Aims: Diagnostic systems for neurodevelopmental disorders, including DSM–5–TR and ICD–11, provide essential categorical classifications for clinical communication, service eligibility, and care planning. However, these systems offer limited capacity to explain the marked heterogeneity observed within diagnostic groups or to link diagnosis meaningfully to underlying neurocognitive mechanisms. In parallel, dimensional frameworks grounded in developmental neuroscience have generated substantial mechanistic insight yet remain difficult to operationalise in routine clinical practice. This gap between descriptive diagnosis and mechanistic understanding limits formulation, training, and translational consistency across clinical settings.

Aim

To propose a neurocognitive profile specifier framework that integrates developmental neuroscience constructs into DSM/ICD-based diagnosis using a shared, clinically usable language applicable across education, clinical practice, and service contexts.

Methods: This conceptual framework defines five neurocognitive profile domains consistently implicated in neurodevelopmental conditions: Social Cognition; Executive Function and Cognitive Flexibility; Reward and Motivation Sensitivity; Sensory Processing; and Emotional Regulation. Each domain is characterised using concise, developmentallyinformed specifiers (e.g. intact, variable, markedly impaired), derived from information routinely obtained during neurodevelopmental assessment, including clinical interview, collateral history, and standardised measures interpreted relative to developmental norms. The framework is designed to be applied following categorical diagnosis, preserving existing descriptive specifiers while adding a mechanistically coherent profile layer to clinical formulation.

Results: The framework produces a concise neurocognitive profile embedded within the diagnostic formulation. Clinically, this supports clearer intra-diagnostic differentiation, improves multidisciplinary communication, and facilitates targeted intervention planning without reliance on biological markers not yet suitable for routine use. Across services and training settings, it provides a structured approach for teaching formulation and linking assessment findings to intervention strategies. In addition, the use of clinically familiar but mechanistically grounded domains facilitates alignment with neuroscience-informed research, supporting cumulative and translational understanding.

Conclusion: Neurocognitive profile specifiers offer a pragmatic means of aligning diagnostic practice with developmental neuroscience while preserving categorical classification. By contextualising diagnosis rather than replacing it, this framework supports more precise formulation, enhances educational clarity, and provides a scalable approach to personalised care in neurodevelopmental psychiatry.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Creating an Educational Neuropsychiatry Network

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Aims: Tobuild a Multiprofessional Neuropsychiatry educational network. To provide high standard educational meetings through complex case presentations which promote neuropsychiatry across the East Midlands.

Methods: Neuropsychiatry as a sub-speciality is not endorsed by the GMC, and as such formal training pathways do not exist for psychiatrists in the UK. The Neuropsychiatry Discussion Group (NPDG thereafter) is a monthly forum designed for clinicians across all levels and specialties to explore complex neuropsychiatric presentations. Each session a clinician presents a complex case that challenges diagnostic frameworks and treatment strategies. In the past 12 months we have expanded the network, hosted guest speakers from experts to trainees with an interest in neuropsychiatry and formalised the programme. We regularly have 70+ attendees across neighbouring trusts in the East Midlands and are continuously expanding the network to foster professional collaboration.

We base the programme on the RCPsych Faculty of Neuropsychiatry suggested syllabus to ensure curriculum coverage over the year and have developed a standardised feedback form for the sessions using a Likert scale as well as free text to collect data.

Results: Analysis of participant feedback across multiple sessions demonstrated strongengagement and consistently high satisfaction with the educational content and delivery.The programme successfully incorporated a broad range of presenters spanning training grades and seniority, from CT1 trainees to Professors of Neuropsychiatry, reflecting an inclusive academic culture and exposure to varied perspectives. This breadth was frequently reflected in comments.

Quantitative data showed that participants rated the clarity of session objectives, clinical and academic relevance, and effectiveness of teaching methods predominantly at levels 4 and 5, indicating a high degree of perceived educational value and quality.

Qualitative feedback reinforced these findings. Attendees frequently emphasised the strengths of the case-based format, praising the sessions for their real-world clinical applicability, multidisciplinary input, and opportunities for collaborative discussion. The format was noted to support deep, reflective learning, particularly in areas where diagnostic and treatment paradigms are complex or evolving.

Conclusion: Ongoing evaluation will remain integral to the development of the group. We will continue to systematically collect and analyse participant feedback across sessions.

We are working with neighbouring trusts and organisations in order that attendance at the sessions can be used for CPD activity.

We aim to continue to widen the NPDG network, therefore fostering rich, cross-specialty dialogue. We wish to deepen clinical insight, share perspectives, and enhance collaborative care across the region.

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Supporting and Retaining Advanced Trainees and New Consultants in AWP

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Aims: High quality patient care in mental health services relies on a robust psychiatric workforce. However, unfilled posts and high staff turnover can become entrenched problems. Here we describe a unique and innovative strategy developed in Avon and Wiltshire

Mental Health Partnership Trust, developed to support and retain advanced trainees and new consultants in the trust. This aimed to support consultants in their first 3–4 years of appointment and to develop consultant roles within the trust that would appeal to trainees.

Methods: The strategy was developed in response to recruitment and retention challenges. The strategy consisted of five elements, including 1) Roll-out of new consultant-specific induction, including a bespoke leadership development programme and leadership coaching for new consultants. 2) Funding and support of a research fellow to conduct qualitative research around experiences of the transition period between higher training and becoming a consultant. 3) Work around support and wellbeing of medical staff. 4) Development of a mentoring programme. 5) Development of compassionate leadership in the trust. Further details of each of the above interventions are described, including challenges faced and how these were overcome. Feedback and outcome measures are then described.

Results: Arising from our work locally, we have generated several recommendations to support and retain advanced trainees and consultants within mental health trusts. We share experiences from developing and implementing these interventions locally. Sharing this information may help other mental health trusts nationally in addressing similar challenges.

Conclusion: We describe an innovative local strategy, developed to support and retain advanced trainees and new consultants in the trust. Future areas for development could include a) sharing successful approaches more widely with other trustsand b) further consolidation of local activities. Further consolidation locally would include promoting more widespread uptake of mentoring, including this being offered to advanced trainees in the two years prior to their completion of training, and continuing to develop cross-trust mentoring with neighbouring trusts.

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Following the Money: The Use of Funds for Undergraduate Medical Education in Psychiatry

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Aims: The Medical Education Tariffs paid to healthcare providers to cover the costs of hosting and training medical students on clinical placements are not a direct payment for teaching quality, but a contribution to provider costs. In England, the 2024/25 allocations were set at £34,355 per medical student. Trusts are required to submit annual accountabilityreports to regulatory bodies on the use of this funding. However, accessing these reports or obtaining clarity on their content is very challenging and the quality assurance provided remains poor.

Methods: We sent a Freedom of Information request to all the mental health trusts and health boards in the UK and Northern Ireland in December 2025 to explore their management of the undergraduate medical education funding and their adherence to reporting tools in place.

Results: The overall response rate was 89% from 70 trusts and health boards across the four nations that offer psychiatric placements to medical students.

England 87% response.

Wales 100% response.

Scotland 85% response.

Northern Ireland 80% response.

Ringfencing of funding specifically for psychiatric undergraduate education happens in 27% of responders across Scotland, Wales and Northern Ireland and 82% of responders in England.

Specific records on the use of funding are kept in 59% of responders across Scotland, Wales and Northern Ireland and 77% responders in England, but less than 5% were able to provide a full breakdown of costs.

Employment of Clinical teaching fellows was the most consistent use of the funds across the four nations.

Reporting tools are used by 90% of responders in Scotland, Wales and Northern Ireland and 69% of responders in England.

Reports are available for public viewing in just 23% responders in Scotland, Wales and Northern Ireland and 10% of responders in England.

Conclusion: There was significant variation in the use and monitoring of funds between the four nations. All providers need to fulfil their statutory obligation to provide detailed reports to the designated regulatory bodies on their management of the undergraduate education tariff. Effective, transparent management of the education budget is crucial to support the development of the future health workforce as discussed in the NHS 10-year plan. The College Undergraduate Education Forum is setting up a working group to develop guidance on the use of tariffs and will continue to encourage transparency and clarity on the process.

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MRCPsych Course – a National Perspective

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Aims: To gather the views of UK-based resident doctors on their local MRCPsych courses.

Methods: MRCPsych courses aim to broaden resident doctors' knowledge of psychiatry andprepare them for the Royal College of Psychiatrists membership examinations. The courses vary widely between deaneries. Understanding resident doctors' experiences is needed to help ensure equitable and high-quality delivery.

A cross-sectional survey was created and disseminated to UK-based resident doctors via the Psychiatric Resident Doctors Committee. Information was gathered on satisfaction, barriers and suggestions for improvement.

Results: A total of 25 responses were received.

69% of respondents felt that their MRCPsych course is useful for their development as psychiatrists, but only 36% felt it was helpful in preparing them for the examinations.

Respondents valued interactive sessions, online flexible learning and recorded sessions, practical sessions, and found it helpful when sessions followed the syllabus. They preferred when sessions were delivered by a clinician and highlighted teaching on subspecialties as particularly helpful due to lack of exposure in certain regions.

Respondents found their courses less helpful when the sessions did not follow the syllabus, out of date material was used, and when there was no introduction to the MRCPsych examinations. Respondents preferred if lecturers had a knowledge of their syllabus

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