CHOOSE PSYCHIATRY in Scotland

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

August 2023

A Threatened Species:
Where Have All The Higher Trainees Gone?

A Core to Higher Training Attrition Report

CONTENTS

Introduction	3
The Challenge of Filling Higher Training Posts	4
So What Did We Do?	5
Feeling unprepared for higher training and greater responsibility	6
Pragmatism of the training programme	7
Experiential Motivators	8
Demographic Motivators	10
Higher Training application criteria	12
The bottleneck of places for higher training	13
Limitations of focus groups	14
Summary	14
Recommendations	16
References	21
Acknowledgements	22
Glossary	23

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Introduction

Psychiatric trainees are increasingly taking longer to complete their training. They are more likely to take a break, and whilst the majority will in time return to higher training, a significant minority are opting for career grade posts, leaving Scotland to continue training elsewhere, or not returning to training at all.

This is an area of concern that has an impact all along the pathway from the timely availability of training places to consultant vacancies.

At the Royal College of Psychiatrists in Scotland (RCPsychiS) we wanted to understand the reasons behind this attrition, the story behind the numbers. We wanted to hear directly from the trainees but also from trainers. We set up two trainee focus groups that were deliberately trainee led to allow for full and frank discussions. In addition, the issues were discussed and debated at a training workforce workshop (as part of the wider Scottish psychiatry workforce report which we will publish shortly), the RCPsychiS Scottish Workforce & Careers Committee, and at the Devolved Council of the RCPsychiS. Similar themes emerged from all the discussions. This wealth of information obtained has allowed us to make clear and bold recommendations.

The remit of this exercise was core to higher trainee attrition and the recommendations here are specific to this issue. But we do not work or train in silos, and for a fuller understanding of the issues this report is best read alongside the wider **Scottish psychiatry workforce report** on the state of the psychiatric workforce in Scotland.

Dr I Kader
RCPsychiS Workforce Lead

The Challenge of Filling Higher Training Posts

In recent years, the attrition between core and higher psychiatry training has become more apparent. Whilst core psychiatry training fill rates in Scotland remain high, poorer fill rates are increasingly evident in higher training.

Following concerted efforts to encourage take-up of psychiatry training in Scotland, core psychiatry fill rates reached 100% in 2021 (1), and have remained there despite successive increases in places. However, data shows that there has been a falloff between core and higher training for the last few years (2022-Recruitment-Data-with-2021-for-comparison.pdf (scot.nhs.uk)). In 2022, only 34 out of 49 higher training posts in Scotland were accepted (69.39%). Further analysis reveals significant regional variation in recruitment rates as noted in the table below (2). This affects both (i) vacant consultant posts being unfilled as sufficient numbers of higher trainees are not getting on to the GMC Specialist Register, and (ii) at the front end, with arguing the case for an increase in medical student places, foundation posts and core training posts, all of which are needed to fill consultant psychiatrist posts going forward.

Table 1: Higher Training Fill Rates 2022 (2)

Region	Posts	Filled	Percentage
South East	11	10	92%
West	20	17	85%
East	8	4	50%
North	9	2	22%

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So What Did We Do?

To better understand the reasons behind this attrition, and as part of a larger project to understand the state of the psychiatric workforce in Scotland(3), RCPsychiS conducted two core trainee focus groups in August and September 2022. These groups were chaired by higher trainees and post-core training clinical fellows and conducted over Microsoft Teams to maximize engagement from trainees and allow for wider participation. The August focus group had seven core trainees, one higher trainee and two facilitators, while the September group had two facilitators and five core trainees. There was representation from all four deanery regions of Scotland.

In addition to the focus groups, the issues formed a significant part of discussions at a trainee workshop held on 7 September 2022 to inform the wider psychiatry workforce report and in dedicated sessions at the RCPsychiS Devolved Council and RCPsychiS's Scottish Workforce & Careers Committee.

The findings from all the forums were analysed and the following themes identified for core trainees choosing not to go directly into higher training:

1. **Feeling unprepared for higher training and greater responsibility**
2. **Pragmatism of the training programme**
3. **Experiential motivators**
4. **Demographic motivators**
5. **Higher training application criteria**
6. **Bottleneck in higher training places**

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1. Feeling unprepared for higher training and greater responsibility

Many core trainees (CTs) felt unprepared for higher training and the associated greater responsibility and considered they required more experience before applying for higher training. They felt that **core training did not provide enough experience in their desired specialty or were undecided on which specialty to pursue**. They believed a break in training by taking up non training posts - especially SAS posts - would offer them the opportunity to gain relevant experience to make a more informed decision on choice of psychiatric sub-specialty without training obligations such as being on call.

Some reported feeling **mentally exhausted after the rigours of core training** and felt the need for a break before returning to training.

Trainees expressed **anxieties around higher training on call** and were keen to know what could be done to prepare them. They did not know what the different aspects of on call entailed and they have heard of the busyness of higher training on call. They felt having clarity on the role in advance and an opportunity to gain some experience could help prepare them.

CTs have told us they don't feel **they've been able to get sufficient leadership experience during training and feel unprepared for the leadership roles expected of a higher trainee**. While they accept that a lot of this comes with experience, they would value training in this area.

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"A lot of my contemporaries quite like the idea of doing specialty doctor posts in between core and higher training just for a bit of a buffer in terms of responsibility and decision making and also, I guess avoiding potentially quite difficult on call rotas and building confidence before going into higher training."

"I kind of want to take some time, maybe as a specialty doctor, just to see what that (the on call rota) looks like before committing to doing it as a higher trainee."

"[I want to be able to) carry on career without mill of ARCP requirements- time to have family, etc."

"[I would] definitely consider it [being a specialty Doctor] rather than all the stress and uncertainty that comes with going straight into ST4."

2. Pragmatism of the training programme

Only 14.7% of psychiatry trainees complete training within six years(4).

Reasons for this include:

i) **taking time out to gain further experience**
ii) **working less than full-time (LTFT)**
iii) **needing a break**
iv) **needing to extend core training because they lack MRCPsych or psychotherapy competencies.**

The perceived need for greater experience has been discussed in the previous section.

During the COVID pandemic the MRCPsych exams were adapted so that applicants could sit the three parts of the exams in any order (currently trainees are required to have passed the written papers [A&B] prior to sitting the clinical exam [CASC]). Our respondents felt completing core training within the three years becomes easier when they have the flexibility to sit the exams in any order.

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Portfolio requirements are a reason cited by some trainees for delays in progressing in training. They feel there are too many different assessments, and it is not uncommon to not have met all the requirements within the time frame. They accept their personal responsibility in this regard, however, other competing demands on their time – clinical work, exams etc – also make some lose track.

Similarly, trainees often need more than three years of core training to complete their psychotherapy competencies as this requires persistent engagement with a single patient over a period of more than six months.

Many feel that they gain a lot of experience when they step off the training pathway after core training and queried if some of their experience could count towards higher training requirements. This will allow them to make up for lost time in training.

> ***"A lot of doctors in their CT3 have not tried any exams yet... or tried only one because they are just overloaded with work."***
>
> ***"I had to delay mine due to psychotherapy as well. So I think that's seems to be a theme for a few people actually. Seems to be a rubbish reason not to be able to move on."***

3. Experiential Motivators

Core training experience has a significant effect on the likelihood of trainees applying for higher training. According to the GMC National Trainees' Survey (2022)(5), **burnout rates among trainee doctors are at their highest since 2018.** Two-thirds of trainees reported feeling worn out at the end of their workday "always" or "often." In 2022, 13% of psychiatry trainees were at high risk of burnout compared to 10% in 2021.

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The Academy of Medical Royal Colleges and Faculties in Scotland's report, 'The Scottish Medical Workforce (6) – an outline of challenges and offer of solutions,' describes several challenges and solutions applicable to psychiatry. Failure to fill CT/ST posts in a recruitment cycle will reduce the eagerness to expand trainee numbers as it is considered pointless to expand a specialty where there are already vacancies. This can widen the gap between likely or existing consultant vacancies and the supply of certified doctors to fill these. LTFT and flexible training opportunities must have wider access, and the impact on training and consultant numbers addressed.

In the discussion with trainees their experience in psychiatry posts (either training or CDF/locum posts) was heavily emphasized. Those who shared positive experiences were more inclined to remain in their training and within the broader specialty.

Previous negative experiences appear to have a significant impact on future planning. Respondents often described **training as difficult, with very little focus on psychiatry (as opposed to general medical tasks particularly repetitive procedural tasks), with minimal autonomy and a lot of hoops to jump through** in relation to their ARCP requirements.

Trainees recognise the significance of psychiatrists also being medical doctors and the relationship between physical and mental health. They acknowledge the importance of investigating and where appropriate treating physical health conditions and accept they are often best placed to do this within a psychiatric setting. However, they find that **most of the physical health related work is repetitive procedural tasks that do not add value to their training and experience, and which could be supported by other specialist staff** such as a phlebotomist, ECG technician or a Physician Associate. This would allow the psychiatric trainee to focus their medical knowledge on the 'organic' aspects of psychiatry and any interface between physical and mental health.

Trainees are also influenced by their interpretation of others' experiences especially those of their consultant supervisors.

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"(I would choose) Liaison… a job that was really supportive and really enjoyable."

"I know many trainees, they choose the subspecialty because of this positive experience with supervisors."

"I think Old Age is for me anyway, but the placement was probably less enjoyable because I was doing catheters half the time, which is not really why I got into psychiatry."

"I could not face applying to Reg training. I was just tired, just tired. I've been a foundation doctor for four years and a core trainee for five years. I had been ticking boxes and jumping through hoops for nine years and it just felt like, actually, I don't want to do that for a wee while, to not have to do the workplace-based assessments and to tick all the boxes and to go to your ARCP just to have a break from that for a year was really attractive."

"Trainees feel like they've been running this race for so long, like after school, medical school, foundation and then core training, and then you get to this point where you get a bit older, and you start having a family and you kind of feel like they just need a breather, so it's not really just about opportunities and all that it is just sometimes people get a bit exhausted."

"Not wanting to rush into a consultant role, … that role of responsibility … definitely seems to be a kind of message coming from Consultants of like it's not something to kind of rush towards."

"I guess what terrifies me about becoming a consultant because I guess, you know, who do you ask? … Sink or swim."

4.Demographic Motivators

When applying for higher training numerous practical issues arise, such as the potential need to relocate for a job. **By the time they have completed core training trainees have often settled down in a region, have families, mortgages, friendships**

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and other personal relationships which they do not wish to break and would often rather wait until a higher training post becomes available in their area than uproot and relocate.

It appears critical that trainees have a sense of certainty when making decisions. The knowledge of where you are going to be throughout your training is appealing to trainees, for instance in the form of run-through training. Staying in one region allows them to **concentrate on their training without the distractions of relocating or the pressure involved in applying for higher training posts.** This would reduce the core to higher training attrition problem and allow for forward planning of consultant posts as these trainees are likely to want consultant posts in the regions where they train.

Trainees have talked about a **lack of knowledge and information on what is available in areas outside of the region where they work**. For instance, which special interest sessions might be available, research and teaching opportunities, future consultant posts etc. Having this information in advance could help inform their planning and decision making.

There are some challenges that are specific to IMG trainees who must consider visa requirements before embarking on their journey. **Having a longer visa gives them confidence that they will be able to stay in the country and progress to higher training**. It might also allow them to remain in one area long enough for instance if the visa is linked to employment. There are other specific IMG related challenges that are beyond the scope of this report but will be addressed in the wider workforce report

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"I just want some autonomy over my own life and hold out until I have chosen where I want to be... I don't think anyone tells you when you are at medical school, how much you have to just put your life in the hands of the people organising your jobs, and it just feels rubbish compared to other professions."

"It would be great to know things about jobs prospects ...how are the chances that for example if you finish higher training in adult psychiatry, what are the prospects that you will find the job, in Glasgow? In Scotland?"

"I am going take some time out before going straight, before going into higher training, I think partly it is the location and not knowing 100% sure whether I want commit to where I want to commit to being for the next three years."

"Practical life things of having bought a flat here and stuff like that. I do not know if I want to go through that again."

"I just hate the idea of having to uproot and move all the time. And that would really put me off some of the locations."

"I'm an IMG, so all my decisions are based on visas, to be honest, ..., so it is kind of those kinds of things not related to psychiatry."

5. Higher Training application criteria

The procedure of applying for higher training has been described as an anxiety-inducing experience for trainees. In 2020, the ST4 application criteria underwent changes and is now structured as follows: 50% based on CASC score, 33% on structured interviews, and 17% on verified self-rating.(7) Feedback from focus groups suggests that the CASC score carries too much weight, and from other discussions it seemed trainees placed a lot of emphasis on self-assessment. It is crucial to provide trainees with information about the application process at an early stage.

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"I (would want) your first week of CT1, someone to very clearly highlight things to you (which would be helpful for applications)"

"There were so many requirements that you need to have when you apply for ST4.... why people might want to take an extra year or two post core training."

6. The bottleneck of places for higher training

Despite efforts to improve higher training numbers there is still room for growth in Scotland. A bottleneck of positions in certain areas and specialties exists. The reasons for these are explored under demographic motivators. It must be noted that although this appears to be a challenge only in some areas the sentiment is echoed by most.

Core trainees are increasingly looking at less than full time options (8) and this is likely to continue into higher training and beyond. National training numbers are not offered in a way that will allow for this increasing trend leading to them not being fully utilised. Offering LTFT trainees the option to share NTNs or radically rethinking how NTNs are structured could allow for more trainees to choose the specialty. A clear knowledge of the throughput of LTFT trainees will allow Health Boards to plan consultant posts accordingly.

"They are only releasing one number each time, ... I've got kids here and my husband's business is here, so I really didn't want to move, and it's not an option."

"There is this mismatch or bottleneck from coming out of core to how many higher training positions."

"The number of jobs that are available and how it's quite competitive, there is an increasing number of people applying for these jobs."

"Chosen specialty not available in a certain area- impact on specialty choice or whether to progress"

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Limitations of focus groups and workshops

It is clear that the groups included in this paper only represent a small fraction of the overall trainee cohort and, as a result, may not fully capture the sentiments of the wider group. It is also important to acknowledge diversity of training experiences and external factors that may impact on trainees' career planning decisions outside of their training posts.

Summary

According to TURAS data obtained from the census conducted on 31st December 2022, the average age of consultant psychiatrists in Scotland is 47 years old. When looking at whole-time equivalents (WTE), 18.8% of consultants are over 55 years old. However, the percentage increases to 23.6% when considering headcount. The data also reveals a 14.9% WTE vacancy rate, which translates to 93.9 vacancies, with 8.2% of posts remaining vacant for over six months, equivalent to 51.8 positions. In comparison, the WTE vacancy rate for all medical specialties was 6.5%.(8)

This paper highlights the issue of attrition between core and higher training in psychiatry, with the corresponding absence of those completing training contributing to a significant gap in the consultant workforce. Although there is no attrition data for higher training to consultant posts, anecdotal evidence suggests that most trainees who begin higher training will go on to accept a substantive consultant post. Of those commencing psychiatry training only 14.7% will complete within six years, indicating that the consultant vacancy rate may take longer than expected to decrease, **necessitating an increase in higher training numbers to address this shortfall.**

By opting to move temporarily (in most cases) to a career grade/SAS post, trainees feel they can gain more clinical and decision-making experience as these flexible posts allow for greater responsibility without the pressures of on call and without affecting their work-life balance. This also allows them to gain the points required in their higher training application which is something that they would like reviewed. They feel **the**

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current application process does not allow them to fully showcase their skills and experience.

A trainee's experience in post can be crucial in determining whether they decide to continue in training, in which specialty and in which region. It has a direct impact on whether they want to work at a consultant grade at all. Positive role modelling by consultants - often in the face of real-world service pressures - has a major impact on trainee attitudes.
A trainee's life outside of work and training is seen as one of the biggest reasons for not wanting to move and take up posts that are available, and instead **choose to wait as long as needed or move to a career grade post if it is in the interests of their personal life. This is something that can no longer be ignored.**

It must be noted, however, that whilst for some the requirement to relocate one's life to continue in training is a major barrier, many trainees are quite happy to move to other areas. They see this as a new work and life experience. However, they feel **they do not know enough about training opportunities and services in other areas and what future job prospects are in order to inform their decision making.**

It could therefore be argued that future strategies targeting reduced attrition rates from core training to higher training should **adopt a flexible approach to training and national training numbers. The clinical and other experiences during core training needs to be reviewed regularly. Trainees should also be supported, valued, and treated as individuals where it is acknowledged that they have aspirations, goals and responsibilities outside the realm of medicine**.

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Recommendations

The Royal College of Psychiatrists in Scotland has concluded from our extensive research to date that there is a lack of sense of belonging in the trainee workforce.

A full review, and potentially even an overhaul, of the psychiatric training model is required. This document offers a series of recommendations which could help stabilise the situation in the interim.

RCPsychiS analysis of the experiences of core trainees and higher trainees found that:

- Early, positive experiences in psychiatry coupled with better understanding of expectations and preparedness for progression at each training stage, leads to greater numbers of doctors specialising in and completing training in psychiatry.
- This requires positive role models in the form of consultant psychiatrists with adequate protected time to offer both high quality training and functioning, supportive working environments.
- Run through training from core to completion of higher training would enable trainees to embed themselves in a region for at least six years, offering a sense of security and geographical certainty. This could then potentially encourage them to take up consultant posts in that locality – an attractive option in regions that are struggling to recruit higher trainees and consultants.
- Less than full time training is now commonplace. Offering training structures that embed flexibility and enable accreditation of non-training experiences to count towards training will result in faster completion of training and increases in the consultant workforce.
- Providing both projected training and substantive consultant posts and/or vacancies would be welcomed. The transparency of available posts and their localities would better support doctor's career planning from an earlier stage.

Core Trainees

Key Findings:

- Core training posts across Scotland have been 100% filled for the last three years (including this year) and had only one vacancy in 2020.

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- Demand for core training in psychiatry is very high: data for the UK shows the number of applications for core training in psychiatry has increased by 130% in the last eight years across all nations, from 797 in 2014 to 1,876 in 2022[1].
- The number of core training places available in Scotland has reduced from 68 in 2020 to 45 in 2023. This is partly because doctors are staying in core training for longer than three years, making posts unavailable to new core trainees until they are vacated.
- The allocation of core training places is weighted towards the west and southeast of Scotland, together accounting for 81% of core places.
- Despite a 100% fill rate for core training, only 69% of higher training posts across Scotland were filled in 2022. The transition between core and higher training represents a key attrition point in the workforce pathway. Across the UK, only 14.7% of psychiatry trainees complete training within six years[2].
- Core trainees highlight a perceived need for more experience in their chosen field, concern about feeling inadequately prepared for the transition and a lack of time to complete professional exams and competencies as key reasons for delaying moving on to higher training.
- Doctors find the assessment and exam process inflexible and often cite that these require more time than they can give when working in demanding clinical settings.
- At present it can be difficult for core trainees to ascertain whether higher training posts in their desired specialty will be available when they complete core training. This uncertainty often leads to trainees taking time out of the training pathway until a suitable post arises.

Key Recommendations:

- Collate and monitor Scotland specific data on applications and fill rates for core training posts in psychiatry with an emphasis on understanding regional variation.
- Urgent review of the current model of training, including duration of the core training programme, to ensure it is fit for purpose and able to provide trainees with the necessary experience to progress into higher training.
- As an interim measure to better prepare core trainees for higher training and address perceived gaps, set up systems allowing core trainees to shadow higher trainees whilst on call, offer opportunities to lead MDT meetings, contribute to

[1] Competition ratios for 2022 from Health Education England.
[2] Silkens MEWM, Sarker SJ, Medisauskaite A. *Uncovering trends in training progression for a national cohort of psychiatry trainees: discrete-time survival analysis.* BJPsych Open [Internet]. 2021 Jul 28 [cited 2023 Jun 12];7(4):e120. Available here:

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MHTs, and join consultants at management and service improvement meetings to improve confidence in decision making, leadership and management.

- Collate Scotland specific data on core trainees' duration of training, factors contributing to delays in transition to higher training and regional variations in this. This would include information on proportion of trainees that extend core training due to delays associated with achieving exams and other associated competencies, such as psychotherapy training, or external factors such as unavailability of desired higher training posts or difficulties ascertaining information about availability of options.
- Increase the number of core training places in psychiatry, especially in areas that find recruitment more challenging across the workforce. Consider alternative supervision models including utilising SAS and retired and returning psychiatrists, to address shortage of supervisers due to consultant vacancies.
- Ensure adequate capacity within the consultant workforce to provide the high-quality supervision needed to ensure that core trainees meet their required training needs. Consultant psychiatrists need to have adequate protected time in job plans to offer supervision, guidance, training and pastoral support beyond the one hour per week mandatory supervision requirements. This is a significant challenge within current workforce gaps and job plans.
- Move to ensure training numbers are considered on basis of whole time equivalent (WTE) rather than raw headcount, reflecting the increasing shift towards LTFT training at all stages of the training pathway.
- Review and change the current exam and assessment process to allow for greater flexibility in the exam timetable and in achieving the necessary assessments.
- Review tasks expected of core trainees to ensure a better balance between psychiatric and generic physical health tasks.
- Offer mid-point and end of placement interviews with trainees and use information obtained to iteratively improve placement experience.
- Consider employing other professional groups for certain tasks to allow trainees to focus on their psychiatric skills. For example, phlebotomists, electrocardiograph (ECG) technicians and Physician Associates.
- Build on early learning from run through training pilots in child and adolescent mental health services (CAMHS) and the psychiatry of intellectual disabilities. Evaluate options for expanding the number of run through training pilots in all sub-specialties, especially in areas of higher trainee and consultant vacancies. **Since completing this report, the GMC has now approved child and adolescent psychiatry run through training in the UK. It is being piloted in Scotland from August 2023. Intellectual Disability psychiatry run through training is currently being piloted in England.*
- Encourage other options for time out of training to broaden experience, such as out of programme training (OOPT), research (OOPR), experience (OOPE), career break (OOPC), and pause (OOPP), ensuring that trainees are aware of these options.

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- To assist career planning, a system should be put in place to ensure trainees are aware of upcoming higher training posts, by specialty and region, and including special interest sessions, teaching, research and quality improvement opportunities. This information should be held centrally and be easily accessible, rather than reliant on word of mouth.

Higher Trainees

Key Findings:

- Around a third of higher training posts were vacant last year. This has been the case since 2018.
- Location plays a part in how many higher training places are filled. The west and southeast had at least 80% of their posts filled last year. However, the figures for the north and east were 20% and 55% respectively.
- Positive experiences during core training encourage trainees to move on to higher training, but many trainees are reporting challenges with their training. In 2022, 13% of psychiatry trainees were at high risk of burnout compared to 10% in 2021.
- By the time they have completed core training, doctors have often settled in a region. Consequently, they would often rather wait until a higher training post becomes available in that region rather than relocate.
- Doctors find the assessment and exam process inflexible and often cite requiring more time than they can give to exam preparations when working in demanding clinical settings.
- Applications for higher training rely heavily on a candidate's clinical assessment of skills and competencies (CASC) score. Trainees have reported that they feel too much emphasis is placed on this, and they feel unprepared to approach the application process.
- Trainees are increasingly working less than full time. This means they stay in training for longer. But because of the way national training numbers are administered, their place cannot be released or shared with another doctor until they complete training.
- Trainees repeatedly ask about dual training options in psychiatry suggesting this would encourage more trainees to progress to higher training. This is a very appealing option to many trainees who have interests in more than one sub-specialty but additionally, at present may also assist with addressing the poorer fill rates into general adult psychiatry training by dualling with other specialties.

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Key Recommendations:

- Ensure training numbers are counted as WTE rather than headcount. Consider the option of sharing training numbers between LTFT trainees.
- Review options for counting relevant experience from out of programme and non-training posts towards higher training.
- Collate and monitor Scotland specific data on total time taken for completion of training to ensure that workforce projections more realistically reflect the changes within this.
- Explore options for temporarily moving training numbers to areas of demand rather than leaving unfilled but with clear safeguards to prevent permanent loss of posts.
- Offer mid-point and end of placement interviews with trainees and use information obtained to iteratively improve placement experience.
- Trainee knowledge and experience to be reviewed prospectively and taster sessions offered in areas of less experience.
- Interested consultant psychiatrists must have time in their job plans to offer supervision, guidance, training and pastoral support beyond the one hour per week mandatory supervision.
- Conduct a review of the various types of out of programme experience and specialty and associate specialist doctors (SAS) posts to see how relevant experience can be counted towards higher training requirements.
- Explore the demand for dual training options and how this could be offered.
- A system should be put in place to ensure pre-CCT trainees are aware of current and projected consultant posts/vacancies, both by specialty and region, to support career planning. This information should be held centrally and be easily accessible, rather than reliant on word of mouth. This may be remedied slightly by the recently created psychiatry careers website which is currently in development.

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Glossary of terms and acronyms

ARCP – Annual Review of Competency Progression

CAMHS – Child and Adolescent Mental Health Services

CASC – Clinical Assessment of Skills and Competencies

Core Training – General Psychiatry Training (CT1-3)

CS – Clinical Supervisor

CT – Core Trainee

DC – Devolved Council (of the RCPsych in Scotland)

ECG Technician – health care professional who specialises in electrocardiogram testing for patients

ES – Educational Supervisor

Foundation – two years of paid rotational training after completing undergraduate medicine

GMC Specialist Register – A list of doctors who are eligible to take up appointment in any fixed term, honorary or substantive consultant post in the NHS

HB – Health Board

Higher training – post CT specialist training. See also ST.

ID – (psychiatry of) Intellectual Disability

IMG - International Medical Graduate (a doctor whose primary medical degree is from outside the UK)

LTFT – Less Than Full Time

MDT – Multidisciplinary Team (includes ward rounds and team clinical meetings)

MHT – Mental Health Tribunal

MRCPsych – Member of the Royal College of Psychiatrists, a post graduate qualification

NES – NHS Education for Scotland

NTN – National Training Number

OOPC – Out of Programme Career break

OOPE – Out of Programme Experience

OOPP – Out of Programme Pause

OOPR – Out of Programme Research

OOPT – Out of Programme Training

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Phlebotomists – healthcare professionals who obtain blood samples from patients

Physician Associate – supports doctors in the diagnosis and management of patients

Psychotherapy competencies – mandatory competencies in psychotherapy as per the psychiatric curriculum required for ARCP.

RCPsych – Royal College of Psychiatrists

RCPsychiS – Royal College of Psychiatrists in Scotland

SAS – Specialist, Associate Specialist and Specialty doctors

SG – Scottish Government (Mental Health & Wellbeing Directorate)

Special Interest Session – Half day/week for ST4-6 to gain additional experience

ST – Specialty Trainee (ST4-6). See also Higher Training.

SWCC – Scottish Workforce and Careers Committee (of the RCPsychiS)

TPD – Training Programme Director

TURAS – NES's centralised platform for its digital services including data

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