to practise as a health psychologist.

5.1.9 Family and systemic psychotherapists

Currently there is a lack of consistency in provision of family and systemic psychotherapy regionally and within services, as well as a growing need for family and systemic psychotherapy in many of the expanding service pathways. While there will be some scope to gain additional supply into the NHS from those who are not currently working for NHS commissioned services, this is unlikely to be sufficient to meet the capacity need by 2023/24.

The training ‘pipeline’ for family and systemic psychotherapists is long. Trainees must hold a prior clinical qualification in a relevant health or social care field, have substantial work experience in the field and then undertake a four-year part-time Masters professional qualification. Trainees also need access to appropriate clinical placements to fulfil the practice requirements of the training.

To support the expansion of access to family and systemic psychotherapy, in both 2020/21 and 2021/22 HEE provided additional funding for qualifying Masters training across all NHS regions. HEE is also working with commissioners, providers and professional bodies to explore the potential for an apprenticeship route into the profession to widen access to this profession.

There are a number of potential pathways that prepare people for family and systemic psychotherapy Masters qualification, such as the recruit to train CYP IAPT Systemic Family Practitioner programme.

5.1.10 Forensic psychologists

Forensic psychologists work primarily in the criminal justice system with psychological problems associated with criminal behaviour. HM Prison Service is the largest single

employer of forensic psychologists in the UK, although a small number of forensic psychologists are also employed by the NHS and private healthcare providers, in specialist mental health settings, social services and offender management services.

5.1.11 Psychological wellbeing practitioners

PWPs work within adult IAPT services to provide short-term, evidence-based low intensity psychological interventions, in line with NICE guidance, to people experiencing mild to moderate anxiety and/or depression. In March 2020, there were an estimated 2,090 WTE PWPs in post in adult IAPT services in England.

Staff turnover amongst PWPs is higher than in other established psychological professions – each year around 30 per cent of PWPs leave their posts. While most leave to progress onto High Intensity training programmes and are therefore not lost to IAPT services, significant numbers of PWPs also leave to take up training or entry level positions within other NHS occupations or leave the NHS altogether. This high turnover of staff creates a sustained pressure on services to keep recruiting and training PWPs, as well as a significant loss of talent and experience.

Addressing the retention of PWPs will be critical to expanding the adult IAPT workforce to meet the NHS Long Term Plan ambitions and additional need arising from COVID-19. ICSs will need to work with employers to improve retention in services and stem the flow of this crucial workforce, particularly to High Intensity trainee posts and other NHS occupations.

Nationally, NHSEI and HEE are supporting this effort in broadening the recruitment focus of high intensity CBT training, NHSEI developing new career progression opportunities for PWPs and establishing a new route into the profession, through the PWP apprenticeship, which may be more attractive for career changers looking to PWP as a later career destination.

5.1.12 Adult psychotherapists and other psychological therapists

Adult psychotherapists and other psychological therapists work across a wide range of NHS settings, including in adult IAPT services, adult community mental health services and children and young people's mental health services. They are trained in-depth as specialists, usually in a single modality of psychotherapy or psychological therapy. They may provide supervision and deliver psychological support for other NHS staff, as well as progress into leadership positions.

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 indicates that a large expansion in psychological therapist posts will be required across a number of service pathways, including adult community mental health services, in-patient care and specialist services by 2023/24.

In 2019/20 and 2020/21, HEE embarked on a large expansion programme in evidence based psychological therapies for people with severe mental health problems, including psychosis, bipolar, personality disorder and eating disorders. Expanding training programmes to grow more psychological therapists include postgraduate programmes for mental health professionals in CBT for Severe Mental Health Problems (with either a personality disorder, psychosis and bipolar or eating disorder specialism), and Dialectical Behaviour Therapy (DBT), with plans in place for Cognitive Analytic Therapy (CAT).

Upskilling programmes for those with existing psychological therapy competence are also underway in Mentalisation Based Therapy (MBT) and planned for Eye Movement Desensitisation and Reprocessing (EMDR). This training expansion is set to accelerate to 2024.

The children and young people's improving access to psychological therapies project (CYP-IAPT) is further supporting workforce expansion through the delivery of specialist education and training in children and young people's mental healthcare. Commissioning of CYP IAPT modality training programmes[6] are contributing to the NHS Long Term Plan target of enabling an additional 345,000 children and young people to access NHS funded mental health services and school-based mental health support teams.

In addition to ensuring there are sufficient qualified staff in place, it will be important to ensure there are career progression and leadership opportunities for psychotherapists / psychological therapists to retain these staff in services.

5.1.13 Mental health and wellbeing practitioners

Mental health and wellbeing practitioner is a new role aimed at supporting transformation of adult community mental health services, helping to shift services to provide trauma-informed care, with wider access to psychologically-informed interventions and NICE psychological therapies for severe mental health problems.

The MHWP role is designed to support collaborative care planning, alongside other members of the multi-disciplinary team. They also will deliver a set of brief, wellbeing-focused psychologically informed interventions (not psychological therapies), including behavioural activation and graded exposure, problem-solving, improving sleep, recognising and managing emotions, guided self-help for bulimia and binge-eating, confidence building and support with medication management.

Trainees will undertake a HEE funded one year programme of clinical and academic learning (due to commence spring-summer 2022) and be recruited jointly by employers and education providers.

[6] Cognitive Behavioural Therapy, Parenting Training, Interpersonal Psychotherapy for Adolescents or Systemic Family Practice, Learning Disability and Autism.

6. Delivering the plan: priority actions

Transforming psychological healthcare will require sustained and long-term effort across the system at local, regional and national levels. HEE, NHSEI and other key organisations have already taken a number of steps in recent years to increase capacity and skills in many of these areas, including:

- Increasing training entry to clinical psychology and child and adolescent psychotherapy by 60% between 2020 and 2022
- Reviewing alignment of clinical psychology and child and adolescent psychotherapy training programmes to the NHS Long Term Plan priorities
- Investing in additional family and systemic psychotherapy training across all regions
- Developing an action plan for improving equity of access and inclusion of black, Asian and ethnic minority candidates in clinical psychology training
- Conducting a strategic review of action required to ensure sustainability of the IAPT workforce
- Reviewing CWP and EMHP training to ensure congruence and sustainability of the two roles and consider development of senior CWP and EMHP roles.

Further action will be needed by arm's length bodies (ALBs), commissioners, regulators, employers and professional bodies in the coming years to 2023/24.

This section sets out the steps we can take collectively to deliver this workforce transformation across the psychological professions. It sets out five strategic priorities as a framework for action:

1. **Grow:** Expanding the psychological professions workforce to improve access to psychological healthcare

2. **Develop:** Establishing clear career paths and development opportunities for all psychological professionals

3. **Diversify:** Attracting and retaining people of talent from all backgrounds

4. **Lead:** Developing the right local, regional and national leadership

5. **Transform:** Embracing new ways of working

6.1 Grow: Expanding the psychological professions workforce to improve access to psychological healthcare

Local services will decide on their own staffing requirements, based around the needs of their local population and HEE is working with local providers to support them in developing these local workforce plans. But there is a risk that without a strategic understanding of the long-term, national workforce need, local decisions about 'demand' for staff will become conflated with 'affordability', or we will end up with just more of the same.

Delivering the minimum 60 per cent net growth needed across the psychological professions workforce by 2023/24 will be challenging, particularly given the lengthy training pathways for many of these disciplines. The scale of the challenge requires all organisations in the system to use their respective levers in a concerted and collaborative effort to deliver the net growth of staff and skills.

Key actions for growth:

- **Increasing commissioned posts:** ICSs and NHS commissioned employers must work together to increase the number of salaried expansion posts, in line with the requirements set out in the Mental Health Implementation Plan. Psychological professions networks can support this process in facilitating regional conversations bringing together the workforce, chief psychological professions officers, providers, commissioners and ICSs.

- **Retaining and supporting our existing staff:** A high turnover rate is often associated with poorer quality of care, as well as being costly for employers. While retention rates for many of the psychological professions are higher than the NHS average, there are specific professions, like PWPs, where retention rates are low – around 30 per cent of PWPs leave their posts each year.

  To improve retention of the PWPs, NHSEI is supporting IAPT services to create new career progression opportunities for PWPs that will enable more to develop professionally within IAPT services, rather than needing to leave services. Across the psychological professions, employers, together with ICSs, NHSEI and professional bodies, are taking action to prevent staff 'burn out', particularly in the light of the COVID-19 pandemic, and to improve mental health support for their own workforces.

- **Broadening supply 'pipelines':** To address specific challenges in IAPT services, HEE and NHSEI are taking targeted action to broaden the supply pipeline for high intensity therapists (CBT therapists, counsellors and psychotherapists) in adult IAPT services.

  In 2020/21 this included a specific recruitment initiative to encourage qualified, accredited counsellors and psychotherapists into NHS commissioned IAPT services. ICSs and employers will also need to act to identify new pools of potential supply for other service pathways locally and regionally.

- **Expanding education and training commissions:** Psychological professions training programmes typically attract large numbers of applicants and enjoy high retention and completion rates. HEE commissions the core professional training programmes for six psychological professions. In 2019/20 and 2020/21 HEE has been

investing in the extensive expansion of training places for these professions, as well as expanding scope to others.

For example, HEE has expanded clinical psychology and child and adolescent psychotherapy training places by 25 per cent year-on-year and invested in qualifying Masters level family and systemic psychotherapy training across all regions. Further expansion in training is dependent on ongoing funding being secured beyond 2021/22.

- **Opening up new training pathways:** In addition to investing in existing education and training programmes, HEE is developing innovative new training pathways into professions. This includes piloting a high intensity psychotherapeutic counselling training programme to support the expansion of the IAPT High Intensity workforce in line with modelled requirements for the expansion of NICE-recommended modalities.

  Employers are also developing apprentice training routes into professions, notably PWP, clinical associate in psychology and family and systemic psychotherapy training.

- **International recruitment to help fill short-term gaps:** The specific training requirements, governance and accreditation frameworks of the psychological professions make international recruitment challenging. However, ICSs and the ALBs could explore whether new routes could be developed to support the expansion of specific professions in the short term, such as ethically sourcing more clinical psychologists from the global market.

- **Widening participation in training programmes:** HEE are introducing changes to HEE-commissioned psychological professions core professional training programmes to widen participation to groups that have been historically excluded from taking up these opportunities. This includes exploring the potential for part-time training options for core professions training and providing bursaries for disadvantaged applicants to CAPT training programmes.

- **Encouraging staff to return to practice:** Historical data suggests that return to practice programmes are likely to have limited impact on the size of the psychological professions workforce. Instead, the system should focus on targeted recruitment initiatives to attract professionals working outside of NHS services into training and roles.

- **Embedding new roles:** Targeted design and deployment of new roles can expand access to psychological healthcare at pace, taking care to avoid counter-productive disruption to existing roles. Employer-led initiatives, such as clinical associates in psychology across a number of areas, associate psychological practitioner in the North West, and graduate mental health practitioners in the South East, are helping to meet specific regional workforce challenges.

  Nationally, NHSEI is working with HEE, ICSs and employers to recruit, train and embed EMHPs (including senior psychological practitioner roles) and Mental Health Support Teams across the country. HEE is also deploying new psychological practitioner roles in adult community mental health (MHWPs) and CYP inpatient and

crisis mental health services (YIPPs) that will improve access to psychological therapies and interventions in these service pathways nationally.

- **Expanding recruit to train:** Recruit to train programmes have an important role to play in contributing to net growth in skills and competences across key service areas, particularly children's and young people's mental health services (CYPMHS). For example, recruit to train roles are being made available through CYP IAPT training programmes[7] that seek to transform clinical practice in a range of evidence-based interventions, including CBT for anxiety and depression. Over 1,100 clinical professional staff have been trained in CBT through CYP IAPT since 2012, and 96 per cent of CYPMHS community teams report staff trained to deliver CBT, compared to 86 per cent of inpatient teams, and 63 per cent of community eating disorders teams.

- **Improving data quality:** The information required to guide workforce planning at local, regional and national levels has not always kept pace with the development of the professions and, as a result, there may be some data gaps regarding the psychological professions workforce, measures of need and estimates of capacity requirements to meet future need.

  These gaps reflect a number of specific and historical issues, such as the complex commissioning arrangements for psychological services and that many psychological professionals hold dual qualifications and/or multiple contracts with different employers.

  Changes to NHS Electronic Staff Records (ESR) Occupation Codes and Job Roles introduced in April 2019 have made significant improvements to the accuracy of workforce data, but further changes are likely to be required. The ALBs, together with ICSs and employers, will need to consider whether further guidance is needed to support providers in implementing the coding and additional revisions are needed given the rapidly evolving nature of this field. Workforce data must also be used routinely across the system to monitor expansion posts and progress in growing the psychological professions.

[7] Cognitive Behavioural Therapy, Parenting Training, Systemic Family Practice, Interpersonal Psychotherapy for Adolescents, Learning Disability and Autism.

6.1.1 Grow actions

Across all levels of the system (national, regional, system, employers and HEIs) to work together to deliver the actions in Table 3.

Table 3: Psychological professions Grow actions

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
1. Expand clinical psychology training and child and adolescent psychotherapy places by 25 per cent in 2021/22 and support further expansion in line with funding	●	●	●
2. Continue to expand IAPT training and other workforce interventions to fulfil the expected growth of the IAPT clinical workforce	●	●	●
3. Increase the proportion of IAPT High Intensity recruitment from outside of IAPT services		●	●
4. Align IAPT trainee posts to all High Intensity modalities in proportion to modelled requirement for NICE-recommended therapies and choice of treatment	●	●	●
5. Launch a paid core professional training pathway into adult IAPT services for psychotherapeutic counsellors to deliver NICE-recommended therapies for depression	●		●
6. Continue to expand Mental Health Support Teams and EMHP posts nationally	●	●	●
7. Expand access to NICE recommended psychological therapies for severe mental health problems at scale across adult community services through upskilling existing staff and recruiting new staff into psychological therapy trainee positions, ensuring staff have	●	●	●

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
substantial dedicated time to deliver therapies on qualification			
8. Invest in family and systemic psychotherapy training to support expansion of this discipline in CYP mental health services and beyond	●		●
9. Support the development of an apprenticeship in family and systemic psychotherapy for entry from 2022	●		●
10. Deploy new psychological practitioner roles in adult community mental health and CYP inpatient and crisis services to deliver multi-disciplinary team care planning and psychologically informed interventions, underpinned by a formulation	●	●	●
11. Use annual workforce surveys and improve Electronic Staff Record data to monitor expansion in posts	●	●	
12. Expand part-time core professional training pathways across the psychological professions	●		●

6.2 Develop: Establish clear career paths and development opportunities for all psychological professions

Improving access to evidence-based psychological healthcare demands not only that more staff are trained and employed, but also that we make best use of the staff we have. Alongside delivering rapid growth in the psychological professions workforce, the system needs to upskill staff to ensure they have the competences we need and establish clear and efficient career paths to provide opportunities for psychological professionals of all disciplines to progress in a managed and fair way.

HEE is implementing a comprehensive programme to upskill the workforce in line with the national transformation plans for mental health. Key priorities include:

- Up-skilling staff to provide evidence-based psychological therapies and interventions in Early Intervention in Psychosis (EIP) and eating disorder services
- Training practitioners in adult services to meet the developmental needs of young adults
- Up-skilling IAPT staff to work with long term conditions
- Training staff working in community mental health services to deliver evidence-based psychological therapies

Reflecting the whole system approach to workforce planning, many of these skills development opportunities are open across professions (such as, to mental health nurses, social workers, and occupational therapists) who do not have existing psychological therapy qualifications. Other shorter trainings are designed to upskill staff with existing psychological therapy qualifications.

Alongside providing these skills development opportunities for employers and staff, NHSEI and HEE are also working closely with professional bodies and training providers to align existing core professional training programmes, such as clinical psychology and child and adolescent psychotherapy training, to the priorities of the NHS Long Term Plan.

These conversations will identify areas where training programmes could helpfully align to support the delivery of national policy and what supervisors, placement providers and courses need to achieve this. The alignment of these training programmes to national policy includes ensuring trainees have the tools and cultural competence to work explicitly to redress inequality of access and outcome in psychological healthcare across the protected characteristics and socio-economic status.

Retaining talent within the workforce means developing more integrated and coherent career paths with clearer and more efficient routes of entry, progression and development for all of the psychological professions. This includes making better use of entry routes into professions (paid work experience, apprenticeships, core training programmes, undergraduate placements and direct-entry clinical roles), designing more efficient pathways between the professions and developing clear career progression opportunities through the leadership hierarchy for all the psychological professions.

Priority areas of action for the system by 2023/24 include:

- **New roles:** Developing clear career progression paths for new roles, such as CWP, EMHP, MHWP, YIPP and CAPT. This includes considering the development of

senior CWP and EMHP roles, as well as ensuring all new roles are fully integrated into the wider professions, with clear career progression opportunities to support retention.

- **Supervision:** The unprecedented expansion in the psychological professions over the next few years is likely to put pressure on supervision capacity, particularly in areas like CYPMHS and perinatal mental health. Historically the need for supervision capacity has not always been identified within workforce planning processes. This is a significant omission that will need to be addressed in workforce planning process at all levels – national, regional and local - in order to ensure workforce expansion is sustainable and delivers maximum impact for service users, families and carers.

  The delivery of new roles is predicated on the availability of suitably qualified staff able to provide the supervision and leadership required. Where supervision capacity is a concern, particularly in the short-term, looking at capacity across larger geographical areas or utilising technological solutions to be able to deliver supervision to individuals and teams should be explored.

- **Governance and accreditation:** As the psychological professions workforce expands and new roles are embedded, our governance and accreditation frameworks must keep pace. Individual registration is now being introduced for PWPs, CWPs and EMHPs. The ALBs will also engage with the Department of Health and Social Care in their planned review of regulation of psychological therapies to support effective protection of service users, families and carers.

6.2.1 Develop actions

Across all levels of the system (national, regional, system, employers and HEIs) to work together to deliver the actions in Table 4.

Table 4: Psychological professions Develop actions

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
1. Develop more integrated and coherent career paths for each of the psychological professions, including into leadership roles	●	●	●
2. Widen participation by enabling entry to wellbeing practitioner training roles to accept more entrants with level 5 qualification / credit, and graduates of all disciplines	●		●
3. Ensure all new roles in the psychological professions are meaningfully aligned to existing roles and have clear career progression pathways to support retention	●	●	●
4. Review HEE-commissioned core professional trainings to ensure they align to the NHS Long Term Plan and national policy priorities, with targeted investment to support HEIs in progressing this	●		●
5. Implement a policy change for future eligibility for NHS funding across specific psychological professions training programmes for individuals who wish to undertake more than one NHS-funded training	●		●
6. Ensure there is sufficient supervision and management capacity for new roles	●	●	●

6.3 Diversify: Attract and retain people of talent from all backgrounds

There is strong evidence that where an NHS workforce is representative of the community it serves, service users' experience is more personalised and improves. Our current psychological professions workforce is under-representative of ethnic minorities, people with disabilities and men, and is increasingly skewed towards youth. Senior leadership positions under-represent ethnic minorities and women. Across the system, there needs to be systemic action – from training and recruitment to leadership - to diversify our psychological professions workforce, giving due consideration across all protected characteristics.

Ethnic diversity varies between the psychological professions and between NHS service pathways. The IAPT workforce, for example, is broadly reflective of ethnic diversity across England. However, the clinical psychologist and child and adolescent psychotherapist professions are less ethnically representative of the national population. Across all service pathways, ethnic minority staff are also more likely to experience racism and discrimination.

The creation of new roles, such as PWPs, CWPs and EMHPs, has filled an important career pathway gap for many of the key service areas. However, it has also had a significant impact on the age profile of the psychological professions workforce. These roles have provided valuable new routes into the NHS for young people. Now more needs to be done to open up roles and training opportunities for career changers and those with caring responsibilities.

HEE and NHSEI are taking targeted action to improve inclusivity and diversity at all levels of the psychological professions, from leadership to training. Specifically:

- In 2020/21 and 2021/22 HEE invested in leadership mentoring for ethnic minority psychological professionals to tackle the continued lack of visible diversity in the leadership of the psychological professions workforce
- HEE is working with professional and accrediting bodies and training providers to improve equity of access and inclusion in HEE-commissioned psychological professions training programmes. This includes implementing the Action Plan to Improve Equity of Access and Inclusion for Ethnic Minority Entrants to Clinical Psychology Training
- HEE is encouraging part-time training options and funding bursaries, mentoring schemes and paid work experience opportunities for disadvantaged aspiring psychological professionals to widen participation in the workforce
- In IAPT services, NHSEI is improving equity of access and outcome to psychological care through a programme of funded and targeted action to challenge racism and further sustain embedding of the recommendations of the IAPT Positive Practice Guide

As the psychological professions expand, employers, ICSs, HEE and NHSEI will need to monitor and report on diversity in the psychological professions across the protected characteristics, identify where there are systemic barriers to diversity and design interventions to target inequities in recruitment, training and development opportunities.

6.3.1 Diversify actions

Across all levels of the system (national, regional, system, employers and HEIs) to work together to deliver the actions in Table 5.

Table 5: Psychological professions Diversify actions

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
1. Support HEE-commissioned training programmes to deliver measurable improvements on equity and inclusion for ethnic minority applicants, including implementing the Action Plan to Improve Equity of Access and Inclusion for Black, Asian and Minority Ethnic Entrants to Clinical Psychology Training	●		●
2. Target investment to reduce systemic obstacles to disadvantaged aspiring psychological professionals from entering the psychological professions. This includes: 2.1. Creating paid work opportunities for disadvantaged psychology graduates wishing to enter clinical psychology careers 2.2. Providing bursaries to support disadvantaged aspiring child and adolescent psychotherapists to undertake pre-clinical training	●	●	●
3. Deliver a programme of funded and targeted action to challenge racism in IAPT services	●	●	●
4. Invest in a leadership mentoring programme for ethnic minority psychological professionals aspiring to leadership roles	●		
5. Monitor and report on ethnic diversity in the psychological professions, across all pay bandings, designing future interventions to target inequities	●		●

6.4 Lead: Develop the right local, regional and national leadership

The psychological professions are starting from a relatively low base in terms of leadership and engagement at all levels of the system. Until recently, there were no formal national professional leadership roles within the NHS that cover the full territory of the psychological professions. As a result, workforce planning has been neither integrated across the psychological professions, nor with the wider mental health workforce and beyond.

This gap in embedded leadership has been replicated at local and regional levels. Employers usually do not have a psychological professional at Board level, resulting in missed opportunities for shaping systems of care and delivery. Regionally there has also often been a lack of input from the psychological professions in NHS decision-making and workforce planning.

In recent years, important progress has been made:

- Nationally, NHSEI has established the role of National Lead for Psychological Professions to provide a strong and coherent input into policy making, policy delivery and workforce planning.

  The role is supported by the National Psychological Professions Workforce Group, which brings together the ALBs, professional bodies, experts by experience and other key stakeholders. In the coming years, NHSEI will build on this infrastructure to ensure the psychological professions continue to have a strong and unified input into policy formation, workforce planning and delivery.

- Psychological Professions Networks (PPNs) have been established in all seven NHS regions to offer professional leadership across systems. PPNs are membership networks commissioned by HEE to provide a joined-up voice for the psychological professions in workforce planning and development, and support excellence in practice. As such, they offer an important resource to support delivery of psychological professions workforce requirements.

More needs to be done. Strong leadership will be particularly critical in the coming months and years as services are transformed, the psychological professions workforce expands and the system continues to respond to the COVID-19 pandemic. In CYP services, for example, embedding CWPs and EMHPs in substantial numbers into existing and newly emerging service pathways will require significant change management and leadership support. This historic deficit in leadership capacity therefore needs to be addressed at all levels of the system.

Regionally, it is essential that Chief Psychological Professions Officers (the most senior psychological professional in each provider organisation) are fully integrated into the workforce planning process. This will help to ensure ICS workforce planning is informed by and co-produced with those with the clinical expertise and experience of psychological service delivery to maximise the benefit for service users, families and carers.

Leadership also needs to be fully inclusive and diverse to be effective. Traditionally those psychological professions outside of clinical psychology have had limited opportunities to progress into senior leadership positions. This is despite many psychological professions

possessing specific strengths in understanding systemic approaches to teams and organisations.

Employers, ICSs and NHSEI must work together to take targeted action to open up leadership opportunities to all the psychological professions and to improve diversity and inclusion amongst those who lead the psychological professions.

6.4.1 Lead actions

Across all levels of the system (national, regional, system, employers and HEIs) to work together to deliver the actions in Table 6.

Table 6: Psychological professions Lead actions

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
1. Adopt and promote a multi-disciplinary approach to leadership and development of the psychological professions as a united group, recognising each's unique strengths	●	●	●
2. Support the integration of Chief Psychological Professions Officers in ICSs workforce planning processes	●	●	●
3. Embed the Psychological Professions Networks as providers of the united professional leadership for the psychological professions at regional level, supporting and enabling workforce planning, expansion and development	●	●	●
4. Take targeted action to make leadership positions more inclusive of all psychological professions based on competency requirements of the roles	●	●	●
5. Establish a long-term national NHS professional leadership infrastructure for the psychological professions	●		

6.5 Transform: Embrace new ways of working

We know that expanding workforce capacity by simply doing more of the same is no longer a viable solution. Organisations across the NHS system need to be open to new ways of thinking and challenge established ways of working in order to address workforce supply challenges and meet changing needs.

The psychological professions have demonstrated their ability to embrace change. Throughout the COVID-19 pandemic, these professions have risen to the challenge, with many taking on different roles, working in new settings or moving their practice to remote delivery methods. These professions have shown strengths in drawing on evidence, expertise and the voices of service users, families and carers to develop and embrace new ways of working. NHSEI and HEE are committed to continuing to work in genuine partnership with services users, families and carers to support service design, development and delivery. HEE is, for example, requiring all HEE-commissioned psychological professions training programmes to embed meaningful involvement of experts by experience in the design and delivery of programmes.

In the coming years, the ALBs, together with ICSs, providers, commissioners, regulators and professional bodies, will need to support staff and services to continue to innovate and adapt. Key areas for action include:

- **Breaking down traditional hierarchies:** Continually improving what we do requires us to look beyond traditional roles and professional silos and be open to new ways of working. HEE and NHSEI are rolling out investment in training and salary backfill to improve the spread and adoption of Responsible Clinician roles, traditionally held by psychiatrists, to include a wider group of professions including practitioner psychologists.

- **New ways of working:** The COVID-19 pandemic has shown that remote delivery can support the expansion in access to psychological therapies and enable better continuity of care for some service users, such as students and looked after children. Where outcomes have been reported, the evidence shows that this move has not reduced the overall effectiveness of psychological interventions.

  In the coming years, NHSEI will work with employers and the professions to develop flexible approaches to delivering psychological therapies and interventions that puts service users', families and carers' needs and choices at the heart of how psychological therapies are delivered.

- **Digital learning:** The pandemic has required many training providers to deliver part or all of their programmes online and it is a mark of the flexibility and adaptability of training providers, accrediting bodies, placement providers and trainees that courses have been able to continue and delays to qualification have been minimal. Blended learning programmes offer opportunities, as well as challenges in the delivery of psychological professions training and education.

  HEE has developed a digital capability framework to support the improvement of the digital capabilities of everyone working in health and care.

- **New roles:** Nationally, a number of new roles are being developed and established to support delivery in key service pathways. This includes investing in MHWP roles in adult community mental health and YIPP roles in CYP inpatient and crisis services, to increase access to psychologically informed interventions and support multi-disciplinary team care planning.

  These innovations will help to improve supply across the mental health workforce and open up new career pathways into key expansion service areas. In addition, employer-led, new roles initiatives such as the CAP and APP are also under development and proving popular with services and applicants. Across new roles, further work is needed to ensure the different roles and associated career paths are coherently described and integrated.

- **Contribute to the emerging evidence base:** Psychological professionals are continuing to support the development of our knowledge and evidence-base[8] through research and evaluation across therapy modalities, service models and psychological practice. This includes improving how meaningful progress in service users' recovery and quality of life is reported.

  By 2023/24, services are expected to expand the introduction and publication of routine patient-reported outcome measurements beyond IAPT services. There will be a need for training to enable all practitioners to use these measures in their clinical work.

- **New settings:** It is now widely acknowledged that integrating physical and mental health by embedding talking therapies and psychologically informed practice into physical health care improves patient outcomes and recovery. The expansion of IAPT Long Term Conditions services marks a significant shift towards psychological practice in physical healthcare.

  But there is scope to integrate psychological practice within physical healthcare more widely. HEE and NHSEI have therefore established an Expert Advisory Group on Psychological Practice in Physical Health to explore the case for the development of psychological practice in physical healthcare and support change. HEE is also investing in the deployment of trainee health psychologists to support service development across a range of settings.

[8] The term 'evidence-based' refers to the application of research knowledge in light of clinical expertise and service user choice.

6.5.1 Transform actions

Across all levels of the system (national, regional, system, employers and HEIs) to work together to deliver the actions in Table 7.

Table 7: Psychological professions Transform actions

Action	HEE and NHSEI implementation	ICSs implementation	Employers / HEIs implementation
1. Adopt a well governed and consistent approach to the expansion in psychological therapies: guided by NICE, published competence frameworks, national curricula, course accreditation and individual practitioner registration / multi-disciplinary markers of competence	●	●	●
2. Facilitate and support the routine collection and service-level publication of patient-reported outcome measures for psychological professions' activity	●	●	●
3. Embrace and embed meaningful involvement of experts by experience in psychological professions service design, development, delivery and training	●		●
4. Invest in and expand the spread and adoption of Responsible Clinician roles among practitioner psychologists, alongside other disciplines, subject to funding	●	●	●
5. Develop frameworks for the optimal use of blended learning in psychological professions training	●		●
6. Support the extension of psychological professions and psychological practice in physical healthcare settings and primary care. This will include:	●	●	●

6.1. The completion of a case for change in psychological practice in physical healthcare 6.2. Investment in a programme to deploy trainee health psychologists to support service transformation development projects			

7. Conclusion

The Psychological Professions Workforce Plan for England has been developed in alignment with the NHS Long Term Plan, Five Year Forward View for Mental Health, the We are the NHS: People Plan 2020/21 and the National Vision for the Psychological Professions. The overall aim is to support delivery of the NHS Long Term plan ambitions for meeting people's mental health needs. However, psychological professionals also have a broad scope across physical health and integrated healthcare and can support the health and wellbeing of service users, families and carers across multiple settings of the NHS.

Achievement of all five strategic priorities (Grow, Develop, Diversify, Lead and Transform) will require collaborative working across all levels of the system to create lasting change. Through action now to 2023/24, and beyond, we will deliver sustainable improvements in access, quality and outcome of psychological healthcare for the public.

Statutory/Mandatory Training – Speech and Language Teams

Core (all staff) NAME:_____

Training Programmes	Frequency	f = face to face e = eLearning	Date	Staff required to complete Statutory/Mandatory Training
Corporate Welcome / Induction	Once	f		
Local Induction	Once	f		All staff who are new to a department/role must have a local induction.
Fire & Environmental Awareness (includes Waste Management)	Annually	f		All staff
Health & Safety Awareness	3 yearly	f/e		All staff (further consideration being given to enhanced frequency for other staff e.g.: Estates)
Adverse Incident Reporting	Once	f/e		All staff
Data Protection Awareness	3 yearly	f/e		All Staff
Equality for Staff/Managers	5 yearly	f/e		All staff (Staff with management/supervisory responsibilities must complete Equality training for Managers course).
Manual Handling Awareness	2 yearly	f/e		All staff

Job Specific

Training Programmes	Frequency	f = face to face e = eLearning	Date	Staff required to complete Statutory/Mandatory Training
Management of Attendance	Once	f		All staff who have staff management/supervisory responsibilities
KSF/PCF Development Review	Once	f		All reviewers
Complaints Management	Once	f		All staff who have direct patient/client contact
Safeguarding Adults	Variable	f		**ALL** staff **must** attend Full day training in the first instance and then a half day refresher course every 3 years.
BLS (Basic Life Support)	2 Yearly	f – 2 hour course		All AHP staff with direct patient contact.
Infection Prevention & Control for staff with direct patient care	2 Yearly	e		All staff in primary or secondary healthcare settings with direct patient care responsibilities including those with responsibility for invasive devices i.e.: all AHP staff.
HIV Awareness	Once	f		All AHP staff with patient/client contact.
Medical Devices Awareness	3 Yearly	f/e		All staff who use and manage medical devices
Display Screen Awareness (DSE)	Once	e		All staff who use display screen equipment.
Basic Personal Safety Training – Theory	2 years	f		All community staff who have client handling duties.
Moving & Handling Awareness	2 yearly	e		All community staff who have client handling duties.
COSHH Awareness	3 yearly	f/e		All staff who are exposed to hazardous substances

				in the course of their work activity and where a risk assessment deems it necessary. Please also refer to the RQIA Training Matrix.
Fraud Awareness	Once	f – 1 hour		

Individual Role Specific

Training Programmes	Frequency	f = face to face e = eLearning	Date	Staff required to complete Statutory/Mandatory Training
Recruitment & Selection – B7 & Above	3 yearly	f/e*		All staff who will be sitting on a recruitment panel. *Refresher training
Fire Warden	3 yearly	F		Designated staff in each workplace.
General Health & Safety Risk Assessment Workshop – B7 and Above	3 yearly	F		Designated risk assessors
PCP	Annually	F		All staff

Occupational Therapy Learning Disability

Inservice Programme 2014/15

Date	Topic	Location
Wednesday 26th Nov 2014 2pm	Sensory Attachment Overview	Conference room , Finaghy HC Clare Donahue – Clinical Lead OT, CAMHS
Wednesday 25th Feb 2015 10am	IQ Assessments	MAH Siobhan Keating – Consultant Forensic Psychologist, MAH
Monday 6th July 2015 2-4pm	Peer supervision	Finaghy HC
Wednesday 29th July 2015 2-4pm	Epilepsy and LD	Finaghy HC Ena Bingham
Wednesday 19th August 2-4pm	Overview of financial capacity and money management with people with LD	MAH Katie Carson
Friday 4th September Time TBC	Sensory Integration and Peer Supervision	MAH Olivia Boyle
Friday 11th September (Full day)	Pressure care	MAH Shelley Crawford
Friday 18th September (Full day)	Postural management	MAH Shelley Crawford
Friday 25th September Time TBC	OT assessments in LD	MAH Shelley Crawford and Katie Carson
Wednesday 28th October	Peer Supervision	Carlisle HBC
Wednesday 25th November	LD and the environment (presenting her MSc thesis)	Finaghy HC Heather McFarlane
December	NO INSERVICE	

Training Matrix		Required Frequency	Delivery Method f=face to face, e=elearning
			MANDAT
Corporate Welcome includes	CLICK HERE TO BOOK	Once	f
Local Induction	See Line Manager	Once	f
Fire Safety & Environmental Awareness	CLICK HERE TO BOOK	Annual	f
Manual Handling	CLICK HERE TO BOOK	Once	f
Manual Handling Update	CLICK HERE TO BOOK or CLICK HERE TO BOOK	2 years	f&e
In Hospital Life Support	CLICK HERE TO BOOK	Annually	f
Infection Prevention & Control	CLICK HERE TO BOOK or CLICK HERE TO BOOK	2 yearly	f/e
Safeguarding Vulnerable adults	CLICK HERE TO BOOK	3 yearly	f
Safeguarding Children Level 2 (previously known as level 1)	CLICK HERE TO BOOK	3 yearly	f
MAPA (5 day)	CLICK HERE TO BOOK	Once	f
MAPA (2 day update)	CLICK HERE TO BOOK	12 Months	f
MAPA Foundation	CLICK HERE TO BOOK	Yearly	f
Complaints Handling	CLICK HERE TO BOOK	Once	f
Adverse Incident Reporting	CLICK HERE TO BOOK	Once	f
My Data Your Business (Data protection)	CLICK HERE TO BOOK	3 yearly	f/e
General Health and Safety Awareness	CLICK HERE TO BOOK	Once	e
Attendance awareness		Once	f
PCF/KSF Appraisee		Once	f
COSHH Awareness	CLICK HERE TO BOOK	3 yearly	e
HRPTS Employee Self Service	CLICK HERE TO BOOK	Once	f
Disability Awareness	CLICK HERE TO BOOK	Once	f
HIV Awareness	CLICK HERE TO BOOK	Once	f
Medical Devices Awareness	CLICK HERE TO BOOK	3 yearly	f/e
Display Screen Equipment	CLICK HERE TO BOOK	once	e
Deprivation of liberty	CLICK HERE TO BOOK	Once	f
Consent and capacity	CLICK HERE TO BOOK	Once	f
Human Rights Training	CLICK HERE TO BOOK	Once	f
Equaity for staff	CLICK HERE TO BOOK or	5 yearly	f/e
Security Awareness		once	e
PBS Awareness intro		once	e
PBS Awareness face to face		once	f

Mental capacity Act Level 2	CLICK HERE TO BOOK	3 yearly	e
Mental capacity Act Level 3	CLICK HERE TO BOOK	3 yearly	f
Mental capacity Act Level 4a	CLICK HERE TO BOOK	3 yearly	f
Mental capacity Act Level 4b	CLICK HERE TO BOOK	3 yearly	f
TRAINING FOR THOSE WITH MAN			
Health and safety risk assessment	CLICK HERE TO BOOK	3 yearly	f
Recruitment and Selection Training	CLICK HERE TO BOOK	Once	f
Recruitment and Selection Refresher	Phone 90635678, Request link for online refresher course.	3 yearly	f/e
Management of Attendance	CLICK HERE TO BOOK	3 yearly	f
Equality for managers	CLICK HERE TO BOOK or	5 yearly	f/e
Managing Diversity	CLICK HERE TO BOOK	Once	f
PCF/KSF Appraiser		Once	f
HRPTS Manager Self Service	CLICK HERE TO BOOK	Once	f
BRATT awareness	CLICK HERE TO BOOK	once	f
DATIX web for incidents	CLICK HERE TO BOOK	Once	f
Practice Educator Introductory		Once	f/e
Practice Educator Refresher		3 Yearly	f/e
LD OT GOOD			
Foundation wheelchair training	CLICK HERE TO BOOK	Once	f
Intermediate wheelchair training	CLICK HERE TO BOOK	Once	f
Advanced wheelchair training	CLICK HERE TO BOOK	Once	f
AMPS	CLICK HERE TO BOOK	Once	f
Seating and Posture CEC course		Once	f
Complex seating Masters Module		Once	f
Pressure Ulcers CEC course		Once	f
Pressure Care Masters Module UU		Once	f
Housing Programme		Once	
Sensory Integration Module 1	CLICK HERE TO BOOK	Once	f/e
Sensory Integration Module 2/3	CLICK HERE TO BOOK	Once	f
Sensory Integration Module 4	CLICK HERE TO BOOK	Once	f
Is it Sensory or is it behaviour?		Once	f
Sensory Attachment		Once	f
Record Keeping and Legal issues	CLICK HERE TO BOOK	Once	e

Who should carry out the training			
ORY FOR ALL STAFF			
All staff			
All new staff who are new to a department/role			
All staff, locally			
All staff			
All Staff (includes e-learning which must be completed prior to practical session)			
All Clinical Staff			
All staff who have contact with patients and clients			
All Staff			
All staff who have direct contact with children OR adult carers/parents OR adults suspected of posing a risk to children			
All staff on hospital sites i.e. MAH and Iveagh			
As above			
All OT staff and rotational OT staff not receiving MAPA (5 day)			
All staff			
All staff			
All Staff			
All staff			
All staff			
All Staff			
All staff who may be exposed to hazardous substances			
All Staff Members			
All Staff members			
All clinical staff			
All staff who use equipment			
All staff			
all staff			
All staff working in low secure units			
all Muckamore staff			
all Muckamore staff			

All staff			
OT's			
Trust Panel Members			
AGERIAL/SUPERVISORY RESPONSIBILITIES			
Staff who have supervisory/line management responsbility			
All staff who will be engaging in the recruitment process			
All staff who have been on the R&S Training within the last 3 years and will be sitting on a recruitment panel within this period			
All staff who have staff management/supervisory responsibilities			
All staff who do not have staff management/supervisory responsibilities.			
All staff who have staff management/supervisory responsibilities			
All staff who have staff management/supervisory responsibilities			
Staff who have supervisory/line management responsbility			
Staff who have supervisory/line management responsbility			
those who approve or invesigate incidents			
) PRACTICE TRAINING			

Physiotherapy Service Trust Mandatory Training Matrix V3. Revised November 2022				
Complete within 3 months	Complete within 6 -12months	Complete as role requires		
Core Training for all staff	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Trust Welcome Programme	HR send out link to new staff which includes the following * training. Virtual	Once		
*Fire Safety Awareness	Virtual. Book here: Estates - Fire Training (sharepoint.com)	Annually		
*Health and Safety Awareness	Virtual. Loop>Digital Apps>BHSCT E-Learning>Statutory and Mandatory Training. Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	Once		
*Adverse Incident Reporting	Virtual. Loop>Digital Apps>BHSCT E-Learning>Statutory and Mandatory Training. Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	Once		
*Data Protection GDPR	Virtual. Loop>Digital Apps>BHSCT E-Learning>Statutory and Mandatory Training. Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	3 yearly		
*Equality, Good Relations and Human Rights: Making a Difference	Virtual. Loop>Digital Apps>BHSCT E-Learning>Human Resources Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	5 yearly		
*Manual Handling Theory	Virtual. Loop>Digital Apps>BHSCT E-Learning>Course Categories>Risk And Governance	2 yearly		

	Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)			
*Quality 2020: Level 1 Awareness	Virtual. Loop>Digital Apps>BHSCT E-Learning>Human Resources Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	Once		
*Safeguarding Awareness (Adults and Children)	Virtual. Loop>Digital Apps>BHSCT E-Learning>Course Categories>Risk And Governance Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	Once		
*Infection Prevention Control	Virtual. Loop>Digital Apps>BHSCT E-Learning>Statutory and Mandatory Training. Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	2 yearly		
Physiotherapy Service Specific	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Service and Learning & Development Induction	Date and time offered by L&D team. Face to face and Virtual.	Once		
Local Induction	Arrange with Team Lead. Face to face	Once		
Basic Life Support Hospital / Community	Contact your site Resus Officer for E-learning link and to book follow up 20minutes face to face assessment MPH and Knockbracken: Deirdre Campbell RVH: Siobhan Acheson or Elaine McWhinney City: Mary Murphy MIH and Muckamore: Barbara Carson Community: Neil Montgomery	2 yearly		

Paediatric BLS Hospital / Community All staff working with children	Contact your site Resus Officer (See above) for E-learning link and to book follow up 30minutes face to face assessment	2 yearly		
Manual Handling Hospital / Community update	Contact your site Ergonomics lead for face to face training RVH/MIH: Maria Rush MPH/BCH: Angela Clarke Community: Claire Campbell	2 yearly		
Safeguarding Adults Level 2: All staff who have direct contact with service users/patients	HRPTS. Virtual. Delivered by SW L&D team (places limited+), CEC also deliver courses. If level 2 training is unavailable via HRPTS, in the interim, please complete L2 here: Safeguarding Adults - elearning for healthcare (e-lfh.org.uk)	3 yearly		
Safeguarding Adults Level 3: All front Line managers/Adult Safeguarding Champions, Managers not acting as DAPO's/IO's.	HRPTS. Virtual. Delivered by SW L&D team.	2 yearly		
Safeguarding Children Level 2: Staff who have direct contact with: Children and young people. Adult carers/parents and those who have regular contact with children. Adults known/suspected of posing a risk to children	HRPTS. Virtual	3 yearly		

Safeguarding Children Level 3: All staff who: Have a managerial or supervisory role. Have a specific safeguarding role.	HRPTS. Virtual.	Initial 6 hour course. 3 yearly refresher, 3 hours.		
Supervision	Book minimum of 2 1:1 sessions with your supervisor in addition to group sessions	x4 Annually		
Medical Device Awareness	Virtual. Loop>Digital Apps>BHSCT E-Learning>Course Categories>Risk And Governance Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	3 yearly		
Records Management Awareness	Virtual. Loop>Directorates>Performance, Planning and Informatics>Planning and Performance>Information Governance and Data Protection>Training and Awareness Records Management (sharepoint.com)	3 yearly		
COSHH Awareness	Virtual. Loop>Digital Apps>BHSCT E-Learning>Course Categories>Risk And Governance Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)	3 yearly		
Complaints Management	Page Tiger Online Work book: Complaint's in Health and Social Care - 1 (pagetiger.com)	Once		
Display Screen Equipment	Virtual. Loop>Digital Apps>BHSCT E-Learning>Course	Once		

	Categories>Risk And Governance Belfast Health and Social Care Trust eLearning LMS Platform: Log in to the site (hscni.net)			
Deprivation of Liberty	Virtual. HSC Learning Centre E-Learning Health and Social Care (NI) Learning Centre: Log in to the site (hsclearning.com)	Once		
Basic Medical Gases Safety for all staff using, moving, transporting and storing gases	Contact Colin Drain or Annie Cassells. Virtual	3 yearly		
Additional for PNR	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Clinical Holding Skill for Essential Care and Treatment (CH-3) 2 days for all static Neuroscience, stroke and RABIU staff. Rotational B6 – discuss training requirements with Team Lead	HRPTS. Face to face	Once		
CH-3 Update 1 day	HRPTS. Face to face	Annually		
Personal Safety and Disengagement 1 day for all PNR Community staff	HRPTS. Face to face	Annually		
Additional for MH&LD	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
MAPA Foundation 2 days for Learning Disability static staff	HRPTS. Face to face	Once		

MAPA Foundation Renewal 1 day Learning Disability static staff	HRPTS. Face to face	Annually		
Personal Safety and Disengagement 1 day for new/rotational Community staff	HRPTS. Face to face.	Annually		
Additional for Admin	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Archive Training	Virtual. Loop>Directorates>Performance, Planning and Informatics>Planning and Performance>Information Governance and Data Protection>Training and Awareness Archive Training (sharepoint.com)	Once		
Additional for Service Management	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Absence Management	Virtual. Book via HR Learning Development portfolio > Leadership and Management LDPortfolioLIVE - 1 (pagetiger.com)	Once		
Absence Management Refresher	Virtual. Book via HR Learning Development portfolio > Leadership and Management LDPortfolioLIVE - 1 (pagetiger.com)	3 yearly		
Staff Development Reviewer	Virtual. Book via HR Learning Development portfolio > Leadership and Management LDPortfolioLIVE - 1 (pagetiger.com)	Once		
Recruitment and Selection	Virtual. Book via HR Learning Development portfolio > Leadership and Management LDPortfolioLIVE - 1 (pagetiger.com)	Once		

Recruitment and Selection Refresher	Virtual. Book via HR Learning Development portfolio > Leadership and Management LDPortfolioLIVE - 1 (pagetiger.com)	3 yearly		
Training applicable for designated staff in Functional Group / Site	**Booking and Delivery Method**	**Frequency**	**Date completed**	**Review Date**
Display Screen Facilitator	HRPTS. Face to face	Once		
Fire Warden	HRPTS. Virtual	3 yearly		
General Health and Safety Risk Assessment	HRPTS. Virtual	Once		
General Health and Safety Risk Assessment Refresher	HRPTS. Virtual	5 yearly		
Moving and Handling Facilitator	Contact your site Ergonomics lead for face to face training RVH/MIH: Maria Rush MPH/BCH: Angela Clarke Community: Claire Campbell	Once		
HIV Awareness	Virtual. Email shealth.team@belfasttrust.hscni.net to book a place	Once		
Safeguarding Adults Level 4: Investigating Officer - professionally qualified and experienced individual nominated for that role (B6 minimum)	Delivered by SW L&D Team	No refresher requirements CPD requirement, attendance at forums once per annum. Participate in a minimum of 2 investigations per annum		
Safeguarding Children Level 4: All staff with specialist	Delivered by SW L&D Team			

safeguarding roles and responsibilities including leaders and policy makers.				

*Please note training accessibility, booking and delivery may be subject to change.