

A Competency Based Curriculum for Specialist Training in Psychiatry

Specialists in
General Psychiatry
with endorsement
in Rehabilitation
Psychiatry



Royal College of Psychiatrists

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Specialists in Rehabilitation Psychiatry work with others to assess, manage and treat people with severe and enduring mental health problems, and contribute to the development and delivery of effective services for these people and their relatives and carers. The culture of services reflects the prime importance of personal and social outcomes over conventional cure of symptoms.

1. Introduction

The advanced curriculum provides the framework to train Consultant Psychiatrists for practice in the UK to the level of CCT registration and beyond and is an add-on to the [Core Curriculum](#). Those who are already consultants may find it a useful guide in developing new areas of skill or to demonstrate skills already acquired.

What is set out in this document is the generic knowledge, skills and attitudes, or more readily assessed behaviour, that we believe is common to all psychiatric specialties, together with those that are specific to specialists in General Psychiatry with endorsement in Rehabilitation Psychiatry. This document should be read in conjunction with *Good Medical Practice* and *Good Psychiatric Practice*, which describe what is expected of all doctors and psychiatrists. Failure to achieve satisfactory progress in meeting many of these objectives at the appropriate stage would constitute cause for concern about the doctor's ability to be adequately trained.

Achieving competency in core and generic skills is essential for all specialty and subspecialty training. Maintaining competency in these will be necessary for revalidation, linking closely to the details in *Good Medical Practice* and *Good Psychiatric Practice*. The Core competencies are those that should be acquired by all trainees during their training period starting within their undergraduate career and developed throughout their postgraduate career. **The Core competencies need to be evidenced on an ongoing basis throughout training.** It is expected that trainees will progressively acquire higher levels of competence during training.

2. Rationale

The purposes of the curriculum are to outline the competencies that trainees must demonstrate and the learning and assessment processes that must be undertaken for an award of a certificate of completion of training (CCT) in General Psychiatry, with an endorsement in Rehabilitation Psychiatry.

The curriculum builds upon competencies gained in Foundation Programme training and Core Psychiatry Training and guides the doctor to continuing professional development based on *Good Psychiatric Practice* after they have gained their CCT.

3. Specific features of the curriculum

The curriculum is outcome-based and is learner-centred. Like the Foundation Programme Curriculum, it is a spiral curriculum in that learning experiences revisit learning outcomes. Each time a learning outcome is visited in the curriculum, the purpose is to support the trainee's progress by encouraging performance in situations the trainee may not have previously encountered, in more complex and demanding situations and with increasing levels of autonomy. The details of how the Curriculum supports progress is described in more detail in the Trainee and Trainer Guide to ARCPs that is set out later. The intended learning outcomes of the curriculum are structured under the Good Medical Practice (2013) headings that set out a framework of professional competencies.

The curriculum is learner-centred in the sense that it seeks to allow trainees to explore their interests within the outcome framework, guided and supported by an educational supervisor. The Royal College of Psychiatrists has long recognised the importance of educational supervision in postgraduate training. For many years, the College recommended that all trainees should have an hour per week of protected time with their educational supervisor to set goals for training, develop individual learning plans, provide feedback and validate their learning.

The competencies in the curriculum are arranged under the Good Medical Practice headings as follows:

1. Knowledge, skills and performance
2. Safety and Quality
3. Communication, partnership and teamwork
4. Maintaining trust

They are, of course, not discrete and free-standing, but overlap and inter-relate to produce an overall picture of the Psychiatrist as a medical expert.

It is important to recognise that these headings are used for structural organization only. The complexity of medical education and practice means that a considerable number of the competencies set out below will cross the boundaries between different categories. Moreover, depending on circumstances, many competencies will have additional

components or facets that are not defined here. This curriculum is based on meta-competencies and does not set out to define the psychiatrist's progress and attainment at a micro-competency level.

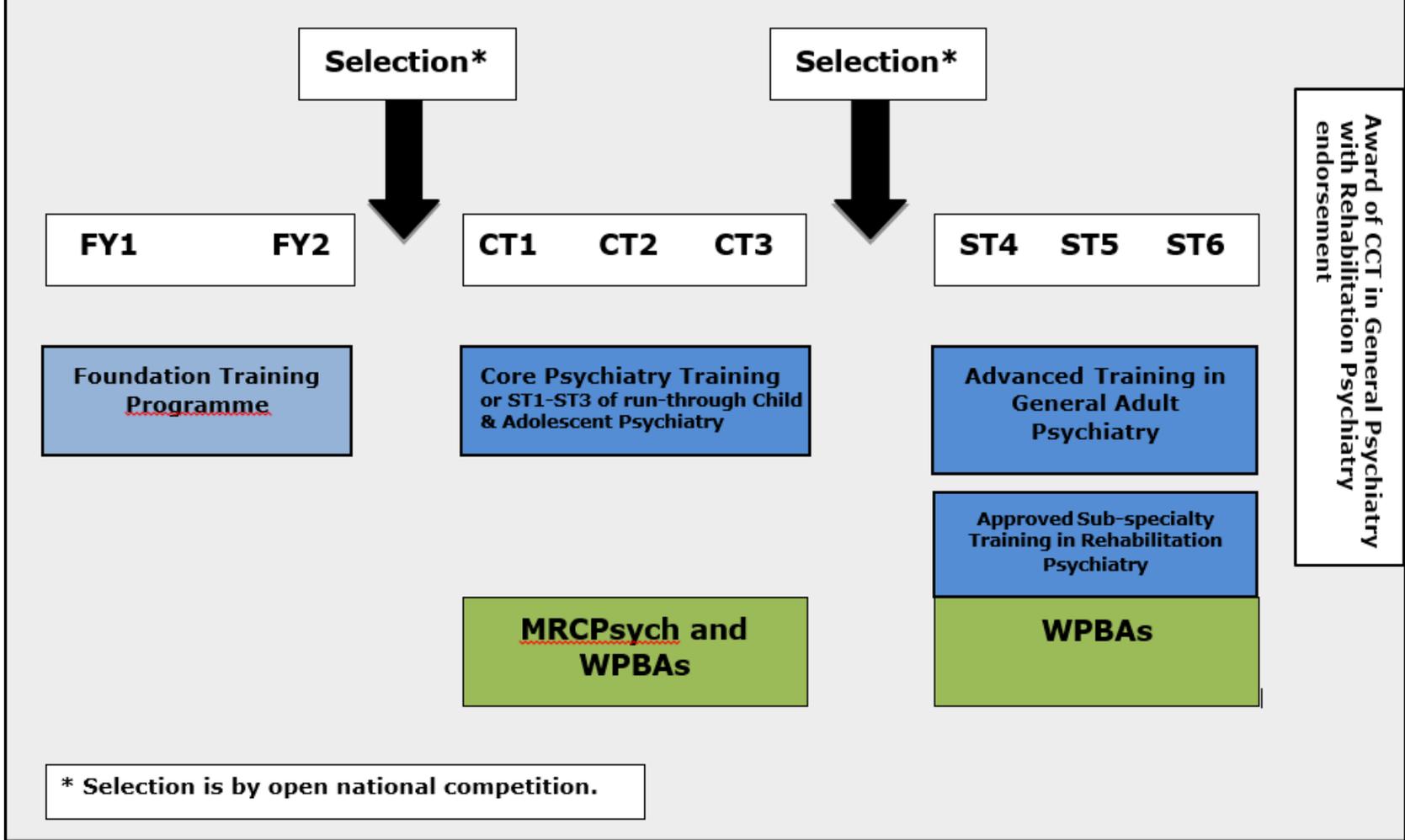
With these points in mind, this curriculum is based on a model of intended learning outcomes with specific competencies given to illustrate how these outcomes can be demonstrated. It is, therefore, a practical guide rather than an all-inclusive list of prescribed knowledge, skills and behaviours.

4. Training pathway

Trainees enter General Psychiatry with endorsement in Rehabilitation Psychiatry Specialty Training after successfully completing both the Foundation Training Programme (or having evidence of equivalence) and either the Core Psychiatry Training programme or the early years (ST1-ST3) of the run-through Child and Adolescent Psychiatry Training programme. They must then enter an Advanced Training Programme in General Psychiatry and apply to enter the Sub-Specialty Programme in Rehabilitation Psychiatry. The trainee will complete a total of three years advanced training, of which two years will be in approved General Psychiatry and one year in approved clinical experience in Rehabilitation Psychiatry. In order to be awarded a CCT in General Psychiatry with an endorsement in Rehabilitation Psychiatry, the trainee must meet the requirements for ST4 and ST6 for General Psychiatry and for the year in Rehabilitation Psychiatry. It therefore follows that it is recommended that the sub-specialty year be in ST5. The progression is shown in Figure 1.

The six psychiatry specialties are Child and Adolescent Psychiatry, Forensic Psychiatry, General Psychiatry, Old Age Psychiatry, the Psychiatry of Learning Disability and Medical Psychotherapy. In addition, there are three sub-specialties; Substance Misuse Psychiatry, Liaison Psychiatry and Rehabilitation Psychiatry. Specialty training in General Psychiatry and Rehabilitation Psychiatry is therefore one of the options that a trainee may apply to do after completing Core Psychiatry Training or the early years (ST1-ST3) of the run-through Child and Adolescent Psychiatry Training programme.

Figure 1. Training pathway to obtain a Certificate of Completion of Training (CCT) in General Psychiatry with endorsement within Rehabilitation Psychiatry.



5. Acting Up

Up to a maximum of three months whole time equivalent (for LTFT trainee the timescale is also three months, Gold Guide 6.105) spent in an 'acting up' consultant post may count towards a trainees CCT as part of the GMC approved specialty training programme, provided the post meets the following criteria:

- The trainee follows local procedures by making contact with the Postgraduate Dean and their team who will advise trainees about obtaining prospective approval
- The trainee is in their final year of training (or possibly penultimate year if in dual training)
- The post is undertaken in the appropriate CCT specialty
- The approval of the Training Programme Director and Postgraduate Dean is sought
- There is agreement from the employing trust to provide support and clinical supervision to a level approved by the trainee's TPD
- The trainee still receives one hour per week education supervision either face to face or over the phone by an appropriately accredited trainer
- Trainees retain their NTN during the period of acting up
- All clinical sessions are devoted to the 'acting up' consultant post (i.e., there must be no split between training and 'acting up' consultant work). Full-time trainees cannot 'act up' in a part-time consultant post.
- The post had been approved by the RA in its current form
- If a trainee is on call there must be consultant supervision
- If the period is sat the end of the final year of the training programme, a recommendation for the award of a CCT will not be made until the report from the educational supervisor has been received and there is a satisfactory ARCP outcome

If the post is in a different training programme*, the usual Out of Programme (OOPT) approval process applies and the GMC will prospectively need to see an application form from the deanery and a college letter endorsing the AUC post

*A programme is a formal alignment or rotation of posts which together comprise a programme of training in a given specialty or subspecialty as approved by the GMC, which are based on a particular geographical area.

6. Accreditation of Transferable Competences Framework (ATCF)

Many of the core competences are common across curricula. When moving from one approved training programme to another, a trainee doctor who has gained competences in core, specialty or general practice training should not have to repeat training already achieved. The Academy of Medical Royal Colleges (the Academy) has developed the Accreditation of Transferable Competences Framework (ATCF) to assist trainee doctors in transferring competences achieved in one core, specialty or general practice training programme, where appropriate and valid, to another training programme.

This will save time for trainee doctors (a maximum of two years) who decide to change career path after completing a part of one training programme, and transfer to a place in another training programme.

The ATCF applies only to those moving between periods of GMC approved training. It is aimed at the early years of training. The time to be recognised within the ATCF is subject to review at the first Annual Review of Competence Progression (ARCP) in the new training programme. All trainees achieving Certificate of Completion of Training (CCT) in general practice or a specialty will have gained all the required competences outlined in the relevant specialty curriculum. When using ATCF, the doctor may be accredited for relevant competences acquired during previous training.'

The Royal College of Psychiatrists accepts transferable competences from the following specialties core medical training, Paediatrics and Child Health and General Practice. For details of the maximum duration and a mapping of the transferable competences please refer to our [guidance](#).

7. RESPONSIBILITIES FOR CURRICULUM DELIVERY

It is recognised that delivering the curriculum requires the coordinated efforts of a number of parties. Postgraduate Schools of Psychiatry, Training Programme Directors, Educational and Clinical Supervisors and trainees all have responsible for ensuring that the curriculum is delivered as intended.

Deanery Schools of Psychiatry

Schools of Psychiatry have been created to deliver postgraduate medical training in England, Wales and Northern Ireland. The Postgraduate Deanery manages the schools with advice from the Royal College. There are no Schools of Psychiatry in Scotland. Scotland has four Deanery Specialty Training Committees for mental health that fulfil a similar role.

The main roles of the schools are:

1. To ensure all education, training and assessment processes for the psychiatry specialties and sub-specialties meet General Medical Council (GMC) approved curricula requirements
2. To monitor the quality of training, ensuring it enhances the standard of patient care and produces competent and capable specialists
3. To ensure that each Core Psychiatry Training Programme has an appropriately qualified psychotherapy tutor who should be a consultant psychotherapist or a consultant psychiatrist with a special interest in psychotherapy.
4. To encourage and develop educational research
5. To promote diversity and equality of opportunity
6. To work with the Postgraduate Deanery to identify, assess and support trainees in difficulty
7. To ensure that clear, effective processes are in place for trainees to raise concerns regarding their training and personal development and that these processes are communicated to trainees

Training Programme Directors

The Coordinating/Programme Tutor or Programme Director is responsible for the overall strategic management and quality control of the General Psychiatry programme within the Training School/Deanery. In a large programme a Training Programme Director in Liaison Psychiatry may assist them. The Deanery (Training School) and the relevant Service Provider (s) should appoint them jointly. They are directly responsible to the Deanery (School) but also have levels of accountability to the relevant service providers(s). With the increasing complexity of training and the more formal monitoring procedures that are in place, the role of the Programme Director/Tutor must be recognized in their job plan, with time allocated to carry out the duties adequately. One programmed activity (PA) per week is generally recommended for 25 trainees. In a large scheme 2 PA's per week will be required. The Training Programme Director for General Psychiatry:

1. Should inform and support College and Specialty tutors to ensure that all aspects of clinical placements fulfil the specific programme requirements.
2. Oversees the progression of trainees through the programme and devises mechanisms for the delivery of co-ordinated educational supervision, pastoral support and career guidance.
3. Manages trainee performance issues in line with the policies of the Training School/Deanery and Trust and support trainers and tutors in dealing with any trainee in difficulty.
4. Ensures that those involved in supervision and assessment are familiar with programme requirements.
5. Will provide clear evidence of the delivery, uptake and effectiveness of learning for trainees in all aspects of the curriculum.

6. Should organise and ensure delivery of a teaching programme based on the curriculum covering clinical, specialty and generic topics.
7. Will attend local and deanery education meetings as appropriate.
8. Will be involved in recruitment of trainees.
9. Ensures that procedures for consideration and approval of LTFT (Less Than Full Time Trainees), OOPT (Out of Programme Training) and OOPR (Out of Programme Research) are fair, timely and efficient.
10. Records information required by local, regional and national quality control processes and provides necessary reports.
11. Takes a lead in all aspects of assessment and appraisal for trainees. This incorporates a lead role in organisation and delivery of ARCP. The Tutor/Training Programme Director will provide expert support, leadership and training for assessors (including in WPBA) and ARCP panel members.

There should be a Training Programme Director for the School/Deanery Core Psychiatry Training Programme who will undertake the above responsibilities with respect to the Core Psychiatry Programme and in addition:

1. Will implement, monitor and improve the core training programmes in the Trust(s) in conjunction with the Directors of Medical Education and the Deanery and ensure that the programme meets the requirements of the curriculum and the Trust and complies with contemporary College Guidance & Standards (see College QA Matrix) and GMC Generic Standards for Training.
2. Will take responsibility with the Psychotherapy Tutor (where one is available) for the provision of appropriate psychotherapy training experiences for trainees. This will include:
 - Ensuring that educational supervisors are reminded about and supported in their task of developing the trainee's competencies in a psychotherapeutic approach to routine clinical practice.
 - Advising and supporting trainees in their learning by reviewing progress in psychotherapy
 - Ensuring that there are appropriate opportunities for supervised case work in psychotherapy.

Medical Psychotherapy Tutor

Where a scheme employs a Psychotherapy Tutor who is a Consultant Psychiatrist in Psychotherapy there is evidence that the Royal College of Psychiatrists' Psychotherapy Curriculum is more likely to be fulfilled than a scheme which does not have a trained Medical Psychotherapist overseeing the Core Psychiatry Psychotherapy training (Royal College of Psychiatrists' UK Medical Psychotherapy Survey 2012). This evidence has been used by the GMC in their quality assurance review of medical psychotherapy (2011-12).

It is therefore a GMC requirement that every core psychotherapy training scheme must be led by a Medical Psychotherapy Tutor who has undergone higher/advanced specialist training in medical psychotherapy with a CCT (Certificate of Completion of Training) in Psychotherapy. The Medical Psychotherapy Tutor is responsible for the organisation and educational governance of psychotherapy training in the core psychiatry training scheme in a School of Psychiatry in line with the GMC requirement of medical psychotherapy leadership in core psychotherapy training (GMC medical psychotherapy report and action plan, 2013).

Where there is no Medical Psychotherapy CCT holder in a deanery a period of derogation up to two years will be accepted by the GMC. Within this period a Medical Psychotherapy Tutor post will be required to be established in the deanery or LETB. The College will ask the Heads of School of Psychiatry what the interim arrangements are to develop the Medical Psychotherapy posts.

The Medical Psychotherapy Tutor:

- Provides a clinical service in which their active and ongoing psychotherapy practice provides a clinical context for psychotherapy training in accordance with GMC requirements (2013)
- Ensures that all core trainees have the opportunity to complete the psychotherapy requirements of the core curriculum
- Advises and support core and higher trainees in their learning by reviewing progress in psychotherapy
- Will be familiar with the ongoing psychotherapy training requirements for psychiatry trainees beyond core training and will lead on ensuring this learning and development continues for higher trainees in line with curriculum requirements
- Oversees the establishment and running of the core trainee Balint/case based discussion group
- Provides assessment and oversee the waiting list of therapy cases for core trainees and higher trainees
- Monitors the selection of appropriate short and long therapy cases in accordance with the core curriculum
- Selects and support appropriate therapy case supervisors to supervise and assess the trainees
- Ensures the therapy case supervisors are aware of the aims of psychotherapy training in psychiatry and are in active practice of the model of therapy they supervise according to GMC requirements (2013)
- Ensures the therapy case supervisors are trained in psychotherapy workplace based assessment
- Ensures active participation of medical and non medical psychotherapy supervisors in the ARCP process
- Maintains and builds on the curriculum standard of core psychotherapy training in the School of Psychiatry through the ARCP process.

Supervision

Supervision in postgraduate psychiatry training encompasses three core aspects:

- Clinical Supervision
- Educational Supervision
- Psychiatric Supervision

Supervision is designed to:

- Ensure safe and effective patient care
- Establish an environment for learning and educational progression
- Provide reflective space to process dynamic aspects of therapeutic relationships, maintain professional boundaries and support development of resilience, well-being and leadership

This guidance sets out the varied roles consultants inhabit within a supervisory capacity. Key principles underpinning all types of supervision include:

- Clarity
- Consistency
- Collaboration
- Challenge
- Compassion

Clinical Supervisors/Trainers

The clinical work of all trainees must be supervised by an appropriately qualified senior psychiatrist. All trainees must be made aware day-to-day of who the nominated supervisory psychiatrist is in all clinical situations. This will usually be the substantive consultant whose team they are attached to but in some circumstances this may be delegated to other consultants, to a senior trainee or to an appropriately experienced senior non consultant grade doctor during periods of leave, out-of-hours etc.

Clinical supervision must be provided at a level appropriate to the needs of the individual trainee. **No trainee**

should be expected to work to a level beyond their competence and experience; no trainee should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise. Trainees should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence; **both trainee and supervisor should at all times be aware of their direct responsibilities for the safety of patients in their care.**

The clinical supervisor:

1. Should be involved with teaching and training the trainee in the workplace.
2. Must support the trainee in various ways:
 - a) direct supervision, in the ward, the community or the consulting room
 - b) close but not direct supervision, e.g. in the next door room, reviewing cases and process during and/or after a session
 - c) regular discussions, review of cases and feedback
3. May delegate some clinical supervision to other members of clinical team as long as the team member clearly understands the role and the trainee is informed. The trainee must know who is providing clinical supervision at all times.
4. Will perform workplace-based assessments for the trainee and will delegate performance of WPBA's to appropriate members of the multi-disciplinary team
5. Will provide regular review during the placement, both formally and informally to ensure that the trainee is obtaining the necessary experience. This will include ensuring that the trainee obtains the required supervised experience in practical procedures and receives regular constructive feedback on performance.

Time for providing clinical supervision must be incorporated into job planning, for example within teaching clinics.

Educational Supervisors/Tutors

An Educational Supervisor/tutor will usually be a Consultant, Senior Lecturer or Professor who has been appointed to a substantive consultant position. They are responsible for the educational supervision of one or more doctors in training who are employed in an approved training programme. The Educational Supervisor will require specific experience and training for the role. Educational Supervisors will work with a small (no more than five) number of trainees. Sometimes the Educational Supervisor will also be the clinical supervisor/trainer, as determined by explicit local arrangements.

All trainees will have an Educational Supervisor whose name will be notified to the trainee. The precise method of allocating Educational Supervisors to trainees, i.e. by placement, year of training etc, will be determined locally and will be made explicit to all concerned.

The educational supervisor/tutor:

1. Works with individual trainees to develop and facilitate an individual learning plan that addresses their educational needs. The learning plan will guide learning that incorporates the domains of knowledge, skills and attitudes.
2. Will act as a resource for trainees who seek specialty information and guidance.
3. Will liaise with the Specialty/Programme tutor and other members of the department to ensure that all are aware of the learning needs of the trainee.
4. Will oversee and on occasions, perform the trainee's workplace-based assessments.
5. Will monitor the trainee's attendance at formal education sessions, their completion of audit projects and other requirements of the Programme.
6. Should contribute as appropriate to the formal education programme.
7. Will produce structured reports as required by the School/Deanery.
8. In order to support trainees, will: -
 - a) Oversee the education of the trainee, act as their mentor and ensure that they are making the necessary clinical and educational progress.
 - b) Meet the trainee at the earliest opportunity (preferably in the first week of the programme), to ensure that the trainee understands the structure of the programme, the curriculum, portfolio and system of assessment and to establish a supportive relationship. At this first meeting the educational agreement should be discussed with the trainee and the necessary paperwork signed and a copy kept by both parties.
 - c) Ensure that the trainee receives appropriate career guidance and planning.
 - d) Provide the trainee with opportunities to comment on their training and on the support provided and to discuss any problems they have identified.

Psychiatric Supervision

Psychiatrists in training require regular reflective 1:1 supervision with a nominated substantive consultant who is on the

specialist register. This will usually be the nominated consultant who is also providing clinical, and often education, supervision.

Psychiatric supervision is required for all trainees throughout core and higher levels and must be for one hour per week. It plays a critical role in the development of psychiatrists in training in developing strategies for resilience, well-being, maintaining appropriate professional boundaries and understanding the dynamic issues of therapeutic relationships. It is also an opportunity to reflect on and develop leadership competencies and is informed by psychodynamic, cognitive coaching models. It is imperative that consultants delivering psychiatric supervision have protected time within their job plans to deliver this. This aspect of supervision requires 0.25 PA per week.

The psychiatric supervisor is responsible for producing the supervisor report informing the ARCP process and will ensure contributions are received from key individuals involved in the local training programme including clinical supervisors. Often the psychiatric supervisor will also be the nominated educational supervisor.

Assessors

Assessors are members of the healthcare team, who need not be educational or clinical supervisors, who perform workplace-based assessments (WPBA's) for trainee psychiatrists. In order to perform this role, assessors must be competent in the area of practice that they have been asked to assess and they should have received training in assessment methods. The training will include standard setting, a calibration exercise and observer training. Assessors should also have up to date training in equality and diversity awareness. While it is desirable that all involved in the training of doctors should have these elements of training, these stipulations do not apply to those members of the healthcare team that only complete multi-source feedback forms (mini-PAT) for trainees.

Trainees

1. Must at all times act professionally and take appropriate responsibility for patients under their care and for their training and development.
2. Must ensure they attend the one hour of personal supervision per week, which is focused on discussion of individual training matters and not immediate clinical care. If this personal supervision is not occurring the trainee should discuss the matter with their educational supervisor/tutor or training programme director.
3. Must receive clinical supervision and support with their clinical caseload appropriate to their level of experience and training.

4. Should be aware of and ensure that they have access to a range of learning resources including:
 - a) a local training course (e.g. MRCPsych course, for Core Psychiatry trainees)
 - b) a local postgraduate academic programme
 - c) the opportunity (and funding) to attend courses, conferences and meetings relevant to their level of training and experience
 - d) appropriate library facilities
 - e) the advice and support of an audit officer or similar
 - f) supervision and practical support for research with protected research time appropriate to grade
5. Must make themselves familiar with all aspects of the curriculum and assessment programme and keep a portfolio of evidence of training.
6. Must ensure that they make it a priority to obtain and profit from relevant experience in psychotherapy.
7. Must collaborate with their personal clinical supervisor/trainer to:
 - a) work to a signed educational contract
 - b) maximize the educational benefit of weekly educational supervision sessions
 - c) undertake workplace-based assessments, both assessed by their clinical supervisor and other members of the multidisciplinary team
 - d) use constructive criticism to improve performance
 - e) regularly review the placement to ensure that the necessary experience is being obtained
 - f) discuss pastoral issues if necessary
8. Must have regular contact with their Educational Supervisor/tutor to:
 - a) agree educational objectives for each post
 - b) develop a personal learning and development plan with a signed educational contract
 - c) ensure that workplace-based assessments and other means of demonstrating developing competence are appropriately undertaken
 - d) review examination and assessment progress
 - e) regularly refer to their portfolio to inform discussions about their achievements and training needs
 - f) receive advice about wider training issues
 - g) have access to long-term career guidance and support
9. Will participate in an Annual Review of Competence Progression (ARCP) to determine their achievement of competencies and progression to the next phase of training.
10. Should ensure adequate representation on management bodies and committees relevant to their training. This would include Trust clinical management forums, such as Clinical Governance Groups, as well as mainstream

training management groups at Trust, Deanery and National (e.g. Royal College) levels.

11. On appointment to a specialty training programme the trainee must fully and accurately complete Form R and return it to the Deanery with a coloured passport size photograph. The return of Form R confirms that the trainee is signing up to the professional obligations underpinning training. Form R will need to be updated (if necessary) and signed on an annual basis to ensure that the trainee re-affirms his/her commitment to the training and thereby remains registered for their training programme.
12. Must send to the postgraduate dean a signed copy of the Conditions of Taking up a training post, which reminds them of their professional responsibilities, including the need to participate actively in the assessment process. The return of the Form R initiates the annual assessment outcome process.
13. Must inform the postgraduate dean and the Royal College of Psychiatrists of any changes to the information recorded.
14. Trainees must ensure they keep the following records of their training:
 - Copies of all Form Rs for each year of registering with the deanery.
 - Copies of ARCP forms for each year of assessment.
 - Any correspondence with the postgraduate deanery in relation to their training.
 - Any correspondence with the Royal College in relation to their training.
15. Must make themselves aware of local procedures for reporting concerns about their training and personal development and when such concerns arise, they should report them in a timely manner.

8. ADVANCED TRAINING IN GENERAL PSYCHIATRY WITH SUB-SPECIALTY ENDORSEMENT IN REHABILITATION PSYCHIATRY

Having completed Core Training, the practitioner may enter Advanced Training in their chosen psychiatric specialty. The outcome of this training will be an autonomous practitioner able to work at Consultant level. This Curriculum outlines the competencies the practitioner must develop and demonstrate before they may be certificated as a Specialist in General Psychiatry with an endorsement in Rehabilitation Psychiatry. Because this level of clinical practice often involves working in complex and ambiguous situations, we have deliberately written the relevant competencies as broad statements. We have also made reference to the need for psychiatrists in Advanced Training to develop skills of clinical supervision and for simplicity, rather than repeat them for each component in the Good Clinical Care Domain; we have stated them only once, although they apply to each domain and will also apply to all specialties and sub-specialties.

The Advanced Training Curriculum builds on Core Psychiatry Training in two ways.

Firstly, Specialty Registrars in Psychiatry all continue to achieve the competencies set out in the Core Psychiatry Training throughout training, irrespective of their psychiatric specialty. This involves both acquiring new competencies, particularly in aspects such as leadership, management, teaching, appraising and developing core competencies such as examination and diagnosis to a high level and, as an expert, serving as a teacher and role model.

Secondly, the Advanced Curriculum set out those competencies that are a particular feature of this specialty. These include competencies that are specific to the specialty, or that feature more prominently in the specialty than they do elsewhere, or that need to be developed to a particularly high level (mastery level) in specialty practice

Some of the intended learning outcomes set out in the Core Curriculum are not included in this Advanced Curriculum. However, for consistency, the numbering system for the intended learning outcomes has been left unchanged here. Therefore, there are gaps in the sequences below.

In order to be awarded a CCT in General Psychiatry with an endorsement in Rehabilitation Psychiatry, the trainee must demonstrate the competencies of General Psychiatry as well as those of Rehabilitation Psychiatry.

9. THE INTENDED LEARNING OUTCOMES FOR SPECIALIST TRAINING IN REHABILITATION PSYCHAITRY

Good Medical Practice, Domain 1: Knowledge, skills and performance

- *Develop and maintain professional performance*
- *Apply knowledge and experience to practice*
- *Record work clearly, accurately and legibly*

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| Intended learning outcome 1 | |
| <p>The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:</p> <ul style="list-style-type: none"> • Presenting or main complaint • History of present illness • Past medical and psychiatric history • Systemic review • Family history • Socio-cultural history • Developmental history | |
| Intended learning outcome 1 | Assessment methods |
| Knowledge | |
| Skills | |
| Evaluate through information obtained from patients, their families and other relevant sources, the patient's strengths, disabilities, risks and vulnerabilities | CBD, CP |
| Apply in practice the principles of assessment of disability associated with primary and secondary impairment and tertiary handicap | ACE, CBD, CP |
| Demonstrate in clinical practice the use of structured tools used in the assessment of psychosis, disability, social function, quality of life and to monitor change | ACE, Mini-ACE, CBD |
| Assess change in social function and predict capability to move between settings | ACE, CBD, CP |

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| Attitudes demonstrated through behaviours Understand the individual as a person with a narrative and how they conceptualise their illness in relation to this | CBD, CP |
| Understand how this affects their self esteem, sense of autonomy and motivation | CBD, CP |

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| Intended learning outcome 2 | |
| <i>The doctor will demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses</i> | |
| Intended learning outcome 2 | Assessment methods |
| Knowledge | |
| Skills Be able to determine capacity, based on an understanding of the concepts | ACE, Mini-ACE, CBD |
| Attitudes demonstrated through behaviours | |

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| Intended learning outcome 4 | |
| <i>Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies</i> | |
| Intended learning outcome 4 | Assessment methods |
| Knowledge Understand the range of potential risk behaviours which service users with SMI/complex needs may exhibit and how these may overlap and interact (e.g. risk of physical aggression/self harm, physical aggression/ vulnerability to aggression from peers in inpatient settings, self-neglect/fire-setting) | CBD, ACE, DONCS |
| Understand the epidemiological factors which may increase risk of harm to others in populations with long term severe mental disorders, how these overlap with factors in the general population and how these factors may interact (e.g. social deprivation, substance misuse, adverse early life experience) | CBD, CP DONCS |

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| <p>Understand the various aspects of mental health legislation including those aspects which relate to courts/Criminal Justice System</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Understand the range of structured risk assessment tools available (including those used in CJS) including their strengths (e.g. structured way of collating factors which may contribute to risk which may then contribute to development of formulation) and weaknesses (e.g. predict risk in populations only, not individuals and do not cover important areas of risk assessment/formulation including situational and victim factors)</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Understand the way in which clinical features of psychosis may increase the likelihood that risk behaviours will occur (e.g. positive psychotic symptoms particularly 'threat/control override' type, high arousal, impulsivity secondary to cognitive difficulties, limited insight leading to non-adherence with medication regimes)</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Understand the way in which other factors may contribute to increasing the likelihood of risk behaviours occurring (e.g. substance misuse, personality, lifestyle and lack of social supports)</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Understand the way in which characteristics of the victim and their relationship with the service user may increase the risk of violence or other risk behaviours (e.g. family members in high EE situations, specific victim groups for particular individuals which may derive from content of persecutory positive symptoms)</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Understand the way in which the particular circumstances surrounding a risk incident may have contributed to that incident occurring (e.g. over stimulating environment in an inpatient setting, lack of support, other social stresses or real threats within the environment such as being arrested etc)</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |

Skills

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| Use mental health legislation including those aspects which relate to courts/Criminal Justice System | CBD, CP, Mini-ACE, ACE, DONCS |
| Apply a the range of structured risk assessment tools available (including those used in CJS) | CBD, CP, Mini-ACE, ACE, DONCS |
| Consider clinical features of psychosis, associated factors which may increase likelihood of risk behaviour occurring, characteristics of the victim and their relationship with the service user and particular circumstances surrounding a risk incident in the context of previous history of risk behaviours collated from the widest possible range of sources to contribute towards development of formulation (e.g. consistent patterns of risk behaviour in similar circumstances, changes in pattern or escalation, new behaviours emerging) | CBD, CP, Mini-ACE, ACE, DONCS |
| Consider protective factors and strengths which may reduce the likelihood of such a risk behaviour occurring in the future, to contribute towards development of formulation (e.g. motivation to take medication, stable lifestyle, empathy towards others) | CBD, CP, Mini-ACE, ACE, DONCS |
| Work collaboratively with the service user to explore all of these issues in such a way that s/he can increase understanding, insight and motivation and view self-management of risk as an essential part of the Recovery process. | CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT |
| Work collaboratively with the service user to develop a coherent shared formulation of risk using all of the above information. | CBD, CP, Mini-ACE, ACE, DONCS |
| Work collaboratively with the service user to identify early signs of deterioration in mental state and behaviour plus potential triggers and situational factors which may lead to risk behaviours recurring | CBD, CP, Mini-ACE, ACE, DONCS |
| Work collaboratively with the service user to develop a coherent plan aimed towards reducing the likelihood of risk behaviours recurring in future, identifying clearly the service user's own role and that of other people including care co-ordinator/MDT members. | CBD, CP, Mini-ACE, ACE, DONCS |

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| Work collaboratively with service user to incorporate this risk management plan into a comprehensive care plan which is agreed and shared with all involved parties including carers and other involved agencies (CPA - Care Programme Approach). | CBD, CP, Mini-ACE, ACE, DONCS |
| Work collaboratively with service user to incorporate this risk management plan into a comprehensive care plan which is agreed and shared with all involved parties including carers and other involved agencies (CPA - Care Programme Approach). | CBD, CP, Mini-ACE, ACE, DONCS, mini-PAT |
| Ensure that all involved parties, including service user and carers, are aware of easy and reliable routes to receive support quickly when there are early signs of deterioration. | CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT |
| Support service users in the development of advanced statements/directives in relation to their care. | CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT |
| Attitudes demonstrated through behaviours | |

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| Intended learning outcome 5 | |
| <i>Based on the full psychiatric assessment, the doctor will demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions</i> | |
| Knowledge | Assessment methods |
| Skills Competently assess and manage carers' needs and stress including the provision of psycho-education | ACE, Mini-ACE, CBD, CP DONCS |
| Attitudes demonstrated through behaviours | |

| Intended learning outcome 7 | |
|---|---|
| <i>To be able to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states</i> | |
| 7a Management of severe and enduring mental illness | Assessment methods |
| <p>Knowledge</p> <p>Understand the psychological effects of chronic illness on interpersonal relationships and intrapersonal structures</p> <p>Describe local and national protocols, laws, benefits and policies relating to mental health service provision in hospitals, residential work, educational settings and other social settings</p> <p>The pharmacological management of psychosis resistant to conventional regimes such as NICE and BNF guidelines</p> <p>Know how to ensure the development of a variety of care settings which allow individuals to pick the least dependent and restrictive and the most socially inclusive environment appropriate as close to where they want to live as possible</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> <p>CBD, CP, Mini-ACE, ACE, DONCS</p> <p>CBD, CP, Mini-ACE, ACE, DONCS</p> <p>CBD, CP, Mini-ACE, ACE, DONCS</p> |
| <p>Skills</p> <p>Contribute a psychotherapeutic perspective to the multidisciplinary assessment and management of patients with severe and enduring mental illness</p> <p>Use high level communication, negotiation and liaison skills with other stakeholders, including primary care, general adult, forensic and substance use services, Criminal Justice System, prisons and Probation Services and other independent providers as appropriate to develop flexible, integrated and comprehensive services</p> <p>Sustain optimism that instills hope for recovery in individuals and those around them</p> <p>Balance the risks of disengagement from services with the potential benefits of challenging unwillingness to face issues or progress</p> | <p>CBD, DONCS, SAPE</p> <p>CBD, DONCS</p> <p>CBD, DONCS, ACE, Mini-ACE</p> <p>CBD, CP, DONCS</p> |

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| <p>When crisis arises, recognise the dynamics in the individuals environment which may contribute and address them sensitively in so far as possible to avert the crisis</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> |
| <p>Attend to the practical needs of the patient, including housing, benefits, education, work, activities of daily living, social and leisure needs</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> |
| <p>Employ evidence based psychological approaches for treatment of disorders resistant to pharmacological intervention</p> | <p>CBD, CP, SAPE DONCS</p> |
| <p>Identify strengths and tensions in the relationship of patients with their families and carers and address appropriately</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> |
| <p>Assess and manage risk as part of a comprehensive package of recovery-based support for people with severe mental illness/complex needs within a wide range of settings from inpatient services to the community</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> |
| <p>Provide comprehensive adapted rehabilitation programmes for service users with cognitive deficits associated with severe mental illness/co-morbid conditions</p> | <p>CBD, CP, DONCS, Mini-PAT</p> |
| <p>Attitudes demonstrated through behaviours</p> | |
| <p>Help professionals from different backgrounds to understand and use psychotherapeutic concepts in managing this patient group</p> | <p>CBD, CP DONCS</p> |
| <p>Provide psychotherapeutic assessment and specific evidence based interventions for people with chronic, disabling and complex mental health problems</p> | <p>ACE, SAPE, CBD</p> |
| <p>Ensure that care plans are consistent with the patient's strengths and level of function and that access to interventions is not precluded by disability</p> | <p>CBD, CP, Mini-ACE, ACE, DONCS, Mini-PAT</p> |
| <p>Maintain a strategic focus on the provision of work, leisure, social and educational services for patients with severe mental illness</p> | <p>CBD, CP, DONCS, Mini-PAT</p> |

| Intended learning outcome 8 | |
|--|--------------------|
| <i>To develop an understanding of research methodology and critical appraisal of the research literature</i> | |
| | Assessment methods |
| Knowledge | |
| Skills Demonstrate understanding of research methodologies that identify benefits from services to patients whose long-term conditions are resistant to conventional physical and psychological treatments | DONCS, JCP |
| Behaviours | |

Good Medical Practice, Domain 3: Communication, partnership and teamwork

- *Treat patients as individuals and respect their dignity*
- *Work in partnership with patients*
- *Work with colleagues in the ways that best serve patients' interests*

| Intended learning outcome 14 | |
|---|---------------------------------|
| <i>To demonstrate the ability to work effectively with colleagues, including team working</i> | |
| | Assessment methods |
| Knowledge | |
| Skills Liaise effectively with a range of stakeholders, including user organisations, Advocacy Services, Independent service providers, Criminal Justice System, Probation Services, patients' legal representatives in developing care plans and understand the different roles and responsibilities of those bodies | CBD, DONCS, supervisor's report |

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| <p>Attitudes demonstrated through behaviours</p> <p>Work with staff and carers to address challenging behaviour in a manner that is sensitive to the individual and sustains the therapeutic relationship</p> <p>Inspire, encourage and support other professional staff to work long-term with patients with severe and enduring mental illness</p> | <p>CBD, DONCS, Mini-PAT, supervisor's report</p> <p>CBD, DONCS, Mini-PAT, supervisor's report</p> |
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| Intended learning outcome 15 | |
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| <i>Develop appropriate leadership skills</i> | |
| Knowledge | Assessment methods |
| <p>Skills</p> <p>Sustain staff to work long-term with patients and their families with complex problems where progress is slow and where social function, quality of life, confidence and autonomy take precedence over "cure"</p> <p>Use negotiation and management skills to promote and develop rehabilitation services for patients with severe and enduring mental illness and to develop strategies to tackle adverse commissioning cultures</p> | <p>CBD, DONCS, Mini-PAT, supervisor's report</p> |
| <p>Behaviours</p> <p>Promote enthusiasm for and satisfaction with work with long term and enduring condition, amongst trainees and other staff</p> <p>Promote a social psychiatry/recovery culture amongst staff of services delivering rehabilitation</p> | <p>CBD, DONCS, Mini-PAT, supervisor's report</p> <p>CBD, DONCS, Mini-PAT, supervisor's report</p> |

| Intended learning outcome 17 | |
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| <i>Develop the ability to teach, assess and appraise</i> | |
| Knowledge | Assessment methods |
| <p>Skills</p> <p>Sensitively develop understanding of staff in partner services/agencies, such as residential and community support staff, of concepts and culture of recovery, social inclusion and social psychiatry both in the immediate clinical situation and through teaching programmes</p> | <p>CBD, DONCS, AoT, Mini-PAT, supervisor's report</p> |

10. METHODS OF LEARNING AND TEACHING

The curriculum is delivered through a number of different learning experiences, of which experiential workplace learning with supervision appropriate to the trainee's level of competence is the key. This will be supported by other learning methods as outlined below: -

1. Appropriately supervised clinical experience
2. Psychotherapy training
3. Emergency psychiatry experience
4. Interview skills
5. Learning in formal situations
6. Teaching
7. Management experience
8. Research
9. ECT Training
10. Special interest sessions

Appropriately supervised clinical experience

Trainees must at all times participate in clinical placements that offer appropriate experience i.e. direct contact with and supervised responsibility for patients. **All training placements must include direct clinical care of patients.** Placements based on observation of the work of other professionals are not satisfactory. **Each placement must have a job description and timetable. There should be a description of potential learning objectives in post.** Training placements should not include inappropriate duties (e.g. routine phlebotomy, filing of case notes, escorting patients, finding beds, etc) and must provide a suitable balance between service commitment and training.

Psychotherapy training

The aim of psychotherapy training is to contribute to the training of future consultant psychiatrists in all branches of psychiatry who are psychotherapeutically informed, display advanced emotional literacy and can deliver some psychological treatments and interventions. Such psychiatrists will be able to:

- Account for clinical phenomena in psychological terms
- Deploy advanced communication skills

- Display advanced emotional intelligence in dealings with patients and colleagues and yourself.
- Refer patients appropriately for formal psychotherapies
- Jointly manage patients receiving psychotherapy
- Deliver basic psychotherapeutic treatments and strategies where appropriate

A senior clinician with appropriate training (preferably a consultant psychotherapist) should be responsible for organising psychotherapy training within a School in line with current curriculum requirements. There are two basic requirements: -

Case based discussion groups (CBDG) are a core feature of early training in psychotherapeutic approach to psychiatry. They involve regular weekly meetings of a group of trainees and should last around one and one and a half hours. The task of the meeting is to discuss the clinical work of the trainees from a psychotherapeutic perspective paying particular attention to the emotional and cognitive aspects of assessment and management of psychiatric patients in whatever setting the trainee comes from. Trainees should be encouraged to share their feelings and thoughts openly and not to present their cases in a formal or stilted manner. Most trainees should attend the group for about one year. Attendance and participation in the CBDG will be assessed

Undertaking specific training experiences treating patients is the only reliable way to acquire skills in delivering psychotherapies. The long case also helps in learning how to deal with difficult or complicated emotional entanglements that grow up between patients and doctors over the longer term. Patients allocated to trainees should be appropriate in terms of level of difficulty and should have been properly assessed. Trainees should be encouraged to treat a number of psychotherapy cases during their training using at least two modalities of treatment and at least two durations of input. This experience must be started in Core training and continued in Advanced Training, so that by the end of Core Training the trainee must have competently completed at least two cases of different durations. The psychotherapy supervisor will assess the trainee's performance by using the SAPE.

Care should be given in the selection of psychological therapy cases in Advanced Training in General Psychiatry and Rehabilitation Psychiatry to make the experience gained is relevant to the trainee's future practice as a consultant. Trainees in Rehabilitation Psychiatry should gain experience in providing psychological therapy to patients with medication resistant symptoms and those with an interest in personality disorders should consider developing their knowledge of treatments such as dialectical behaviour therapy, mentalisation based therapy and cognitive analytic therapy.

The psychotherapy tutor should have selected supervisors. Psychotherapy supervisors need not be medically qualified but they should possess appropriate skills and qualifications both in the modality of therapy supervised and in teaching and supervision.

Emergency Psychiatry

Trainees must gain experience in the assessment and clinical management of psychiatric emergencies and trainees must document both time spent on-call and experience gained (cases seen and managed) and this should be "signed off" by their Clinical Supervisor/Trainer.

A number and range of emergencies will constitute relevant experience. During Core Psychiatry training, trainees must have experience equivalent to participation in a first on call rota with a minimum of 55 nights on call during the period of core specialty training (i.e. at least 50 cases with a range of diagnosed conditions and with first line management plans conceived and implemented.) (Trainees working part time or on partial shift systems must have equivalent experience.)

Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes Core Psychiatry trainees from the initial assessment of deliberate self-harm patients or DGH liaison psychiatry consultations, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.

Psychiatric trainees should not provide cross specialty cover for other medical specialties except in exceptional circumstances where otherwise duty rotas would not conform to the European Working Time Directive. No trainee should be expected to work to a level beyond their clinical competence and experience.

Where daytime on call rotas are necessary, participation must not prevent trainees attending fixed training events.

Advanced trainees in General Psychiatry must have opportunities to supervise others as part of their experience of emergency psychiatry. They should not routinely perform duties (such as clerking emergency admissions) that would normally be performed by less experienced practitioners.

Interview skills

All trainees must receive teaching in interviewing skills in the first year Core Psychiatry Training (CT1). The use of feedback through role-play and/or video is recommended. Soliciting (where appropriate) the views of patients and carers on performance is also a powerful tool for feedback.

Learning in formal situations

Learning in formal situations will include attending a number of courses for which the trainee should be allowed study leave: -

- It is essential that trainees in Core Psychiatry Training attend an MRCPsych course that comprises a systematic course of lectures and /or seminars covering basic sciences and clinical topics, communication and interviewing skills.
- Local postgraduate meetings where trainees can present cases for discussion with other psychiatrists, utilising information technology such as slide presentations and video recordings.
- Journal clubs, where trainees have the opportunity to review a piece of published research, with discussion chaired by a consultant or specialty registrar (ST4-ST6), Postgraduate meetings where trainees can present and discuss audit.
- Multi-disciplinary/multi-professional study groups.
- Learning sets which can stimulate discussion and further learning.
- Trainees must also exercise personal responsibility towards their training and education and are encouraged to attend educational courses run by the College's divisional offices.

Experience of teaching

It is important that all trainee psychiatrists have experience in delivering education. In Core Psychiatry training, trainees should have opportunities to assist in 'bedside' teaching of medical students and delivering small group teaching under supervision. Advanced trainees in General Psychiatry & Rehabilitation Psychiatry should be encouraged to be involved in teaching CT1-3 trainees on the MRCPsych course and to be involved in the design, delivery and evaluation of teaching events and programmes.

Management experience

Opportunity for management experience should be available in all training programmes and should begin with simple tasks in the clinical, teaching and committee work of the hospital or service.

Attending courses and by shadowing a medical manager to get insight into management. For example, the final month of a ST4 placement could be spent working with a manager.

"Hands on" experience is especially effective, e.g. convening a working group, and it may be possible for a trainee to be given a relevant management task to complete.

Opportunity for involvement in administration and collaboration with non medical staff at local level on the ward or unit, at Trust level or on the training scheme itself to gain familiarity with and an understanding of management structure and process as part of a trainee's professional development as a psychiatrist.

ECT Training

All Core Psychiatry training programmes must ensure that there is training and supervision in the use of ECT so that trainees become proficient in the prescribing, administration and monitoring of this treatment.

Research

Opportunities must be made available for trainees to experience supervised quantitative or qualitative research and a nominated research tutor should be available within the programme to advise trainees on the suitability of projects. In Core Psychiatry training, research may be limited to case reports or a small literature review. In advanced training in General Psychiatry, trainees should have the opportunity to participate in original

Special interest sessions

It is educationally desirable that Advanced Trainees in General Psychiatry and Rehabilitation Psychiatry have the ability to gain additional experiences that may not be available in their clinical placement. Two sessions every week must be devoted during each year from ST4-6 should be set aside for such personal development, which may be taken in research or to pursue special clinical interests. Special interest sessions are defined as "a clinical or clinically related area of service which cannot be provided within the training post but which is of direct relevance to the prospective career pathway of the trainee". For instance, a special interest session in Substance Misuse Psychiatry may be of direct relevance to a trainee wishing to subsequently work in a psychiatry rehabilitation service. Special interest sessions may also be used for gaining psychotherapy experience that builds upon the experience the trainee had in Core Training. This experience must be appropriately managed, supervised and assessed. The Training Programme Director must prospectively approve the use of special interest time. Special interest and research supervisors must provide reports for the trainee's ARCP as required by the School of Psychiatry.

11. THE ASSESSMENT SYSTEM FOR ADVANCED TRAINING IN GENERAL PSYCHIATRY WITH ENDORSEMENT IN REHABILITATION PSYCHIATRY.

Purpose

The Royal College of Psychiatrists Assessment System has been designed to fulfill several purposes:

- Providing evidence that a trainee is a competent and safe practitioner and that they are meeting the standards required by Good Medical Practice
- Creating opportunities for giving formative feedback that a trainee may use to inform their further learning and professional development
- Drive learning in important areas of competency
- Help identify areas in which trainees require additional or targeted training
- Providing evidence that a trainee is progressing satisfactorily by attaining the Curriculum learning outcomes
- Contribute evidence to the Annual Review of Competence Progression (ARCP) at which the summative decisions regarding progress and ultimately the award of the Certificate of Completion of Training (CCT) are made.

Assessment blueprint

The Assessment Blueprint supplement to this Curriculum shows the assessment methods that can possibly be used for each competency. It is not expected that all trainees will be assessed by all possible methods in each competency. The learning needs of individual trainees will determine which competencies they should be assessed in and the number of assessments that need to be performed. The trainee's Educational Supervisor has a vital role in guiding the trainee and ensuring that the trainee's assessments constitute sufficient curriculum coverage.

Trainees must pass the MRCPsych examination and successfully completed core training before entering Advanced Training in General Psychiatry.

Workplace Based Assessment (WPBA) is the assessment of a doctor's performance in those areas of professional practice best tested in the workplace. The assessment of performance by WPBA will continue the process established in the Foundation Programme and will extend throughout Core Psychiatry Training and Advanced Training in General Psychiatry. It must be understood that WPBA's are primarily tools for giving formative feedback and in order to gain the full benefit of this form of assessment, trainees should ensure that their assessments take place at regular intervals

throughout the period of training. All trainees must complete at least one case-focused assessment in the first month of each placement in their training programme. A completed WPBA accompanied by an appropriate reflective note written by the trainee and evidence of further development may be taken as evidence that a trainee demonstrates critical self-reflection. Educational supervisors will draw attention to trainees who leave all their assessments to the 'last minute' or who appear satisfied that they have completed the minimum necessary.

An individual WPBA is not a summative assessment, but outcomes from a number of WPBA's will contribute evidence to inform summative decisions.

The WPBA tools currently consist of:

Assessment of Clinical Expertise (ACE) modified from the Clinical Evaluation Exercise (CEX), in which an entire clinical encounter is observed and rated thus providing an assessment of a doctor's ability to assess a complete case

Mini-Assessed Clinical Encounter (mini-ACE) modified from the mini-Clinical Evaluation Exercise (mini-CEX) used in the Foundation Programme, part of a clinical encounter, such as history-taking, is observed and rated.

Case Based Discussion (CBD) is also used in the Foundation Programme and is an assessment made on the basis of a structured discussion of a patient whom the Trainee has recently been involved with and has written in their notes.

Direct Observation of Procedural Skills (DOPS) is also used in the Foundation Programme and is similar to mini-ACE except that the focus is on technical and procedural skills.

Multi-Source Feedback (MSF) is obtained using the Mini Peer **Assessment Tool (mini-PAT)**, which is an assessment made by a cohort of co-workers across the domains of *Good Medical Practice*.

Case Based Discussion Group Assessment (CBDGA) has been developed by the College to provide structured feedback on a trainee's attendance and contribution to case discussion groups (also known as Balint-type groups) in Core Psychiatry Training.

Structured Assessment of Psychotherapy Expertise (SAPE) has been developed by the College to provide evidence of satisfactory completion of a psychotherapy case.

Case Presentation (CP) developed at the College; this is an assessment of a major case presentation, such as a Grand Round, by the Trainee.

Journal Club Presentation (JCP) similar to CP, and also developed at the College, this enables an assessment to be made of a Journal Club presented by the Trainee.

Assessment of Teaching (AoT) has been developed at the College to enable an assessment to be made of planned teaching carried out by the Trainee, which is a requirement of this curriculum.

Direct Observation of non-Clinical Skills (DONCS) has been developed by the College from the Direct Observation of Procedural Skills (DOPS). The DONCS is designed to provide feedback on a doctor's performance of non-clinical skills by observing them chairing a meeting, teaching, supervising others or engaging in another non-clinical procedure.

WPBA for Advanced Trainees

Doctors in Advanced Training Programmes should participate in at least one or two rounds of multi-source feedback a year and have at least one other WPBA performed a month. It is likely that the CbD will be an important assessment tool for these doctors because this tool permits a deep exploration of a doctor's clinical reasoning. The mini-ACE may be less important for most advanced trainees, except perhaps those engaged in areas of clinical work that they had not encountered in core training. As stated above, the College is developing the DONCS as a means of assessing performance of skills in situations that do not involve direct patient encounters. In time, it is possible that some psychiatric sub-specialty Advanced Training Curricula may introduce novel WPBA tools for specialised areas of work. Detailed information is contained in the Guide to ARCP panels.

Decisions on progress, the ARCP

Section 7 of the **Guide to Postgraduate Specialty Training in the UK** ("[Gold Guide](#)") describes the **Annual Review of Competence Progression (ARCP)**. The ARCP is a formal process that applies to all Specialty Trainees. In the ARCP a properly constituted panel reviews the evidence of progress to enable the trainee, the postgraduate dean, and employers to document that the competencies required are being gained at an appropriate rate and through appropriate experience.

The panel has two functions:

1. To consider and prove the adequacy of the trainee's evidence.
2. Provided the documentation is adequate, to make a judgment about the trainee's suitability to progress to the next stage of training or to confirm that training has been satisfactorily completed

The next section is a guide for regarding the evidence that trainees should submit for their year of Rehabilitation Psychiatry training. There are several different types of evidence including WPBA's, supervisor reports, the trainee's learning plan, evidence of reflection, course attendance certificates etc. The evidence may be submitted in a portfolio and in time, this will be done using the College e-portfolio.

Trainees may submit WPBA's that have been completed by any competent healthcare professional who has undergone training in assessment. In a number of cases, we have stipulated that a consultant should complete the assessment. WPBA's in developmental psychiatry (i.e. in children and patients with learning disability) should be performed by a specialist child psychiatrist or learning disability psychiatrist.

The trainee should map the evidence that they wish to be considered for each competency. A single piece of evidence may be used to support more than one competency.

12. Guide for ARCP panels to Assessments required in Rehabilitation Psychiatry

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| Intended learning outcome | ST Year in Rehabilitation Psychiatry |
| <p>1. Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:</p> <ul style="list-style-type: none"> • Presenting or main complaint • History of present illness • Past medical and psychiatric history • Systemic review • Family history • Socio-cultural history • Developmental history | |
| | <p>In general this is best assessed through CBDs and at least one should be with a rehabilitation accredited consultant so that the particular culture of rehabilitation spelt out in the Curriculum can be demonstrated.</p> <p>Individual elements can be assessed through MiniACE</p> |
| <p>2. Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses</p> | |
| | <p>This will be demonstrated through CBDs, at least one with a rehabilitation accredited Consultant</p> |
| <p>5. Based on the full psychiatric assessment, demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor will also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions</p> | |
| | <p>Wherever possible there should be an ACE covering observation of the trainees assessment and handling of a crisis, for instance in a residential home.</p> |

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| | Areas of the assessment and management of situations can be assessed through CBD and also by a DONC in handling a review or CPA |
| 7. Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states | |
| 7a Management of severe and enduring mental illness | The measured approach of Rehabilitation will mean that the basis of assessment will be through multiple CBDs. As most patients in Rehabilitation have long term complex conditions there will be overlap with those done in 1-5. Communication and negotiating skills should be assessed through a DONC. The culture, and approach to problems should be reflected in the supervisor's reports. |
| 8 To develop an understanding of research methodology and critical appraisal of the research literature | |
| | There should be a report from a supervisor of the trainees research. A journal Club Assessment could also elicit some of these skills in presenting research on service benefit for those with treatment resistant conditions. |
| 9. To demonstrate the ability to work effectively with colleagues, including team working | |
| | This can be demonstrated through Mini PAT and through DONC. It should be reflected in the supervisor's report |
| 10 Develop appropriate leadership skills | |
| | One round of Mini-PAT Supervisor's reports |
| 17 To ensure that the doctor acts in a professional manner at all times | |
| | An ACE or Mini Ace can be used to assess respect for patients as people and this should also be reflected in the supervisors report to ensure it is generalised. |
| 17f Probity | Supervisor's reports |

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| 17g Personal health | Supervisor's reports |
| 18 To develop the habits of lifelong learning | |
| 18a Maintaining good medical practice | Supervisor's reports |
| 18b Lifelong learning | An effective individual learning plan outlining learning needs, methods and evidence of attainment Evidence of self-reflection |
| 18c Relevance of outside bodies | Evidence of continued GMC registration |