General Medical Council

Regulating doctors
Ensuring good medical practice

Small specialties thematic review

Quality assurance report for medical psychotherapy

2011/12

Contents

Overview

Specialty	Medical psychotherapy
Review dates	2011-12
Areas of exploration	See appendix 1
Were any patient safety concerns identified during the visit?	No
Were any significant educational concerns identified?	No
Has further regulatory action been requested via the responses to concerns element of the QIF?	No

Background to the review

1. We are piloting new methods of quality assuring small specialties across the UK. By small specialties, we mean those with fewer than 250 current trainees in post or those where, in order to protect the identity of the trainees concerned, we are unable to publish deanery-level trainee survey results for more than 10% of that specialty's training programmes due to there being fewer than three trainees in posts.

2. We identified this as a matter for UK-wide investigation because we were concerned that there were possible gaps in our evidence base about the quality of these small specialties and we wanted to develop new methods of investigation which would improve the way we quality assure small specialties in the future.

3. We have assessed the quality of training within the specialty to ensure that it meets our standards for postgraduate training: *The Trainee Doctor* and the *Standards for Curricula and Assessment Systems*. In the review, we focused on the delivery of postgraduate education within the specialty and considered the policies, processes and systems in place to support this.

Background to the specialty

4. Medical psychotherapy is one of the six psychiatry higher specialties. The training duration for medical psychotherapy is three years in core psychiatry training, followed by a further three years of higher specialty training for single CCT or five years for dual CCT (for a full time trainee). All psychiatry trainees are required to demonstrate competency in psychotherapy during their core psychiatry training.

5. Specialists in medical psychotherapy work with others to assess, manage and treat adults with mental health difficulties using talking therapies and applied psychotherapeutic techniques in supervision, consultation and reflective practice. Psychotherapy is practised by a multi-disciplinary workforce including psychoanalysts, adult psychotherapists, clinical psychologists and nurse therapists. Non-medical psychotherapists play a role in training medical psychotherapists.

6. Our 2012 national training survey identifies 45 medical psychotherapy trainees across the UK, working across ten deaneries in England, as well as within the national training programme in Scotland and in Northern Ireland. According to our data, there are currently no trainees in a higher training programme in psychotherapy in Wales. Between 8 and 10 of the 45 trainees work less than full time and 9 trainees are on a dual training programme. The majority of the trainees (22 out of 45, 48.8%) are based in London. The next highest proportion of trainees are NHS Education for Scotland with five trainees (11.1%) and Severn and Yorkshire and the Humber deaneries with four trainees each (8.9%) The spread between the other deaneries is fairly even, with one or two trainees at each.

7. We note that data collected by the Royal College of Psychiatrists (the College) for its 2012 pilot *UK Psychotherapy Survey* identifies 48 medical psychotherapy trainees (see paragraph 77). The timing of data collection and validation explains the variation with the national training survey data.

8. The college membership qualification for psychotherapy is the MRCPsych (Member of the Royal College of Psychiatrists). In order to obtain membership candidates must normally complete 30 months of post foundation experience in psychiatry and pass all four components of the MRCPsych examinations: three written exams and a clinical assessment of skills and competencies (CASC).

Executive summary

1. The review of medical psychotherapy looked at medical education and training within the speciality and how the stakeholders work together to assure the quality of the training. A number of our findings were supported in the College's 2012 pilot *UK Psychotherapy Survey* and we look forward to seeing this initiative develop.

2. Psychiatry remains difficult to recruit to and has a high proportion of non-UK graduate trainees. We acknowledge the efforts the Medical Psychotherapy Faculty Education and Curriculum Committee has made to the work of the College and deaneries to enhance recruitment into psychiatry. For example, foundation year Balint groups, summer schools, dual training programmes in psychotherapy and medical student placements in medical psychotherapy.

3. There is uncertainty regarding the future of medical psychotherapy. All the parties we spoke with voiced concerns about the reduction in NHS psychological services in general and consultant medical psychotherapy posts in particular. The Centre for Workforce Intelligence reported that the number of training and consultant posts has decreased since 2006, although there was a slight upwards trend in 2011. In response, the College has identified the need to develop psychotherapeutic psychiatry and to seek to protect threatened consultant medical psychotherapy posts represented in the undergraduate to postgraduate therapeutic education strategy *Thinking Cradle to Grave* (2012). The strategic aim in developing psychotherapeutic psychiatry is to maintain and improve clinical services through medical psychotherapy training leadership.

4. All trainees were committed to the specialty, but aware of the difficulties in finding consultant medical psychotherapy posts at the end of training. Many trainees considered that completing a dual programme would increase their chances of employment. Overall trainees were positive about the standard of their clinical training. However, they raised concerns about variation between deaneries in the standard of academic programmes and availability of funding for academic programmes and self reflective development sessions.

5. Trainees have representation at College level, and trainee representatives are encouraged to be actively involved in curriculum development and amendments. Higher trainees outside London described feeling isolated from their medical peers and we found limited awareness of national trainee communication networks.

6. Some core trainees had difficulties completing the core competencies by end of CT3, because of difficulties finding appropriate cases, and deaneries need to work with the College to ensure training opportunities are provided. The monitoring of completion of the core psychotherapy cases must also be strengthened. Consultant Psychiatrists in Psychotherapy should lead core and higher psychotherapy training in Psychiatry and be responsible for its educational governance.

7. Non-medical psychotherapists play an important role in the training of psychotherapy trainees, the extent of which varies between deaneries. We found no evidence of deanery quality management of the non-medical trainers and consider that all those who complete assessments must be trained and supported.

8. We recognise the challenge of quality managing a small specialty which has a low number of trainees across a number of local education providers. We heard some examples of innovative practice to share resources, such as the collaborative approach to deanery teaching, which provides a larger trainee peer group and larger pool of trainers.

9. We found that communication and engagement from the College to heads of school, training programme directors and trainers should be enhanced.

10. We found some variability in the delivery of workplace based assessments and ARCP panels and the College and deaneries should work together to standardise the approach.

Key findings

Requirements

Number	Detail	Report reference	Standards reference
1.	Deaneries must ensure that all those completing assessments that contribute to a trainee's CCT, including non-medical supervisors, are trained and supported for this role.	29-35	2.2 6.30 6.34 6.35
2.	Deaneries must monitor the completion of core psychotherapy cases to ensure all trainees meet the curriculum requirements by the end of CT3. The College must clarify the duration of the long case for core psychotherapy competency in the curriculum.	58-63	2.2 5.1 5.2
3.	Consultant Medical Psychotherapists must lead both core and higher psychotherapy training in psychiatry and be responsible for its educational governance.	15	6.33 6.36

Recommendations

Number	Detail	Report reference	Standards reference
1.	All psychotherapy supervisors should have training in the model of psychotherapy they are supervising and continue to be practitioners of the model.	15a	6.29 6.39
2.	The College should ensure that there are effective structures for communicating guidance about curriculum implementation and psychotherapy supervision requirements to psychotherapy tutors as well as heads of school	15b	Standard for deanery 3.1
3.	The College should check that the mechanisms in place for sharing information with medical psychotherapy	25-28	Standard for deanery

	training programme directors and trainers are effective for all deaneries and enhance engagement between the College and trainers.		3.1
4.	The College should work with deaneries to ensure that opportunities for trainee engagement with the College are signposted effectively.	37-40	Standard for deanery 2.1, 2.2
5.	The College should work with deaneries to monitor the higher psychotherapy academic programme to ensure consistency in quality.	80-85	2.2 2.3 5.4
6.	The College should work with deaneries to monitor implementation of the WPBA guide.	101	5.6 6.34

Good practice

Number	Detail	Report reference	Standards reference
1.	The training provided for non-medical trainers in North Western and Mersey deaneries, recognising the importance of their role in supporting training.	36	6.34 6.35
2.	Initiatives aimed at medical students and foundation doctors that have improved recruitment into psychiatry. For example, medical student placements in psychotherapy run by Severn deanery; and Balint groups for foundation doctors in Yorkshire and the Humber and North Western deaneries to promote psychological understanding of healthcare.	43-44, 54	4.2
3.	The College's proactive approach to monitoring the relevance of training for workforce needs and identifying possible solutions. For example, the dual training programme in general adult psychiatry and medical	51-52	4.1

	psychotherapy as a way to retain medical psychotherapy in psychiatry and to enhance recruitment.		
4.	The collaborative approach to deanery teaching in Oxford and the West Midlands, and North Western and Mersey which provides a larger trainee peer group and a larger pool of trainers to enhance learning.	87	6.33 Standard for deanery 5.1
5.	The mid-year formative review and educational supervisors' report for higher trainees in Scotland and Yorkshire, which enables early identification of any gaps in meeting the curriculum requirements.	105	5.1 5.18

The report

Roles and responsibilities

The College

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

    a. national recruitment for core and higher training in England and Wales (see paragraph 41)

    b. developing the curriculum and assessment tools

    c. preparation and organisation of examinations

    d. advising the GMC and deaneries on individual trainee applications for a certificate of completion of training (CCT) or certificate of eligibility for specialist registration (CESR)

    e. provision of training days and guidance in relation to education and training, and ensuring deaneries quality manage the training of their faculty.

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

Relationship with stakeholders

3. The College hosts a number of meetings every year with various stakeholders to facilitate and encourage them to share information. The heads of specialty schools, or equivalents meet with the College four times a year (see paragraph 16), and at one of these meetings they are also joined by the training programme directors (see paragraphs 25-26). The College has continued its programme of engagement with the psychiatry training faculty through training events, such as the Annual Medical Education Conference and courses for educational supervisors and workplace assessors.

4. Regional specialty advisors and their deputies are all brought together to meet with the College twice a year. The College also has a faculty education and curriculum committee for each psychiatric specialty. These groups are broadly equivalent to the specialty advisory committees in place at a number of other colleges and faculties, and provide a forum for the College to monitor the implementation of the curriculum across the UK. The Medical Psychotherapy Faculty Education and Curriculum Committee (MPFECC) meet two to three times

a year. The College involves service users, experts by experience and the public through lay representation on committees, including its education and training standards, curriculum, and quality assurance committees. The MPFECC acknowledges the central contribution of expert patients and carers in the reflective practice core curriculum amendments which will be proposed by the College to the GMC in January 2013.

5. The College interacts with trainees through the Psychiatric Trainees Committee and trainee representation on other College Committees, including the Education, Training and Standards Committee, social networking including Twitter, and through their local contacts. The MPFECC and the Faculty of Psychotherapy Executive Committee have trainee representation; there is a national medical psychotherapy trainee organisation and a higher psychotherapy trainee e-forum. However, most of the trainees we spoke with were unaware of these mechanisms for contact, and the College advised that it is currently revamping the medical psychotherapy faculty website, including the trainee section. The College considers the website the most effective way of communicating with trainees, other than through the committees.

6. The College has recruited and trained approximately 120 consultants as external advisers to provide an external perspective on deanery visits and annual review of competence progression (ARCP) panels. The College estimates that 70-80% of deaneries currently use its external advisers, and reports that this is an improvement on 2011. The College notes that it cannot insist that deaneries use its external advisers, and some deaneries have objected to paying their expenses. The College considers that external advisers provide valuable feedback on visit and ARCP processes. The College recognises that there is scope for further development of the use of external adviser reports, such as collating information for quality improvement. We support this development and encourage all deaneries to use external advisers for their professional expertise and to provide external assurance of deanery processes.

7. External advisers are asked to review the documentation that deaneries use to check whether trainees have met the required core competencies and to report on core psychotherapy training and any anomalies. This information feeds into the College's annual specialty report (ASR). The external advisers do not, however, analyse the performance of individual trainees. The Lead Dean suggested that a monitoring tool would be useful for all colleges, which would enable them to be clearer about the reporting expectations of external advisers so that these can be of maximum benefit to deaneries as well as the colleges.

8. We did not establish if consultant medical psychotherapists have been recruited as external advisers and if so, if they have been invited to sit on ARCPs for higher medical psychotherapy trainees.

9. We note the UK wide survey of psychotherapy training at core and higher level which was undertaken by the MPFECC (*2012 UK Psychotherapy Survey*). The aim of the survey was to map psychotherapy training delivery and curriculum

fulfilment. The MPFECC intends that this survey should become the benchmark for subsequent evaluation of psychotherapy training delivery, combining qualitative and quantitative evidence.

10. We note that the 2012 *UK Psychotherapy Survey* is a pilot and look forward to seeing the actions arising from this to improve the quality of core and higher training in medical psychotherapy.

Deaneries

11. Deaneries are responsible for the design and delivery of psychotherapy programmes including workplace-based experience, based on the approved curriculum and assessment system. This includes funding and managing the quality of training, supervision and support for trainees. The programme must enable trainees to meet the curriculum and assessment requirements, but can be tailored to the services of local education providers, providing there is a balance between service and education.

12. Higher clinical supervision was generally described as reliable and of good quality by the higher trainees we spoke to. It is provided by consultant medical psychotherapists and non medical supervisors including psychoanalysts, adult psychotherapists, clinical psychologists and nurse therapists. There was also evidence of a deanery-led response to supervision arrangements where concerns had been raised.

13. Some deaneries without higher psychotherapy training programmes found it more challenging to find appropriate psychotherapy training for core trainees. It was reported that College faculty had advised some heads of school verbally in 2011 that consultant general adult psychiatrists, with an interest but no training in psychotherapy could sign-off core psychotherapy competencies. This had occurred in deaneries with an insufficient number of qualified psychotherapy trainers. We note that the existing MPFECC saw this as a transitional arrangement.

14. The College's 2012 *UK Psychotherapy Training Survey* provided evidence of the core psychotherapy curriculum not being fulfilled in six schemes which are led by a psychotherapy tutor without a CCT in psychotherapy.

15. We fully support the recommendation of the 2012 *UK Psychotherapy Training Survey* that Consultant Medical Psychotherapists should be appointed as psychotherapy tutors to lead core and higher psychotherapy training in psychiatry and be responsible for its educational governance. The visiting team felt that this recommendation should be adopted and introduced as a mandatory requirement. In addition:

    a. All psychotherapy supervisors should have training in the model of psychotherapy they are supervising and continue to be practitioners of the model.

b. The College should ensure that there are effective structures for communicating guidance about curriculum implementation and psychotherapy supervision requirements to psychotherapy tutors as well as heads of school.

16. Specialty schools (or equivalents) manage the postgraduate medical training in their respective specialty within a local deanery. The schools are managed by the deanery in conjunction with the royal colleges and faculties. One of the key interface roles between the College and deaneries is the heads of the specialty schools. We found good networking between the heads of schools. In London, which has a quarter of all psychiatry trainees, the head of school is a dual College and deanery appointment, which appeared to work well.

17. We met heads of school, or equivalents, from seventeen deaneries across the UK. All felt supported by their deaneries, but there was variability in the time allowed in their job plans for this role. There was general consensus that the time designated in job plans for the head of school role was insufficient. Some heads of schools also felt that, due to resource constraints in the central team, deaneries were devolving more responsibilities to the specialty schools but with insufficient administrative resource to support the increased workload. Heads of school were also uncertain about the future of their role.

18. We noted that in two deaneries, the training programme director had responsibility for both core and higher psychotherapy training. This was described as providing helpful continuity.

19. The Lead Dean suggested that it would be helpful to collect GMC National Training Survey data on psychotherapy over time and feed this back to the heads of school. The low number of medical psychotherapy trainees across the UK and in each training location means that it is difficult to use the current data in the National Training Survey to identify psychotherapy-specific issues. We have been gathering longitudinal data through the National Training Survey since 2010. Due to small trainee numbers in psychotherapy, there is currently limited reporting capacity for the specialty in order to preserve trainee anonymity, but this capacity will increase over time as more data aggregates.

The Lead Dean

20. The Lead Dean for Medical Psychotherapy is the lead for all psychiatry specialties. She is involved in high level overview of the specialty and has a role in enhancing quality standards in psychotherapy training.

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

Trainers

Medical trainers

22. A Centre for Workforce Intelligence (CFWI) report to the government in August 2010 notes that '[a]s psychotherapy experience is a mandatory training requirement for all psychiatric specialties, the training role of medical psychotherapists is important'.

23. All trainers we interviewed enjoyed being a psychotherapy trainer but spoke of bureaucratic pressures from the College and GMC, coupled with a discouraging climate of NHS provision of medical psychotherapy which included the closure and cutting back of NHS psychological services.

24. Trainers felt that the trainer role was reasonably well protected by LEPs and included in their job plans. However most said that they had to spend more time on their educational role than is included in job plans.

25. Several trainers reported no engagement with the College and all would like more contact. We heard from some trainers that the College had not sought their views about curriculum development or implementation. Most trainers considered that this relationship could be improved.

26. Training programme directors stated that they received written information from the Faculty Executive but their feedback was not requested by the College. We found that if training programme directors were not also on the Medical Psychotherapy Faculty Education and Curriculum Committee (MPFECC), they only receive a worked through summary from the Executive and they would appreciate having more detail. No reference was made by any training programme director to the usefulness of their annual meeting with the College. Training programme directors who were on College committees had greater involvement with the College.

27. It was noted that the reduction in the number of members on the MPFECC may have created a gap in the communication between the College and the training programme directors. MPFECC returned to full membership in October 2012 and aims to use the regional medical psychotherapy representatives as a link with medical psychotherapy training programme directors and psychotherapy tutors.

28. The College should check that the mechanisms in place for sharing information with medical psychotherapy training programme directors and trainers are effective for all deaneries and enhance the engagement between the College and trainers, particularly at this time of uncertainty for the profession.

Non-medical trainers

29. Non-medical psychotherapists play an important role in the training of medical psychotherapy trainees, although the nature and extent of which varies between deaneries.

30. We found no evidence of deanery quality management of the non-medical trainers who provide core and higher psychotherapy training. We heard that there was a lack of clarity about whether supervision of medical trainees is identified in the job plans of the non-medical trainers. There is variability in the formality of the training role that non-medical supervisors undertake, and we were concerned about the apparent lack of training and quality management of non-medical supervisors in a specialty where they play such a central role. Trainees reported that non medical trainers were not represented at ARCP panels.

31. The general opinion of medical psychotherapy trainers was that quality control of non-medical trainers was at least as good as that of medical trainers, but some considered that lack of deanery quality management was an issue.

32. All trainers and trainees agreed that non-medical trainers are essential to the provision of core and higher psychotherapy training quality. Trainees confirmed that non-medical supervisors were generally psychotherapists of a very high quality. Although the quality of supervision varied, trainees did not differentiate between the quality of medical and non-medical supervision.

33. Trainees and trainers stated that the non-medical trainers do not appear to have deanery training or support for completing core and higher psychotherapy WPBAs. Heads of school were concerned that trainees are encouraged to have WPBAs completed by the multi-professional workforce and while this was acknowledged to be of value, there was concern that non-medical trainers are not provided with training to do this. The College was aware that trainees had voiced concerns about the lack of support and training for non medical trainers to feed into training and assessment. The College noted that there is no agreed national model for the contribution of non-medical trainers to psychiatry training. The view of the College is that all trainers need to be represented on deanery specialty training committees. We note that this model is in place in the Yorkshire and the Humber deanery.

34. Despite the important role which non-medical psychotherapists play, heads of school stated that their views are not generally sought in curriculum implementation and they are not involved in the ARCP of trainees they supervise. The heads of school considered that that this involvement would be useful.

35. It is clear that there is variability in formalising the role of non-medical supervisors in medical psychotherapy training. The 2012 *UK Psychotherapy Survey* recommends that non medical trainer involvement in core and higher medical psychotherapy training should be strengthened with medical

psychotherapy leadership. The survey states that such a strengthening should include the formalised participation of non medical trainers in ARCPs. We are also concerned about the lack of training for non medical trainers in medical psychotherapy assessment requirements. Deaneries must ensure that all those completing assessments that contribute to a trainee's CCT, including non-medical supervisors, are trained and supported for this role.

36. We found evidence of deaneries that recognise the importance of non-medical trainers. We commend the training provided for non-medical trainers in North Western and Mersey deaneries as good practice. We were pleased to note the two recent developments:

    a. North Western deanery plans to roll out training for non-medical trainers in WPBAs in medical psychotherapy, old age psychiatry and child/adolescent psychiatry. These are all specialties where non-medical practitioners provide training.

    b. Mersey deanery has provided funding and training for non medical supervisors of core psychotherapy trainees. Previously, medical psychotherapy training had not been in the job plans of the non medical supervisors and core medical psychotherapy training was in jeopardy.

Trainees

37. Trainees stated that there was little direct communication from the College and generally looked for information from the deanery, with which they had a better link. Most trainees had not received direct contact from the College about the curriculum and assessment requirements.

38. We heard that trainee views could be fully expressed at the Medical Psychotherapy Faculty Education and Curriculum Committee (MPFECC) and Faculty Executive through the trainee representatives. This was confirmed by the trainee representatives, who were encouraged to be actively involved in curriculum development and amendments.

39. Other trainees felt less involved and voiced feeling isolated from their medical psychotherapy peers in other deaneries. A number of trainees we spoke to were unaware of the trainee e-forum for national discussion of psychotherapy training or of the existence of trainee representatives on the MPFECC.

40. We heard that the peer group for some higher trainees were the non-medical psychotherapy trainees in their local independent training organisations, particularly where there is only one higher trainee in the deanery. While some trainees had been funded to attend national medical psychotherapy conferences, to facilitate a medical peer group, this was not universal. The College should work with deaneries to ensure opportunities for trainee engagement with the College are signposted and supported effectively.

Recruitment and selection

41. The College runs a national recruitment process for all psychiatry specialties (including psychotherapy) for England and Wales. Separate national recruitment processes are in place in Scotland and Northern Ireland.

42. Psychiatry remains difficult to recruit to and has a high proportion of non-UK graduates (1437 or 44% according to deanery figures). The College advises that this has not changed significantly in the past few years since Modernising Medical Careers (MMC) and despite changes in UK visa regulations. To fulfil workforce requirements, psychiatry would have to recruit approximately 11% of all UK graduates each year and currently the specialty is recruiting at a rate of approximately 4%.

43. The difficulty with recruitment into core psychiatry training is a widespread and a commonly identified issue, although heads of school indicated that most deaneries had come at least close to filling their posts in the later local recruitment rounds. A number of initiatives to improve recruitment have been introduced by the College and deaneries, specifically targeted at increasing awareness of psychiatry as a career choice to medical students and foundation trainees. A number of events had been run within the deaneries of those we met. The MPFECC has been involved in the Summer Schools in Leeds and Sheffield in 2011 and 2012. We heard of MPFECC plans to introduce Balint Groups to undergraduate medical students. See paragraph 54 for information on Balint Groups for foundation doctors.

44. Severn deanery recruits six undergraduate medical students for six month placements in which they complete a psychotherapy case with appropriate supervision. This has been running for four years and it was described as a successful initiative which has positively affected recruitment to psychiatry. We consider this good practice in improving recruitment to the specialty.

45. Despite the general issues of recruitment into psychiatry, recruitment into higher psychotherapy training is not an issue. Trainers described applicants as motivated and able. The primary concern at the higher training level is about employment opportunities available post CCT for trainees in medical psychotherapy.

46. The diversity of the trainee population is important to support increasing access to psychotherapy services by black and minority ethnic communities. In Yorkshire and the Humber Deanery the trainee profile is diverse, with only one white British trainee out of six trainees on dual medical psychotherapy programmes, where psychotherapy remains a predominantly white profession. We note the increased numbers of international medical graduates completing core psychiatry training, which will lead to greater diversity in medical psychotherapy trainees and consultants of the future.

47. The 2010 Centre for Workforce Intelligence (CFWI) report identified a need to increase training posts and consultant numbers by 2018 in all psychiatric specialties by 0.5-2.0%. However the report recommends that no change is made to the current number or geographical distribution of training posts; and prioritises addressing recruitment and retention of trainees. The report recommends that work continues to improve the attractiveness of the specialty.

48. The 2010 CFWI report also highlights some of the key issues affecting recruitment to training and filling of consultant posts, particularly highlighting that 'trainees perceive a shrinking employment market'. The report highlights the effect of the 'new ways of working' guidance, regarding exploring opportunities to deliver service through the skill mix of a multidisciplinary team, with LEPs often replacing medical psychotherapist roles with non-medical practitioners (mainly clinical psychologists).

49. All trainees we spoke to were aware of potential difficulties in finding a consultant job at the end of training and considered that completing a dual programme might increase their options. All voiced concerns about the reduction in NHS psychological services in general and consultant medical psychotherapy posts in particular.

50. Of the eight trainees we spoke to from outside London, four were on a dual programme with general adult psychiatry; three were on a single psychotherapy programme and one had already completed general adult psychiatry training and was completing a second CCT in psychotherapy. The trainees on dual programmes were all very positive and regarded that the training was relevant to future mental health service development.

51. The College has energetically responded to the threat to medical psychotherapy posts and is addressing this through the new dual training model. Fewer core trainees post membership are applying for single CCT higher medical psychotherapy training, and the College considers that dual training will make medical psychotherapy more attractive as a career choice, with pure medical psychotherapy training not being a viable future option. Now that the dual programme has been approved by the GMC, the College hopes that more deaneries will begin to offer this.

52. The Lead Dean agreed that the way the College is currently tackling workforce issues is extremely helpful and that the way to retain psychotherapy is through dual training. There was also consensus amongst the heads of school in their desire to develop dual programmes (eg general adult psychiatry and medical psychotherapy; forensic psychiatry and medical psychotherapy) whilst maintaining the output of consultant medical psychotherapists. Many trainers regarded the dual programme as essential in order to maintain and develop access to psychological therapies in NHS mental health services. We commend the College's proactive approach to monitoring the relevance of training for workforce needs and identifying possible solutions, including the implementation of dual training programmes in general adult psychiatry and medical

psychotherapy as a way to retain medical psychotherapy in psychiatry and to enhance recruitment.

The foundation programme

53. The Collins report 'Foundation for excellence: an evaluation of the Foundation Programme', published in 2010 by Medical Education England (MEE), addressed the current predominance within foundation experience of adult medicine and surgery, and called for a review of this within its recommendations. The report specifically states that, 'successful completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, eg community paediatrics, general practice or psychiatry'.

54. The Lead Dean noted that there were excellent opportunities for promoting psychotherapy in foundation programmes. She is supporting a pilot in North Western deanery where one leadership trainee has been involved in running Balint groups for foundation trainees, which she advised is going very well. A Balint Group for Foundation Years 1 and 2 has also successfully run in Leeds in 2011 and 2012. The Lead Dean recommends that the College considers developing this initiative.

55. The Temple report 'Time for training', also published by MEE in 2010, reports on the impact of the working time regulations (WTR) on training for doctors (and a number of other healthcare professions). It discusses the impact of the increased number of junior doctor posts on the quality and quantity of training opportunities, and highlights the following issue in specific relation to psychiatry: 'In psychiatry, as a result of the implementation of the new ways of working, consultants look after the most complex cases with nurses doing most of the initial assessment of patients. This poses the question of how to train junior doctors to deal with and have experience of all cases if they are not seeing them as part of their training'.

Core training

The impact of working time regulations

56. The College highlighted a concern that the WTR have pulled core trainees away from daytime supervised work to nighttimes where there may be relatively less supervision. The College advised that the effects of the WTR are well highlighted in the Temple report. A particular concern was noted in the ASR 2011 with regard to psychotherapy experience during core training. Timetabling of therapeutic work and its supervision were cited as major issues, but this was not reported as an issue in 2012. Both core and higher trainees continue to receive one hour dedicated one-to-one supervision per week from their educational supervisors and this is generally protected throughout the country.

57. Training programme directors stated that on-call duties, especially nights, make it somewhat difficult for core trainees to sustain regular weekly sessions with

psychotherapy patients and attend weekly supervision. They reported that many trainees try hard to maintain their attendance, often doing so in their own time. On balance however, on call duties did not appear to prevent the trainees from meeting core psychotherapy competencies.

Curriculum delivery and assessment

Completion of competencies

58. In December 2011, the Heads of school described difficulties in meeting the core psychotherapy competencies of the 2010 curriculum, particularly in a service environment where there is a limited amount and range of psychotherapy experience. We heard that the Faculty of Psychotherapy had provided verbal guidance in 2011 to the heads of school about how experience available to a core trainee could be used as evidence for the curriculum competencies, even if this did not meet the 2010 curriculum requirements. We note that the existing MPFECC saw this as a transitional arrangement. There was also a difficulty with providing the long psychotherapy case as the length was not specified in 2010 curriculum. The Faculty indicated to us that it will specify to psychotherapy tutors the required length for the long psychotherapy case and there was a proposal for this to be submitted for curriculum approval in 2013. The College must clarify the duration of the long case for core psychotherapy competency in the curriculum.

59. We are concerned that this variation in approach, including the details of psychotherapy competencies required and the assessment processes used, may mean that the standard of competence between trainees across deaneries is variable. The heads of school, however, thought that the ARCP process was robust, and that core trainees would not be passed without achieving psychotherapy competence.

60. In 2011, the College stated that core trainees who had not quite been able to achieve the psychotherapy competencies should be allowed to progress to ST4, and gain the competencies at this stage. In 2012, with the new curriculum having been in place for over a year, trainees were not eligible to progress to ST4 if they had not achieved the psychotherapy competencies. The heads of school were concerned that there is potential for a number of appeals at the end of the academic year 2011-12, if trainees are prevented from progressing into higher training owing to lack of opportunity to demonstrate the competencies.

61. Trainers stated that core trainees on the whole do complete core competencies by the end of CT3, but sometimes with difficulty. The 2012 *UK Psychotherapy Survey* demonstrated that 30 out of 42 schemes gave assurance that all core psychotherapy competencies were completed before passing ARCP. In three schemes there was a lack of clarity and eight schemes permitted core trainees to carry over the completion of the long case requirement into ST4, after being signed off at ARCP. While WTR did not affect completion of competencies, finding cases of the appropriate level of difficulty was a challenge, as referrals to tertiary psychotherapy services were often too complex. Two training programme

directors stated that they found ways around this, but for a third this remained a problem. One stated that hard work and good liaison had resulted in nearly all of approximately 50 core psychiatry trainees completing their psychotherapy competencies, with only a couple failing each year for reasons unrelated to case availability.

62. A regional tutor stated that most core trainees are able to meet their competencies by the end of CT3 but thought that the requirements have become diluted. For the long case, core trainees were often presenting a shorter therapy such as cognitive behavioural or supportive therapy, instead of a long psychodynamically informed case. It was thought that this was due to the limited number of psychodynamic supervisors. The 2012 *UK Psychotherapy Survey* demonstrated the predominant use of psychoanalytic or psychodynamic psychotherapy for the long case (41 of 52 schemes).

63. Deaneries must monitor the completion of core psychotherapy cases to ensure all trainees meet the curriculum requirements by the end of CT3. The College should work with deaneries to monitor the completion of core psychotherapy cases to ensure consistency in approach.

64. One training programme director expressed concern about a MPFECC proposal to spread the core psychotherapy Balint group competencies from CT1 to CT3, retain short therapy cases and move long cases to ST4 to ST6. This proposal was considered to dilute core psychotherapy training and the MPFECC recommended building on core psychotherapy requirements, rather than reducing them. Therefore the core psychotherapy curriculum requirements of seeing both a short and long therapy case in CT2 and CT3 will be maintained. In addition, the recommendation has been made in the amended curriculum that the Balint groups continue from CT1 through to CT2 and CT3.

65. The College first introduced an electronic portfolio for psychiatry in 2007 and released the current version in August 2010. The e-portfolio is used by trainees to record evidence for presentation at the ARCP to demonstrate their competence.

66. Feedback from trainers and trainees on the use of the e-portfolio was generally negative and many described it as a tick box exercise that does not add value. Most trainers considered the recent College psychotherapy e-portfolio to be a good idea but in practice it was not useful. It was described as bureaucratic and intensive. All trainers thought the general psychiatry portfolio was inadequate for psychotherapy. It was described as needing to be moulded to fit psychotherapy training.

67. The College is aware of these issues. There is an active College e-portfolio working group and further work has been done to improve the e-portfolio for psychotherapy competencies in core training.

68. The College considers that having the assessments online is positive, as this demonstrates that psychotherapy is on a par with other elements of training. It noted that some trainers do not use the e-portfolio as it is intended and that trainees train the consultants to use it. The College is running training and road shows to familiarise trainers with the e-portfolio, which we support, but notes that there is more work to be done. It also noted evidence that reflective practice in WPBAs as a therapeutic principle could be enhanced. The College plans to incorporate reflective practice into every intended learning outcome in the MPFECC's curriculum proposals that will be submitted for approval in January 2013.

69. The College stated that there are mechanisms for trainees to provide feedback on the e-portfolio via the trainee representatives on the MPFECC though, as previously noted, the trainee representatives are not well known to trainees (see paragraph 39).

Annual review of competence progression (ARCP)

70. In the 2011 ASR, the College identified via its external advisers that in the Wessex and West Midlands deaneries, there were some trainees who had not met all the competencies by the end of CT3. For example, some trainees had not completed psychotherapy cases in two modalities as required.

71. The 2011 ASR also noted that, out of ARCP outcomes reported to the College by 15 deaneries, a high proportion of outcome threes were given, the main reason for this being failure to achieve psychotherapy competencies at core training level.

72. In response to the higher rate of unsatisfactory outcomes in ARCPs for international medical graduates (IMG), some deaneries have introduced additional support. We heard from some heads of school that early training is given for the clinical assessment of skills and competencies (CASC) exam to improve communication skills. In the London Deanery there is a dedicated communications skills unit. A checklist identified trainees who are failing in history taking or communication skills and they are referred to the unit for remediation. Oxford Deanery arranges locum appointments to provide additional training on communication skills.

73. In addition, the College 'training the trainer' course includes a section on risk factors for progression of trainees, including IMG status.

Member of the Royal College of Psychiatrists examination

74. The high MRCPsych failure rate is concerning, and this concern is shared by trainees and trainers. We note that the high failure rate is largely restricted to international medical graduates; in 2011 the overall CASC pass rate was 39.3% and for those with a UK PMQ it was 84.7%.

75. Schools of psychiatry have reported to the College that some failing trainees leave the scheme after one year of remedial training. This adversely affects deaneries' ability to fill higher specialty training posts. Consequently there are currently a number of vacancies at ST4 and ST6. The College indicated that the high failure rate makes it difficult to plan the next round of recruitment, as recruitment precedes exam results by at least two cycles. The College acknowledges the need for improvement in the Clinical Assessment of Skills and Competencies (CASC), and confirmed that this work is being taken forward.

Higher specialty training

Curriculum delivery and assessment

Curriculum requirements

76. The College advised that the majority of deaneries have moved trainees to the 2010 curriculum for psychiatry training programmes and we encourage all deaneries to move trainees onto the current approved curriculum. Following a recent decision by the GMC this will soon be mandatory for all specialties.

77. Higher medical psychotherapy trainees are required to major in and develop an in-depth knowledge of theory and practice in one of either psychoanalytic, cognitive behavioural or systemic therapy. Trainees undertake more general training in the other two therapies. The College stated in its 2011 ASR that 'higher specialist training in psychotherapy remains centred on psychoanalytic approaches with only a small number of trainees majoring in cognitive behavioural therapy and no trainees in systemic therapies'. The MPFECC advised that in January 2012 there were a total of 48 higher trainees, 46 majoring in psychoanalytic psychotherapy and 2 in cognitive behavioural therapy.

78. There was some concern amongst trainees about the length of single CCT training being too short to cover all the curriculum requirements, particularly the amount of general adult psychiatry.

79. Trainees completing the single psychotherapy CCT considered on-call work to be beneficial for general adult psychiatry competences and most thought that it did not impact on psychotherapy training.

80. The College advised that there is no required template in the curriculum for the academic programme in higher medical psychotherapy. Programmes vary considerably and deanery interpretation of the curriculum differs. The College appreciated the value of deanery quality management visits, but commented that visits did not always appear to appreciate the particular requirements of medical psychotherapy training. The College noted that the former Faculty visits had been effective in ensuring that academic programmes were fit for purpose.

81. We heard from trainers and trainees that the academic programme for higher psychotherapy is delivered in different ways. For example:

a. one deanery provided twice weekly reading groups, led by local faculty, with no required written work or assessment and no charge to the trainee.

b. three deaneries provided a programme of lectures, seminars and workshops for half a day per week, led by deanery faculty including non-medical trainers. Written work in the form of essays, assessments or a dissertation was required. There was no charge to the trainee.

c. four deaneries arranged for trainees to enrol on an external programme with an independent training provider. These training institutes, registered with either UK Council for Psychotherapy (UKCP) or British Psychoanalytic Council (BPC), provided training in psychodynamic psychotherapy, integrative therapy or group analysis.

82. Successful completion of either (a) or (b) above satisfied the CCT requirement. We heard that some trainees in option (c) could choose to attend the programme without completing written assignments. If so, we heard that the deanery partially met the cost and the trainee's attendance was sufficient for the CCT requirement. Although some trainees on external programmes had received partial deanery funding, we were told that this was not guaranteed and it was reviewed annually.

83. A TPD expressed concern that two tiers of higher trainees appeared to be exiting with a CCT: those with, and those without an external training qualification.

84. Trainees from the London Deanery indicated that there were some parts of their academic programme that were not provided in-house, and they had to attend external courses to receive this, meeting the cost themselves. There was significant variability amongst trainees in the London Deanery with regards to the academic programme they received and trainees stated that it depended on their employing Trust. Some trainees outside London expressed concern about the quality and consistency of the academic programme provided by the deanery.

85. Two training programme directors described good collaboration with independent training institutes. Trainees attending independent providers spoke of increased work in otherwise pressured jobs but also considered that being with a multi-professional peer group enhanced their learning. The College should work with deaneries to monitor the higher psychotherapy academic programme to ensure consistency in quality.

86. The College advised that all medical psychotherapy CCT holders receive independent registration with the UKCP (United Kingdom Council for Psychotherapy). Medical psychodynamic psychotherapy registration with the BPC (British Psychoanalytic Council) can also be sought with a medical psychotherapy CCT. The majority of medical psychotherapy trainees who seek 'external training' (outside the CCT training) frequently do so after obtaining their CCT as consultant psychiatrists in medical psychotherapy as part of their continuing professional development. Such training is used to build on the College CCT

training with the BPC to be registered as psychoanalysts or psychoanalytic psychotherapists, or training with the BABCP (British Association of Behavioural and Cognitive Psychotherapies) as cognitive behavioural psychotherapists, placing medical psychotherapists in a comparable position in terms of qualification as non-medical psychotherapists.

87. The academic programme provided a valued peer group for medical psychotherapy trainees. We also heard that four deaneries each provide teaching in conjunction with one other adjacent deanery (Oxford and the West Midlands, and North Western and Mersey deaneries). This enhances experiential learning by having a sufficient number of trainees for small group work. It also provides a critical mass of peers with otherwise small numbers and shares the cost of faculty time. Trainers included non-medical faculty. We commend this collaborative approach to teaching as good practice and a model that might be shared.

Self reflective development

88. Although all trainees are required to undertake their own self reflective development as part of medical psychotherapy training, this is currently not in the curriculum. Funding support for self reflective development significantly varied across deaneries.

89. We only spoke to trainees majoring in psychoanalytic psychotherapy. The required frequency for self reflective development sessions varied. In the London deanery and the Yorkshire and the Humber deanery, they must be in therapy at least three times a week, in other deaneries twice a week. Although London trainees received some deanery funding this did not cover the cost of personal psychotherapy and there was variability in the amount received and by whom it was provided.

90. Trainees, trainers and heads of school from other deaneries also expressed concern about the requirement for trainees to fund, either in whole or in part, their self reflective development. The most common pattern was one third paid by the deanery, a third by the trust and a third by the trainee. Trainees and trainers had concerns that the trust and deanery contributions will significantly reduce. We heard that higher psychotherapy training is considered expensive by deaneries. With the provision of dual programmes, there could be a greater cost to deanery and trusts as self reflective development may extend over the full duration of the dual CCT. In the Yorkshire and the Humber deanery, where dual training has been in place since 2008, funding of one session per week for therapy was agreed in 2011.

91. The College noted that deanery funding of self reflective development has been drastically cut and stated that, in addition to economic challenges, this could also be due to the lack of clarity in the curriculum about the essential nature of self reflective development. The College intends to propose to the GMC that model congruent self reflective development should be a mandatory requirement in the

curriculum from 2013. The College seeks to ensure that this will be in part deanery funded for all trainees as a part of their training because it is cognisant of the personal investment for the trainee in their self reflective development.

92. None of the trainers we spoke with considered that the cost to the trainee of self reflective development prevented an interested and motivated trainee from applying for higher training.

Access to modalities

93. All the higher trainees we spoke to majored in psychoanalytic psychotherapy and there were no problems in finding appropriate cases. Most trainees reported fairly good access to their other modalities (models of therapeutic intervention).

94. Most higher trainees minor in cognitive behavioural therapy (CBT) and systemic therapies. Some trainers stated that appropriate cases are hard to find for the minor modalities. Training programme directors spoke of spending considerable time organising this for their trainees and often they had to rely on the good will of a trainer to secure appropriate cases and supervision arrangements. Trainees sometimes struggle to obtain cases to complete the required hours. CBT is often provided through a primary care trust or private provision and it can be difficult to facilitate service agreements for this training. We were told that this arrangement works well where there is a consultant psychiatrist with a special interest in CBT.

95. In one deanery, systemic therapy caused the most difficulty in finding appropriate experiences for trainees as there were no medical psychotherapy trainers in systemic work. They use colleagues in child and adolescent psychiatry for training.

96. A reported benefit identified by the single psychotherapy trainee in a deanery was being able to tailor her own training and use the training budget to seek minor modality training within a different region.

97. We heard from one deanery that trainees appointed to posts for CBT training had asked to change to psychoanalytic psychotherapy training posts after starting, or failing, to take up CBT posts. The training programme director stated that it is easier to make a case to service providers about the added value of a psychoanalytically trained medical consultant than a CBT medical consultant, as providers already have CBT provision from clinical psychology services.

Annual review of competence progression

98. In 2010 and 2011 the GMC and COPMeD have collated data from deaneries on all RITA and ARCP outcomes from deaneries across the UK. We have not attempted to explain variation, as the reasons are multivariate and include trainees' ability. It is a sign that deaneries need to examine why a difference exists and whether it needs addressing.

99. Higher medical psychotherapy trainees who have a primary medical qualification (PMQ) from the 'rest of the world' category received a higher proportion (33.3%) of unsatisfactory outcomes at annual review of competence progress (ARCP) in 2010 and 2011. The percentage of trainees receiving an unsatisfactory ARCP outcome falls to 15% for trainees with a UK PMQ, and to 0% for those trainees from inside the EEA in 2010 and 2011.

100. The deaneries that awarded a high proportion of outcome threes in 2010 and 2011 include Wessex and North Western (40%). The NHS West Midlands Workforce Deanery awarded a high proportion of outcome twos (28.6%).

Assessment

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

102. The tools and supporting documentation provided by the College for the delivery of the higher psychotherapy assessment systems were mostly being used by the deaneries. However, we heard from heads of school of local adaptations to the assessment documentation and this raises concerns about a lack of standardised approach (see paragraph 106). The MPFECC reported that a WPBA guide for higher medical psychotherapy had been produced in order to improve the standard and quality of assessments. The College should work with deaneries to monitor implementation of the WPBA guide.

103. A number of trainees and trainers were very concerned that the WPBA tools do not work well for psychotherapy assessments. Trainees stated that some trainers use the tools flexibly because they do not feel that they adequately assess psychotherapy competencies.

104. We heard that some deaneries had supplemented the assessment of higher trainees with record of in-training assessment (RITA) logbooks which include assessment of experiential learning and development. All agreed that use of e-portfolios from 2012 will make it difficult to use add on assessments from RITA. A trainee who had completed the RITA system had found the logbook more helpful as it allowed more time for discussion about training and cases.

105. Some trainees commented that scores are not as appropriate for reflective practice in psychoanalytic training as descriptive supervisory reports. Most higher trainees thought that formative trainee issues would be identified through supervision rather than through the work place based assessments. Trainers felt

that trainees requiring support would be picked up at an earlier stage due to regular educational supervision. Higher trainees in Yorkshire and in Scotland have a mid-year formative review, structured like an ARCP and a mid-year educational supervisors report which enables early identification of any gaps in meeting the curriculum requirements. We commend this as good practice.

106. Each ARCP panel decides how it will use reports and this varies hugely. Some used e-portfolio, while others do not look at it, and others still are paper-based. The College should work with deaneries to monitor ARCP/ RITA outcomes and panel approaches to ensure that outcomes are awarded consistently.

107. We heard that one deanery had adjusted the ST6 assessments to include more direct observation of non-clinical skills (DONCS), to reflect the need for management and leadership areas to be assessed at this stage.

108. Trainees stated that non-medical trainers are permitted to sign-off their WPBAs (Structured Assessment of Psychotherapy Expertise) and submit them to the ARCP, usually with a narrative supervision assessment (as were used in RITA logbooks). Trainees and trainers reported to us that non-medical trainers did not sit on the ARCP panels. The MPFECC however stated that in one deanery there was inclusion of non medical trainers at ARCP. There is an opportunity for the College to work with deaneries and standardise the involvement of all training faculty in assessment.

Annex 1: Sources of evidence

Visit team	
Team Leader	Professor Neil Jackson
Visitor	Jane Nicholson
Visitor	Dr Maria Slade
GMC staff	Sarah Beattie/ Elizabeth Leggatt/Sarah Adams/ Louise Wheaton

QA activity	**Date**	**Who we met**
Royal College of Psychiatrists Annual Postgraduate Medical Education & Training Conference	29 September 2011	Heads of School
UK higher medical psychotherapy trainee winter conference (London) Heads of School meeting with College	15 December 2011	Higher medical psychotherapy trainees Heads of Schools
Telephone interviews with higher medical psychotherapy trainees (outside of London) and trainers/TPDs (from across UK)	March – April 2012	Higher medical psychotherapy trainees TPDs and trainers
Meeting with College and Lead Dean	14 May 2012	College and Lead Dean

Domain in *The Trainee Doctor*	**Areas for exploration 2011/12**	**Documentation**
2	External advisor process: - training of advisors - planned mechanisms for structured feedback - analysis of feedback - communication of feedback between the College and Deanery	Summary of external advisor reports ASR
2	Development of quality management, including identification and sharing of notable practice	ASR
2	Role of trainee in promoting educational standards. i.e. use of trainee representatives within schools of psychiatry	RCPsych website College information submitted in response to formal review

Domain in *The Trainee Doctor*	Areas for exploration 2011/12	Documentation
	Use of representatives of non medical trainers	
2	Patient and public involvement (i.e. use of service users in College Committees)	College information submitted in response to formal review
3	Equality diversity and opportunity - monitoring of policy implementation	ASR data set - E&D analysis of MRCPsych pass rates
4	Recruitment to Psychiatry and initiatives to increase recruitment	ASR Temple Report Recruitment data from RCPsych website College new initiatives document College contextual document College information submitted in response to formal review
4	Workforce need for Consultant Medical Psychotherapists in future - availability of posts after CCT for trainees in psychotherapy	ASR Workforce numbers prediction from CFWI College contextual document
5	- Assessments - reliability, and utility of assessments - Training of trainers and local faculty in assessment methodology and implementation - Links between curriculum, teaching and assessment - Systems for ensuring continuous review of assessment, including evaluation from trainees and trainers	ASR College information submitted in response to formal review
5	Poor MRPsych pass rate and how this is monitored	ASR MRPsych pass rate info College information submitted in response to formal review
5	Psychotherapy experience and implementation of curriculum to ensure all trainees have opportunities to meet outcomes	ASR Summary of external adviser reports/ processes College contextual document College information submitted in response to formal review

Domain in *The Trainee Doctor*	Areas for exploration 2011/12	Documentation
5	- Availability of psychotherapy experience in core psychiatry training - Role of Educational Supervisor - Use of trainee portfolios	Use of the IAPT initiatives College contextual document ASR
5/ 7	The impact of working time regulations (WTR) and service reconfiguration on psychotherapy training in CPT, including balance of service and education and access to teaching	ASR CfWI report 2012 Survey of Psychotherapy training in the UK and a comparative analysis with GMC survey results Summary of external adviser reports/ processes Temple report
5	Availability of training placements and training in psychotherapy ST4+	ASR CfWI report
5	Initiatives for training trainees to fit future workforce: - Dual CCTs in General Adult Psychiatry and Psychotherapy programmes - Access to modalities	ASR College contextual document FECC notes College information submitted in response to formal review
5	Use of non-medical psychotherapists in provision of education	College contextual document 2012 Survey of Psychotherapy training in the UK College information submitted in response to formal review
6	Research opportunities within psychotherapy	
6	Availability and funding for self reflective development	College contextual document FECC notes College information submitted in response to formal review
6	Training of trainers and other faculty (eg TPDs) and support for training.	Information from the College's Education & Training Centre regarding training of trainers and training in assessments

Domain in *The Trainee Doctor*	Areas for exploration 2011/12	Documentation
		ASR
9	IMG ARCP failure rate - monitoring and plans to address	ARCP outlier reports College contextual document
9	ARCP process and how outputs are shared and monitored	ARCP outlier reports Information from the College's Education & Training Centre regarding training of trainers and training in assessments
9	How well the Foundation Programme prepares trainees for training in core psychiatry	ASR Collins Report ARCP outlier reports College contextual document

Annex 2:Action Plan for medical psychotherapy

Requirements

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
29-35		Deaneries must ensure that all those completing assessments that contribute to a trainee's CCT, including non-medical supervisors, are trained and supported for this role.		Deaneries must ensure that contracts with LEPs stipulate that all trainers including non medical receive training and support for assessments within their role, and deaneries must monitor this. RCPsych to produce training guidance for trainers on assessments, linking into work carried out in this area by NW Deanery (see good practice).	March 2014 – need to ensure that opportunity for training is in place even if take up is not yet fully achieved.	Lead Dean RCPsych: Medical Psychotherapy FECC
58-63	To be updated in next ASR.	Deaneries must monitor the completion of core psychotherapy cases to ensure all trainees meet the curriculum requirements by the end of CT3.		Deaneries to be reminded of standards in this area, and the need to use the potential removal of trainees from posts where the curriculum cannot be met as a lever to achieve this. There is also a role for HoS to review trainee progress and psychotherapy resources (therapy cases, supervision) at CT2 to ensure the trainee will be able to meet the	August 2013 August 2013	Lead Dean RCPsych: Dean, Heads of School, Lead Dean.

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		The College must clarify the duration of the long case for core psychotherapy competency in the curriculum.		curriculum by end of CT3. RCPsych had submitted a curriculum amendment to GMC in January 2013 which specifies the length of the long and the short therapy cases. This is now with the GMC.	GMC timescales	GMC RCPsych: Medical Psychotherapy FECC
15		Consultant Medical Psychotherapists should lead both core and higher psychotherapy training in psychiatry and be responsible for its educational governance.		Deaneries to be informed that medical psychotherapy leadership in psychotherapy training is a curriculum requirement and must be enforced within each core psychiatry training scheme.	August 2013	GMC RCPsych: Dean, Heads of School, Lead Dean.

Recommendations

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
15a		All psychotherapy supervisors should have training and be registered in the model		RCPsych and Heads of School to monitor delivery of psychotherapy training to ensure all supervisors are	March 2014	RCPsych Dean, Heads of School

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		of psychotherapy they are supervising and continue to be practitioners of the model.		registered in and practising the model they supervise and teach.		Lead Dean
15b		The College should ensure that there are effective structures for communicating guidance about curriculum implementation and psychotherapy supervision requirements to psychotherapy tutors as well as heads of school		This is an ongoing project; the Medical Psychotherapy Faculty Education and Curriculum Committee and the HoS committee all contain representation, and the College are looking at providing more training days for TPDs.	March 2014	RCPsych Dean, Heads of School
25-28		The College should check that the mechanisms in place for sharing information with medical psychotherapy training programme directors and trainers are effective for all deaneries and enhance engagement between the College and trainers.		RCPsych sign off TPDs and the education committee ratifies these appointments. RCPsych to provide guidance for deaneries on this area, and strengthen Faculty Education and Curriculum Committees (FECCs). The deaneries to enhance and support the Medical	Ongoing	RCPsych Dean, Heads of School Lead Dean

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
				Psychotherapy TPD role in leading scheme Medical Psychotherapy Tutors in core programme delivery. Improve links between the College, TPD and trainers.		
37-40		The College should work with deaneries to ensure that opportunities for trainee engagement with the College are signposted effectively.		There are plans to review the medical psychotherapy section of the RCPsych website, and the trainee section will be strengthened. The PTC (Psychotherapy Trainee Committee) meets regularly. RCPsych to maintain current efforts.	Ongoing	RCPsych: Medical Psychotherapy FECC
80-85		The College should work with deaneries to monitor the higher psychotherapy academic programme to ensure consistency in quality.		Ongoing – RCPsych to look at cross deanery working.	Ongoing	RCPsych Dean, Heads of School Lead Dean
101		The College should work with deaneries to monitor implementation of the WPBA guide.		Develop Deanery workplace based assessment training template for medical and non-medical trainers.	Ongoing	RCPsych: Medical Psychotherapy FECC

Good practice

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month / year)	Lead
36		The training provided for non-medical trainers in North Western and Mersey deaneries, recognising the importance of their role in supporting training.		Deaneries to be assisted in formalising the role of non-medical trainers in core and higher psychotherapy training (psychoanalysts, adult psychotherapists, child psychotherapists, clinical psychologists) under the auspices of medical psychotherapy leadership.	Ongoing	RCPsych Dean, Heads of School Lead Dean
43-44, 54		Initiatives aimed at medical students and foundation doctors that have improved recruitment into psychiatry. For example, medical student placements in psychotherapy run by Severn deanery; and Balint groups for foundation doctors in Yorkshire and the Humber and North Western deaneries to promote psychological understanding of healthcare.	The group wished to highlight work carried out at UCL on this – work is being carried out on a template to be used across medical schools.	To explore with UKFPO and Foundation School leads the use of Balint groups for foundation doctors.	Ongoing	Lead Dean RCPsych: Medical Psychotherapy FECC

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month / year)	Lead
51-52		The College's proactive approach to monitoring the relevance of training for workforce needs and identifying possible solutions. For example, the dual training programme in general adult psychiatry and medical psychotherapy as a way to retain medical psychotherapy in psychiatry and to enhance recruitment.		The dual medical psychotherapy training was ratified by the GMC in 2012. Dual training (medical psychotherapy and general adult psychiatry) is being delivered across the UK from 2013. The Yorkshire and the Humber deanery model of integrated training (training in two sub-specialties simultaneously) is being adopted by some deaneries while others are adopting a sequential dual model (one sub-specialty followed by the other). Single CCT higher training in medical psychotherapy will continue alongside dual training.	Ongoing	RCPsych Dean, Heads of School Medical Psychotherapy FECC
87		The collaborative approach to deanery teaching in Oxford and the West Midlands, and North Western and Mersey which provides a larger trainee peer group and a larger pool of trainers to enhance learning.				

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month / year)	Lead
105		The mid-year formative review and educational supervisors' report for higher trainees in Scotland and Yorkshire, which enables early identification of any gaps in meeting the curriculum requirements.		The Yorkshire and the Humber deanery and the Scottish model of mid-year review to be developed across higher training schemes.	Ongoing	RCPsych: Medical Psychotherapy F ECC Lead Dean