

School of Psychiatry

ARCP Standard Operating Procedure

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1. Introduction

1.1 The annual review of competency progression (ARCP) is a summative assessment of a period of training. This procedure sets out the process and minimum curriculum requirements for psychiatry trainee ARCPs in the Yorkshire and Humber region.

1.2 Source documents:

- 1.2.1 ARCP Operational Guidance (HEE YH 2016)
- 1.2.2 A Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide Seventh Edition 2018)
- 1.2.3 Recommendations of RCPsych Annual Review of Competency Progression (ARCP) Working Group (RCPsych 2018)
- 1.2.4 GMC approved RCPsych curricula for core, specialty and subspecialty psychiatry training
- 1.2.5 rcpsych.ac.uk/about-us/responding-to-covid-19/covid-19-and-psychiatric-training**
- 1.2.6 yorksandhumberdeanery.nhs.uk/covid-19-hee-yh-information**
- 1.2.7 [Contingency planning for ARCPs – Covid-19 outbreak \(aomrc.org.uk/covid-19-education-and-training/\)](https://aomrc.org.uk/covid-19-education-and-training/)**

1.3 The ARCP panel can give the following outcomes:

- **Outcome 1**; satisfactory progress – Achieving progress and the development of competences at the expected rate
- **Outcome 2**; development of specific competences required – additional training time not required
- **Outcome 3**; inadequate progress – additional training time required
- **Outcome 4**; released from training programme – with or without specified competences
- **Outcome 5**; incomplete evidence presented – Additional training time may be required
- **Outcome 6**; gained all required competences – will be recommended as having completed the training programme (core or specialty)
- **Outcome 8**; Out of programme for clinical experience, research or a career break (OOPE/OOPR/OOPC)
- **Outcome N**; no outcome awarded – these can be used for trainees on sick leave, maternity leave, those not in post long enough (less than full time trainees), inter-deanery transfer, resignations etc.

1.4 Each trainee will have a minimum of one ARCP per calendar year. The frequency of ARCPs may be increased for trainees who have received an adverse outcome or where concerns have been raised by the training programme director (TPD).

1.5 ARCPs are routinely held each summer (June-August) and each winter (December-February) towards the end of a trainee's CT/ST year. For 'out of sync' trainees it is necessary to schedule an ARCP outside of these periods, for instances, trainees anticipating a move between CT/ST years who are outside of the typical rotation periods (February, August or October) due to time out of training (TOOT) or LTFT status.

1.6 The summer 2020 ARCP process will be significantly affected by the NHS and wider societal response to the Covid-19 outbreak. All core and higher trainees in psychiatry have

experienced disruption to their training placements since March 2020. The impact for each trainee varies, some will be redeployed to new duties, some will experience breaks in training due to ill health or isolation, some will experience reduced access to clinical and educational supervision, and for all trainees most curriculum delivery activities will cease. The personal stress and anxiety associated with external events will increase the usual pressures of meeting intended learning objectives for ARCP.

1.7 It is therefore recognised that ARCP processes will need to be adapted to ensure that patient care remains the primary focus and this means the usual comprehensive ARCP requirements may be compromised. The School of Psychiatry will adhere to latest guidance from HEE and the Royal College of Psychiatrists to ensure trainees are assessed with fairness and transparency, and judgements are made in a pragmatic manner based on available evidence.

1.8 Trainees facing revalidation or at a critical transition point (CT3 or ST6) will be prioritised. Other trainees may have their ARCPs temporarily suspended. The aim will be to ensure that the disruption to training after March 2020 does not lead to unnecessary extensions to CCT date or adverse outcomes.

2. Royal College ePortfolio

- 2.1 All trainees will use the RCPsych electronic portfolio. Trainees must allow access to their psychiatric (clinical) supervisor, educational supervisor, TPD and Head of School. A number of administrative staff from Health Education England (HEE) and the local employing trusts have access rights to set up ARCP forms on the portfolio and gain panel members access.
- 2.2 Trainees must allow access to the designated members of the ARCP panel prior to the ARCP.
- 2.3 It is the responsibility of the employing trust administrators to set up any local ARCP panels. HEE administrative staff are responsible for the organisation and set up of any central ARCP panels.
- 2.4 Since the ARCP panel will make their decision based on the evidence presented on the portfolio trainees must ensure the relevant information is easily accessible to panel members, for instance, uploaded documents such as audit reports must be clearly signposted in the portfolio.
- 2.5 The portfolio must include all information relevant to a trainee's progress in training, including details of complaints, serious incidents, and educational review meetings; as well as details of compliments and achievements.
- 2.6 The portfolio must not contain any patient identifiable data (e.g. name, date of birth, hospital number) but allowance is made for basic demographic and diagnostic details in respect of case logs and reflective practice entries.
- 2.7 Similarly, the trainee must take care not to use unprofessional language in their description of colleagues within reflective practice entries.
- 2.8 **The ePortfolio will continue to be the evidence base for the summer 2020 ARCPs. For most trainees this will be the first review since June/July 2019. As a consequence of the March 2020 Covid-19 outbreak the 10-12 month review period of "normal" training placements will be reduced to 7-9 months. This pro rata reduction in the normal training time will be taken into account by ARCP panels, who will need to make an assessment of a trainee's progress to March 2020, and their anticipated trajectory to June/July 2020.**
- 2.9 **Whilst it is recognised that the quantity and content of the evidence will differ from normal training placements the evidence added during or after March 2020 will still be assessed as this will still be counted as time in training. Although there may be less scope to undertake WPBAs, psychotherapy, teaching, and other academic activities, there will still be a lot of learning for all grades of doctors as the NHS adapts to rapidly changing circumstances. Evidence of reflective practice, Online learning, and involvement in service development or innovation, is encouraged.**
- 2.10 **Trainees who are being assessed will still need to provide an up to date Form R and CCT calculator, as well as clinical and educational supervisor reports (4.1.2-4.1.6). Clinical and educational supervisors will have additional external pressures during this period and therefore the completion of reports is encouraged over a longer period (April-May) rather than**

just before the usual cut off dates. The Form R remains crucial for revalidation and will need to include periods of sickness, isolation or shielding related to Covid-19, which alongside the CCT calculator will be helpful in determining any adjustment of CCT date.

3. ARCP Panel Structure

- 3.1** The School of Psychiatry has a structure of local (or preliminary) panels and central panels.
- 3.2** The local panel will usually be chaired by the TPD or another senior educator and will be rotation specific. In addition to the chair there will be a minimum of two educational supervisors, a lay representative (for panel sizes of 4 or more trainees), and local administrative support (ACF trainees will also require an academic representative). The local panel may award outcomes 1,5,6,8 and N. If the local panel concludes that the trainee may require an adverse outcome (2,3 or 4) then he/she will be referred to the central panel using the required referral form (Appendix K).
- 3.3** For specialty trainees on dual training programmes there will need to be TPD or educational supervisor representation from the specialties experienced on placement since the previous ARCP. For instance, if a dual general adult / old age trainee undertakes placements in both specialties during the period being assessed then the local ARCP panel will have representation from both specialty rotations.
- 3.4** Local panels may wish to recognise trainees performing above and beyond curriculum requirements with a letter or certificate of commendation, or a trainee of the year recommendation.
- 3.5** The ARCP is a summative assessment and trainees do not participate in the decision. Trainees should however receive feedback on their performance and individual rotations will need to have their own arrangements for providing feedback after a satisfactory outcome, for instance, by the local panel immediately after the decision is made, or by the educational supervisor or TPD in a separate meeting. The feedback will assist the trainee to develop their PDP and where a face to face meeting cannot be arranged it is good practice to document feedback in a letter to the trainee.
- 3.6** Central panels will usually be chaired by the Head of School or another senior HEE-appointed educator and will consider trainees from all psychiatric rotations. There will, in addition, be a minimum of two senior educators (usually TPDs), a lay representative, HEE administrative support, and possibly an Associate Postgraduate Dean (APD) or Royal College representative (ACF trainees will also require an academic representative).
- 3.7** All trainees referred to the central panel are formally invited through HEE and feedback will be provided after the decision is made. Trainees receiving an adverse outcome are required to attend the panel date. In exceptional circumstances, and with written consent from the trainee, adverse outcomes may be awarded in their absence.
- 3.8** When a trainee receives an adverse ARCP outcome 2 or 3 the ARCP form will contain a detailed action plan that will usually be reviewed in the first instance by the local panel after six months, at which stage the trainee may have achieved their targets and will receive an outcome 1 or 6. Alternatively, depending on individual circumstances, the central panel may specify an earlier review or an automatic central panel referral within six months.
- 3.9** If there is a potential conflict of interest, for instance, a panel member is the current clinical or educational supervisor of the trainee, then this will be acknowledged on the ARCP form. The electronic ARCP forms on the portfolio allow the chair of the panel and the trainee to sign off the

outcome on the day of the ARCP. In addition, following an adverse outcome the trainee will receive written confirmation from HEE with details of Appeals procedures.

- 3.10** When an ARCP outcome 5 is awarded (incomplete evidence presented) it will last for a maximum of two weeks for missing evidence. Once the two weeks have passed, the trainee must be reviewed again locally and an appropriate outcome decided (award ARCP an satisfactory outcome or refer to central panel for an adverse outcome).
- 3.11** In some instances an ARCP outcome 5 may need to be awarded for up to four weeks in the case of pending MRCPsych examination results.
- 3.12** When the follow up assessment is satisfactory, the chair of the panel may be delegated authority to sign off the anticipated outcome once the missing information is available on the portfolio.
- 3.13** For the summer 2020 ARCPs the panel structures will change and there will be closer working arrangements between HEE administrators and local administrators, and TPDs and Head of School / Deputy Dean.
- 3.14** The TPDs will identify the trainees who would be subject to an ARCP in summer 2020 (in practice April-July 2020). The trainees will then be prioritised according to whether they are approaching (a) a transition point, (b) are on an adverse outcome (c) might be anticipating an adverse outcome or added time to training, or (d) neither of above.
- 3.15** Trainees in (a) and (d) will be reviewed locally via teleconference by the TPD and an educational supervisor. Another educational supervisor will be required if one of the panel supervises one of the trainees. The Head of School or Deputy Dean will be available for advice, for instance, where an adverse outcome or time added to training may be necessary.
- 3.16** Trainees in (b) and (c) will be reviewed centrally by the Head of School or Deputy Dean and a TPD.
- 3.17** ACF and dual CCT specialty trainees will continue to require academic and second specialty representation on their ARCP panels.

3.18 The structure is summarised in the table below:

ROTATION <i>e.g West Yorkshire Core</i>	Trainee name	Local representation	HEE central representation
(a) Trainees at key transition point i.e: CT3-ST4 ST6/7/8-CCT		TPD + ES (± ES where COI) Local administrator	HoS / DD available for discussion
(b) Trainee on adverse outcome: Outcome 2 / 3 from previous ARCP			HoS / DD + TPD (± TPD where COI) HEE administrator
(c) Trainee might be anticipating adverse outcome or added time to training			HoS / DD + TPD (± TPD where COI) HEE administrator
(d) Trainee expected to progress at non-key transition point: CT1/2 ST4/5		TPD + ES (± ES where COI) Local administrator	HoS / DD available for discussion

3.19 The identification of trainees and prioritisation will be initiated by the TPD, and in contentious cases discussed with the Head of School or Deputy Dean, and then the dates of respective panels will be agreed by local and HEE administrative teams with a view to completing the teleconference panels in June and July (or where out of sync. April or May). The timetables will need to be agreed by the end of April 2020 so that trainees are aware of when they will be reviewed.

3.20 Local or HEE administrators will coordinate their respective panels, setting up ARCP forms for panel chairs and determining the most appropriate teleconference platform (Skype, Microsoft teams, or Zoom)

3.21 The structure aims to reduce the time demands of panel members and trainees by: (a) removing the local panel filter for all trainees (all panels will be able to award adverse outcomes), (b) reducing duplication of administrator work, (c) reducing the size of panel membership, (d) providing telephone or teleconference feedback only to those trainees receiving an adverse outcome, and (e) enabling prioritisation where external demands require panel postponement.

3.22 Once trainees are aware of their ARCP date they will need to ensure all the evidence is added to portfolios at least a week before the ARCP. TPDs need to be informed if the trainee is unable to complete a supervisor report due to external pressures or absence from work.

3.23 Alternative arrangements for feedback to discuss strengths and developmental needs, via the TPD or the educational supervisor, will be determined locally when the trainee receives a satisfactory outcome.

4. Trainee ARCP Evidence

4.1 An ARCP cannot take place without the following:

4.1.1 ARCP panel access to the portfolio.

4.1.2 An annual structured report (ASR) completed by the educational supervisor (the 2015 version for core trainees and 2014 version for specialty trainees), which can be downloaded from the HEE School of Psychiatry website; Appendices A and B).

4.1.3 A psychiatric supervisors report (at least one for each placement or a minimum of two per year), which can be found in the reviews section of the portfolio.

4.1.4 An educational supervisors report, which can be found in the reviews section of the portfolio.

4.1.5 An up to date Form R Part B, which can be downloaded from the HEE School of Psychiatry website; Appendix C. This is an important standalone form required for revalidation and must include all work outside contracted employment (e.g. locum shifts or category 2 work), time out of training (TOOT) days, details of all untoward incidents and complaints, details of any ongoing investigations into performance / conduct / probity, and information on health conditions that may impact on performance.

4.1.6 An up-to-date RCPsych CCT calculator. This is important for LTFT trainees or trainees with TOOT >14 days since it enables local and central panels the scope to re-calculate CCT date. TOOT >14 days does not necessarily require additional training time, providing competency progression has been satisfactory, and ARCP panels should be mindful of the factors listed by the GMC (Time Out of Training, GMC Position Statement 2012) and the Supported return to training (SuppoRTT) guidance (HEE YH 2019) in determining the decision. (Where ARCP panel chairs are uncertain there should be discussion with the Head of School or Deputy Postgraduate Dean).

4.2.6 Consideration of adding time to the CCT date should be part of the discussion between the trainee, the educational supervisor and the TPD within the Pre-absence, Initial Return and Return Review meetings as part of the SuppoRTT process. A supernumerary period of more than two weeks after return to work cannot be counted as training time whereas there is more discretion for periods of occupational health approved phased return or enhanced supervision periods where targeted training activities may contribute to competency development. If there is a difference of opinion regarding the question of recalculating CCT date, then the question should be considered by the central ARCP panel. It is good practice that any consideration of recalculation of the CCT date is discussed with the trainee in advance of their ARCP.

4.1.7 Accrued annual leave taken at the end of statutory leave can add up to a month or more to the period of absence. Both the length and the timing of the accrued leave differ from periods of annual or study leave taken within training placements, which is likely to impact on clinical skills and knowledge. For some trainees, where there are pre-existing or subsequent concerns about competency progression, there is a case to add this period to the CCT date, particularly for trainees where he/she is supernumerary for more than two weeks after return to work, since this period cannot count towards training. Once again it is good practice that any consideration of adding time to the CCT date is discussed prospectively as part of the SuppoRTT process.

4.1.8 For trainees who elect to count accrued annual leave and Keeping in Touch days as training time the ARCP panel must be satisfied that evidence of competency progression is demonstrated for the whole period counted as training and not just the period after the actual return date. For instance, if a trainee works 4.5 months of a 6 month placement (the initial 1.5 months accrued annual leave counted as training), then the portfolio evidence base of competency progression will

need to be equivalent to a 6 month period. These trainees will therefore benefit from enhanced supervision and targeted training objectives as part of the SuppoRTT process.

4.2 Guidance on the use of assessment forms is contained in Appendix D.

4.3 Additional information may be available to panel members that are not uploaded to the portfolio, for instance, exception reports or private correspondence, which may be of relevance to ARCP outcomes. Where possible, the trainee should always be informed of any additional information submitted to panel members.

5. Core Curriculum Requirements

- 5.1** Trainees and supervisors should be familiar with the nineteen intended learning outcomes (ILOs) contained within the RCPsych Core Psychiatry Curriculum (revised 2017). The portfolio allows linkage of evidence to ILOs, which may be useful prior to ARCP.
- 5.2** The ILOs are broad-ranging covering the whole scope of professional, academic and clinical practice. It is unlikely that one piece of evidence will enable an ARCP panel to “pass” or “fail” a trainee, and trainees should be aware that the panel will consider the whole scope of practice in determining an outcome, utilising their judgement based on experience as educators and knowledge of curriculum requirements.
- 5.3** However, there are minimum requirements set out in the curriculum that will almost certainly lead to an adverse outcome if not achieved. But trainees should recognise that mere completion of a minimum requirement (e.g. the requisite number of workplace-based assessments) is not necessarily sufficient to avoid an adverse outcome.
- 5.4** The MRCPsych examination (paper A, paper B, CASC) must be achieved before completion of core training. Failure to complete any part of the examination before the end of CT2 will almost always necessitate extension to training. The trainee should therefore anticipate an outcome 3 extension to CT2 (up to twelve months) in order to complete at least one part of the examination before progressing to CT3.
- 5.5** Workplace-based assessments (WPBAs) are formative assessments and minimum numbers required are specified in the table below:

	CT1	CT2	CT3
ACE	2	3	3
Mini-ACE	4	4	4
CbD	4	4	4
CP	1	1	1
JCP	1	1	1
Mini-PAT	2	2	2
AOT	**	**	**
DOPS	**	**	**
DONCS	**	**	**
CBDGA	2*	-	-
SAPE	-	1*	2*
PACE	-	1*	1*

* may be completed in other CT years

** no specified number – but at least one DOPS necessary to demonstrate ECT training

- 5.6** The WPBAs should in most cases be completed by consultants experienced in core training since they are more likely to be familiar with the curriculum and give constructive feedback. Other assessments may be completed by higher trainees, specialty doctors, and non-medical clinicians (band 7 or above). Written feedback by assessors is strongly encouraged so that undue weight is not given to scores.

- 5.7** The content of WPBAs in CT1 should be arranged around the ten essential competencies set out in School of Psychiatry guidance Appendix E.
- 5.8** The mini-PAT will only be valid if there are a minimum of six responses from at least eight members of staff (at least two should be your clinical supervisor and another senior colleague). The list of respondents should be checked with your clinical supervisor to ensure a balanced response list that includes a variety of clinical and non-clinical colleagues.
- 5.9** Psychotherapy competencies require satisfactory completion of a case-based discussion group of approximately 30 sessions (assessed by two CBDGAs), an individual short case of 12-20 sessions (assessed by one SAPE and one PACE) and an individual long case in a different therapy modality of > 20 sessions (assessed by two SAPEs and one PACE). The SAPEs will usually be completed by the psychotherapy supervisor and the PACEs will usually be completed by the psychotherapy tutor.
- 5.10** Trainees must demonstrate evidence of ECT competency by the end of training, this is usually during old age placements in CT1 by way of a DOPS assessment.
- 5.11** Trainees must evidence 50 emergency cases with first line management plans by the end of training and 55 nights on call. There is no uniform document to record emergency cases or nights on call across the rotations (other than declarations on the ASR). One example of good practice is an anonymised cumulative case log, contained on an uploaded Word or Excel document, providing a summary of the setting, presentation and first line management plan of each case. Further guidance on identifying and recording emergency cases is contained in Appendix F.
- 5.12** A minimum of two audit projects during core training are required by the curriculum. This is easily achieved by most trainees and it is therefore the expectation of the School of Psychiatry that at least one Quality Improvement Project is completed by trainees during each CT year utilising at least two different methodologies during the course of training. Evidence of completed projects and a reflective template must be uploaded to the portfolio – a statement of involvement or certificate is not sufficient. Guidance on the scope of projects available to demonstrate quality improvement, research or clinical governance competencies, and the reflective template, is contained in Appendix G.
- 5.13** **Reflective practice is highlighted as part of the ILO for life-long learning in both core and higher training RCPsych curriculum. Within the ePortfolio the focus should be on the qualitative capacity to reflect rather than the quantity of reflections. The current GMC guidance states that the trainees should discuss their reflective experiences with their clinical and educational supervisors; the content of which may include original, non-anonymised information. This discussion should then be confirmed by the supervisor in the learning portfolio. Written reflections on the ePortfolio should not include any factual or case-identifiable details although a succinct narrative of the experience may be helpful. Documented reflections should be brief, include any insights gained from the experience along with changes made to an individual's practice as a result. Reflections can be based on positive and negative experiences. Reflection should not be used to substitute or override other processes used to investigate significant events and serious incidents. Further information can be sought from the GMC reflective practitioner guidance and the Academy of Royal Colleges and COPMed Reflective Practice Toolkit.**
- 5.14** LTFT trainees will complete a pro rata number of clinical (ACE, mini-ACE, CbD, mini-PAT) WPBAs per calendar year, for instance, a 50% CT1 LTFT trainee will do a minimum of five ACE,

mini-ACE and CbD, and one mini-PAT. Regarding other targets they will be expected to complete the same number of quality improvement projects, psychotherapy assessments, emergency cases and nights on call during the three years whole time equivalent of core training.

- 5.15 The effect of Covid-19 on curriculum delivery and cancellation of MRCPsych examinations will not in themselves adversely effect ARCP outcomes providing the evidence up to March 2020 demonstrates that the trainee was on course to achieve a satisfactory outcome. Trainees will not expect an outcome 2, 3 or 5 where the training programme has failed to deliver an ILO due to external circumstances.**
- 5.16 Trainees in CT2 who have not passed paper A or B because of examination cancellation will not automatically require an outcome 3 extension to training.**
- 5.17 The Royal College of Psychiatrists have agreed that trainees in CT3 who have been unable to complete the final psychotherapy short or long case will be assessed by the psychotherapy tutor on their progress to March 2020 where face-to-face or teleconference patient contact has ended, and will not require an extension to training if they were on a trajectory to complete the psychotherapy competencies before August 2020. When a case has not been completed a comment will be made on the ARCP form and the trainee will be given opportunity to gain additional evidence by the first ARCP in ST4.**

6. Higher Specialty Curriculum Requirements

- 6.1** Specialty trainees will be assessed according to one or more of the specialty curricula, depending on whether the trainee is a dual CCT or seeking an endorsement. The trainee and the supervisor will need to be familiar with the ILOs specific to their curriculum, linking evidence in their portfolio (see 5.1, 5.2).
- 6.2** The relevant curriculum or curricula should be consulted in respect of WPBA content and minimum numbers. The number of mini-PAT responses required is the same as 5.8.
- 6.3** For instance, the General Adult psychiatry curriculum suggests a minimum of:

	ST4 50/50 IP/OP	ST5 (specialty)	ST6 (specialty)
ACE	2	1	1
Mini-ACE	2	2	2
CbD	6	4	4
Mini-PAT	2	1	1
SAPE	1	1	1
AoT	2	2	2
DONCS	3	3	3

- 6.4** The Old Age Psychiatry curriculum has a similar specification, differing only with respect to 1 mini-PAT in ST4.
- 6.5** The CAMHS curriculum suggests a minimum of 12 WPBAs per year, at least 2 ACE, 2 mini-ACE, 1 JCP, and several CbDs. At least 1 mini-PAT is required per year.
- 6.6** The Medical Psychotherapy curriculum suggests a minimum for each year: 2 ACE, 4 CbD, 1 mini-PAT, 2 SAPE, 1 SAPA (structured assessment of psychodynamic assessment), 1 AoT and 1 DONCS (there are no specified number of mini-ACE).
- 6.7** The Learning Disability curriculum suggests a minimum of 1-2 mini-PAT per year and at least one other WPBA performed a month.

6.8 The Forensic psychiatry curriculum suggests a minimum of:

	ST4	ST5	ST6
ACE	1	1	1
Mini-ACE	3	2	2
CbD	6	5	5
Mini-PAT	1	1	1
SAPE	0	1	0
AoT	1	1	1
DONCS	2	3	4

6.9 Specialty trainees will also need to evidence:

- 6.9.1 Development of psychotherapeutic competencies: this will vary according to specialty curriculum guidance and the placement characteristics, an example of guidance for General Adult and Old Age Specialty trainees is shown in **Appendices H1 and H2**
- 6.9.2 Reflective practice: see 5.13
- 6.9.3 Special interest sessions: these will be assessed by the relevant clinical supervisor on the Special interest assessment form **Appendix I** and uploaded on the portfolio.
- 6.9.4 Research or academic sessions (where applicable): these will be assessed by the relevant academic supervisor on the Special interest assessment form **Appendix J** and uploaded on the portfolio. Not all specialty trainees will undertake a research project but the curricula (see for instance ILO8 General adult psychiatry) require a more sophisticated understanding of applied research methodology and critical appraisal compared to core training, and additional evidence will need to be uploaded, for instance, attendance at generic HEE courses (e.g. “Research skills for the Specialty trainee”)
- 6.9.5 Quality Improvement Projects: the principles of 5.12 will apply - there should be evidence of at least one project per year, the use of at least two different methodologies across the three years, and the option to undertake one supervised research project across two years.
- 6.9.6 Clinical and organisational leadership and management: this could include evidence of - shadowing of an Executive Director, supervised leadership in project management, or chairing meetings. Leadership and management activity should be assessed by DONCS and included in reflective practice. In addition, specialty trainees should supplement experience with attendance at generic HEE courses (e.g. Management and leadership”) or similar academic activities such as the Edward

Jenner programme.

6.9.7 Training and development: this could include – teaching undergraduates or postgraduate trainees, organising a teaching programme, and involvement in coaching, appraisal or mentoring. There should be evidence on the portfolio by way of: anonymised feedback, WPBAs (AOTs, DONCS) and reflective practice. In addition, specialty trainees should supplement experience with attendance at generic HEE courses (e.g. “Training the trainers”, “CV writing and self-presentation”, “Making the transition to consultant”, “Medical ethics” and “The job interview”).

6.10 The principles set out in 5.15 will apply to specialty trainees.

6.11 Where trainees in ST4, ST5 or another penultimate year have been unable to complete a psychotherapy case but were on a trajectory to complete a case and assessment before August 2020 then the trainee will be allowed to continue the case into the next year without an adverse outcome. A trainee in ST6 or another final year who is not a Medical Psychotherapy trainee will not need to complete the psychotherapy case by extending training unless there are pre-existing concerns about psychotherapy competencies.

6.12 From March 2020 most specialty trainees will be withdrawn from special interest or academic roles. Academic or special interest supervisor reports should continue to be added to portfolios and ARCP panels will take into account the reduction in experience.

6.13 The Royal College of Psychiatrists have recommended that specialty Forensic Psychiatry ST6 trainees will not require completion of a High Secure Hospital placement for CCT where the placement has been cancelled due to Covid-19. The portfolio should contain sufficient evidence of assessments and experience of high security patients, for instance, assessments of high secure stepdown or referrals to high security, or case-based discussions and other academic activities relevant to different levels of security.