Curricula Implementation Survey Report 2026

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Background

The updated psychiatry curricula, approved by the General Medical Council (GMC) in June 2022 and implemented from August 2022, have now been fully embedded across UK psychiatry training following the completion of the transition period in August 2024. The revised curricula introduced several significant changes, including the move from Intended Learning Outcomes (ILOs) to High Level Outcomes (HLOs), aligned with the GMC's Generic Professional Capabilities (GPC) framework. Additional developments included the introduction of Placement-specific Personal Development Plans (PsPDPs), revisions to Workplace-Based Assessments (WBPAs) and supervisor reports to improve consistency, the renaming of 'Substance Misuse Psychiatry' to 'Addiction Psychiatry', and the publication of supplementary guidance through the *Silver Guide*.

To support implementation, the Royal College of Psychiatrists established a comprehensive Curricula Implementation Hub, which provided a range of resources for resident doctors, trainers and programme teams. These included eLearning modules, recorded drop-in sessions, training videos, transition guidance, CESR applicant information, frequently asked questions, and presentations from key national events, including the 2022 International Congress. Communication and support were also provided to Heads of Schools, Training Programme Directors and Deanery administrators throughout the transition period.

A wide range of supporting documentation accompanied the new curricula, including curriculum handbooks, example PsPDPs, ARCP decision aids, guidance on end-of-year standards, comparisons between the previous and updated curricula, and the revised suite of workplace-based assessments.

Four years on from implementation, attention has shifted from transition to evaluation and continuous improvement. Resident doctors, trainers and educational leaders have now had substantial experience of working within the new curriculum framework, providing valuable insight into its impact on training quality, progression, assessment, supervision and day-to-day clinical practice. Their experiences continue to inform ongoing curriculum development and refinement, ensuring that psychiatry training remains responsive to the evolving needs of learners, patients and healthcare services.

Summary of the data

It is important to note that the response rate was lower than anticipated. We believe this may be attributable, at least in part, to the survey being conducted concurrently with the National Training Survey. To mitigate this risk in future iterations, we propose revising the timing of the survey.

Whilst we value and take seriously the views of all stakeholders who responded, the relatively low response rate means that caution should be exercised when

interpreting the findings. As such, it is difficult to conclude that the results are fully representative of the wider stakeholder population, and they should therefore be considered alongside other available evidence and sources of feedback.

The survey provides a comprehensive picture of stakeholder experiences of the 2022 curriculum. Respondents were generally supportive of the curriculum's principles and recognised its positive contribution to patient care. However, consistent concerns were raised regarding curriculum complexity, implementation challenges, supervision capacity, and access to certain training opportunities.

Overall, stakeholders reported that:

- Understanding of Higher Learning Outcomes (HLOs) is generally moderate, with relatively few respondents reporting a comprehensive understanding.
- Supervisors often lack confidence in interpreting and applying curriculum requirements consistently across training settings.
- Heavy clinical workloads and service pressures remain the most significant barriers to delivering curriculum-aligned supervision.
- Psychotherapy competencies continue to be the most frequently reported challenge for residents across specialties and regions.
- The curriculum can be perceived as overly complex, lengthy and difficult to translate into day-to-day clinical practice.
- Despite these implementation challenges, many residents and trainers reported that curriculum components relating to clinical skills, communication, safeguarding, quality improvement, leadership and reflective practice have had a positive impact on patient care and patient safety.

Key Findings

1. Understanding and Usability of the Curriculum

Feedback on the curriculum highlighted a recurring concern that both residents and trainers find it difficult to navigate. Respondents reported that the High-Level Outcomes (HLOs) are too numerous and overly detailed, with significant overlap between capabilities. Many also found it challenging to translate the curriculum language into everyday clinical practice and expressed uncertainty about what constitutes acceptable evidence. The curriculum was frequently described as "wordy", "too broad", "tick-box focused", "difficult to evidence", and "disconnected from clinical work". To address these issues, respondents commonly requested a

reduction in the number of HLOs, streamlined capabilities, clearer examples of acceptable evidence, and improved mapping between routine clinical activities and curriculum requirements.

Despite these challenges, respondents also identified several strengths of the curriculum. They valued its outcome-based approach, the structured progression it provides throughout training, and its increased emphasis on leadership, professionalism, and patient safety. Many participants also recognised the greater flexibility offered by the curriculum when compared with previous versions.

2. Supervision and Faculty Preparedness

The strongest and most consistent finding across all stakeholder groups related to the capacity and effectiveness of supervision. Respondents repeatedly identified a range of barriers that were limiting the quality of educational supervision, including increasing clinical workloads, consultant shortages, service pressures, reduced Supporting Professional Activities (SPA) time, growing numbers of residents, and competing demands during supervision sessions.

Supervisors also reported challenges in keeping pace with curriculum changes, with many expressing limited understanding of current portfolio requirements, uncertainty about what constitutes curriculum-compliant supervision, and a lack of training in applying High-Level Outcomes (HLOs) effectively during supervision discussions.

As a result of these pressures, supervision sessions were often reported to focus primarily on clinical caseload management, pastoral support, leave and rota issues, and addressing immediate service demands, rather than on explicit curriculum progression and educational development. To address these concerns, stakeholders suggested several improvements, including increased supervisor development opportunities, joint trainer–resident curriculum workshops, better communication regarding curriculum updates, protected time for supervision activities, and enhanced support for educational supervisors and Training Programme Directors (TPDs).

3. Curriculum Relevance to Clinical Practice

Respondents were divided in their views on how effectively the curriculum translates into day-to-day clinical practice. Many provided positive feedback, stating that the curriculum supports the development of key areas of professional practice, including clinical assessment skills, communication, risk management, safeguarding, quality improvement, professional behaviours, and leadership development. These respondents felt that the curriculum reflects many of the

core competencies required for modern psychiatric practice and encourages broader professional growth beyond clinical knowledge alone.
However, others expressed concerns about the practical application of some curriculum requirements. Several respondents felt that certain competencies are difficult to evidence, while some capabilities appear detached from routine psychiatric practice. A common view was that a disproportionate amount of time and effort is spent collecting evidence for the portfolio, sometimes at the expense of developing clinical expertise. Portfolio-related activities were frequently described as administrative rather than educational in nature. Areas most commonly identified as challenging included sustainability, public health, leadership evidence, research competencies, health inequalities competencies, and digital competencies, the latter being highlighted by several respondents as an emerging gap within current training and practice.

4. Equity, Diversity and Inclusion

Views on equity, diversity and inclusion (EDI) within the curriculum were mixed. Many respondents were supportive of strengthening EDI-related learning and highlighted the value of approaches such as case-based learning, incorporating lived-experience contributions, neurodiversity education, and training focused on race, culture, sexuality, gender identity, and disability. There was also strong support for providing greater assistance to International Medical Graduates (IMGs) to help them navigate training requirements and clinical practice.
Frequently suggested additions to the curriculum included greater awareness of neurodiversity, cultural psychiatry, communication across different cultures, effective use of interpreters, understanding hidden disabilities, and the application of reasonable adjustments in clinical and educational settings.
However, a substantial minority of respondents raised concerns about the implementation of EDI competencies within the curriculum. Some felt that these competencies may be difficult to demonstrate and evidence in practice, while others perceived current EDI requirements as being somewhat disconnected from day-to-day clinical priorities. A recurring view was that the existing complexity of the curriculum should be addressed before introducing additional EDI requirements, with respondents emphasising the need for greater clarity and simplification to ensure meaningful engagement with both current and future curriculum expectations.

5. Preparation for Progression

Several senior educators noted that residents may have less exposure to acute clinical decision-making than previous generations of psychiatrists.

Most respondents felt that the curriculum prepares residents reasonably well for progression through the various stages of training. However, a number of concerns were raised regarding key transition points, where residents may experience challenges in meeting the expectations of the next stage of training. The transition from core to higher training was identified as a particular area of difficulty, with respondents highlighting challenges related to completing psychotherapy requirements, demonstrating leadership competencies, fulfilling research requirements, developing confidence in independent clinical decision-making, and undertaking quality improvement activities.
Concerns were also raised about the transition from higher training to consultant practice. Respondents questioned whether some residents are receiving sufficient preparation for the level of autonomy and responsibility expected of newly appointed consultants. Areas most frequently identified included consultant-level decision-making, service leadership, team management, crisis management experience, and access to acting-up opportunities that provide exposure to consultant responsibilities before completion of training. Several senior educators also observed that current residents may have less exposure to acute clinical decision-making than previous generations of psychiatrists, potentially affecting their confidence and readiness for independent practice.

6. Availability of Clinical Experiences

Respondents identified significant regional variation in the availability of clinical experiences required to meet curriculum outcomes. The most frequently reported challenge across all respondent groups related to psychotherapy training. Participants described limited access to suitable psychotherapy cases, shortages of appropriately trained supervisors, delays in obtaining cases, and considerable variation in provision between regions. Many respondents expressed concern that these barriers could delay completion of training requirements and, in some cases, increase the risk of training extensions.

Research opportunities were also highlighted as an area of concern. Respondents reported limitations in research infrastructure, a lack of available supervisors, and difficulties balancing research activities alongside demanding clinical workloads. Many felt that meaningful opportunities to engage in research were not consistently available, making it challenging to develop and demonstrate the required competencies. Beyond psychotherapy and research, stakeholders identified several other areas where access to relevant clinical experience could be limited. These included addiction psychiatry, electroconvulsive therapy (ECT), forensic psychiatry, learning disability psychiatry, digital health, public health activities, and leadership and management experience. Overall, respondents suggested that unequal access to these opportunities may affect the consistency

of training experiences and residents' ability to achieve curriculum requirements across different regions.

7. Impact on Patient Care and Safety

A significant positive theme emerging from the feedback was the perceived impact of the curriculum on patient care and safety. Respondents particularly valued curriculum components that focus on risk assessment, safeguarding, reflective practice, communication skills, clinical governance, quality improvement, and patient-centred care. Many participants felt that these areas align closely with the core responsibilities of psychiatric practice and contribute to the delivery of safer, higher-quality care.

Respondents described several tangible benefits arising from the curriculum's emphasis on these domains. These included improvements in clinical formulation skills, more effective multidisciplinary team working, increased awareness of patient safety principles, and more structured approaches to clinical decision-making. Participants also reported that the curriculum has helped promote engagement with quality improvement activities, supporting a culture of continuous learning and service development. Overall, the feedback suggested that, despite concerns about curriculum complexity and implementation, many stakeholders recognise its positive contribution to the development of clinicians who are better equipped to provide safe, reflective, and patient-centred care.

Conclusion

The findings from this survey suggest that four years after implementation, the 2022 Psychiatry Curricula are now firmly embedded within postgraduate psychiatric training. Feedback from residents, trainers and educational leaders indicates broad support for the curriculum's outcomes-based approach and its emphasis on developing psychiatrists who are clinically competent, reflective, professional and responsive to the needs of patients and services. Strengths were identified in the curriculum's focus on patient safety, communication, leadership, quality improvement and holistic patient-centred care.

At the same time, the survey highlights several challenges that continue to affect the learner and trainer experience. Across stakeholder groups, respondents reported concerns regarding the complexity of the curriculum, difficulties navigating requirements and guidance, and variable understanding of how best to demonstrate achievement of High-Level Outcomes. The capacity and consistency of supervision emerged as the most significant implementation challenge, with workforce shortages, service pressures and limited protected time constraining opportunities for meaningful curriculum-focused supervision. Psychotherapy training remains a significant concern, alongside access to research, leadership and other specialist experiences, with marked regional variation in opportunities.

The findings suggest that future curriculum development should focus on improving simplicity, clarity and usability. Stakeholders called for streamlined requirements, clearer examples of appropriate evidence, enhanced training and support for supervisors, and stronger alignment between curriculum outcomes and day-to-day clinical practice. Respondents also identified opportunities to strengthen areas such as digital psychiatry, health inequalities and neurodiversity, while emphasising the importance of avoiding additional complexity wherever possible.

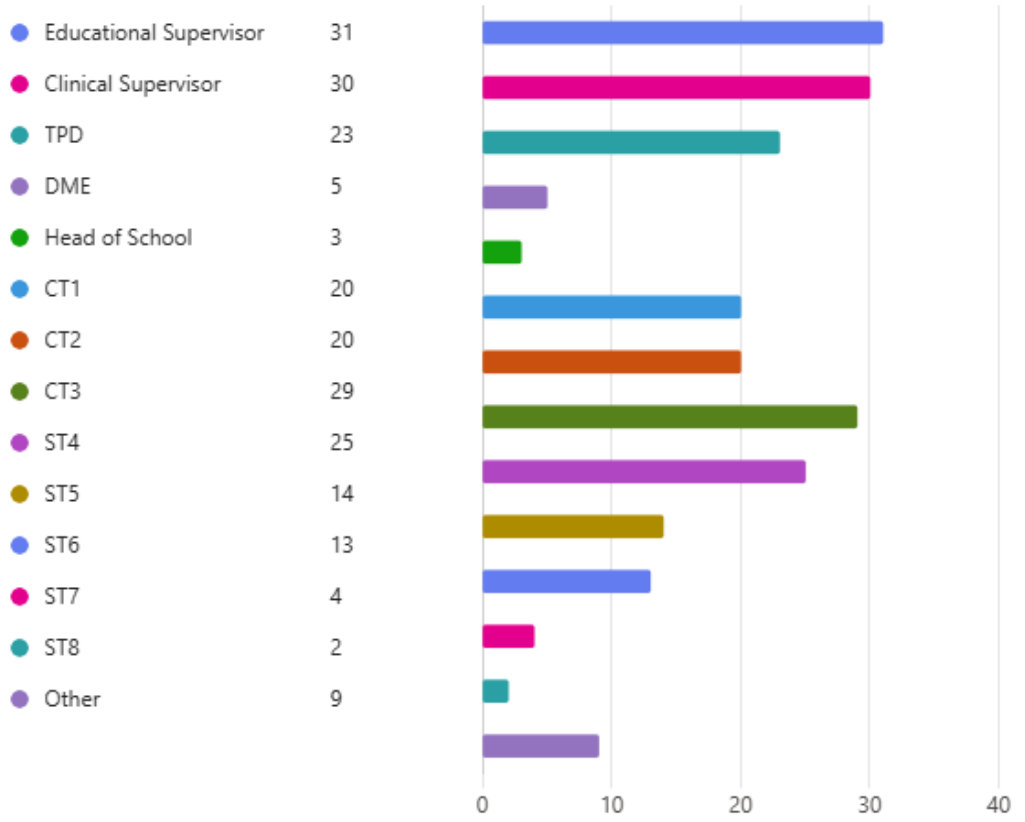
The 2026–27 training year will mark the implementation of the revised formative assessment framework, representing the next phase of curriculum enhancement. Future evaluation activity will therefore focus not only on the continued effectiveness of the curricula themselves, but also on the impact and usability of the new assessment arrangements. In parallel, the College has published an updated edition of the *Silver Guide*, reflecting learning from implementation, stakeholder feedback and subsequent curriculum developments. Regular review and updating of guidance will remain an important part of supporting residents, trainers and programme teams to navigate curriculum requirements consistently and effectively.

Overall, the survey presents a picture of a curriculum that is educationally robust, aligned with contemporary psychiatric practice and valued by many of those using it. While the response rate was lower than anticipated, despite extensive promotion across multiple stakeholder channels, the consistency of themes reported across residents, trainers and educational leaders provides useful insight into both the strengths of the curriculum and the challenges associated with its implementation. The findings demonstrate that successful curriculum delivery depends not only on curriculum design, but on sustained investment in supervision, trainer development and access to high-quality learning opportunities. The insights shared through this survey provide an important evidence base for future improvements and will help ensure that psychiatry training continues to evolve in response to the needs of learners, patients and the wider healthcare system.

Raw Data

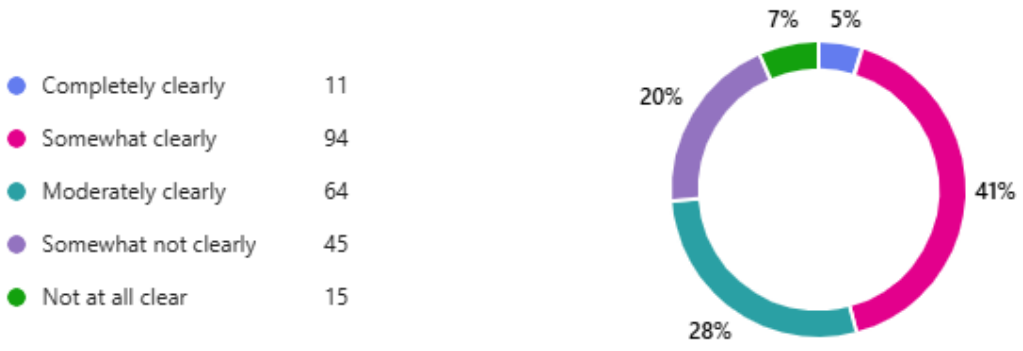
1. Please Select;

More details



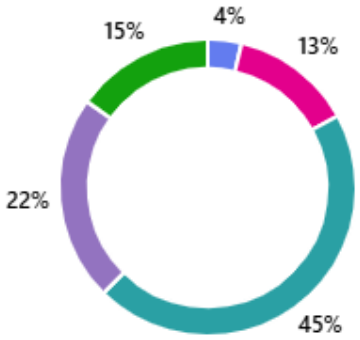
2. How clearly do resident doctors understand the higher learning outcomes (HLOs) in the 2022 curriculum?

More details



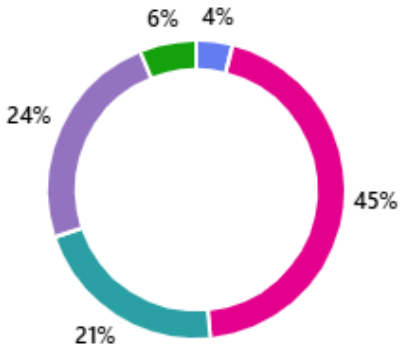
3. To what extent do trainers feel confident explaining the expected capabilities to resident doctors? More details

Completely confident	8
Very confident	29
Moderately confident	99
Slightly confident	49
Not confident at all	33



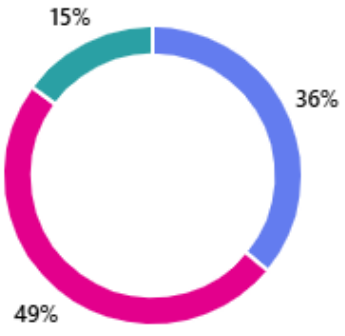
4. How effectively does the curriculum translate into day-to-day clinical practice? More details

Completely effectively	9
Somewhat effectively	102
Neither effectively nor ineffectively	49
Somewhat ineffectively	55
Completely ineffectively	14



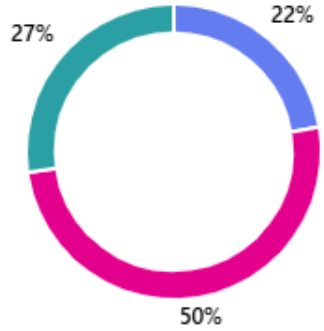
5. Are there competencies that are regularly addressed in training but difficult to achieve in real clinical settings? More details

Yes, definitely	82
Yes, somewhat	112
No, not really	34



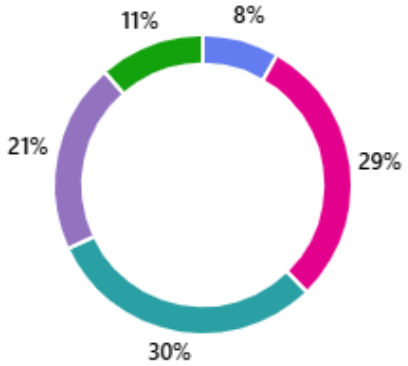
6. Are trainers able to provide high-quality, timely feedback within the current workl oad? More details

Yes, definitely	50
Yes, somewhat	113
No, not really	61



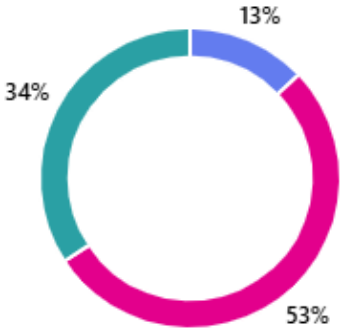
7. How well aligned are supervision sessions with curriculum requirements? More details

Fully aligned	19
Mostly aligned	67
Moderately aligned	69
Slightly aligned	47
Not aligned at all	26



8. Do supervisors feel adequately supported and trained in delivering supervision ali gned with the 2022 curriculum? More details

Yes, definitely	27
Yes, somewhat	111
No, not really	72



9. What barriers exist to achieving curriculum-compliant supervision?

147 Responses

ID ↑	Name	Responses
1	anonymous	-workload for both supervisor and trainee -expectations within service placed on supervisor and trainee -resource and staff shortages -fragmentation of services means less exposure and experience of different services for trainees
2	anonymous	Time and service pressures can make it challenging to consistently deliver structured, curriculum-aligned supervision.
3	anonymous	Trainers not fully aware of constantly changing portfolio and curriculum requirements. For example, in the supervision HLO, one of my supervisors was insistent it applied for supervision I would provide to medical students and does not not relate to my involvement in the supervision process with the supervsisor.
4	anonymous	workload
5	anonymous	time constraints and workload pressures Supervision is not supposed to be solely about competency and curriculum
6	anonymous	the competencies around research and management are outwith the experience of most supervisors. rather than ask a placement supervisor to to this, it would be more helpful and more consistent for each area to have one person sign these off for all. the same could be said for teaching too, though this is more embedded in everyday work
7	anonymous	Mainly clinical commitments preventing adequate time. Patient numbers have risen exponentially over the past 5 years.
8	anonymous	There are so many issues to discuss. It can be hard for the trainers to map everything onto the curriculum. We tend to leave this to the trainees to do.
9	anonymous	staffing issues and rotas
10	anonymous	Time constraints.
11	anonymous	Predominantly work load pressures, numbers of locum consultants in trust limiting supervisors
12	anonymous	Consultant workloads too high, Resident doctor expectations are mismatched and can be difficult to give feedback on improvement that isn't taken as criticism or results in complaints from resident doctors against a placement, some curriculum requirements are hard to match with reality of resources - eg availability of research supervisors, access to public health information, enabling residents to contribute to health promotion unless they are very proactive and willing to work beyond usual expectations. I think the Silver guide gives too much emphasis on how much the supervisor and training programme needs to provide, rather than highlighting the resident doctors need to see themselves as adult learners with responsibilities to step up and learn and demonstrate these skills in vivo rather than be "taught" it all and given all the required opportunities ready-made. It means that as new consultants they continue these expectations and it is not creating a workforce of empowered colleagues because the gap is too high. Perhaps it should make it clear that at ST6, residents need to take charge more of their own progress
13	anonymous	not at all

14	anonymous	Lack of opportunities to take up in terms of getting everything on the curricula covered leading to inefficient supervision sessions.
15	anonymous	Lack of knowledge by consultants on some areas of the curriculum, eg QI, health inequality, etc
16	anonymous	Mostly time pressures in the current climate of resource and financial challenges faced by NHS. Services are now a days 'Consultant delivered' which is a significant shift from 'Consultant led' as it used to be. Also, there has been an expansion of non-medical specialists within the MDT with heavy reliance on Consultants to provide support and supervision, at the expense of prioritising medical training.
17	anonymous	limited SPA sessions for supervision
18	anonymous	no good quality training and preparation. it was not well planned
19	anonymous	My supervisor is always busy.
20	anonymous	There is so much in the curriculum it tends to focus on what we are doing clinically now and can achieve at the moment in the case load.
21	anonymous	The basic fact is that it is difficult to supervise with a curriculum one has not used oneself. The aim of the HLOs seemed to be to reduce complexity, but the volume of key capabilities required has had the opposite effect and rendered it much less usable in practice than the old version.
22	anonymous	Knowing the up to date expectations of the HLOs etc, changes to assessments, changes to ARCP requirements and documentation which are not clearly disseminated or explained to the supervisors.
23	anonymous	time due to emergency or unplanned clinical commitments
24	anonymous	none
25	anonymous	clinical and managerial workload
26	anonymous	Time pressures - short-staffing, long waiting lists, prioritising risk management
27	anonymous	Time availability.
28	anonymous	too busy, supervisors who aren't interested, portfolio forms can be lengthy and laborious to fill in
29	anonymous	Consultants ringfencing the time required for dedicated clinical supervision of resident doctors
30	anonymous	Trusts do not protect the time required to do all the tasks of supervising. Mostly done in own time. Trainees expectations and need for support is greater. More LTFT trainees who need as much supervision but provide less service and are restricted in what days they are available.
31	anonymous	Workload
32	anonymous	Workload, practicalities of annual leave and days off due to on calls and lack of capacity to rearrange supervision missed for these reasons due to workload
33	anonymous	Knowing what the curriculum is, actually seeing one's trainee do their clinical job, and having time to discuss address clinical and professional development, rather than just complete online WPBA forms.

34	anonymous	Variable knowledge of supervisors of details of HLOs / curriculum. Size and extent of curriculum makes it difficult to cover details of this within 1 hour weekly supervision without excluding softer aspects of support and development
35	anonymous	time
36	anonymous	psychiatric supervision had never been about the curriculum and should not just be about the curriculum. It was meant to be a safe space to discuss progress, pastoral issues, on call issues and feedback, ARCP planning. "curriculum compliant supervision" sounds awful
37	anonymous	Lack of awareness Individual learning barriers
38	anonymous	Supervisor working Less than full time
39	anonymous	Some degree of vagueness in the curriculum. WPBA forms do not necessarily evaluate what has been assessed.
40	anonymous	Very odd HLO causing difficulties to achieve in clinical / practice. Being more specific / offering guidance on how to achieve each would be essential than keeping it non-specified.
41	anonymous	Time to deliver this at relevant points with trainers often supervising multiple trainees
42	anonymous	protected weekly supervision time.
43	anonymous	curriculum is too wide based, lack of specific outcomes, often looks too prescriptive
44	anonymous	As a working consultant reading the curriculum documents and integrating them into a day to day approach is difficult to achieve beyond completing WPBAs
45	anonymous	I find it challenging to manufacture opportunities to demonstrate leadership competencies and safeguarding vulnerable groups consistently (HLO 5 & 7)
46	anonymous	Supervisor not given enough time to supervise multiple trainees.
47	anonymous	I honestly don't know what non-compliant supervision would look like. Is that not doing supervision? Not covering all the KCs? Actively encouraging trainees to do the opposite of KCs? I have put in the above answers that my supervision is mostly aligned to the curriculum because it is in line with KCs, but I certainly don't keep a tick-list of all the KCs to see which ones we haven't covered yet.
48	anonymous	Trainees have no protected time to spend with their supervisors seeing patients together. Trainees don't really learn how to speak with patients, how to manage difficult symptoms and presentations, how to identify clinical signs such as thought disorder or insight or confabulation. These are learnt through theory and studying for exams but not really through real life experience where a senior would be able to point these out and discuss with trainees.
49	anonymous	Curriculum requirements changed without considering day to day experience, WPBA changed with little relevance to regular work, No training provided
50	anonymous	Time

51	anonymous	The curriculum is very long, is difficult to predict what the RD will be exposed to and each placement will focus more often in supervision on clinical aspects to develop for that particular placement.
52	anonymous	The curriculum as expressed in the HLOs can come across as quite abstract and different from clinical practice. As an example, in completing the Likert scale of feedback for a very meaningful WPBA, I can find myself ticking only a few boxes that are relevant and putting 'unable to comment' for the vast majority. This seems a shame particularly where the trainee has performed very well or this has been a significant learning experience.
53	anonymous	Some are very aspirational e.g. sustainability.
54	anonymous	Time constraints
55	anonymous	Heavy clinical workload making it difficult to dedicate enough time to supervision.
56	anonymous	Time to both meet and also review up to date requirements, and be up to date with a regularly changing portfolio.
57	anonymous	Lack of understanding of the current curriculum Use of supervision time to discuss clinical cases and planning
58	anonymous	Other things to talk about - pastoral issues for example,
59	anonymous	Awareness. Time.
60	anonymous	Time, sustantive staffing and trainees working shifts meaning they are often absent.
61	anonymous	Supervision appears mostly to happen effectively and with feedback from trainees and supervisors mostly positive; time is normally well protected and is job-planned. Training opportunities with regard to effective supervision practice are widely available both via the deanery on region-wide basis and via in-house LEP CPD programmes. Barriers to accessing these are pressures on time due to clinical service need. Financial pressures across all LEPs/services along with staffing vacancies can reduce ability of trainers to avail themselves of developmental opportunities at times. Support available from TPDs has been inevitably diluted due to expansion in recent years in some programmes by up to 50% without any funding to increase TPD time for programme delivery.
62	anonymous	The way the curriculum is laid out currently, there are certain HLOs that do not lend themselves to being achieved or assessed in day to day practice. Some thought needs to be given to combining some of the HLOs, for e.g. academic/scholarly to cover research, teaching/training and Health promotion could be combined with patient safety and safeguarding. The separation of these into separate HLOs does not make sense.
63	anonymous	Familiarity with the curriculum
64	anonymous	Time to understand how to do this. The need for better understanding of the curriculum and what is expected to be covered by who and at what stage of training.
65	anonymous	Very high workload burden

66	anonymous	Clinical workload is phenomenally high for supervisors who are truly struggling with this. There needs to be more ownership and structure/organisation also coming from the trainees themselves in terms of more assertive awareness of the competencies they need to fulfil so they can help influence the productivity of each supervision session.
67	anonymous	Depending on placement. Usually inpatient services are more stretched and there is a greater demand/work-load. As a result, supervision can be delayed, or missed.
68	anonymous	Trainees and trainers tend not to base supervision around the curriculum. Training remains overall quite organic and supervision mostly covers what comes up in the clinical service. The majority of the time this allows coverage of the curriculum but it is not the curriculum that is driving training.
69	anonymous	Time pressures re: clinical work.
70	anonymous	Although the curriculum covers the higher-order learning skills and competencies for trainees, the large number of key capabilities, however, unintentionally makes it a tick-box exercise for the trainee as well as the trainer.
71	anonymous	high clinical workloads
72	anonymous	The curriculum is cumbersome and does not appear clinically relevant to many "jobbing psychiatrists." There is limited guidance on standardisation across training guides, and many supervisors are unsure how to judge adequacy, or in what contexts.
73	anonymous	None
81	anonymous	Time. Lack of understanding. Complicated portfolio website - very difficult to understand the current PSPDP structures etc on the portfolio.
82	anonymous	All supervisors complain about the PSPDP and how long and unwieldy it is.
83	anonymous	Time constraints. Heavy workload
84	anonymous	Supervisors' awareness of trainee requirements
85	anonymous	Large number of clinical supervisors, staff turnover, limited interest, capacity and awareness for taking on new information, other issues to manage, e.g. doctors in difficulty
86	anonymous	The curriculum has a lot of unnecessary points in it that don't test the capability or development of us a holistic psychiatrist and there is a lot of repetition. Some also don't seem relevant or needed as mandatory requirements. The curriculum should be something that can be attained regardless of where you train in the country
87	anonymous	Supervisors awareness of the curriculum...and potentially the unneccessary length of the curriculum.
88	anonymous	Locality variation
89	anonymous	Trainers are often not up to date with curriculum requirements, therefore they are not aware what is needed.
90	anonymous	Supervisor familiarity with the current curriculum
91	anonymous	Applicability to certain rotations

92	anonymous	There is no fixed day/time for supervision - so it often gets pushed back to later in the week, then if its a busy day for the team it doesnt happen. I'd say I have roughly 1 supervision per month.
93	anonymous	The sheer volume of higher learning objectives. When I did core training from 2020-2023, I had 43 learning objectives to match to, and almost all of them were relevant. I now have more than double, and many are duplicates, and some are niche to the point where it is not relevant to clinical practice (sustainability is a ridiculous HLO). Supervisors are not able to be aware of being fully curriculum compliant because there are too many individual HLOs to do so.
94	anonymous	More specific clinical goals rather than broad descriptions that are difficult to translate on the clinical aspect
95	anonymous	The HLOs are so wordy and extensive it is difficult to access what they are trying to achieve. Day to day work doesn't fit neatly in boxes and it feels like a tickbox practice. While I still map my WBPAs to the curriculum most other trainees I know don't do this and pass their ArCP , which just makes them feel pointless
96	anonymous	Some supervisors don't do supervision and they just make sure you're okay and that's it
97	anonymous	Need for clinical discussion, lack of expected structure
98	anonymous	Infrequent supervisions, mainly discussing service provision and logistics eg leave etc
99	anonymous	Time and opportunities
100	anonymous	some trainees struggle to use supervision for their actual learning, rather using it as a space to vent/waste time curriculum is not always relevant to every job - some jobs are more for development in general than curriculum focussed
101	anonymous	Clinical workload, reluctance from trainer/difficulty arranging regular sessions
102	anonymous	The supervisor's knowledge of the curriculum.
103	anonymous	The curriculum contains more than 100 items and seems to empasise quantity rather than depth. Some items actually contain multiple points within them
104	anonymous	The curriculum needs to be relevant to clinical practice; where there are competencies that aren't achievable in real settings this can often be an exercise in finding ways to achieve competencies 'on paper' just for the sake of trainee progression
105	anonymous	I feel like a lot of the requirements of the curriculum are vague and non clinical so this does not easily translate in supervision unless both trainer and trainee are really familiar with HLOs
106	anonymous	Work load
107	anonymous	Workload
108	anonymous	The curricula are completely divorced from clinical work so we end up needing to do two things in parallel: work on the curriculum and work on developing clinical skills.

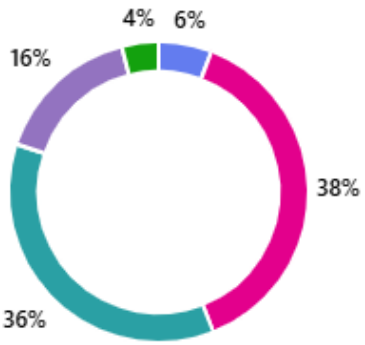
109	anonymous	It isn't clear what compliance with the curriculum would mean.
110	anonymous	the rota
111	anonymous	Lack of understanding of the the curriculum due too complicated
112	anonymous	None
113	anonymous	there feels like a lack of training for both the trainees and trainers
114	anonymous	NA
115	anonymous	Many objectives do not naturally translate into clinical discussion or teaching opportunities in supervision sessions. Significant variation in how supervision is delivered by different supervisors
116	anonymous	Workload! Almost never enough time for weekly supervision
117	anonymous	In my experience supervisors do not seem to know the HLOs, and do not discuss them.
118	anonymous	I am not a trainer. There needs to be a facility in this questionnaire to input n/a to some answers! There is a degree of lip-service paid to the curriculum. There are lots of rather vague and aspirational elements. "lead a service"??? sustainability etc... The curriculum feels divorced from my training.
119	anonymous	Availability of suitable psychotherapy experience within subspecialty settings. Lack of clarity around expectations and processes for dual-trainees
120	anonymous	N/A
121	anonymous	No clarity in how to make it relevant to placements within current work load
122	anonymous	Time constraints, lack of knowledge of curriculum
123	anonymous	Time Supervisors not knowing the curriculum well
124	anonymous	I was not aware there were guidelines for supervision regarding curriculum.
125	anonymous	Ensuring all key curriculum areas are covered over the span of training. Difficult to judge in a single 6 month placement.
126	anonymous	Time, trainee interest, curriculum does not match real world requirements
127	anonymous	Too much emphasis on portfolio requirements. Distracts trainees from pursuing and follow up clinical presentations to required extent.
128	anonymous	Vagueness of curriculum
129	anonymous	Service demands
130	anonymous	Time
131	anonymous	Ward based job, frequent interruption with telephone calls and staff visiting
132	anonymous	High clinical workload, staffing issues and busy supervisors, hectic schedules
133	anonymous	Residents working outside the core team (e.g. on call), co-ordinating supervised assessments within clinic schedules

134	anonymous	supervision is adhoc and minimal
135	anonymous	Clinical work, ongoing on calls, and other responsibilities.
136	anonymous	I usually find supervision is never focussed on curriculum HLOs, it is very focussed on how I am managing my caseload and clinical issues that have arisen over the week that do not translate to curriculum outcomes. The focus of each job is usually managing the ever increasing workload and finding time to organise study leave etc in between, there is no capacity that supervisors have for discussing the curriculum in supervision and I have found supervisors have little to no knowledge of the curriculum itself and rely on the trainee to explain it to them. Many of the HLO points also overlap or are often covered by the same complex cases we discuss in supervision however we can only map WBPAs to 3 HLOs as per our TPD.
137	anonymous	Supervisors think there is an "out-of-hours" competency in the CAP Curriculum 2022. The curriculum only mentions "emergency" competencies and does not specify out-of-hours or in-hours timings to meet these. Supervisors also follow the Silver Guide like it is Gospel when it says "indicative" numbers of shifts. This results in discriminatory practices from training programmes and TPDs against trainees who cannot work out-of-hours due to disability.
138	anonymous	Format of e-portfolio. PDPs and curriculum coverage feel harder to gauge in current portfolio set up. Would selecting HLOs to assess against for WBPAs help link this. Consider what are key HLOs for each services/placements.
139	anonymous	never had training
140	anonymous	some of these. I've never had a supervision session that has used them, I think because it's too impenetrable and verbose. I feel like it could be chunked differently and the descriptions made much sharper, then it would be easier to go through and use it for e.g. supervision.
141	anonymous	time, structure of sessions being clear and, to a degree, standardised across the deanery. understanding what gaps remain present between MRCPscych course training, mandatory training experiences etc
142	anonymous	It's difficult to know what depth of reflection on a topic 'counts' as the resident achieving competency in that domain. I usually err on the side of making the supervisions lead by the resident and the agenda that they would like to bring, I wonder if this means that we don't cover things that I 'should'?
143	anonymous	N/A
144	anonymous	Curriculum is too broad

145	anonymous	Variable expertise and support from trainers - I've had a few trainers/clinical supervisors which are knowledgeable about the HLOs and curriculum, and can help identify opportunities for WBPAs based on the various HLOs. More often than not, most clinical supervisors do not have the time to be knowledgeable about the CT curriculum and this is something which the trainee has to learn themselves and suggest which assessments to complete to the trainer themselves. The issue with this, is that as a CT trainee, you often don't have feedback or others you can speak to ensure you are doing this correctly. We often speak amongst each other informally for this but the advice given can be variable. Throughout my core trainee years, I have had a clinical supervisor in my later post be quite knowledgeable about this and was able explain in more detail the rationale and template for completing WBPAs and linking these to the HLOs. In essence barriers include: - time for the trainer (& trainee) to learn about the curriculum - people for both the trainer or trainee to turn to when facing questions about the curriculum
146	anonymous	HLos are unecessarily long and very removed from clinical practice
147	anonymous	Regular supervision by an experienced trainer has the potential to cover many important aspects of the curriculum, in some areas this will be more or less in-depth. There can be difficulties identifying suitable learning experiences in some areas.

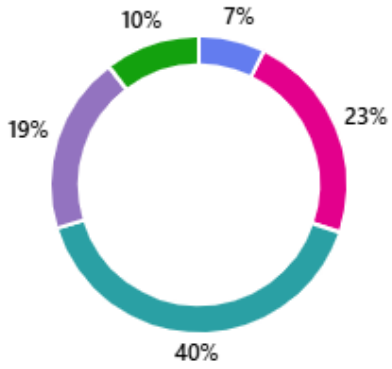
10. How well does the curriculum prepare resident doctors for each stage of ARCP progression? More details

Fully prepared	13
Mostly prepared	87
Moderately prepared	82
Slightly prepared	36
Not prepared at all	9



11. To what degree does the curriculum support equitable progression for resident doctors from diverse backgrounds? More details

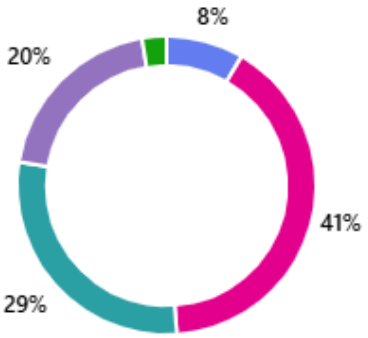
Fully supportive of equitable progression	16
Very supportive	51
Moderately supportive	89
Slightly supportive	43
Not at all supportive of equitable progression	23



12. How effectively does the curriculum support resident doctors in developing the s kills required for safe clinical decision-making?

More details

Extremely effectively	19
Somewhat effectively	92
Moderately effectively	65
Somewhat ineffectively	45
Extremely ineffectively	6



13. Are there elements of the curriculum that have directly improved patient care or safety?

110 Responses

ID ↑	Name	Responses
1	anonymous	space to discuss difficult cases or go over trust policies and regulations
2	anonymous	Yes—structured supervision, reflective practice, and workplace-based assessments have positively enhanced patient care and safety.
3	anonymous	HLOs concerning Clinical skills, safeguarding and communication have been helpful for me in determining my priorities in patient care
4	anonymous	not sure
5	anonymous	Resident doctors should be encouraged to take decisions and be more independent / proactive in their clinical interactions with patients.
6	anonymous	no
7	anonymous	Can't think of any
8	anonymous	i think the patient feedback change will be very positive
9	anonymous	Teamworking and leaderhsip skills required are helpful, although residents don't seem to focus on developing this themselves as much as seem to want to be "given" opportunities rather than realising onus is on them to develop themselves with support and guidance
10	anonymous	Most of the elements of curriculum improve patient care and safety
11	anonymous	N/A

12	anonymous	not sure
13	anonymous	yes certainly
14	anonymous	not really
15	anonymous	Yes
16	anonymous	HLOs with specific clinical works and with the MDT
17	anonymous	I can't think of any.
18	anonymous	Assessment and management of clinical scenarios and risk, clinical governance
19	anonymous	psychopathology and risk assessments
20	anonymous	all
21	anonymous	LOs of curriculum are broad and comprehensive, with themes relating to reflective practice and governance running throughout.
22	anonymous	No
23	anonymous	no
24	anonymous	Perhaps
25	anonymous	I'm unaware of any
26	anonymous	Addictions requirements within core curriculum
27	anonymous	none come to mind
28	anonymous	Yes
29	anonymous	Patient safety and quality improvement objective means trainees will complete projects, many of which result in service improvement and improved patient care.
30	anonymous	Definitely yes
31	anonymous	There are, but remains limited to be offered in real due to shortage of clinical courses.
32	anonymous	not sure
33	anonymous	Quite a few, important to distinguish the core Vs Higher trainee GPCs
34	anonymous	Not really
35	anonymous	None in my experience
36	anonymous	No
37	anonymous	Not sure, I find the silver guide and the ARCP preparation checklist most helpful than the curriculum per se
38	anonymous	No. One could have an excellent understanding of the curriculum demonstrated in discussion or one's portfolio but be a middling or poor practitioner.

39	anonymous	I dont know.
40	anonymous	Yes. Several elements of the curriculum have directly and meaningfully improved patient care and safety in my day-to-day practice. Yes. Curriculum elements including trauma-informed assessment, structured risk assessment, and neurodevelopmental psychiatry have directly improved patient care and safety by reducing misdiagnosis, supporting safer risk management, improving MDT communication, and enabling more accurate formulation and treatment planning
41	anonymous	Uncertain
42	anonymous	CBDs / ACEs
43	anonymous	This is a weirdly worded question.... I'm not certain what its asking... the clinical and QI/Audit work as part of (or in order to evidence the curriculum) have improved patient care and safety.
44	anonymous	yes
45	anonymous	NO
46	anonymous	.
47	anonymous	Supervision
48	anonymous	Case Based Discussions and ACE/Mini ACE assessments are clinically focused and do improve clinical practice of trainees, from my observation.
49	anonymous	The audit/QI work that is expected of us.
50	anonymous	Helps to have clear safeguarding requirements
51	anonymous	I do not think that the current curriculum has directly led to any improvement in patient care or safety. It lays out some of the core clinical skills, but it remains very placement-specific if the trainee can get opportunities to achieve those key capabilities.
52	anonymous	No
53	anonymous	No
54	anonymous	Seeking regular and immediate feedback with a mindset to improve is helpful learning skill
55	anonymous	Exams, particularly CASC
56	anonymous	Audit/QIP cycle
57	anonymous	None, everything is a tick box exercise
58	anonymous	The key issue is to align the curriculum to the realities of clinical practice, which is not the case at present. There are elements that are missing or too limited in the curriculum which if enhanced I think would improve patient care: that is in relation to deeper understanding of the causes of mental disorder. At present this seems a superficial focus on bio-psycho-social risk factors. Curriculum should cover knowledge of evolutionary science and how that can be applied to psychiatry - this is totally missing at present and.
59	anonymous	-

60	anonymous	I have not encountered this personally as a direct effect.
61	anonymous	The clinical elements I think are for the purpose of improving patient care.
62	anonymous	Yes. Reflective practice, case log and WPBAs and Mini PATs
63	anonymous	Mostly the supervised learning events
64	anonymous	Not really, it's just several checklist tabs rather than few meaningful competencies, it's quantity over quality
65	anonymous	Not that I'm aware
66	anonymous	Don't think so
67	anonymous	They are generally good patient care guidelines.
68	anonymous	Things related to clinical skills, patient safety, teamwork/leadership, legal frameworks
69	anonymous	Yes. QIPs and audits
70	anonymous	No
71	anonymous	No. Every curriculum will have clinical learning, patient safety and quality improvement objectives that improve patient safety. Any change or revamp simply rebrands the content without meaningful improvement
72	anonymous	No
73	anonymous	Having a specific section for risk assessments
74	anonymous	N/A
75	anonymous	Aspects related to medication management and psychotherapy delivery, and efficient teamwork
76	anonymous	Nope
77	anonymous	I think there are several redundant items in the curriculum. Some items are impossible to evidence
78	anonymous	No, if anything I feel like if trainees focused more on the curriculum they would become more unsafe as there is so much focus on non clinical bits
79	anonymous	mini-ace's area easy to deliver and allow for directly supervised practise. If one ACE = 2 x mini-ACE then total assessment burden could be reconfigured for more frequent supervised learning events.
80	anonymous	HLO 2,3
81	anonymous	None at all
82	anonymous	Unsure how to answer this question.
83	anonymous	Not sure
84	anonymous	Not really

85	anonymous	NA
86	anonymous	Unsure
87	anonymous	This would imply my patient encounters are curriculum led?
88	anonymous	-
89	anonymous	Yes
90	anonymous	QI needs
91	anonymous	patient safety/quality improvement
92	anonymous	Not really
93	anonymous	Quality improvement principles
94	anonymous	Yes, mainly regarding leadership, team working, attitudes expected from medics
95	anonymous	May be safeguarding
96	anonymous	no
97	anonymous	Somewhat
98	anonymous	Reflective practice, HLO5
99	anonymous	communication reflective practice
100	anonymous	Yes there are, but it is difficult to understand which activities are required to be consider enough for such safety HLO.
101	anonymous	Yes beyond the specific patient safety HLO I feel that all HLOs have a focus on safe practice and I think HLO 4.1 is the most important example of that which directly improves patient care.
102	anonymous	Addictions focus helping build confidence in dual diagnosis.
103	anonymous	only if trainees are actually learning about how to improve patient care or safety, just having this huge verbose list makes it an abstract task
104	anonymous	Unsure
105	anonymous	?
106	anonymous	I think residents could do with more time working under direct supervision of trainers in their CT1 years. I also think that residents need to simply see as many cases as possible. There seems to be more and more pulls on their times to do other things which can impair the amount of core clinical time that they get assessing and managing patients.

	107	anonymous	The need to get some competencies like ECT and addiction.
	108	anonymous	N/A
	109	anonymous	Mandatory reflections
	110	anonymous	Emphasis on advanced communication skills, comprehensive assessment/formulation, clinical judgement, professionalism, managing uncertainty, team working are all important areas, as are clinical governance and legal frameworks.

14. What additional EDI learning experiences would improve the curriculum?

99 Responses

ID ↑	Name	Responses
1	anonymous	nil, stop pushing EDI onto us when we already have a busy schedule. college should focus on tackling more pressing issues.
2	anonymous	More interactive, case-based EDI training and lived-experience input would further strengthen the curriculum and its impact on clinical practice.
3	anonymous	not sure
4	anonymous	More emphasis on seeing real life patients / doing clinics / making decisions. At present it feels that the balance between protected learning time and resident doctors actually putting that into practice seeing patients is weighted far too heavily towards abstract learning to the detriment of clinical experience.
5	anonymous	not sure
6	anonymous	Special attention needs to be paid to sexuality and gender identity issues and race and ethnicity
7	anonymous	This is over focussed and more time should be allocated to the basics of being a good doctor and a good psychiatrist, the more it is pushed the more it becomes a tick boxing exercise that is ignored by trainees
8	anonymous	what is EDI ?
9	anonymous	Better exposure and training for research and audit.
10	anonymous	not sure

11	anonymous	I am not a fan of EDI initiatives as it risks impacting quality assurance and may bring down standards
12	anonymous	seminars / workshops training for trainees and clinical supervisors
13	anonymous	Mandatory clinical attachments with the clinical supervisor to observe certain assessments like capacity, legal aspects in older adults, Sec 117 meeting involving older adults.
14	anonymous	
15	anonymous	I really don't know what this question means or what problem it is trying to addresss. I haven't had a single white male trainee in 3 years. My clinical director, AMD, deputy MD and MD are all South Asian or British-South Asian, as are the majority of the trainees in our trust. If the college has a diversity problem, my anecdotal experience would strongly suggest it is definitely not an over-representation - or preferential treatment - of white men.
16	anonymous	Understanding of working with colleagues/patients who have hidden disabilities or require reasonable adjustments. Explanation to residents of the possibility of LTFT careers and practical advice as to how this works.
17	anonymous	none
18	anonymous	Nil specific
19	anonymous	more understanding around those with developmental background or with learning difficulties
20	anonymous	Not sure
21	anonymous	The problem is the training rota and availability/presence of the resident more than the curriculum
22	anonymous	learning about neurodiversity in medics, discussing how sexual harassment at work is inappropriate
23	anonymous	Not sure
24	anonymous	Consideration for support from EDI guidance.
25	anonymous	not sure
26	anonymous	Engagement with the EDI team in the trust with a leoject
27	anonymous	The differences in population across different areas of the UK means that trainees will inevitably have different exposure to working with varied populations. This means that in trainee's clinical practice there will naturally be uneven learning about the needs of different groups, and that when the trainee moves to a permanent position they may find the local population composition quite different. Therefore, provision of some baseline resources to 'top up' the understanding of different groups would be good. I wouldn't suggest these would be mandatory - that would end up with, for example, trainees who had themselves come to the UK as refugees having to do modules on understanding the refugee experience, or trans trainees having to go through modules on supporting trans patients - but available to ensure equity of learning experience. I would also deem it essential that any such learning resources are strongly based in lived experience.

28	anonymous	Assessing/reviewing patients together with senior clinicians, ideally consultants.
29	anonymous	Recognition of actual clinical skills
30	anonymous	More freetext
31	anonymous	I think it would be important to get include some contact with other community services in training. Activities involving local or national public health teams, councils, schools (for CAMHS), probation, drug and alcohol services (where no addiction psychiatry provision exists), third sector organisations as charities would be quite good to widen our knowledge of what happens in civil society, outside our services.
32	anonymous	For IMG trainees - support with and teaching early on in the program with understanding of the English language, semantics, and unspoken communication / body language. Which would be beneficial in the introductory stages and would hopefully help with differential attainment in the CASC examinations down the road. This is something I regularly support my trainees with, for patient interactions and understanding patient phenomenology.
33	anonymous	I dont know.
34	anonymous	Case-based EDI teaching using real clinical scenarios (e.g. race, culture, migration status, disability, neurodiversity, sexuality, gender identity) to demonstrate how inequities affect diagnosis, risk assessment, safeguarding and treatment decisions.
35	anonymous	Attending a local meeting or resource already organised by their Trust to improve access to local communities.
36	anonymous	Access to training courses around this - reliance on reflection to evidence these competencies at this time
37	anonymous	I work in a very white area of the country.... while clearly EDI issues are very important..... adding additional EDI experiences to the curriculum probably wouldn't add much extra to what is already delivered and would be hard for trainees to achieve evidence of here. Perhaps the college could offer some simulation based EDI training virtually to meet the needs of trainees in this area who don't work in areas with much ethnic diversity?
38	anonymous	enhanced edi training
39	anonymous	More psychotherapy teaching - we are expected to undertake long and short psychotherapy cases often with very little background knowledge on psychotherapy.
40	anonymous	EDI is not the answer to improve the curriculum. To drive up the quality of education, clearer clinical and professional requirements that can be evidenced in a reliable manner is required. Also, the current forms for WPBAs which list all the HLOs are very difficult to use. There should be an option to choose any two or three HLOs to assess for every WPBA.
41	anonymous	.

42	anonymous	I do not feel the virtual case presentations and journal clubs offer enough richness and peer engagement nor do they allow the trainee presenting enough of a learning opportunity. There was more learning and confidence/ leadership skill gleaned from needing to present live in person and there was also a richness to the active involvement of peers. We may need to rethink the modality/ way we accept case presentations and Journal Clubs to be hosted post-covid. I think there needs to be more requirement for core trainees to demonstrate studying of official material such as Maudsley prescribing guidelines, ICD11, DSM etc and then being able to apply the knowledge. I am not observing that the majority of trainees are successfully doing this. Perhaps we need to explicitly specify that these principles are demonstrated to be included within case presentations and Journal Clubs.
43	anonymous	Unsure
44	anonymous	Removing sustainability
45	anonymous	Reflection on cases that were managed well, learning from excellence and sharing
46	anonymous	NA
47	anonymous	Protected time to shadow/collaborate other professionals within mental health to understand their role.
48	anonymous	Something that actually matters clinically in psychiatry
49	anonymous	nothing to add here
50	anonymous	-
51	anonymous	Not sure.
52	anonymous	I can't see how additional EDI learning experiences would improve the curriculum
53	anonymous	There is vastly too much focus on EDI that risks alienating doctors, healthcare professionals and patients. Excessive focus and attention is given to "group identity". Instead of focussing on clinical excellence and evidence-based care, resources are allocated to promoting radical political ideology within the College.
54	anonymous	Not sure what this refers to - "EDI" for patients or doctors?
55	anonymous	The ones implemented are useless. Making them separate tabs in itself feels discriminatory. Rather make meaningful clinical competences than it just being a checklist
56	anonymous	Incorporating specific skills such as letter writing to other specialties for advice, tribunal reports, formulation meeting notes, etc.
57	anonymous	Rebuild
58	anonymous	None. The curriculum is too complex and convoluted as is.
59	anonymous	Intersectionality training
60	anonymous	There is probably too much focus on EDI at present as this is often the main focus - and learning how to actually be a good doctor is a lesser priority.

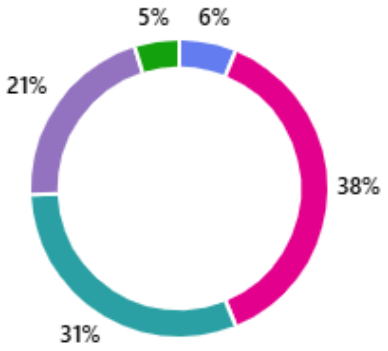
61	anonymous	There are EDI HLOs within the curriculum and it is embedded in pieces of teaching (such as our local leadership and training trainer days)
62	anonymous	I don't know what this is
63	anonymous	N/A
64	anonymous	Addressing poor correlation between exams and real-world clinical experience, and avoiding tick-boxy practices that don't actually improve understanding of or participation in QIP/research
65	anonymous	Actual opportunities and funding to get involved in research. More teaching opportunities.
66	anonymous	na
67	anonymous	Not sure
68	anonymous	transgender medicine is frequently in the media but not explicitly addresesed in curriculum. putting this in could allow for training on Thursdays which specifiaccly addresses the issues. n It has been brought up at congress a few times.
69	anonymous	Opportunities to do an extended diploma relevant to the subspecialty
70	anonymous	The curriculum itself is not an EDI issue. Differential attainment in exams and career progression is a bigger issue
71	anonymous	Perhaps encouraging individuals to share their own life stories? Rather than a didactic, paternalistic approach.
72	anonymous	Not sure. There are already mandatory training and clinical encounter with patients with diverse backgrounds.
73	anonymous	are there any?
74	anonymous	Unsure
75	anonymous	I don't know.
76	anonymous	-
77	anonymous	It should not be performative. It should be based on the natural approach towards daily team working/ clinical working
78	anonymous	More teaching sessions
79	anonymous	Not really
80	anonymous	More training on faith and spirituality-based approaches to mental health
81	anonymous	Expanded experience of working with people with a learning disability, and increase focus on the particular physical and mental health needs of this population. Improved understanding of communication needs and ways to support communication.
82	anonymous	Gender, sexuality topics
83	anonymous	Emphasis on formulation need to be enhanced.

84	anonymous	nil
85	anonymous	Enhancing EDI in the RCPsych curriculum requires bridging structural competencies with clinical psychopathology and phenomenology to understand how social adversity alters the subjective experience of distress. This integration moves beyond basic cultural competence, training clinicians to distinguish culturally normative expressions from formal psychopathology during assessments. Trainees examine how systemic racism, migration trauma, and minority stress shape a patient's inner world, symptom presentation, and personal model of illness. By embedding these inclusive learning experiences, psychiatrists can conduct highly nuanced phenomenological assessments, mitigate the risk of diagnostic overshadowing, and deliver tailored, trauma-informed care.
86	anonymous	Not sure
87	anonymous	time management
88	anonymous	nil
89	anonymous	If sessions were delivered in RAP/LAP focussed solely on EDI, experiences of patients and practitioners that have EDI characteristics. This could be the focus of a case presentation or journal club if it was added to the teaching programme.
90	anonymous	Align the Silver Guide with the curriculum
91	anonymous	Simulation experiences for difficult patient encounters to improve history taking.
92	anonymous	don't know
93	anonymous	Unsure
94	anonymous	?
95	anonymous	Assessment of skills like full psychiatric history taking and MSE like in long cases of the past.
96	anonymous	N/A
97	anonymous	Mandatory reflections
98	anonymous	You need to speak to IMGs directly to understand this, I am not
99	anonymous	Patient and carer forums, exposure to relevant working groups and forums within organisations, systemic/narrative therapy perspectives on contextual factors such as culture. Ensure breadth of training placements within a rotation including in more urban/culturally diverse settings.

15. How effectively does the curriculum prepare resident doctors for the expectation s at the next stage of training?

More details

Extremely effectively	14
Somewhat effectively	85
Moderately effectively	69
Somewhat ineffectively	47
Extremely ineffectively	11



16. Are there competencies or expectations in the new curriculum that resident doctors struggle to achieve at transition points?

121 Responses

ID ↑	Name	Responses
1	anonymous	psychotherapy case completion - RCPsych should change expectations, remove arbitrary number of 20 sessions and change to significant number which trainee can reflect and discuss case effectively and supervisor happy with them.
2	anonymous	Some competencies at transition points can be challenging, but clearer guidance and structured support can help trainees achieve them more consistently.
3	anonymous	Psychotheraoy competencies remain a difficulty for trainees overall
4	anonymous	no most residents under stand the requirement and educators and support to reach them
5	anonymous	Time keeping, confidence in decision making / emergency management.
6	anonymous	no
7	anonymous	Some trainees struggle with achieving competencies which are less well defined such as sustainability. Other issue is some trainees struggle with independent working.
8	anonymous	I have major concerns over the level of crisis experience and acute management that trainees see. they are excessively risk adverse and in experienced and it is impacting new ST4s doing S12 work and new consultants lack the grounding that would historically be expected.
9	anonymous	As above - leadership, management, teaching - current cohorts seem to want to be given opportunities and the curriculum and silver guide puts too much onus on what supervisors need to so. Same with QI - they want a project suggested, etc and lose interest as soon as they can tick a box. WOuld be better to suggest they see through a project for longer rather than new QI or audit every year
10	anonymous	no
11	anonymous	Yes. Audits and research etc
12	anonymous	QI
13	anonymous	psychotherapy and research competencies mainly as this is dependent on host trust having invested in these services.
14	anonymous	Not applicable
15	anonymous	Changes to the HLOs concerning psychotherapy competencies as it has been an emerging difficulty for most residents to achieve these in a timely manner. The current curriculum also has grounds for varying competencies to meet criteria that while helpful in circumstances translates to variations in training that somewhat defeats the purpose of a standardised national curriculum. Specifications for each HLO would be helpful for residents to understand what they are being scored against and also help in building their portfolio for career progression

16	anonymous	Safeguarding competencies - reporting and contributing to safeguarding concerns is difficult as this is mostly not medic led. Opportunities for meaningful participation in research remain very difficult to come by Psychotherapy training opportunities are also very limited and the most common reason for failure to progress, but the curriculum has neither helped nor hindered this.
17	anonymous	Some of the harder to evidence HLOs which can usually only be achieved by end of Higher Training
18	anonymous	none
19	anonymous	I work in a holistic remote and rural service and we can provide a wider range of experiences and competencies, except for inpatient care. I know some other areas struggle with infant/perinatal (CAMHS training)
20	anonymous	Psychotherapy, Research, QI
21	anonymous	new technologies and sustainability
22	anonymous	None that I am aware of
23	anonymous	Addictions CBDs and ECT DOPS
24	anonymous	exam progression
25	anonymous	sustainability
26	anonymous	Yes
27	anonymous	yes- research competencies
28	anonymous	Yes research requirements beyond Journal club.
29	anonymous	There are many including QIP and Research could be potentially hardest to achieve.
30	anonymous	psychotherapy competancies
31	anonymous	This question needs to be narrowed down, depending on curriculum- Some TPDs are known to recommend/ interpret silver guide differently causing significant unavoidable burden on STs and sometimes making the system sound like too prescriptive and causing barriers to skill development at their own pace. Psychotherapy competencies in CAMHS curriculum in some regions is problematic as interpretation of recommended modalities for Dual training in some regions is not in line with silver guide.
32	anonymous	Psychotherapy is very hard to achieve with changing rotations and the case spanning different jobs. Supervisors count psychotherapy as 'special interests'. It's hard to fit in ethically approved researcharound clinical work. Hard to do QI due to long processes of applying and setting up projects. (it took 9 months to set up previous QI but then I was rotating and it's hard to implement change in another job). Changing trusts makes everything harder too.
33	anonymous	The only KC that my trainees consistently struggle to prove is "Demonstrate an understanding of the principles of sustainability and how they underpin sustainable psychiatric practice." I am not disagreeing that sustainability is important, rather that this is more difficult to prove than others.

34	anonymous	WBPA's don't really showcase how a clinical interview/assessment should be done, what's important to ask and bear in mind and how to identify sings and symptoms. Personally, and for most of my colleagues with whom I've discussed this, these skills were learnt mostly after studying for CASC, which is a shame because they could have been improved from CT1.
35	anonymous	Psychotherapy, Addiction Psychiatry requirements
36	anonymous	Not sure
37	anonymous	Psychotherapy, research, and addictions as well as some of the community and prevention key capabilities.
38	anonymous	Research elements
39	anonymous	I dont know.
40	anonymous	Yes, between CT to ST; Demonstrating leadership and systems-level impact early, especially QI, service development, which many trainees have had limited protected time or prior exposure to. Explicit mapping of routine clinical work to HLOs and Capabilities, which requires a shift from competency accumulation to reflective, outcomes-focused documentation.
41	anonymous	Psychotherapy as an advanced resident doctor.
42	anonymous	Sustainability outcomes Psychotherapy - requirement for different competencies Research - reliant on local projects being run
43	anonymous	Audit sometimes,
44	anonymous	not sure
45	anonymous	We are expected to undertake long and short psychotherapy cases often with very little background knowledge on psychotherapy.
46	anonymous	Psychotherapy competencies moving from core to higher are also an issue The forensic curriculum is difficult for doctors in specialist services remote from a medium secure unit.
47	anonymous	no consistent pattern
48	anonymous	HLOs 4 and 7 are hard to demonstrate, and when they are linked to activities, it seems quite arbitrary.
49	anonymous	.
50	anonymous	ECT and Psychotherapy competencies
51	anonymous	Yes-psychotherapy is a recurrent and never-ending issue. Trainees are regularly struggling to complete their psychotherapy competencies within core training. I think we ought to stretch the requirement to 'need to complete by end of higher training'
52	anonymous	HLOs on sustainability.

53	anonymous	Psychotherapy at higher training remains problematic. It is not clearly stated that psychotherapy tutors have the same responsibility to higher residents as to core making access to patients and supervision challenging. There is also conflicting information on the RCPsych website about whether psychotherapy tutors should be in each trust or just one per deanery. There is no clear requirement for core resident psychiatrists to have inpatient experience - this is a significant gap in the curriculum / silver guide and should be addressed. It is not clear why the CAP curriculum has different wording / requirements in relation to research (requiring a paper written to publication standard) whereas the other curriculum do not require this. I would suggest that the CAP wording should be modified to align with other higher specialties.
54	anonymous	Core: research HLO appears irrelevant to most trainees, as this is not a requirement and trainees are not given time to develop this.
55	anonymous	Psychotherapy Sustainability
56	anonymous	Digital health and data is an essential skills for senior leadership
57	anonymous	Psychotherapy competencies consistently problematic. Sometimes prevent progression but more commonly require an inordinate amount of extra work (including outside rostered hours) to prevent the need to extend. Not currently competency based but time based
58	anonymous	The requirements for qip/audit/presentations then all the random niche aspects - sustainability, tech, edi
59	anonymous	Yes
60	anonymous	Psychotherapy Research
61	anonymous	Yes
62	anonymous	The key expectation at ST4 is that the trainee has confidence in managing most cases independently - this is often not the case, because of insufficient exposure of clinical decision making at CT3. The key expectation at CCT is that the trainee has confidence in leading a clinical team - this again is often not the case, because of insufficient exposure to acting at that level at ST6.
63	anonymous	Obviously
64	anonymous	Getting patient feedback in the upcoming changes will be detrimental, especially for people who are working in acute wards, forensic wards or PICUs
65	anonymous	Moving between CT3 and ST4, ensuring psychotherapy capabilities were adequately met in time, so as not to have to extend training solely for this reason, was challenging - lack of suitable patients in my own Trust despite requesting a case very early on meant that during CT3 I had to seek a suitable psychotherapy case and appropriate supervisor myself elsewhere in order to meet long case competencies in time for CT3 ARCP. This was anxiety inducing as I had accepted an ST4 training offer in a different deanery. I'm aware of several colleagues, in Thames Valley and KSS, who have extended core training having waited to be allocated a case.

66	anonymous	It is difficult to get Band 8 staff to assess STs. Band 8 staff in most organisations are nonclinical, as they hold higher management portfolios. It is unrealistic to ask for STs to be assessed by them, as this really limits the pool of assessors for STs to achieve required clinical WPBAs such as ACEs, mini-ACEs, etc. This needs to be expanded to include Band 7s as this will include Clinical Lead posts in most organisations.
67	anonymous	"Demonstrate an understanding of the principles of sustainability and how they underpin sustainable psychiatric practice." Why does this competency exist and how does a trainee demonstrate understanding in this area? It feels like it exists as a a tick box exercise that makes no meaningful addition to training
68	anonymous	don't know
69	anonymous	Several, again, the curriculum would be so much more engaging if it were few meaningful competencies rather than just several that feel like checklists
70	anonymous	Yes. Indeed. Physical treatments. Epilepsy. Dementia where training is in areas not commisoned for such practice
71	anonymous	Psychotherapy and research. The HLOs in research for higher trainees are too difficult to obtain within normal working hours. They require more commitment and often force trainees to use their special interest time to complete having to give up what they truly want to develop.
72	anonymous	none for a CT1 as it stands
73	anonymous	Sustainability Health promotion
74	anonymous	Very difficult to achieve psychotherapy competencies, as we have to find our own patients, rooms to work from etc.
75	anonymous	Psychotherapy requirements are often very difficult. For core trainees arranging short and long cases is often tricky with little support from faculty. If a patient pulls out before the end through no fault of the trainee this could delay progression. As a general adult SpR the psychotherapy requirement is rather ridiculous. There is no guidance as to what the requirement actually is. We're supposed to complete a SAPE each year - but I dont know of anyone who has done this. Trainees instead cobble together random stuff thats vaguely related to psychotherapy and generally get a pass from the TPDs/ARCP panels. Its a shame as I feel psychotherapy is a very important aspect of developing as a psychiatrist and to have it turned into a box ticking charade is disappointing. There are also vague points on the curriculum about 'sustainability and the environment' etc. which no one really acknowledges or addresses. This contributes to the curriculum often feeling irrelevant to training other than ticking the boxes at the end of the year for ARCP.
76	anonymous	Psychotherapy is a huge barrier simply due to the lack of structured access to participating in psychological cases, and is very variable based on departments. Certain pieces of the curriculum are also very limited in ways to meet, such as sustainability, experts by experience, and depending on areas in which you work, EDI HLOs may be difficult to attain.
77	anonymous	I don't know as I find it hard to understand what is new. The new thing seems to be PDPS. These seem to be a new twist on something old. The only useful thing is it gives you example of what to use for each type of job. I've never had supervision where I felt doing this is a helpful experience

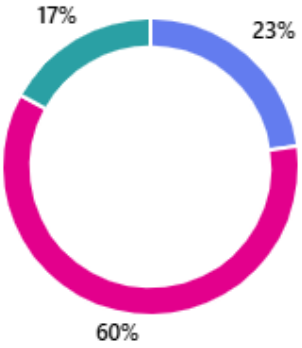
78	anonymous	Formulation and shifting to fourteenfish whis is harder to navigate
79	anonymous	Research and psychotherapy
80	anonymous	Research
81	anonymous	QIP and research participation, and achieving psychotherapy competencies in adequate time
82	anonymous	Teaching, research, audits.
83	anonymous	Research
84	anonymous	Section 12 Approved Clinician Course by the end of CT3 so that we can commence Higher training asao.
85	anonymous	the one about sustainability
86	anonymous	Completion of long psychotherapy cases and passing exams in time
87	anonymous	Yes, audit, psychotherapy, sustainability, public health, research
88	anonymous	All 3 components of MRCPsych in 3 years is a lot to fit in. It appears that a lot of people are saving CASC for January of year 3 which leaves no chance for resit and risks progression. Potentially a third CASC diet would be helpful but spread through year. e.g. March, July, November. Another option might be relaxing the sign-up lead time somehow to allow for people to sit an exam summer of year 2 and still enter for September CASC.
89	anonymous	Various pieces around sustainability in healthcare and early intervention
90	anonymous	The curriculum is pretty vague and not assessed in a consistent or meaningful way. That leads to disenfranchisement and confidence rot. People just middle along and make it up because it's expected of them.

91	anonymous	These are more difficult to evidence (not struggle to achieve in the real sense of it) Old Age Psychiatry 2022 Curriculum 2 Professional Skills • 2.1) Communication Demonstrate skills in supporting those in whom English is not their first language, including the use of interpreters, and providing information in other languages. 4 Health promotion and illness prevention • 4.1) Health promotion and illness prevention in community settings Apply an understanding of the factors (including physical economic and cultural factors) that contribute to health inequalities, and the social, cultural, spiritual and religious determinants of health as relevant to older adults. 4 Health promotion and illness prevention • 4.1) Health promotion and illness prevention in community settings Apply, where appropriate, the basic principles of global health including governance, health systems and global health risks, and use these in your practice. 4 Health promotion and illness prevention • 4.1) Health promotion and illness prevention in community settings Apply the principles of patient self-management, self-care and "expert by experience" in your practice. 4 Health promotion and illness prevention • 4.1) Health promotion and illness prevention in community settings Lead, advocate and educate health and non-health professionals in health promotion and illness prevention for older adults. 4 Health promotion and illness prevention • 4.1) Health promotion and illness prevention in community settings Promote physical health, mental health and wellbeing in older adult patients, and the wider community. 5 Leadership and teamworking • 5.2) Leadership Demonstrate inclusive leadership style and awareness of the impact of hierarchy and power within relationships with patients and colleagues. 7 Safeguarding vulnerable groups • 7.1) Safeguarding Demonstrate clinical expertise in recognising all forms of abuse in older adults, families and carers of all ages, and the wider community. 8 Education & Training • 8.1) Education & Training Effectively complete appropriate workplace-based assessment tools for other medical colleagues.
92	anonymous	none i experienced
93	anonymous	NA
94	anonymous	Sustainability based competencies are difficult to achieve
95	anonymous	Long case for psychotherapy Addictions CBd and ACE
96	anonymous	Research based HLOs. Patient Safety HLOs. Some of the clinical HLOs are difficult to reference in the WBPAs / forms currently available.
97	anonymous	Yes. Sustainability, lead a service etc. There are far too many competencies. Do an HLO like communication really need to be broken down into 8 elements?
98	anonymous	-
99	anonymous	Psychotherapy access timely
100	anonymous	Psychotherapy/ ECT competencies
101	anonymous	Psychotherapy supervision. Inpatient learning disability setting experience.
102	anonymous	Leadership, decision making abilities.
103	anonymous	They continue to approach clinical assessments/management in very cross sectional here and now manner.
104	anonymous	yes

105	anonymous	Niche competencies
106	anonymous	Psychotherapy cases ECT competencies On-call cases
107	anonymous	Research
108	anonymous	research and QI projects
109	anonymous	Yes, points relating to research are very hard to achieve and whilst sustainability is another area that is important to be aware of, it is very difficult to build up evidence of competence in this area.
110	anonymous	Psychological interventions, especially in higher training
111	anonymous	psychotherapy!!!!
112	anonymous	Yes- sustainability as an HLO can be vague or unclear what to apply in this HLO, also ECT competencies are very much based on being placed in a locality that regularly provides ECT clinic access which is not the case for most of the deanery.
113	anonymous	As above
114	anonymous	Academic vs practical knowledge. Trainee may know when a medication e.g. Lithium may be clinically indicated e.g. presentation/diagnosis but struggle with practicalities of starting it until had this experience in a clinical post e.g. what/how to arrange baseline checks, Lithium registers, how to titrate, how often to check levels initially, how to transfer shared care and need for secondary care annual reviews.
115	anonymous	don't know
116	anonymous	Unsure
117	anonymous	I think that they are achieving the requirements of the curriculum but I worry that they do not have sufficient clinical exposure. They effectively work 3 days in core training and 3.5 days as higher trainees meaning that some of them are not getting enough clinical exposure to prepare them for complex case management.
118	anonymous	N/A
119	anonymous	Psychotherapy
120	anonymous	7.1) Safeguarding - 2. Work within legislative frameworks and local procedures to raise and report safeguarding and welfare concerns in a timely manner and contribute to safeguarding processes. Safeguarding process are often initiated and discussed by other members of the MDT, there is often little opportunity to be involved in this as a CT psychiatrist unless they are directly involved in the safeguarding or are the first ones to identify and raise them.
121	anonymous	Barriers to opportunities for medico-legal report writing, inpatient psychiatry and family therapy experience for CAMHS higher trainees in some areas and placements, difficulties identifying CBT-based cases for core trainees (due to services demands, resistance from non-medical therapist supervisors who are not inclined or released to do such work unfunded). We have been able to create DBT-oriented short case experience and supervision in our placement. Completion of systematic review for CAMHS higher trainees can be a challenge - shortage of trainers willing/experienced to supervise such projects

17. Are services equipped to provide the necessary clinical experiences for resident doctors to meet the curriculum requirements? More details

Yes, definitely	51
Yes, somewhat	135
No, not really	38



18. What additional support or resources would make future implementations more effective?

113 Responses

ID ↑	Name	Responses
1	anonymous	better pay more protected time RCPsych to put on more free events for trainees to attend
2	anonymous	Enhanced guidance, accessible training resources, and well-coordinated support would help make future implementations more effective.
3	anonymous	More sessions for the supervisors to understand portfolio and WPBA changes
4	anonymous	see my answer to 9 - pasted again here: the competencies around research and management are outwith the experience of most supervisors. rather than ask a placement supervisor to to this, it would be more helpful and more consistent for each area to have one person sign these off for all. the same could be said for teaching too, though this is more embedded in everyday work
5	anonymous	Clinics are running all the time - resident docs need to be encouraged more to attend them and be proactive about seeing patients.
6	anonymous	As always, access to LD, Forensic and D&A experience can be more difficult to source.
7	anonymous	Simplification and more transparency of the ARCp process.
8	anonymous	All CTs should do crisis team or liaison posts to get adequate crisis experience.
9	anonymous	some explanations on what minority means, what sustainability means this all can mean different things to different people
10	anonymous	As Above

11	anonymous	not sure
12	anonymous	there has been a surge in LTFT training and trainees with Neurodiversity. we need to consider allocating more resources / support in this area.
13	anonymous	SPA time for supervision
14	anonymous	Ensure the clinical supervisor got to sign in for the trainee after each supervision weekly and must clock in certain numbers. If not, this must be questioned during the panel review.
15	anonymous	Presently there are several health boards where residents are struggling to meet their psychotherapy competencies. More support in this aspect would be helpful
16	anonymous	The research base in the UK is very thin. Academics themselves are too busy meeting onerous regulatory requirements to do much research, let alone ever meet a real-life trainee. We won't fix the research part of the curriculum until academic psychiatry in the UK more broadly can be deregulated down to manageable levels of bureaucracy and reinvigorated. Medical psychotherapy provision is very poor as they are an endangered species and cannot meet the demand for supervision. Psychologists are increasingly pulling out of providing supervision for trainees. Trainees should just have 1 day per week allocated to psychotherapy throughout and see as many patients as possible in that time, rather than the highly precarious and inefficient system of 1 short and 1 long case.
17	anonymous	No suggestions
18	anonymous	more structured clinical timetable
19	anonymous	none
20	anonymous	massive demand and mis-matched workforce are main issues
21	anonymous	Joint training sessions for resident doctors and trainers provided both online by the college and locally.
22	anonymous	More time available in rotation to complete expected curriculum competencies that are not directly related to clinical care (e.g. audit, reflection, research, etc).
23	anonymous	its hard to keep up with portfolio and exams, the curriculum for portfolio and the exams really needs to be looked at and slimmed down as there is an overlap, i feel as if i have to jump through hoops more than once and even then, it doesn't seem clinically relevant but more a tickbox, also make feedback a lot easier, i can trainers literally sigh when they see how big the form is, it puts them off. having to do a case log for each WPBA just seems long, please figure out a way to make this process easier.
24	anonymous	None that I can think of
25	anonymous	Proper support from Trusts and from Deanery. No good part funding posts like TPD roles when Trusts won't pay the balance of what is due.
26	anonymous	increased funding for places to ensure all employers support trainers with additional time and/or funding to train residents
27	anonymous	Early and more awareness Curriculum should reflect current and global evidence based practice

28	anonymous	Due to the low number of core trainees, FY2s, GP trainees allocated to us locally in old age psychiatry, they are mainly based on the wards to ensure adequate resident doctor cover. This along with a lack of clinical space, mean that trainees often get very little outpatient experience.
29	anonymous	Guidance on how to achieve each curriculum HLO into real practice with the support of a number of courses and accredited courses would be very helpful.
30	anonymous	Trainees could more often recognise the wider benefits of some service delivery tasks in terms of learning
31	anonymous	more psychotherapy supervision and availability of long and short cases
32	anonymous	This question needs clarity around whats the intended curricula in question, core has different requirements than Higher Training and hence resources vary so are the barriers.
33	anonymous	More time to research. Psychotherapy and QI time made clear.
34	anonymous	Unfortunately I think that one of the major factors affecting trainee experience and fulfillment of the curriculum (if not the major factor) is the overall state of the service that they are placed in - and this is something that no specific support or resources from the College is going to change. A service which is working well, with good staff morale, is generally welcoming to trainees and able to give a good range of experiences to inform their learning. Where a service is struggling trainees are merely workhorses. They may end up seeing a lot of patients, but often these clinical experiences will be repetitive (the supervisor gives the trainee cases where they know the trainee will need the least supervision and thus least supervisor time), lacking time to reflect or feedback on performance.
35	anonymous	training on curriculum- webinars
36	anonymous	Training
37	anonymous	More funded time for educators - PS, TPDs- so this can be better implemented.
38	anonymous	See pt 14 above.
39	anonymous	I dont know.
40	anonymous	Additional support would include clearer exemplar portfolio entries, transition-specific guidance, and protected time for QI, leadership and teaching activities.
41	anonymous	Period of stability without constant change.
42	anonymous	none.
43	anonymous	not sure
44	anonymous	Availability of short and long cases
45	anonymous	Psychotherapy is a difficult one to meet as I do not directly do any psychotherapy and the psychologists have their own trainees.

46	anonymous	Doctors to be able to spend more time with the clinical team and for training opportunities to be more streamlined. There is insufficient direct clinical time to provide an optimal experience, especially for things that occur unpredictably or infrequently.
47	anonymous	Modify existing requirements and allow psychotherapy competencies to be met by end of higher training.
48	anonymous	Clear description / support / resource allocation for psychotherapy tutor working with Higher specialist residents.
49	anonymous	More regular Balint sessions
50	anonymous	Clear national special adjustments for neurodiverse doctors Clear national support for doctors unable to do oncalls Clear national support for doctors who are carers Clear national rules for study leave to attend conferences as core trainees (when we do NOT present posters)
51	anonymous	It can feel that a resident is not embedded in a team due to multiple commitments and multiple roles. Emphasising robust clinical training and in calls in the core years would be helpful
52	anonymous	Dedicated portfolio time for core trainees in the work schedule, increased study budget funding with greater ability to take targeted study leave to fill the gaps (more discretionary)
53	anonymous	Yes
54	anonymous	Less focus on number of WPBAs but instead focus on the quality of WPBAs.
55	anonymous	Make jobs less of service provision and more of learning.
56	anonymous	Higher expectations on trainees to make decisions about patient care.
57	anonymous	-
58	anonymous	PROTECTED TIME adequate resources
59	anonymous	See above re: availability of suitable psychotherapy training cases.
60	anonymous	It is difficult to get Band 8 staff to assess STs. Band 8 staff in most organisations are nonclinical, as they hold higher management portfolios. It is unrealistic to ask for STs to be assessed by them, as this really limits the pool of assessors for STs to achieve required clinical WPBAs such as ACEs, mini-ACEs, etc. This needs to be expanded to include Band 7s as this will include Clinical Lead posts in most organisations.
61	anonymous	More guidance on what evidence is required to demonstrate more obscure competencies such as "Demonstrate an understanding of the principles of sustainability and how they underpin sustainable psychiatric practice."
62	anonymous	Use of AI and Co-pilot to reduce documentation burden and to give actionable insights to both trainers and trainees
63	anonymous	Could more explicit links with ARCP be made? The domains are GMC-based, not curricular.
64	anonymous	Reduce the competencies from all the fluff to some meaningful requirements that are relevant to the rea world setting and attainable where ever you end up training in England

65	anonymous	Training to supervisors
66	anonymous	If you wish to have such in depth research HLO, a separate special interest time needs to be organised.
67	anonymous	nil
68	anonymous	Better contacts with non-NHS services
69	anonymous	Better organised provision of psychotherapy cases and training for CTs is very important.
70	anonymous	Psychotherapy availability is the number one difficulty I and others have encountered. Addictions CBDs for Core trainees also appears to be a challenge due to systemic underfunding and privatisation of that subspecialty
71	anonymous	More explanation for supervisors and trainees about what this is trying to achieve. Right now it continues to feel like a tickbox exercise. The only useful thing I found about the portfolio is when doing my consultant applications everything was saved in one place.
72	anonymous	More relevant teaching
73	anonymous	More focus on non-clinical aspects of training, and streamlining access to psychotherapy/improved patient allocation
74	anonymous	Money and time
75	anonymous	I think its needs a re-write. If it needs to be so long it should be split into core and optional components. Having a curriculum of more than 100 items effectively means it will be poorly utilised and large parts brushed over. How much time does an item need to be though of and completed properly? I think it would be better to have a shorter section which needs to be done really well and then other optional components
76	anonymous	There is very little support for achieving the non clinical parts of the curriculum, it basically depends on luck and who you know
77	anonymous	Limits on how many trainees one educational supervisor can supervise.
78	anonymous	Protected PDP time in ST6 to reflect on consultant level work and step up.
79	anonymous	The curriculum has no real clinical content meaning that any service could provide experience
80	anonymous	Try to build verifiable assessment mechanisms. Too reliant on 'expert opinion' which is too often based on how much a supervisor likes the supervisee.
81	anonymous	Make things less complicated
82	anonymous	NA
83	anonymous	Clearer definitions of evidence to meet each specific competencies
84	anonymous	More guidance and experience in addictions psychiatry More psychotherapy
85	anonymous	Examples of how each HLO could be met and evidenced.

86	anonymous	Simplify it! Fewer HLOS, far fewer sub categories, focus on core elements
87	anonymous	Please, more online resources that are IMG friendly to explain expectations of the curriculum.
88	anonymous	More direct regular 1 to 1 teachings
89	anonymous	Training guides for supervisors , ensure modules of learning topics for each stage of training
90	anonymous	Additional time to complete portfolio in rota
91	anonymous	A webinar from the Royal College regarding the Curriculum and HLOs
92	anonymous	Services also require emphasis on here and now treatment(psychopharmacological)
93	anonymous	clarity of expectations
94	anonymous	To make future implementations completely effective across the totality of postgraduate psychiatry residency, systemic infrastructure must merge structural competency with rigorous clinical assessment. Training deaneries must provide protected academic time, mandatory supervisor training, and fully funded lived-experience consultants to co-lead curriculum design. Crucially, the assessment framework must be overhauled to mandate that trainees present complex cross-cultural cases they have personally interviewed and assessed, rather than gathering retrospective data from electronic records. Furthermore, clinical competence should be solidified by introducing compulsory 3-to-6-month clinical rotations in both neurology/neuropsychiatry and addiction psychiatry for all trainees, alongside the reintroduction of the long-case clinical examination to rigorously test face-to-face diagnostic formulations, phenomenological precision, and the differentiation of structural trauma from primary psychopathology
95	anonymous	Sim training
96	anonymous	RCPsych link to help and support
97	anonymous	more protected time
98	anonymous	Simplifying the requirements, with greater focus on clinical tasks which is what we are employed to do rather than jumping through hoops that don't always feel relevant to the day job and are done more as box-ticking exercises.
99	anonymous	session or FAQ's to explain HLO's and capabilities in detail and how to achieve them. It sometimes becomes difficult to understand what does the capability mean and what should be covered under it.

100	anonymous	Educational programmes for trainers, wider inclusion of psychological therapies (e.g. working without medical psychotherapists), support for differential attainment at earlier stages
101	anonymous	psychotherapy supervisers identified and cases supported with
102	anonymous	More clear guidance on what sort of activities the trainee is supposed to submit for each HLO to ensure this is not being criticised by the ARCP committee as insufficient evidence.
103	anonymous	A teaching programme that more closely maps to the curriculum. Currently most teaching sessions in both RAP and LAP are very different from the 2022 curriculum. A guide perhaps written by trainees of what to map to each HLO as examples would also be very useful for incoming CTs.
104	anonymous	Reasonable adjustments in cases of disability, not eternal ambiguity from trainers
105	anonymous	See above re. better portfolio linking HLOs re. PDP/WBPAs.
106	anonymous	I would love to see the portfolio made much simpler to engage with regularly, and the curriculum designed and sharpened to make it much clearer to actually use. Myself and many residents I speak with find the job/training becoming increasingly difficult from an administrative perspective. For example, we use 2 separate clinical systems that each require 30 steps to access a patient record, after which information is hidden in various places and not well labelled, and we must fill out numerous boxes that can often feel time consuming, duplicative, and inappropriate for the task. After all of this, which naturally takes time away from potential clinical encounters (where the real work and learning is done), we have to log in to portfolio, navigate its structure (which is not straightforward), and make sense of management jargon acronyms, and work out which boxes to tick. It's therefore no surprise that the prevailing sentiment regarding the portfolio is one of 'tick box exercise' cynicism, which I feel discourages truly deep and meaningful engagement with the material. Instead what I see is many people just entering superficial information and not caring about it. I think it is especially difficult for those of us who are neurodiverse (seemingly many psychiatry trainees), who will struggle much more with convoluted, seemingly meaningless, uninteresting, executive bureaucracy—indeed this could be viewed as a barrier to performance and development for those trainees with a legally registered disability such as ADHD. Here's an idea: wouldn't it be wonderful if our clinical systems could integrate the portfolio curriculum, and through our documentation, current technology could predict and suggest the appropriate curriculum tags to evidence our learning and experience, it could suggest we write e.g. a reflection and such 'tasks' could be kept on a list, even with reminders sent out for their completion. I think additional styling elements could be integrated to enhance engagement, such as progress bars and even gamification. Much could be done to enhance engagement and make trainees feel 'embodied' in the curriculum.

107	anonymous	Unsure
108	anonymous	review of all posts in a locality - some are better equipped to deal with range of educational needs, others less so but a resident doctor is seen as a right for a consultant.
109	anonymous	Greater assistance from technology to assist clinical administration, freeing doctors up to spend more of their time seeing patients and thus improving their clinical skills.
110	anonymous	More training related to required field and supportive supervision .
111	anonymous	More consultation and training
112	anonymous	There are certain clinical posts where the focus is more on service provision than actually being trained. These posts usually face difficulties within due to short staff or other issues within the team, and this attitude is reflected on the clinical supervisor who does not prioritise a trainees needs and portfolio requirements above them turning up, doing physical health checks, being a makeshift GP etc. There are some clinical supervisors however which do prioritise the trainees needs despite their own teams facing these needs and these CS are highly valuable.
113	anonymous	Dedicated funding for psychotherapy supervision in each borough

19. Please feel free to add any further comments here.

62 Responses

ID ↑	Name	Responses
1	anonymous	Nil
2	anonymous	The linking ILO and activity/assessmetn process could be smoother and less arduous
3	anonymous	the curriculum does not have any competencies around digital health despite the fact that services are becoming more digital and this is an area where trainees vary a LOT in skills. the college has agreed digital competencies for all https://www.rcpsych.ac.uk/training/curricula-and-guidance/Digital-Literacy-Framework but these are not yet into the curriculum. i am not saying we need lots of separate competencies, but it would be helpful to ensure that a digital aspect is discussed when signed off say a small number of the competencies [eg how else do you find information about a patient before you see them, how do you communicate with other professionals if not digital] and then consider one or two digital-specific competencies eg [a video assessment - how else can you show you can assess over video?] [eg using some data from your own service obtained from an analyst in order to do audit/qi etc]
4	anonymous	we are losing our distinctive skill set as psychiatrists to non medical ACs and prescribers, we need to focus on high clinical and academic standards. i would advocate for a fellowship pre CCT exam like in surgical and medical specialities to ensure rigorous knowledge and expertise. the MRC Psych level is far too low for sub specialist post CCT expertise.
5	anonymous	as above
6	anonymous	I think that some of these can be very job/area specific. There is not always the opportunity to do specialities or have the same experiences in every area and I think this influences training.
7	anonymous	No suggestions
8	anonymous	none
9	anonymous	A wider, more generalised training pathway and curriculum would be useful, particularly including options for engaging in non-psychiatric care (e.g. gen med, frailty, neurology rotations etc).
10	anonymous	Nil
11	anonymous	In terms of providing high quality and timely feedback with current workload, I do endeavour to do this so am not saying that I can't but it is a challenge and I feel I do not do this as well as I would like to at times
12	anonymous	The job is about what patients and local populations need- this varies from area to area. Trainers teach residents what they need to do to do the job safely and to deliver the care needed. This is then fitted into the curriculum and is the right way round. The curriculum should not impact the delivery of care or dictate things. A lot of work is done by TPD's and es to address things not covered by curriculum to support residents to move to next phase.The forms on the portfolio have a significant impact on the detail of what is recorded and over the years the granularity of what a resident know or the breadth of clinical scenarios they come across has been lost. Informal logs books are a good way of addressing this.

13	anonymous	In general, i think both trainees and trainers struggle with the current curriculum. It is detailed to the point of being overwhelming. Trainees struggle to develop appropriate PSPDPs despite guidance on college website.
14	anonymous	Thank you.
15	anonymous	Acting up should be compulsory. Even if it's 2/4 weeks in current job with with normal consultant observing.
16	anonymous	I think the curriculum would be much better if we had in person clinic time with our CS (please see my explanation above). I also think that CT1's should not be allowed to work in a CMHT seeing patients on their own given patient care is compromised by inexperience, even if cases can be discussed in supervision. I feel strongly that in the first year of training, trainees should have as much exposure as possible to different clinical scenarios with in person supervision and only see patients on their own when there is a plan in place and they already know the patient.
17	anonymous	The new WPBA do not place emphasis on core skills of history taking, MSE, risk assessment etc
18	anonymous	I found this survey a bit confusing as some questions seemed directed at educators and others at resident doctors. Also, I understand that it might not be possible to simplify and reduce the curriculum. However, I think some KCs are very long and repetitive, and could do with some simplification. I also think that neurodiversity assessments should be more of an essential component of training, regardless of sub speciality in the current context.
19	anonymous	To expand on points 12/13. My experience of the curriculum as a trainee and now as a clinical and educational supervisor is that most see it as another box to be ticked. Understanding of or learning alongside the curriculum doesn't (in my experience) make someone more or less competent or effective in their practice, but perhaps in combination with yearly ARCP processes can help identify those who are struggling or unable to meet the requirements of the training program.
20	anonymous	None
21	anonymous	.
22	anonymous	Clearer guidance (perhaps in the silver guide) regarding requirements for psychotherapy residents would be helpful, particularly in relation to individual therapy, attending psychotherapy taught courses etc.
23	anonymous	Patient care, quality outcomes and clinical excellence, including diagnosis, formulation, engagement and health outcomes need to be at the core of profesional development, through the lenses of collaboration and teamwork
24	anonymous	Guidance on ECT competencies could be clearer
25	anonymous	No
26	anonymous	Really want to emphasise the point that making evolutionary medicine a core basic science in psychiatry - equivalent in status to neuroscience - would really help trainees understand psychopathology better.
27	anonymous	-

28	anonymous	Neurodiversity needs to be better recognised, understood and supported by trainers, and issues addressed in supervision where the trainee thinks this is necessary. Throughout core training I was working after hours for several hours daily and through weekends to complete written work, compensating for my dyslexia, which manifests as writing slowly but otherwise entirely hidden. Supervisors were informed at the start of placements and offered to read my diagnostic report (from 2009, during BA History). Throughout placements I was nevertheless told constantly to "just improve my time management skills/be more organised" (to address my difficulty with slow writing speed) without any further support, sometimes week on week in supervision, despite flagging up particular issues to my supervisors, that I anticipated would be challenging during certain placements, early on. The college offered extra time for exams, all passed first time. As an ST4 in Forensics this challenge has been largely mitigated, despite the nature of the work (majority report writing), and I'm responded to completely differently!
29	anonymous	It is difficult to get Band 8 staff to assess STs. Band 8 staff in most organisations are nonclinical, as they hold higher management portfolios. It is unrealistic to ask for STs to be assessed by them, as this really limits the pool of assessors for STs to achieve required clinical WPBAs such as ACEs, mini-ACEs, etc. This needs to be expanded to include Band 7s as this will include Clinical Lead posts in most organisations.
30	anonymous	- I think a competency about recognition and management of catatonia would be appropriate, as it's a presentation that psychiatrists must be comfortable with managing given its potentially life threatening nature - "Demonstrate an understanding of the history of psychiatry, the development of diagnostic concepts and psychiatric treatments, as well as the profession, and the historical relationships between psychiatry and society." - the fact that Paper A tests us on things such as what year ECT was first trialled in, which Freudian analyst described a particular defence mechanism or some other useless fact learned through rote learning (knowledge of which will not make someone a better psychiatrist) when we could instead be tested more on evidence based psychiatry, is a real shame.
31	anonymous	Too many changes for August which gives very little time for systems to prepare. Need to break this down to manageable chunks spread over a larger period of time.
32	anonymous	The survey is a little confusing in that somewhat and moderate are undefined and could perhaps be interchangeable? Also, a "don't know" response to some questions might be more revealing?
33	anonymous	If the college still feels all these competencies are 'relevant' then at least explain them better with examples of what attaining them would be like
34	anonymous	Questionnaire itself could be improved - several answers are not applicable to me yet there's no 'NA' response, similarly it would be useful to have 'I don't know' or 'neutral' responses in the questions.
35	anonymous	Wordly description on competencies which are not easy to understand

36	anonymous	The curriculum goes round in circles with many points and feels like the same point reiterated many times. The idea of 9 HLOs is great, but there are too many subpoints.
37	anonymous	nil
38	anonymous	The sheer volume of higher learning objectives is ridiculous and at times feels overwhelming. When I did core training from 2020-2023, I had 43 learning objectives to match to, and almost all of them were relevant. I now have more than double, and many are duplicates, and some are niche to the point where it is not relevant to clinical practice (sustainability is a ridiculous HLO). The number of HLOs needs to be reviewed and streamlined. It is at the point where many trainees are intentionally reflecting on specific cases, seeking specific experiences or doing pieces of online learning modules purely to meet these hard to fill areas, rather than gaining genuine and more valuable clinical experience.
39	anonymous	There are over a hundred capabilities in my curriculum, and in my opinion many overlap significantly. I think many could be merged to make the curriculum more effective in its purpose as a guide for development without any compromise in thoroughness.
40	anonymous	There aren't much guidance to setting up portfolio and all the requirements for ARCP. Would be helpful to have a full day session guiding this in its entirety when a trainee initially starts their training. This should then be followed up every 3-6 months to ensure it is being progressively updated and if further training / information is required. Learning from other colleagues and online videos alone does make this transition difficult.
41	anonymous	Material covered by membership exams is a particular source of frustration - irrelevant, unhelpful in day to day practice, and ultimately useless
42	anonymous	The current content and format of exams do not align well with the curriculum or clinical practice; they require the development of mostly different skills and knowledge, at substantial cost of time and effort to trainees, while not measuring curriculum outcomes or suitability for progression
43	anonymous	Any clinical service could provide the required experiences to meet the curriculum but that does then mean that people could become a child and adolescent psychiatry consultant with no experience of assessing and managing ADHD because the commissioning in their area has meant that that experience is not available to a trainee. A complete removal of all clinical content removes a minimum standard of clinical knowledge in consultants.
44	anonymous	Really the job is the job and the training is more about doing that job and following NHS culture than it is about anything else. Most learning happens outside of the portfolio and its rituals, which feels invalidating when it is the portfolio that measures the individuals worth. I don't have answers here but it's be good if we can be honest about the situation we are all in.
45	anonymous	Maybe clearly define activities to achieve capabilities
46	anonymous	NA

47	anonymous	The CAMHS ST curriculum has too many competencies, many of which are overlapping or vague in their definitions. Opportunities are not available in all areas of the country to meet all competencies easily.
48	anonymous	Some HLOs can be re-worded as the objectives and expectations are not clear.
49	anonymous	Recommend incorporating evolutionary science into the curriculum
50	anonymous	Service expectations as transmitted to resident doctors through larger clinical team including CS, not aligned with resident doctors developing a rounded all inclusive/thinking clinical approach.
51	anonymous	Sometimes I wonder if the assessment covers or is accurate for a Resident Doctor in higher training who has returned to higher training after several years of working as a non training grade following their core training in a specialist area of Psychiatry which has allowed them to work independently and makes sense to rate them in the new curriculum entrustability scale as a Level 5 for many areas than few (genuinely)
52	anonymous	There should less stress of WPBAs and more focus on becoming confident leaders in the current NHS situation
53	anonymous	Neurodevelopmental condition assessment and management should be core competencies and reflected in a similar manner to Addictions CbDs
54	anonymous	The guideline should be updated to include more helpful information; experts and new consultants would be highly appreciated in providing this work. Thank you.
55	anonymous	I think the curriculum itself is very thorough and robust, my issue is how it is implemented and the gaps in opportunities for trainees to adequately demonstrate they are coving the curriculum. I wonder if advising more frequent formative ES meetings to review curriculum progression would be useful? Currently we are advised to have at minimum one summative ES meeting per year. As the CS usually does not have time to do this and supervision is more focussed on the clinical caseload.
56	anonymous	N/A
57	anonymous	I would value an opportunity to help work on this, if there is such an opportunity I can hope that we are informed about it.

58	anonymous	The Curriculum in its current form does not cover the necessary clinical knowledge and skills essential to practice as a consultant. In previous versions of the curriculum, there has been explicit lists of mental health conditions, presentations and ages of children that Resident Doctors were expected to see, have high levels of knowledge about, and be competent and confident in assessing and managing. There is no such list now. The entire curriculum could be summed up in one or two short paragraphs - it essentially has been boiled down to "Communicate well; Understand normal child development; be able to take a history and examine a child; do some research (optional); do some leadership; understand MH legal frameworks; deliver some teaching." There is nothing about mental health presentations & conditions, psychopharmacology, physical health closely related to MH (e.g. epilepsy, continence in community paeds settings), neurodevelopmental conditions (inc tourette's and FASD, as well as ID, ADHD, autism), nor about developmental trauma. The very knowledge base that distinguishes us as psychiatrists and not generic mental health workers or a RD in any other specialty (given all RDs in all specialties need to have good communication skills, do some research, do some leadership, deliver some teaching etc.) has been removed. This leaves the acquisition of the core knowledge of psychiatry and psychopharmacology to chance - or at least to clinical supervisors discretion. Given there is no exit exam in Child Psychiatry, how can we be assured that RDs are gaining their CCT with the required specialist knowledge and skills essential to practice as a Consultant Psychiatrist? We are at serious risk of producing lovely Consultant Psychiatrists who can communicate well but don't have the core knowledge and skills to actually be a clinically sound and safe, independent Consultant. I would urge changes to the curriculum are made which address these glaring deficits, to ensure that RDs have explicit curriculum requirements that cover the breadth and depth of presentations seen in psychiatry, knowledge of the full range of diagnostic conditions, and the associated psychopharmacology.
59	anonymous	I think due to on-calls and other activities the amount of time spent assessing patients has dwindled and I am concerned that over time this will make trainees less clinically competent.
60	anonymous	N/A
61	anonymous	I think that all psych core trainees should spend a week in prison

62	anonymous	I have a longstanding interest in medical ethics and law and in anthropology and evolutionary perspectives and am a member of the executive committee of the Evolutionary Psychiatry SIG. There is much that evolutionary and anthropological perspectives can bring to enrich and elevate the specialty overall, in particular for psychiatrists in training. Including such principles in the curriculum, supported by a session and recommended reading in regional MRCPsych courses would be an excellent development. This would help to add an additional layer of context to formulating patients' mental health problems. An evolutionary perspective could include, for example, Tinbergen's ultimate (why) v proximate (how) questions of causation of disorder/illness, as well as 'mismatch' of adaptation between modern and ancestral environments i.e. modern living and working conditions and the associated loss of social support structures. We note that resident doctors and even medical students, have a natural curiosity in this area. It is intellectually stimulating and also can bring a wide range of potential benefits to clinical practice. Evolutionary perspectives on a wide range of clinical conditions can be invaluable in psychoeducation with patients and carers, de-stigmatising and rewarding for clinicians. There are also considerable policy and public health opportunities that can arise from an evolutionary/anthropological perspective in addressing vulnerability and perpetuating factors. It would be wonderful if the college could consider incorporating these principles into its public health work and strategy. These may include advocacy for improved nutrition, early attachment security, parental mental health/support, reduced childhood ACEs, reduce mismatch in housing, school, work and clinical environments, efforts to improve social cohesion and capital, to improve public realm environments and addressing concerns about over-digitalisation. My suggestion would be for inclusion in core training of a knowledge/skills competency on anthropological and evolutionary perspectives as well as skills in psychoeducation with patients. I and other colleagues from EPSIG would be very happy to contribute more thinking to this. [redacted]