# 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 Forensic 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

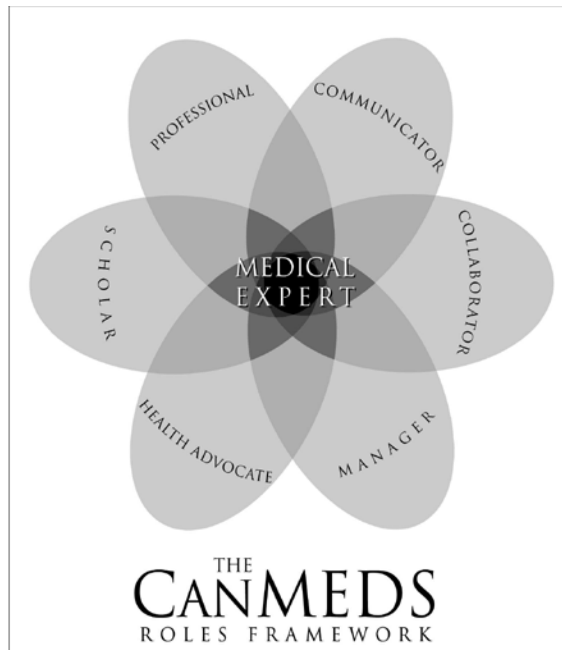
The curriculum is outcome-based and is learner-centred. Like the Foundation Programme Curriculum, it is a spiral curriculum in that learning experiences revisit learning outcomes. Each time a learning outcome is visited in the curriculum, the purpose is to support the trainee's progress by encouraging 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 two Guides to ARCP panels that is set out later. The intended learning outcomes of the curriculum are structured under the CanMEDS (2005) headings that set out a framework of professional competencies. These can be mapped to the headings of *Good Medical Practice,* which were used in the first edition of this curriculum, but CanMEDS has been found to form a more practical structure.

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 CanMEDS headings as follows: -

1. MEDICAL EXPERT
2. COMMUNICATOR
3. COLLABORATOR
4. MANAGER
5. HEALTH ADVOCATE
6. SCHOLAR
7. PROFESSIONAL

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, as the diagram above illustrates. 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. To do so would result in a document of quite impracticable length and detail which would almost inevitably require constant revision.

With these points in mind, this curriculum is based on a model of intended learning outcomes (which are summarised below) 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. How the curriculum was developed

The Royal College of Psychiatrists commenced work on a revision of the curriculum almost immediately upon completion of first approved document. This was because the College felt that the first document was uneven in its coverage of clinical and non-clinical domains and that the structure did not easily lend itself to the psychosocial aspects of the specialty. Feedback from trainers and trainees confirmed this impression, as well as giving a message about difficulties with navigation and an overall problem with "user friendliness".

The College Curriculum Committee, which includes lay membership, had a small working group led by one of the Associate Deans; this working group involved the Dean, Chief Examiner, Chair of the Trainees Committee and College Educational Advisor. The group worked at all times closely with faculties with whom it held individual meetings to explore reception of the current curriculum, suggestions for improvement, and thoughts on progress with regard to in-service assessment. These meetings were held individually, faculty by faculty, and special interest group by special interest group. The group's work was also discussed within the regular meeting of the Heads of Postgraduate School's of Psychiatry, a group that facilitates communication between the College and the national faculty of psychiatric educators. The group consulted with the College Education and Training Committee, which is the central committee within the Royal College of Psychiatrists for all matters in post-graduate medical education, as well as the College Modernising Medical Careers Working Group. This was to ensure that developments were in-line with any other structural changes in training and career pathways.

The group proposed a number of different models for the curriculum and felt that the CanMED's model afforded the right way ahead for psychiatry at this point in time. However, the approach of a mixed economy was taken as the views and arguments of some individuals and specialties around the fact that they felt that changing the format may initially lose some important changes to content and thus the presentation of specialties in slightly different formats and varying degrees of detail in terms of content.

The work has proceeded in consultation with the above mentioned groups, as well as those involved intimately in the day to day delivery of teaching and training, including the college tutors and training programme directors, and, most importantly, those involved in learning, that is the trainees. Presentations have been made at key meetings, for example, the College Annual Medical Education Conference and discussions and feedback received. These consultations were incorporated in the document submitted to General Medical Council (GMC) in January 2013.

The next stage, in terms of communication, will be a strategy for implementation. The College has learned from its successful approach to the implementation of workplace based assessments and will be undertaking a UK wide exercise communicating the content and use of the curriculum, including up-dated information on the assessment programme to fit with examinations and the ARCP and quality management.

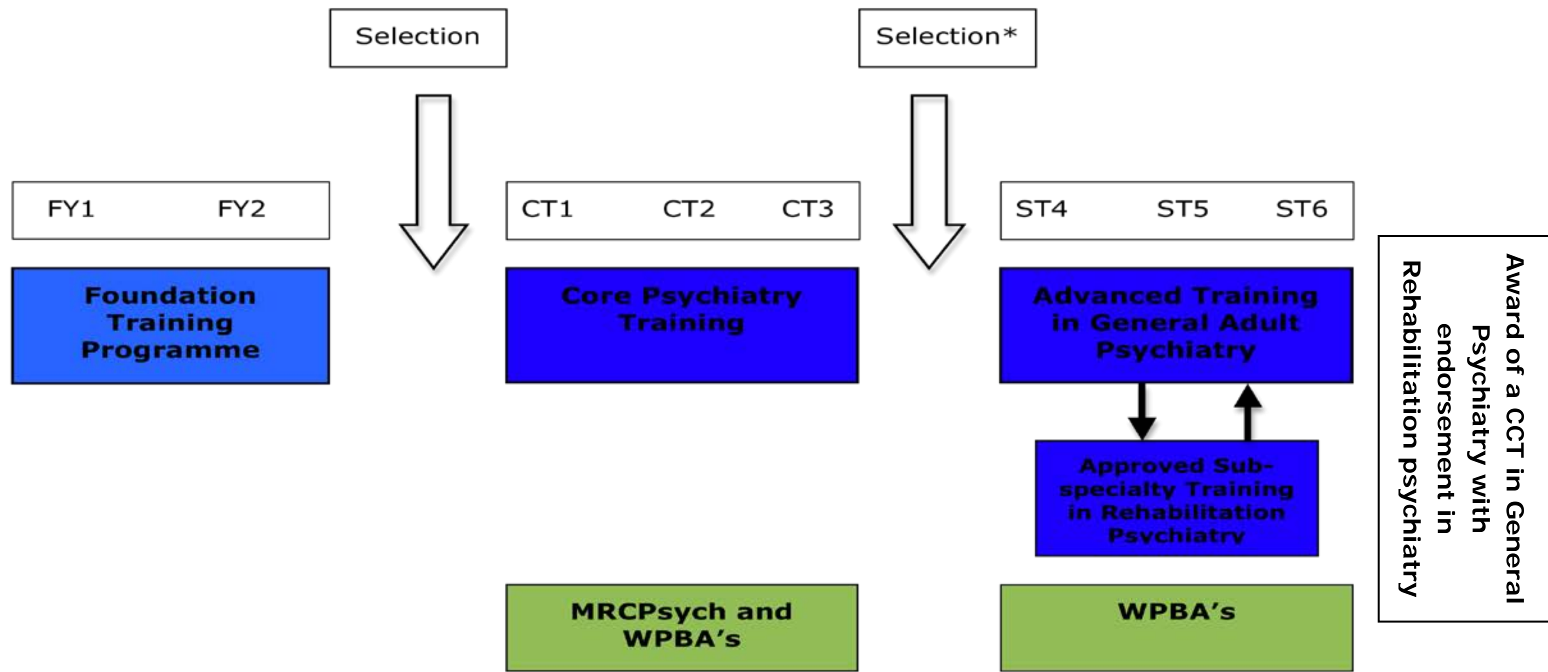
The development of the curriculum is a continuing process that involves a wide community including lay people, trainees, medical managers, psychiatry experts, and trainers. The College Education and Training Committee (ETC) delegated the governance of the curriculum to the Curriculum Committee, which coordinates the input of all these groups. The Curriculum Committee is composed of representatives of each College Faculty, trainee representatives, patient and carer representatives and a lay person who has an educational background. Each College Faculty has an Education and Curriculum Committee (FECC), which is charged with monitoring its Specialty or Sub-specialty Curriculum. From 2009 onwards, every FECC hosted an annual consultation with their Training Programme Directors to review the implementation of its Curriculum. The FECCs will report to the Curriculum Committee. The Curriculum Committee also receives input from the College Quality Assurance Committee, which provides the College Annual Specialty Report, from the College Psychiatry Trainees' Committee and from the College Medical Managers' Group. In 2011, after two cycles of annual review, the Curriculum Committee will host a symposium at the autumn College Medical Education Conference to consolidate our learning about the curriculum and to launch the next phase in its evolution.

## 5. Training pathway

Trainees enter Rehabilitation Psychiatry Specialty Training after successfully completing both the Foundation Training Programme (or having evidence of equivalence) and the Core 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 of the ARCP Guide for General Psychiatry and the ARCP Guide 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.

Psychiatry training was 'decoupled' in August 2008. Since that date, trainees have had to successfully complete the three-year Core Psychiatry Training programme before applying in open competition for a place in a programme leading to a certificate of completion of training (CCT) in one of the six psychiatry specialties. Trainees who were appointed to Psychiatry Specialty Training prior to August 2008 were generally appointed to 'run-through' training posts. The content of their learning and assessment in Rehabilitation Psychiatry is essentially the same as 'decoupled' trainees except that they do not apply to a post in General Psychiatry and Rehabilitation Psychiatry in open competition. Instead, Schools of Psychiatry will have internal systems for selecting into advanced training programmes.

At the present time, 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 of General Psychiatry: 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.




***Selection at this point may be by open or by internal competition. See text for explanation**

Figure 1 Training pathway to obtain a CCT in General Psychiatry with endorsement within Rehabilitation Psychiatry

### 5.1 Core Training in Psychiatry

The core training programme in psychiatry is comprised of:

• Completion of a minimum of 36 months post-foundation/internship in a core training programme approved by the GMC from CT1 to CT3 (or at a level above CT1 to CT3).

• During core training trainees must take the MRCPsych Examination which is comprised of:

- 3 written papers
- A Clinical Assessment of Skills and Competencies (CASC).

Trainees must obtain a pass in all sections of the MRCPsych Examination and achieve all core competencies before they can be considered to have successfully completed/exited core training. An ARCP outcome 1 will then be issued to trainees.

Trainees who leave core training without achieving the core competencies or passing all sections of the MRCPsych Examination can still undertake the Examinations and complete any outstanding competencies whilst in a non-training post.

### 5.2 Advanced Training in Psychiatry

The Advanced Training Programme in Psychiatry is comprised of completion of a minimum of 36 months of advanced training in one of the six GMC approved psychiatric specialties listed below from levels ST4 to ST6.

Trainees must achieve the competencies as set out in the appropriate advanced curriculum and achieve an ARCP outcome 6 on completion of the training programme.

### 5.3 Certificates of Completion of Training (CCT)

Trainees wishing to obtain a CCT in one of the six GMC approved psychiatric specialties must complete an entire programme of training (core and advanced) the whole of which has been approved by the GMC from levels ST4 to ST6 and pass all sections of the MRCPsych Examination.

### 5.4 Career Pathways in Psychiatry

General Psychiatry

The clinical experience in the Advanced Training Programme in General Psychiatry will consist of the equivalent of three years full time experience and will consist of:

2 years in designated General Psychiatry posts. (one year may be in a GMC approved sub-specialty of General Psychiatry in either:

• Substance Misuse
• Liaison Psychiatry

• Rehabilitation Psychiatry

The third year could also be spent in another sub-specialty of General Psychiatry but will not lead to an endorsement on the GMC Specialist Register:
• Peri-natal Psychiatry
• Neuropsychiatry
• Eating Disorder Psychiatry

Or another psychiatric specialty, or another general psychiatry post.
Experience gained in General Psychiatry must include properly supervised in-patient and out-patient management, with both new patients and follow-up cases, and supervised experience of emergencies and 'on call' duties. Training placements will afford experience in hospital and/or community settings. Increasingly training in General Psychiatry will be delivered in functional services that specialise a single area of work such as, crisis, home treatment, early interventions, assertive interventions or recovery models. Thus not all posts will provide all experiences as detailed below.

Old Age Psychiatry
The clinical experience in the Advanced Training Programme in Old Age Psychiatry will consist of the equivalent of three years full time experience and will consist of:

• Twelve months in an old age placement, i.e. a placement that can offer both in-patient and community experience or two six-month placements in inpatient and community settings. The inpatient experience must include managing detained patients under supervision.
• Twelve months in another old age psychiatry setting.
• A third twelve months may be spent in general psychiatry (or one of its sub-specialties) or in any other psychiatric specialty where the training is available, ie, forensic psychiatry, old age psychiatry, psychotherapy, learning disability psychiatry, child & adolescent psychiatry.

Trainees should get experience working with older adults in the following settings:
• In-patient wards for treatment of functional illness
• Assessment wards
• Continuing care and respite wards
• Joint psychiatric/geriatric wards
• Day hospitals

• Sheltered housing
• Residential care in various settings
• Home assessment and treatment
• Out-patients

Trainees undertaking a recognised sub-specialty post listed above in General Psychiatry as part of their Old Age Psychiatry CCT, WILL NOT be able to apply to the College for a recommendation for an endorsement on the GMC Specialist Register. Endorsements are only available if the trainee is undertaking a CCT in General Psychiatry.

Psychiatry of Learning Disability

The clinical experience in the Advanced Training Programme in Psychiatry of Learning Disability will consist of the equivalent of three years full time experience at least two years of which are within designated Psychiatry of Learning Disability posts. This would comprise of experience with:

• In-patients; acute treatment and management of People with Learning Disabilities (PWLD) and their mental health and behavioural problems;
• Working in multidisciplinary community teams;
• Seeing patients and their carers in a variety of out-patient and community settings.

One year of this could be within designated Psychiatry of Learning Disability services for children.

The third year could comprise of either further community-based experience as above, perhaps with an emphasis on:

• Neuropsychiatry,
• Neurodevelopmental disorders,
• Brain injury;
• Experience within designated Psychiatry of Learning Disability posts in Forensic Psychiatry;
• Experience within designated posts in a relevant psychiatric specialty: e.g. General Psychiatry or one of its subspecialties

Child & Adolescent Psychiatry

The clinical experience in the Advanced Training Programme in Child & Adolescent Psychiatry will consist of the equivalent of three years full time experience.

Forensic Psychiatry

The clinical experience in the Advanced Training Programme in Forensic Psychiatry will consist of the equivalent of three years full time experience.

Medical Psychotherapy

The clinical experience in the Advanced Training Programme in Medical Psychotherapy will consist of the equivalent of three years full time experience.

### 5.5 Dual Training

Trainees may apply in open competition for entry into dual training programmes. Trainees must be interviewed for both specialties. A trainee will be given a national training number indicating that the programme is a dual programme. Trainees are expected to complete the programme in full and obtain the competencies set out in both curricula. Application to the GMC for a CCT should only take place when both programmes are complete. The two CCTs should be applied for and awarded on the same date and the expected end of training date for both CCTs therefore becomes the same date. (MMC Gold Guide 6.32).

Where a trainee wishes to curtail the programme leading to dual certification and to apply to the GMC for a single CCT, the trainee must apply to the Postgraduate Dean for agreement to do so. If the Postgraduate Dean agrees, the dual certification programme will terminate and a single CCT will be pursued. (MMC Gold Guide 6.33).

Where a trainee wishes to curtail the programme leading to dual certification and to apply to the GMC for a single CCT, the trainee must apply to the Postgraduate Dean for agreement to do so. If the Postgraduate Dean agrees, the dual certification programme will terminate and a single CCT will be pursued. (MMC Gold Guide 6.33).

Trainees who wish to curtail a dual programme and pursue a single CCT must ensure that they have completed/obtained the following:

- The competencies for a single CCT as stipulated in the curriculum for that specialty.
- The time spent for a single CCT as stipulated in the curriculum for that specialty.
- Confirmation from the Training Programme Director that the competencies for a single CCT have been met.
- A final ARCP outcome 6 for a single CCT.

Completion of two CCTs can be of either four or five years' duration.

**Training Combinations with a minimum of four years' duration**

General Psychiatry & Old Age Psychiatry which must consist of:
2 years in designated General Psychiatry posts (one year may be in a GMC approved sub-specialty of General Psychiatry in either:

- Substance Misuse
- Liaison Psychiatry

• Rehabilitation Psychiatry

Trainees could also spend 12 months in another sub-specialty of General Psychiatry but will not lead to an endorsement on the GMC Specialist Register:
• Peri-natal Psychiatry
• Neuropsychiatry
• Eating Disorder Psychiatry

2 years in designated Old Age Psychiatry Posts.

A trainee who wishes to pursue a single CCT in either old age psychiatry or general psychiatry must ensure they have completed the minimum of 36 months which must consist of two years in either old age psychiatry posts or general psychiatry posts & one further year in another psychiatric specialty or sub-specialty post as listed above.
**All training must be in GMC approved programmes.**

**Training combinations with a minimum of five year's duration**
General Psychiatry & Medical Psychotherapy which must consist of:

2 years in designated General Psychiatry posts (one year may be in a GMC approved sub-specialty of General Psychiatry in either:

• Substance Misuse
• Liaison Psychiatry
• Rehabilitation Psychiatry

Trainees could also spend 12 months in another sub-specialty of General Psychiatry but will not lead to an endorsement on the GMC Specialist Register:
• Peri-natal Psychiatry
• Neuropsychiatry
• Eating Disorder Psychiatry

3 years in designated Medical Psychotherapy Placements.

**A trainee who wishes to pursue a single CCT in either general psychiatry or medical psychotherapy must ensure they have completed the minimum of 36 months which must consist of two years in either general psychiatry posts and one year in another psychiatry specialty, most likely to be medical psychotherapy or 3 years in designated medical psychotherapy posts.**

Forensic Psychiatry & Medical Psychotherapy which must consist of:
- 2 years in designated Forensic Psychiatry placements
- 2 years in designated Medical Psychotherapy Placements
- 1 year in a Forensic Medical Psychotherapy setting

A trainee who wishes to pursue a single CCT in either forensic psychiatry or medical psychotherapy must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated forensic psychiatry posts or 3 years in designated medical psychotherapy posts.

Child & Adolescent Psychiatry & Forensic Psychiatry which must consist of:
- 2 years in designated Forensic Psychiatry placements.
- 2 years in designated Child & Adolescent Psychiatry Placements
- 1 year in a Forensic Psychiatry setting for adolescents & children.

It is up to Postgraduate Deaneries and local educational providers to decide how the competencies for both specialties will be met within the designated timeframe.
A trainee who wishes to pursue a single CCT in either forensic psychiatry or child & adolescent psychiatry must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated forensic psychiatry posts or 3 years in designated child & adolescent psychiatry posts

Child & Adolescent Psychiatry & Psychiatry of Learning Disability which must consist of:
- 2 years in designated Psychiatry of Learning Disability placements.
- 2 years in designated Child & Adolescent Psychiatry Placements
- 1 year in a Psychiatry of Learning Disability setting for adolescents & children.

It is up to Postgraduate Deaneries and local educational providers to decide how the competencies for both specialties will be met within the designated timeframe.
A trainee who wishes to pursue a single CCT in either Psychiatry of Learning Disability or Child & Adolescent Psychiatry must ensure they have completed the minimum of 36 months which must consist of 3 years' in either designated Child &

Adolescent Psychiatry posts & 2 years' in Psychiatry of Learning Disability posts and one year in either Child & Adolescent Psychiatry or another psychiatry specialty.

**All training must be in GMC approved programmes.**

**5.6 Special Interest Sessions**

Trainees undertaking a GMC approved training programme in General Psychiatry or a dual training programme in general psychiatry may undertake training in one of the three GMC approved sub-specialties of General Psychiatry and apply for an endorsement on completion of their training programme. The three GMC approved sub-specialties of General Psychiatry are:

- Substance Misuse Psychiatry
- Liaison Psychiatry
- Rehabilitation Psychiatry

On completion of their training programme trainees can apply for the endorsement on the GMC Specialist Register. Trainees wishing to obtain an endorsement must inform the College in advance.
Training for an endorsement must be of 12 months' whole time equivalent training on a GMC approved training programme. Less than 12 months wte will not be accepted and the endorsement sub-specialty MUST be clearly marked on the Deanery ARCP form.
Training must be undertaken in a substantive placement with appropriate supervision in the above sub-specialties. Special interest sessions do not count towards endorsement as they do not fit the criteria in terms of educational and clinical supervision.
It is not possible to obtain an endorsement in the following psychiatric specialties:

- Child & Adolescent Psychiatry
- Forensic Psychiatry
- Psychiatry of Learning Disability (also known as Psychiatry of Intellectual Disability)
- Medical Psychotherapy
- Old Age Psychiatry

**Trainees in the Psychiatry of Learning Disability and Old Age Psychiatry may undertake training in one of the above sub-specialties but they cannot apply for an endorsement.**

### 5.7 Acting Up

Up to a maximum of three months whole time equivalent (or three months on a pro-rata basis for less than full time trainees) 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 is in their final year of training (or possibly penultimate year if in dual training)
• The post is undertaken in the appropriate CCT specialty
• It is on secondment from a higher training programme
• The approval of the Training Programme Director and Postgraduate Dean is sought
• The trainee still receives one hour per week education supervision either face to face or over the phone by an appropriately accredited trainer
• 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.

## 6. 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.

### 6.1 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

### 6.2 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.

### 6.3 Educational Supervisors/Tutors

An Educational Supervisor/tutor is 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.

### 6.4 Clinical Supervisors/Trainers

A clinical supervisor/trainer is a substantive consultant, senior lecturer or professor who has been appointed to a substantive consultant position.

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**.

The clinical supervisor/trainer works with the trainee not solely for the benefit of patients for whom they are jointly responsible but also works with the trainee to foster the professional development (e.g. clinical and personal skills) of the individual doctor in training. **Clinical supervisors work in close collaboration with the nominated Educational Supervisor (if they are not the same person)**

Supervision of clinical activity must be appropriate to the competence and experience of the individual trainee; 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 so to do; ***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. Ensures that specialty and departmental induction occurs

2. Should be involved with teaching and training the trainee in the workplace and should help with both professional and personal development.
3. 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
4. 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.
5. Will perform workplace-based assessments for the trainee and will delegate performance of WPBA's to appropriate members of the multi-disciplinary team
6. 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.
7. Will produce structured reports as required by the School/Deanery
8. Will hold a documented one-hour meeting with the trainee per week. This is regarded as a minimum; there can be other ad hoc meetings. As described above the fixed "one-hour per week" meeting is focussed on the trainee doctor's personal learning and development needs.
9. Make clear arrangements for cover in the event of planned absence.

The time required to discharge these responsibilities is estimated as 0.25PA's per week per trainee. This time must be identified in the supervisor/trainer's job plan and should be allocated from within the 'Direct Clinical Care' category.

### 6.5 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.

**6.6 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.

## ADVANCED TRAINING 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 that are set out below as well as those of Rehabilitation Psychiatry, set out later.

## The Intended Learning Outcomes FOR SPECIALIST TRAINING IN GENERAL PSYCHIATRY

| *Intended learning outcome 1* |
|---|
| **The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:**<br>• **Presenting or main complaint**<br>• **History of present illness**<br>• **Past medical and psychiatric history**<br>• **Systemic review**<br>• **Family history**<br>• **Socio-cultural history of individual and cultural group**<br>• **Developmental history** |

| *Intended learning outcome 2* |
|---|
| **The doctor will demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses, liaising with other specialists and making appropriate referrals** |

| *Intended learning outcome 3* |
|---|
| **The doctor will demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological, socio-cultural and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains** |

| *Intended learning outcome 4* |
|---|
| **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** |

| ***Intended learning outcome 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** |

| ***Intended learning outcome 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** |

| ***Intended learning outcome 9*** |
| --- |
| **To demonstrate the ability to work effectively with colleagues, including team working** |

| ***Intended learning outcome 10*** |
| --- |
| **Develop appropriate leadership skills** |

| ***Intended learning outcome 11*** |
| --- |
| **Demonstrate the knowledge, skills and behaviours to manage time and problems effectively** |

| **Intended learning outcome 12** |
| --- |
| **To develop the ability to conduct and complete audit in clinical practice** |

| ***Intended learning outcome 15*** |
| --- |
| **To develop the ability to teach, assess and appraise** |

| ***Intended learning outcome 16*** |
| --- |
| **To develop an understanding of research methodology and critical appraisal of the research literature** |

***Intended learning outcome 17***

| ***Intended learning outcome 1*** |
| --- |
| **The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:**<br>• **Presenting or main complaint**<br>• **History of present illness**<br>• **Past medical and psychiatric history**<br>• **Systemic review**<br>• **Family history**<br>• **Socio-cultural history**<br>• **Developmental history** |

| **Intended Learning outcome 1** | **Assessment methods** | **GMP Domains** |
| --- | --- | --- |
| **Knowledge** | | **1** |
| Demonstrate a knowledge of the principles of clinical supervision and their practical application (NB this competency applies across all the intended learning outcomes and subjects of this domain) | Mini-PAT, CBD, DONCS | |
| Demonstrate detailed knowledge of clinical conditions and syndromes affecting working age adult patients | ACE, Mini-ACE, CBD | |
| Demonstrate detailed knowledge of the biological, psychological, social and cultural factors which influence the presentation, course and treatment of these conditions | ACE, Mini-ACE, CBD | |
| Demonstrates detailed knowledge of the phenomenology and psychopathology of | ACE, Mini- | |

| | | |
|---|---|---|
| mental health disorders affecting the working age adult population | ACE, CBD | |
| **Skills**<br><br>Offer psychiatric expertise to other practitioners to enhance the value of clinical assessments (e.g. through clinical supervision) to which the psychiatrist has not directly contributed<br><br>Elicit information required for each component of a psychiatric history; in situations of urgency, prioritise what is immediately needed; and gather this information in difficult or complicated situations<br><br>Be able to apply these knowledge based competencies in the context of clinical assessment<br><br>Demonstrate flexible ability to elicit information salient to a specific model of psychotherapy in the face of difficulties experienced by the patient in collaboratively contributing to the process e.g. initial hopelessness, hostility, lack of recognition of psychological contribution to problems, limitations imposed by setting in which interview occurs<br><br>Describe the patient's illness behaviour patterns, and elicit the patient's view of their problem and what might be helpful in order to fully grasp what the patient brings to the consultation<br><br>Note limitations of the assessment where language or cultural influences impinge on communication and a shared understanding | Mini-PAT, CBD, DONCS<br><br>ACE, Mini-ACE, CBD<br><br>ACE, Mini-ACE, CBD<br><br>ACE, Mini-ACE, CBD, SAPE<br><br>ACE, Mini-ACE, CBD<br><br>ACE, Mini-ACE, CBD | **1** |
| **Attitudes demonstrated through behaviours**<br><br>Display willingness and availability to give clinical supervision to colleagues at all times (NB this competency applies across all the intended learning outcomes and | CBD, DONCS, Mini-PAT | 1 |

| subjects of this domain) | | |
|---|---|---|

| **1-1b Patient examination, including mental state examination and physical examination** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **1** |
| **Skills**<br>By the completion of training, psychiatrists will be able to identify psychopathology in all clinical situations, including those that are urgent and/or complex<br><br>Assess and diagnose patients with multiple and complicated pathologies | ACE, Mini-ACE, CBD<br><br>ACE, Mini-ACE, CBD | **1** |
| **Attitudes demonstrated through behaviours**<br>Display an awareness of complex needs | ACE, Mini-ACE, CBD, Mini-PAT | 1 |

| ***Intended learning outcome 2*** |
|---|
| **The doctor will demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses, liaising with other specialists and making appropriate referrals** |

| **Intended learning outcome 2** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge**<br><br>Develop an awareness of interfaces between adult psychiatry and other psychiatric specialities, other branches of medicine and other service providers | ACE, Mini-ACE, CBD, Mini-PAT | **1** |
| **Skills**<br><br>Demonstrates capability in taking decisions about access to medical care and | ACE, Mini- | **1** |

| | | |
|---|---|---|
| pathways to recovery out of medical care<br><br>Able to resolve management, treatment and interventions on the basis of a completed psychiatric assessment (history, examination and diagnosis)<br><br>Demonstrates ability to manage referrals and to assess, prioritise and allocate according to need<br><br>Develop and maintain effective relationships with primary care services and other care providers, for example the voluntary sector, leading to effective referral mechanisms and educational systems<br><br>Manage a variety of complex cases which require distribution of clinical responsibility<br><br>Work in a multi-disciplinary team where the process of referral from primary care can be described in detail<br><br>Manage a variety of cases which require liaison with other psychiatric specialties, other branches of medicine and other service providers | ACE, CBD, CP<br><br>ACE, Mini-ACE, CBD, CP<br><br>ACE, Mini-ACE, CBD, CP, Mini-PAT<br><br>CBD, Mini-PAT supervisors report<br><br>CBD, CP, Mini-PAT, supervisors report<br><br>CBD, CP, supervisors report<br><br>CBD, CP, Mini-PAT, supervisors report | |
| **Attitudes demonstrated through behaviours**<br><br>Liaise with and make appropriate and timely referral to other specialist services (e.g. for eating disorder) | CBD, CP, Mini-PAT, supervisors report | 1 |

| ***Intended learning outcome 3*** |
|---|
| **The doctor will demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan.  This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains** |

| **Intended learning outcome 3** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **1** |
| **Skills**<br><br>Able to safely prescribe, monitor and, where appropriate, deliver the full range of physical treatments that are required to treat the psychiatric problems that are experienced by working age adults<br><br>By StR5, can apply the principles of long-term therapy in the management of an outpatient clinical caseload of working age adults who have psychiatric problems | CBD, CP, Mini-PAT, supervisors report<br><br>CBD, CP, Mini-PAT, supervisors report | **1** |
| **Attitudes demonstrated through behaviours** | | 1 |

| ***Intended learning outcome 4*** |
|---|
| **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** |

| 1-4b Psychiatric emergencies for all specialties | Assessment methods | GMP Domains |
|---|---|---|
| **Knowledge** | | 1 |
| **Skills**<br><br>Independently assess and manage patients with mental illnesses including uncommon conditions, in emergencies<br><br>Demonstrate expertise in applying the principles of crisis intervention in emergency situations<br><br>Make care plans in urgent situations where information may be incomplete | <br><br>CBD, CP, Mini-PAT, supervisors report<br><br>CBD, CP, Mini-PAT, supervisors report<br><br>CBD, CP, Mini-PAT, supervisors report | 1 |
| **Attitudes demonstrated through behaviours**<br><br>Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty | <br><br>CBD, CP, Mini-PAT, supervisors report | 1 |

| **1-4c Mental health legislation** | **Assessment methods** | **GMP Domains** |
| --- | --- | --- |
| **Knowledge** | | **1** |
| **Skills** | | **1** |
| **Attitudes demonstrated through behaviours**<br><br>Be prepared to give advice to others on the use of mental health and allied legislation | CBD, CP, DONCS, Mini-PAT, supervisors report | 1 |

| **1-4d Broader legal framework** | **Assessment methods** | **GMP Domains** |
| --- | --- | --- |
| **Knowledge**<br><br>Demonstrate awareness of specialist aspects of the law | CBD, CP, DONCS, Mini-PAT, supervisors report | **1** |
| **Skills** | | **1** |
| **Attitudes demonstrated through behaviours** | | 1 |

| **Intended learning outcome 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** |

| **1-5a Psychological therapies** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge**<br><br>Demonstrate the acquisition of more advanced treatment skills | <br><br>CBD, CP, Mini-PAT, SAPE | **1** |
| **Skills**<br><br>Evaluate the outcome of psychological treatments delivered either by self or others and organise subsequent management appropriately<br><br>Explain, initiate, conduct and complete a range of psychological therapies, with appropriate supervision<br><br>Display the ability to provide expert advice to other health and social care professionals on psychological treatment and care | <br><br>CBD, CP, Mini-PAT, SAPE<br><br>ACE, Mini-ACE, CBD, Mini-PAT, SAPE<br>CBD, DONCS, Mini-PAT | **1** |
| **Attitudes demonstrated through behaviours**<br><br>Continue to practice and develop a range of treatment skills | <br><br>Supervisors report, SAPE | 1 |

**MANAGING LONG-TERM PSYCHIATRIC ILLNESS**

| **Intended learning outcome 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** |

| 1-7a Management of severe and enduring mental illness | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **1** |
| **Skills**<br><br>Develop professional alliances with patients over the long-term<br><br>Develop therapeutic optimism and hope<br><br>Assist and guide trainees in assessing and managing patients with severe and enduring mental illness | <br><br>CBD, Mini-PAT, SAPE<br><br>CBD, Mini-PAT, SAPE<br><br>CBD, DONCS | **1** |
| **Attitudes demonstrated through behaviours** | | 1 |

| ***Intended learning outcome 9*** |
|---|
| **To demonstrate the ability to work effectively with colleagues, including team working** |

| **Intended learning outcome 9** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge**<br><br>Maintain and apply a current working knowledge of the law as it applies to | <br><br>DONCS, | **3** |

| | | |
|---|---|---|
| working relationships<br><br>Demonstrate an understanding of the responsibility of the team with regard to patient safety<br><br>Demonstrate an understanding of how a team works and develops effectively<br><br>Demonstrate an understanding of time management, values based practice and information management<br><br>Understand the role of the adult psychiatrist and how this relates to the structure and function of the multidisciplinary team<br><br>Able to explain the role of different teams and services involved in the care of working age adults with psychiatric problems. Knowing when to change the patient's care setting | supervisors report<br><br>CBD, Mini-PAT supervisors report<br><br>CBD, Mini-PAT, DONCS<br><br>CBD, Mini-PAT, DONCS<br><br>CBD, Mini-PAT, DONCS<br><br>CBD, CP, Mini-PAT, DONCS | |
| **Skills**<br><br>Facilitate the leadership and working of other members of the team<br><br>Recognise and resolve dysfunction and conflict within teams when it arises<br><br>Competently manage a service, or a part of the service, alongside consultant trainer | CBD, Mini-PAT, DONCS<br><br>CBD, Mini-PAT, DONCS<br><br>CBD, Mini-PAT, DONCS, supervisors report | **3** |

| | | |
|---|---|---|
| Show competence in supervised autonomous working | CBD, Mini-PAT, DONCS, supervisors report | |
| Use effective negotiation skills | | |
| Be able to work with service managers and commissioners and demonstrate management skills such as understanding the principles of developing a business plan | CBD, Mini-PAT, DONCS, supervisors report | |
| Manage change, with the involvement of service users and carers in teamwork. | Mini-PAT, DONCS, supervisors report | |
| Utilise team feedback | Mini-PAT, DONCS, supervisors report | |
| Manage complaints made about services | Mini-PAT, DONCS, supervisors report | |
| Competently participate in the NHS Appraisal Scheme | Mini-PAT, DONCS, supervisors report | |

| | | |
|---|---|---|
| Contribute to the interface between the adult psychiatry team and other psychiatric teams, medical teams and service providers by working in a collaborative manner<br><br>Develop and maintain effective relationships with primary care services leading to effective referral mechanisms and educational systems<br><br>Work in a multi-disciplinary team where issues of responsibility can be described in detail<br><br>Manage divergent views about patient care or intervention | Mini-PAT, DONCS, supervisors report<br><br>Mini-PAT, DONCS, supervisors report<br><br>Mini-PAT, DONCS, supervisors report<br><br>Mini-PAT, DONCS, supervisors report<br><br>Mini-PAT, CBD, DONCS, supervisors report | |
| **Attitudes demonstrated through behaviours**<br><br>Be prepared to question and challenge the performance of other team members when standards appear to be compromised | <br><br>Mini-PAT, CBD, DONCS, supervisors report | 3 |

| | | |
|---|---|---|
| Be readily available to team members and other agencies for consultation and advice on general adult psychiatry issues | Mini-PAT, CBD, DONCS, supervisors report | |

| *Intended learning outcome 10* |
|---|
| **Develop appropriate leadership skills** |

| **Intended learning outcome 10** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **3** |
| Demonstrate an understanding of the differing approaches and styles of leadership | Mini-PAT, DONCS, supervisors report | |
| Demonstrate an understanding of the role, responsibility and accountability of the leader in a team | Mini-PAT, DONCS, supervisors report | |
| Understand and contribute to the organization of urgent care in the locality | Mini-PAT, DONCS, supervisors report | |

| | | |
|---|---|---|
| Demonstrate an understanding of the structures of the NHS and social care organisations | Mini-PAT, DONCS, supervisors report | |
| Demonstrate an understanding of organisational policy and practice at a national and local level in the wider health and social care economy | Mini-PAT, DONCS, supervisors report | |
| Demonstrate an understanding of the principles of change management | Mini-PAT, DONCS, supervisors report | |
| Understand the principles of identifying and managing available financial and personnel resources effectively | Mini-PAT, DONCS, supervisors report | |
| Demonstrate an awareness of distinction between direct, delegated and distributed responsibility | Mini-PAT, DONCS, supervisors report | |
| **Skills** | | **3** |
| Demonstrate a range of appropriate leadership and supervision skills including:<br>• Coordinating, observing and being assured of effective team working<br>• Setting intended learning outcomes<br>  • Planning<br>  • Motivating | Mini-PAT, DONCS, supervisors report | |

| | | |
|---|---|---|
| • Delegating<br>• Organising<br>• Negotiating<br>• Example setting<br>• Mediating / conflict resolution<br>• Monitoring performance | | |
| Demonstrate ability to design and implement programmes for change, including service innovation | Mini-PAT, DONCS, supervisors report | |
| Displays expertise in employing skills of team members to greatest effect<br>Acts as impartial mediator in conflicts over roles and responsibilities | Mini-PAT, DONCS, supervisors report | |
| Demonstrate active involvement in service design and development | Mini-PAT, DONCS, supervisors report | |
| Show clinical and managerial leadership through modelling and mentoring colleagues in the same and other disciplines | Mini-PAT, DONCS, supervisors report | |
| **Attitudes demonstrated through behaviours**<br><br>Work collaboratively with colleagues from a variety of backgrounds and organisations | Mini-PAT, DONCS, supervisors report | 3 |

## TIME MANAGEMENT AND DECISION MAKING

| **Intended learning outcome 11** |
| --- |
| **Demonstrate the knowledge, skills and behaviours to manage time and problems effectively** |

| **4-11b Communication with colleagues** | **Assessment methods** | **GMP Domains** |
| --- | --- | --- |
| **Knowledge**<br><br>Demonstrate an understanding of the requirements of outside agencies for reports that are timely, accurate and appropriate | Mini-PAT, CBD, DONCS, supervisors report | 3 |
| **Skills**<br><br>Prepare and deliver reports for Mental Health Tribunals, Managers' Hearings, Coroners Courts and Courts of Law | Mini-PAT, CBD, DONCS, supervisors report | 3 |
| Understand the roles and responsibilities of an expert witness | Mini-PAT, CBD, DONCS, supervisors report | |

| **Attitudes demonstrated through behaviours** | | 3 |
|---|---|---|
| Produce reports that are comprehensive, timely, accurate, appropriate and within limits of expertise | Mini-PAT, CBD, DONCS, supervisors report | |

| ***Intended learning outcome 12*** |
|---|
| **Develop the ability to conduct and complete audit in clinical practice** |

| **4-12a Audit** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **2** |
| Demonstrate a knowledge of different audit methods | Supervisors report, DONCS | |
| Demonstrate a knowledge of methods of sampling for audit | Supervisors report, DONCS | |
| Demonstrate a knowledge of obtaining feedback from patients, the public, staff and other interested groups | Supervisors report, DONCS | |
| Demonstrate an understanding of the structures of the NHS and social care organisations (or equivalents) | Supervisors report, DONCS | |

| | | |
|---|---|---|
| Demonstrate an understanding of quality improvement methodologies<br><br>Demonstrate an understanding of the principles of change management | Supervisors report, DONCS<br><br>Supervisors report, DONCS | |
| **Skills**<br><br>Be able to set standards that can be audited<br><br>Be able to measure changes in practice<br><br>Be able to effectively apply audit principles to own work, to team practice and in a service wide context, including to relevant organisational and management systems<br><br>Be able to supervise a colleague's audit project in adult psychiatry | <br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS | **2** |
| **Attitudes demonstrated through behaviours**<br><br>Hold a positive attitude to the potential of audit in evaluating and improving the quality of care | <br><br>Supervisors report, DONCS | 2 |

| | | |
|---|---|---|
| Show willingness to apply continuous improvement and audit principles to own work and practice | Supervisors report, DONCS | |
| Show willingness to support and encourage others to apply audit principles | Supervisors report, Mini-PAT, DONCS | |

**CLINICAL GOVERNANCE**

| ***Intended learning outcome 13*** |
|---|
| **To develop an understanding of the implementation of clinical governance** |

| **4-13a Organisational framework for clinical governance and the benefits that patients may expect** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **2** |
| Demonstrate a knowledge of relevant risk management issues; including risks to patients, carers, staff and members of the public | CBD, CP, supervisors report, | |
| Demonstrate a knowledge of how healthcare governance influences patient care, research and educational activities at a local, regional and national level | Supervisors report, DONCS | |
| Demonstrate a knowledge of a variety of methodologies for developing creative solutions to improving services | Supervisors report, DONCS | |

| Skills | | 2 |
| --- | --- | --- |
| Develop and adopt clinical guidelines and integrated care pathways | Supervisors report, DONCS | |
| Report and take appropriate action following serious untoward incidents | Supervisors report, CBD, CP, DONCS | |
| Assess and analyse situations, services and facilities in order to minimise risk to patients, carers, staff and the public | Supervisors report, CBD, CP, DONCS | |
| Monitor the safety of services | Supervisors report, DONCS | |
| Demonstrate ability to deviate from care pathways when clinically indicated | Supervisors report, CBD, CP | |
| Question existing practice in order to improve service | Supervisors report, CBD, CP, DONCS | |
| **Attitudes demonstrated through behaviours** | | 2 |
| Demonstrate ability to consciously deviate from pathways when clinically indicated | Supervisors report, CBD, CP, DONCS | |

| | | |
|---|---|---|
| Demonstrate willingness to take responsibility for clinical governance activities, risk management and audit in order to improve the quality of the service | Supervisors report, CBD, CP, DONCS | |
| Be open minded to new ideas | Supervisors report, CBD, CP, | |
| Support colleagues to voice ideas | Supervisors report, CBD, CP, DONCS | |

| ***Intended learning outcome 15*** |
|---|
| **To develop the ability to teach, assess and appraise** |

| **Intended learning outcome 15** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **1** |
| Identify learning styles | Supervisors report, DONCS | |
| Develop a knowledge of different teaching techniques and demonstrate how these can be used effectively in different teaching settings relevant to adult psychiatry, in a hospital or community based clinical setting | Supervisors report, AoT, DONCS | |

| **Skills** | | **1** |
|---|---|---|
| Use a variety of teaching methods | Supervisors report, AoT, DONCS | |
| Evaluate learning and teaching events | Supervisors report, AoT, DONCS | |
| Facilitate the learning process and assess performance | Supervisors report, AoT, DONCS | |
| Organise educational events | Supervisors report, AoT, DONCS | |
| Demonstrate an ability to adapt teaching or training to the needs of particular learners e.g. medical students, colleagues from other specialities particularly primary care, paramedical professionals | Supervisors report, AoT, DONCS | |
| Provide supervision to junior colleagues working in adult psychiatry, whilst under appropriate supervision | Supervisors report, AoT, DONCS | |
| To ensure teaching is peer reviewed to improve teaching and learning performance | Supervisors report, AoT, DONCS | |

| Attitudes demonstrated through behaviours | | |
|---|---|---|

| *6-15b Assessment* | Assessment methods | GMP Domains |
|---|---|---|
| **Knowledge** | | 1 |
| **Skills** | | |
| Use appropriate, approved assessment methods | Supervisors report, DONCS | |
| Give feedback in a timely and constructive manner | Supervisors report, DONCS | |
| Provide supervision to others undertaking these tasks | Supervisors report, DONCS | |
| **Attitudes demonstrated through behaviours** | | 1 |

| 6-15c Appraisal | Assessment methods | GMP Domains |
|---|---|---|
| **Knowledge** | | 1 |
| Demonstrate an understanding of the structure of appraisal interviews | Supervisors report, DONCS | |
| **Skills** | | |
| Conduct appraisal effectively and at the appropriate time | Supervisors report, DONCS | |

| **Attitudes demonstrated through behaviours**<br><br>Show respect and confidentiality for the appraisee | Supervisors report, DONCS | 1 |
|---|---|---|

| **Intended learning outcome 16** |
|---|
| **To develop an understanding of research methodology and critical appraisal of the research literature** |

| **6-16a Research techniques** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | 1 |
| Demonstrate an understanding of basic research methodology including both quantitative and qualitative techniques | Supervisors report, JCP, DONCS | |
| Demonstrates an understanding of the research governance framework including the implications for the local employer (NHS Trust or equivalent) of research. | Supervisors report, DONCS | |
| Demonstrates an understanding of the work of research ethics committees and is aware of any ethical implications of a proposed research study | Supervisors report, DONCS | |
| Demonstrate an understanding of how to design and conduct a research study | Supervisors report, DONCS | |

| | | |
|---|---|---|
| Demonstrate an understanding of the use of appropriate statistical methods<br><br>Describe how to write a scientific paper<br><br>Demonstrate a knowledge of sources of research funding<br><br>Use research methods to enrich learning about aetiology and outcomes within adult psychiatry | Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS | |
| **Skills**<br><br>Frame appropriate research questions<br><br>Able to write a research protocol and draw up a realistic time line for the proposed study<br><br>Able to apply successfully for R & D approval (if relevant)<br><br>Able to apply successfully to an ethics committee (if relevant) | Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS | **1** |

| | | |
|---|---|---|
| Carry out a research project and able to modify protocol to overcome difficulties. Can adhere to time lines. Enters data onto standard computer software, eg EXCEL, STATA, SPSS etc<br><br>Able to compare own findings with others<br><br>Able to prepare research for written publication and follow submission instructions for most appropriate journal<br><br>Able to present own research at meetings and conferences<br><br>Apply research methods, including critical appraisal, in adult psychiatry | Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS | |
| **Attitudes demonstrated through behaviours**<br><br>Demonstrate a critical spirit of enquiry<br><br>Ensure subject confidentiality | <br><br>Supervisors report, DONCS<br><br>Supervisors report, DONCS | **1** |

| | | |
|---|---|---|
| Work collaboratively in research supervision | Supervisors report, DONCS | |
| Demonstrate consistent compliance with the highest standards of ethical behaviour in research practice | Supervisors report, DONCS | |

| **6-16b Evaluation and critical appraisal of research** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **1** |
| Demonstrate an understanding of the principles of critical appraisal | Supervisors report, JCP | |
| Demonstrate an understanding of the principles of evidence-based medicine, including the educational prescription | Supervisors report, JCP | |
| Demonstrate knowledge of how to search the literature using a variety of databases | Supervisors report, JCP | |
| **Skills** | | **1** |
| Assess the importance of findings, using appropriate statistical analysis | Supervisors report, JCP | |
| Able to carry out a thorough literature search, critically analyse existing knowledge, synthesise information and summarise the relevant findings coherently. | Supervisors report, JCP | |

| | | |
|---|---|---|
| Able to write a comprehensive literature review of a proposed topic of study<br><br>Able to communicate clearly and concisely with non-medical professionals, i.e. other members of the multidisciplinary team, and staff from other agencies, regarding the importance of applying research findings in everyday practice.<br><br>Able to translate research findings to everyday clinical practice. Inclusion of research findings in case summaries and formulations and in letters to medical colleagues.<br><br>Able to appreciate the 'scientific unknowns' in the relevant field psychiatric practice<br><br>Adopt the principles of evidence based practice at a service level | Supervisors report, JCP<br><br>Supervisors report, DONCS, JCP<br><br>Supervisors report, CBD, JCP<br><br>Supervisors report, CBD, JCP<br><br>Supervisors report, CBD, DONCS | |
| **Attitudes demonstrated through behaviours**<br><br>Be able to appreciate the limitations and controversies within the relevant area of scientific literature | Supervisors report, CBD, DONCS | **1** |

## MAINTAINING TRUST

| **Intended learning outcome 17** |
|---|
| **To ensure that the doctor acts in a professional manner at all times** |

| **7-17a Doctor patient relationship** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge** | | **4** |
| **Skills**<br><br>Support and advise colleagues (both medical and non-medical) in dealing with complex professional interactions | <br><br>Supervisors report, CBD, DONCS | **4** |
| **Attitudes demonstrated through behaviours** | | **4** |

| **7-17c Confidentiality** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge**<br><br>Develop a good understanding of the needs for information of a range of agencies<br><br>Appreciate the different sensitivities of patients to a range of information held about them particularly in relation to psychological material<br><br>Be aware of the principles and legal framework of disclosure | <br><br>Supervisors report, CBD, DONCS<br><br>Supervisors report, CBD, DONCS<br><br>Supervisors report, CBD, DONCS | **4** |

| | | |
|---|---|---|
| **Skills**<br><br>Advise others (including non-healthcare professionals) on the safe and appropriate sharing of information | Supervisors report, CBD, DONCS | **4** |
| **Attitudes demonstrated through behaviours**<br><br>Ensure that reports, evidence and documents you have a responsibility for are complete, honest and accurate | Supervisors report, CBD, DONCS | **4** |

| **7-17e Risk management** | **Assessment methods** | **GMP Domains** |
|---|---|---|
| **Knowledge**<br><br>Demonstrate a knowledge of matters such as health and safety policy | Supervisors report, CBD, DONCS | **4** |
| **Skills** | | **4** |
| **Attitudes demonstrated through behaviours**<br><br>Work in collaboration with patients and the multi-disciplinary team to enable safe and positive decision-making | Supervisors report, CBD, DONCS | **4** |

| 7-17f Recognise own limitations | Assessment methods | GMP Domains |
|---|---|---|
| **Knowledge** | | 4 |
| **Skills**<br><br>Provide clinical supervision | Supervisors report, CBD, DONCS | 4 |
| **Attitudes demonstrated through behaviours** | | 4 |

## THE INTENDED LEARNING OUTCOMES FOR SPECIALIST TRAINING IN REHABILITATION PSYCHIATRY

| *Intended learning outcome 1* |
|---|
| **The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:**<br>• Presenting or main complaint<br>• History of present illness<br>• Past medical and psychiatric history<br>• Systemic review<br>• Family history<br>• Socio-cultural history<br>• Developmental history |

| *Intended learning outcome 2* |
|---|
| **The doctor will demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses** |

| *Intended learning outcome 4* |
|---|
| **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** |

| *Intended learning outcome 5* |
|---|
| **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** |

| *Intended learning outcome 7* |
|---|
| **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** |

| *Intended learning outcome 9* |
|---|
| **To demonstrate the ability to work effectively with colleagues, including team working** |

| *Intended learning outcome 10* |
|---|
| **Develop appropriate leadership skills** |

| *Intended learning outcome 15* |
|---|
| **Develop the ability to teach, assess and appraise** |

| *Intended learning outcome 1* |
|---|
| **The doctor will be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:**<br>• **Presenting or main complaint**<br>• **History of present illness**<br>• **Past medical and psychiatric history**<br>• **Systemic review**<br>• **Family history**<br>• **Socio-cultural history**<br>• **Developmental history** |

| | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Knowledge** | | |
| **Skills** | | **1** |
| Evaluate through information obtained from patients, their families and other relevant sources, the patient's strengths, disabilities, risks and vulnerabilities | **CBD, CP** | |
| Conduct an interview which assesses the history of social and personal functioning and rehabilitation needs | **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** | |
| Collate information from interviews and structured tools to form a basis for clinical decision along the care pathway e.g. at admission, change in needs or discharge | **ACE, CBD, CP** | |

| **Attitudes demonstrated through behaviours** | | **1, 3** |
|---|---|---|
| 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** | |

| **Intended learning outcome 2** |
|---|
| ***The doctor will demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses*** |

| | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Knowledge** | | |
| **Skills** | | **1** |
| Be able to comprehensively summarise an individual's history and summarise it in a formulation which synthesizes personal history, clinical history, social and personal functioning, differential diagnosis, risk history and response to treatment | **ACE, Mini-ACE, CBD** | |
| Be able to determine capacity, based on an understanding of the concepts | **ACE, Mini-ACE, CBD** | |
| Be able to assess insight collaboratively with the individual: their understanding of their mental health problems, their symptoms, factors in their relapse and recovery and the role of medication | **ACE, Mini-ACE, CBD** | |
| **Attitudes demonstrated through behaviours** | | |
| Ability to take into account views of patient, carer and multi-disciplinary team | **ACE, Mini-ACE, CBD** | |

| **Intended learning outcome 4** |
|---|
| ***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*** |

| | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Knowledge** | | **1, 2** |
| 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 others in inpatient settings, self-neglect/fire-setting, vulnerability to exploitation) | **CBD, ACE, supervisor reports** | |
| 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, supervisor reports** | |
| Understand the various aspects of mental health legislation including those aspects which relate to courts/Criminal Justice System | **CBD, CP, Mini-ACE, ACE, supervisor reports** | |

| | | |
|---|---|---|
| Understand the way in which clinical and environmental factors may increase the likelihood of risk behaviours. This may include the following factors:<br>- clinical features of psychosis which may increase the likelihood that risk behaviours will occur<br>- characteristics of the other party and their relationship with the service user (e.g. family members in high EE situations, specific victim groups for particular individuals which may derive from content of persecutory positive symptoms)<br>- 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) | **CBD, CP, Mini-ACE, ACE,** | |
| **Skills**<br><br>Use mental health legislation including those aspects which relate to courts/Criminal Justice System<br><br>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)<br><br>Work collaboratively with the service user to explore ways that s/he can increase understanding, insight and motivation and view self-management of risk as an essential part of the Recovery process.<br><br>Work collaboratively with the service user to develop a coherent shared formulation of risk using all of the above information. | <br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE,**<br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE** | **1, 2, 3** |

| | | |
|---|---|---|
| Work collaboratively with the service user to identify and act on early signs of deterioration in mental state and behaviour, identifying barriers to doing this plus potential triggers and situational factors which may lead to risk behaviours recurring<br><br>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.<br><br>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).<br><br>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).<br><br>Support service users in the development of advanced statements/directives in relation to their care.<br><br>Work effectively with independent advocates in developing risk management plans | **CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE**<br><br>**CBD, CP, Mini-ACE, ACE** | |

| **Attitudes demonstrated through behaviours**<br><br>Promotion of positive risk-taking when possible following assessment and communicating clearly with the staff team | **Supervisor report, CBD** | **2, 3** |
|---|---|---|

| **Intended learning outcome 5** |
|---|
| ***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*** |

| **Knowledge** | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Skills**<br><br>Competently obtain a collateral history from a carer, assess their needs and respond appropriately, e.g. by giving information or referring for carer support<br><br>Provide psychoeducation on an individual level and as part of a multidisciplinary progamme<br><br>Provide low intensity psychological interventions according to clinical need. These would include relapse prevention, anxiety management and motivational interviewing | <br><br>**ACE, Mini-ACE, CBD, CP DONCS**<br><br>**ACE, Mini-ACE, CBD**<br><br>**ACE, mini-ACE** | **1, 3** |
| **Attitudes demonstrated through behaviours** | | |

| **Intended learning outcome 7** |
| --- |
| ***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*** |

| **1-7a Management of severe and enduring mental illness** | **Assessment methods** | **GMP domains** |
| --- | --- | --- |
| **Knowledge** | | **1, 2, 3** |
| Understand the psychological effects of chronic illness on interpersonal relationships and intrapersonal structures | **CBD, CP, Mini-ACE, ACE,Mini-PAT** | |
| 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 | **CBD, CP, Mini-ACE, ACE** | |
| Understand the pharmacological management of psychosis resistant to conventional regimes such as NICE and BNF guidelines | **CBD, CP, Mini-ACE, ACE** | |
| Demonstrate an understanding of care pathways which include a variety of care settings allowing movement to the least dependent and restrictive and the most socially inclusive environment appropriate as close to where they want to live as possible. | **CBD, CP, Mini-ACE, ACE** | |
| Understand the complexity of co-morbid mental and physical disorders and their impact on the needs of individuals with severe mental illness | **CBD, Mini-ACE, ACE** | |

| Skills | | 1,2,3 |
|---|---|---|
| Contribute a psychotherapeutic perspective to the multidisciplinary assessment and management of patients with severe and enduring mental illness | CBD, SAPE | |
| Ability to communicate effectively with multiple agencies to develop comprehensive and integrated care plans | CBD, CP | |
| Sustain optimism that instills hope for recovery in individuals and those around them | CBD, CP, Mini-ACE, ACE, | |
| Balance the risks of disengagement from services with the potential benefits of challenging unwillingness to face issues or progress | CBD, CP, Mini-ACE, ACE | |
| 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 | CBD, CP, SAPE | |
| Recognise and address the practical needs of the patient, including housing, benefits, education, work, activities of daily living, social and leisure needs | CBD, CP, Mini-ACE, ACE | |
| Employ evidence based psychological approaches for treatment of severe and enduring mental illness including work with families and carers | CBD, CP, Mini-ACE, ACE | |
| Identify strengths and tensions in the relationship of patients with their families and carers and address appropriately | CBD, CP | |

| | | |
|---|---|---|
| Provide comprehensive adapted rehabilitation programmes for service users with cognitive deficits associated with severe mental illness/co-morbid conditions | **CBD, CP,** | |
| **Attitudes demonstrated through behaviours** | | **1, 3** |
| Help professionals from different backgrounds to understand and use psychotherapeutic concepts in working with this patient group | **CBD, CP** | |
| 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 | **CBD, CP, Mini-ACE, ACE** | |
| Maintain a strategic focus on the provision of work, leisure, social and educational services for patients with severe mental illness | **CBD, CP,DONCS** | |

| **Intended learning outcome 9** |
|---|
| ***To demonstrate the ability to work effectively with colleagues, including team working*** |

| **Knowledge** | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Skills** | | **1,2 3** |
| 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, supervisors report** | |

| **Attitudes demonstrated through behaviours** | | |
|---|---|---|
| Work with staff and carers to address challenging behaviour in a manner that is sensitive to the individual and sustains the therapeutic relationship | **CBD, DONCS,Mini-PAT, supervisors report** | **1,2,3** |
| Inspire, encourage and support other professional staff to work long-term with patients with severe and enduring mental illness | **DONCS,Mini-PAT supervisors report** | |

| **Intended learning outcome 10** |
|---|
| ***Develop appropriate leadership skills*** |

| **Knowledge** | **Assessment methods** | **GMP domains** |
|---|---|---|
| **Skills**<br>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 are seen as of equal importance to managing symptoms | **CBD, DONCS, supervisors report, mini-PAT** | **1, 2, 3** |
| **Attitudes demonstrated through behaviours**<br>Promote enthusiasm for and satisfaction with work with long term and enduring condition, amongst trainees and other staff | **CBD, DONCS, supervisors report, mini-PAT** | **1, 2, 3** |

| | | |
|---|---|---|
| Promote a social psychiatry/recovery culture amongst staff of services delivering rehabilitation | **CBD, DONCS, supervisors report, mini-PAT** | |

| **Intended learning outcome 15** |
|---|
| ***Develop the ability to teach, assess and appraise*** |

| **Knowledge** | **Assessment methods** | **GMP domains** |
|---|---|---|
| | | |
| **Skills**<br>Develop understanding of the training needs of staff in partner services/agencies, such as residential and community support staff.<br><br>Communicating the concepts and culture of rehabilitation, recovery and social inclusion in the clinical situation and through teaching programmes. | **CBD, DONCS, AoT, Mini-PAT, supervisors report**<br><br>**AoT, DONCS, supervisors report** | **1, 3** |
| **Attitudes demonstrated through behaviours** | | |

## 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

### 1. 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.

The contribution of specialty/sub-specialty placements to Core Psychiatry Training programmes is as follows: -

**General psychiatry** Experience gained in general adult psychiatry must include properly supervised in-patient and out-patient management, with both new patients and follow-up cases, and supervised experience of emergencies and 'on call' duties. Training placements will afford experience in hospital and/or community settings. Increasingly training in general adult psychiatry will be delivered in functional services that specialise a single area of work such as, crisis, home treatment, early interventions, assertive interventions or recovery

models. Thus not all posts will provide all experiences as detailed below. During their rotation a trainee must document experience in all of the below; a trainee may need two or more complimentary placements (e.g. an in-patient placement and a home treatment team placement) to achieve the required breadth of experience: -

- Assessment of psychiatric emergencies referred for admission.
- Assessment and initial treatment of emergency admissions.
- Day to day management of psychiatric inpatients.
- Participation in regular multi-disciplinary case meetings.
- Prescribing of medication and monitoring of side-effects.
- Administration of ECT.
- Use of basic psychological treatments.
- Use of appropriate mental health legislation.
- Assessment of new outpatients.
- Continuing care of longer-term outpatients.
- Psychiatric day hospital.
- CMHT- joint assessments in the community with other professionals.
- Crisis intervention.
- Home treatment.

**General psychiatry sub-specialties** may offer experience as follows: -

a) **Substance misuse:** trainees in general psychiatry should receive appropriate experience in this area. Where a specific service exists for the treatment of alcohol and/or drug dependence it should be possible to offer a whole time or part time placement. For this to be regarded as sub-specialty experience, the trainee must spend at least half their time in the service.

b) **Liaison psychiatry:** experience in liaison psychiatry may be gained during general psychiatry training or via a specialist training post. All trainees should receive adequate supervised experience in the assessment and management of deliberate self-harm, psychiatric emergencies in general and surgical wards and the accident and emergency department. Other valuable experience might include training in renal units, pain clinics and intensive care units.

c) **Rehabilitation:** attachment to a rehabilitation team with particular emphasis on the care of patients with severe chronic disability is recommended. Such experience should involve not only

inpatient care but also community facilities including residential care homes, supported accommodation, training and education, vocational rehabilitation services, social firms and service user organisations, provided by statutory and voluntary mental health services and mainstream services.

d) **Eating disorders, neuropsychiatry and perinatal psychiatry:** as these potential sub-specialties become established, it will be possible to offer whole or part time specialist training posts.

**Psychiatry of old age** Particular importance is attached to experience in this area because of the increasing numbers of elderly people in the population and the special considerations needed in diagnosis and treatment. The psychiatry of old age should constitute a separate attachment within the rotational training scheme. It is important that trainees gain experience in the acute and chronic functional disorders of older people, in addition to the assessment and management of organic illnesses. This should include both hospital and community experience and an opportunity to work as part of the multidisciplinary team. Experience of pharmacological and non-pharmacological strategies and treatments should be gained, including the drugs used to treat cognitive and behavioural symptoms in dementia.

**Forensic psychiatry** Some experience may be gained in general psychiatry but a specialist attachment in forensic psychiatry is recommended. Apart from the experience of the provision of psychiatric care in secure settings it is valuable for trainees to accompany consultants when patients are seen at prisons, hospitals, secure units, remand centres and other establishments. It may be helpful for trainees to prepare shadow court reports for discussion with their consultants. Specific instruction is needed in the principles of forensic psychiatry, detailed risk assessment and management and medico-legal work.

**Psychiatry of learning disability** There should be sufficient exposure to give the trainee an awareness of the nature and scope of the problems with an emphasis on integrated psychiatric and psychological treatment rather than basic physical care. Trainees must get experience of community facilities as well as hospital care.

**Child and adolescent psychiatry** Trainees should play an active part in patient care and not be expected to adopt a passive observer role. The experience should include extensive community experience and include both medical and psychological approaches to treatment.

Not all trainees will have the opportunity to have a post in child and adolescent psychiatry during Core Psychiatry Training. Aspects of developmental psychiatry are important for all psychiatric trainees whatever specialty within psychiatry they subsequently choose. Trainees need to understand child development and the influences that can foster this or interfere with it. To do this they need to understand the bio-psycho-social approach and the varying balance of influences at different stages of development. They need to understand both aberrant development and also how normal development can be disrupted. Whilst this is best learned through clinical experience in a developmental psychiatry post (child and adolescent psychiatry or adult learning disabilities), there will be a few trainees who have to gain these skills through in other ways. The knowledge base will come from clinical experience coupled with lectures, seminars and private study including study for examinations. Those who do not get a post in developmental psychiatry are strongly advised to negotiate a clinical attachment during another placement to best prepare them to undertake the child and adolescent WPBA's that they will be expected to achieve during this stage of their training.

**The clinical experience in the Advanced Training Programme in General Psychiatry with sub-specialty endorsement in Rehabilitation Psychiatry will consist of the equivalent of three years full time experience of which two years must be spent in designated general psychiatry. The three years will be made up as follows:**

- Twelve months in a general placement, i.e. a placement that can offer both inpatient and community experience or two six-month placements in inpatient and community settings. The inpatient experience must include managing detained patients under supervision.
- Twelve months in a specialist psychiatry rehabilitation service. Ideally this placement will take place in ST5.
- Twelve months in another psychiatric specialty which could also include General Psychiatry.

Clinical placements in advanced training in General Adult and Rehabilitation Psychiatry should last l2 months for a full-time trainee. This gives sufficient time for a realistic clinical experience and allows the completion of treatment programmes and time to build up and close down a clinical service. However, placements of up to 15 months may be acceptable if there are problems with rotational dates. It must be emphasised that advanced training in General Adult and Rehabilitation Psychiatry is not simply an extension of Core Psychiatry Training and the duties performed by advanced trainees must reflect this. There should not be a routine

expectation that the higher trainee continues to work at a level appropriate for Core Psychiatry training. The specialty registrar (ST4-6) works more independently and has a greater supervisory, leadership and managerial role. There must be opportunity for the specialty registrar to develop supervisory skills. The clinical load should not be so heavy so as to jeopardise the research, teaching and managerial functions.

### 2. 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.

**Short Case**

The short therapy case needs to be completed with a satisfactory SAPE (Structured Assessment of Psychotherapy Expertise) undertaken by the clinical supervisor of the case and a PACE (Psychotherapy Assessment of Clinical Expertise) completed by the Psychotherapy Tutor who would usually be a Consultant Psychiatrist in Psychotherapy.

The short therapy case is usually between 12 and 20 sessions of therapy. The precise number of therapy sessions is agreed with respect to the patient's needs with the clinical supervisor. The short case would be a derivative of a cognitive model and a psychodynamic case would be acceptable.

**Long Case**

The long therapy case is a core psychotherapy curriculum requirement so needs to be completed with two satisfactory SAPEs (Structured Assessment of Psychotherapy Expertise) undertaken by the clinical supervisor

of the case. A SAPE undertaken early in the therapy after deriving a formulation and presenting this to the supervisor should be coupled with a SAPE undertaken when the case is established or towards the end.

Following completion of the therapy a PACE (Psychotherapy Assessment of Clinical Expertise) should be completed by the Psychotherapy Tutor who would usually be a Consultant Psychiatrist in Psychotherapy. Given that the PACE may be completed by someone other than the clinical supervisor a summary outlining the progress of the therapy should be written by the trainee and agreed with the clinical supervisor.

The long therapy case is over 20 sessions of therapy. The precise number of therapy sessions is agreed with respect to the patient's needs with the clinical supervisor.

### 3. 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.

### 4. 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.

### 5. 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.

## 6. 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.

## 7. 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.

## 8. 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.

## 9. 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

### 10. 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.

## THE ASSESSMENT SYSTEM FOR ADVANCED TRAINING IN GENERAL PSYCHIATRY WITH SUB-SPECIALTY 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 obtain a pass in the MRCPsych examination and successfully complete core training before they can be considered to have successfully completed core training.

**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**" available from www.mmc.nhs.uk) 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 ARCP panels regarding the evidence that trainees should submit at each year of Core Psychiatry and Advanced Specialty training in General Psychiatry. 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 indicate 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.

## Guide for ARCP panels in Advanced Training in General Psychiatry ST4-ST6

**The suggested minimum number of WPBAs for ST4-ST6 trainees in Specialist General Adult Training is:**

| WPBA | Minimum number required per year | | |
|---|---|---|---|
| | STR4 50/50 IP /OP | STR5 (Specialty) | STR6 (Specialty) |
| ACE | 2 | 1 | 1 |
| mini-ACE | 2 | 2 | 2 |
| CbD | 6 | 4 | 4 |
| mini-PAT | 2 | 1 | 1 |
| SAPE | 1 | 1 | 1 |
| AoT | 2 | 2 | 2 |
| DONCS | 3 | 3 | 3 |

– Please note ST4-6 years are interchangeable dependent on rotation order.

ST4 is assumed to be one year of 40% WTE acute general adult outpatient and 40% WTE acute (assessment and treatment in the acute setting) general adult in-patient psychiatry. 10% WTE of this placement will be spent in special interest sessions.  Not all trainees will be able to undertake this placement in the first year of specialist training, although where possible this is the preferred option.

The year that is spent in Rehabilitation Psychiatry will include the assessments that are stipulated for Rehabilitation Psychiatry.

| **Intended learning outcome** | ST4 (50% acute IP and 50% OP) | ST6 (General adult Psychiatry) |
|---|---|---|
| | | |
| 1b Patient examination, including mental state examination and physical examination | CBD of an OP case presentation of a patient the trainee has fully assessed, including a collateral history.<br><br>CBD of an IP case presentation of a patient the trainee has fully assessed, including a collateral history.<br><br>ACE conducted with an OP adult patient not previously known to the trainee, to include mental state examination.<br><br>ACE conducted with an IP adult patient not previously known to the trainee, to include mental state examination. | CBD of a case presentation of a typical patient the trainee has fully assessed within this specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) including a collateral history<br><br>ACE of a case presentation of a typical patient the trainee has fully assessed within this specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) including a collateral history |
| | CBD of differential diagnosis in a complex in-patient case. | CBD of differential diagnosis in a patient in this specialist area (e.g |

| | | |
|---|---|---|
| | CBD of differential diagnosis in a complex out-patient case. | EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| | CBD of investigations and management of a complex in-patient case.<br><br>CBD of investigations and management of a complex in-patient case. | CBD of investigations and management of a patient in this specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| 4b Psychiatric emergencies | Mini-ACE of a Mental Health Act assessment. | DONCS of trainee chairing a case conference / CPA review of a high risk patient |
| 4c Mental health legislation | CBD of an out of hours Mental Health Act assessment and subsequent case management.<br><br>CBD of a Mental Health Act Tribunal Report (or equivalent) the Trainee has written.<br><br>ACE of trainee giving evidence in a Mental Health Act Tribunal (or equivalent). | CBD of relevant mental health legislation and the management of a patient in this specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| 4d Broader legal framework | Evidence of satisfactory completion of an appropriate course to gain approval to exercise | CBD of case involving the management of child protection issues. |

| | | |
|---|---|---|
| | powers under the relevant mental health legislation | |
| 5a Psychological therapies | SAPE of the use of a psychological treatment appropriate to general adult in patients or out patients. | SAPE of the use of a psychological treatment relevant to the management of a patient in this specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| 7a Management of severe and enduring mental illness | Mini-ACE of the inpatient management of a patient with severe and enduring mental illness | CBD of the management of a patient with severe and enduring mental illness in the context of a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| | Two rounds of Mini-PAT – one in the inpatient setting and one in the outpatient setting.<br><br>Supervisors' reports | One round of Mini-PAT<br><br>Supervisors' reports |
| | One round of Mini-PAT<br><br>DONCS of ability to chair and manage an in-patient ward round.<br>DONCS in acting up as consultant in an in-patient unit for a 2 week period under close consultant supervision. | One round of Mini-PAT<br><br>DONCS of ability to chair and manage a team meeting in the context of a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |

| | | |
|---|---|---|
| | Supervisors' reports | Supervisors' reports |
| 11b Communication with colleagues | One round of Mini-PAT<br><br>Supervisors' reports | One round of Mini-PAT<br><br>Supervisors' reports |
| 12a Audit | Completed audit report | DONCS of ability to supervise an audit conducted by a Core trainee |
| 13a Organisational framework for clinical governance and the benefits that patients may expect | Supervisors' reports<br><br>DONCS of ability to manage a clinical complaint | Supervisors' reports<br><br>DONCS of ability to manage a clinical complaint in the context of a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc) |
| 15a The skills, attitudes, behaviours and practices of a competent teacher | AoT of ward based undergraduate teaching.<br><br>AoT of clinic/domiciliary based undergraduate teaching. | AoT of small group teaching for core trainees.<br><br>DONCS of teaching session by consultant colleague. |
| 15b Assessment | Log of shadow supervision sessions provided to core trainee (generally one hour per fortnight). | Log of shadow supervision sessions provided to core trainee (generally one hour per fortnight).<br><br>DONCS of shadow supervision session<br><br>Certificate of observation of CT1-3 interview process. |

| | | |
|---|---|---|
| 15c Appraisal | DONCS on completion of core trainee shadow ARCP appraisal form | DONCS on completion of core trainee shadow ARCP appraisal form<br><br>Completed NHS appraisal<br><br>Certificate of observation of CT1 ARCP process. |
| 16a Research techniques | Special Interest supervisors reports | Special Interest supervisors reports |
| 16b Evaluation and critical appraisal of research | DONCS on the evaluation of an original research paper of relevance to in-patient or out-patient general adult psychiatry. | DONCS on the evaluation of an original research paper in a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc). |
| 17a Doctor patient relationship | One round of Mini-PAT | One round of Mini-PAT |
| 17b Confidentiality | CBD on a case where confidentiality issues are salient. | |

| | | |
|---|---|---|
| 17c Risk management | Mini-ACE on assessment of risk in a complex case in a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc). | Mini-ACE on assessment of risk in a complex case in a specialist area (e.g EIP, AO, crisis, eating disorders, neuropsychiatry etc). |
| 17d Recognise own limitations | Log of cases where discussion with a senior colleague has been sought, due to knowledge limitations, and lessons learnt. | Log of cases where discussion with a senior colleague has been sought, due to knowledge limitations, and lessons learnt. |
| 17e Probity | Supervisors' reports | Supervisors' reports |
| 17f Personal health | Supervisors' reports | Supervisors' reports |
| 18a Maintaining good medical practice | Supervisors' reports<br><br>Reflective prose on issues raised in relation to clinical practice around GMC "good medical practice" | Supervisors' reports<br><br>Reflective prose on issues raised in clinical practice around GMC "good medical practice" |
| 18b Lifelong learning | An effective individual learning plan outlining learning needs, methods and evidence of attainment<br><br>Evidence of self reflection | An effective individual learning plan outlining learning needs, methods and evidence of attainment<br><br>Evidence of self-reflection |
| 18c Relevance of outside bodies | Evidence of continued GMC registration | Evidence of continued GMC registration |

## Guide for ARCP panels in Advanced Training in Rehabilitation Psychiatry

| **Intended learning outcome** | ST Year in Rehabilitation Psychiatry |
|---|---|
| **1 Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:**<br>• **Presenting or main complaint**<br>• **History of present illness**<br>• **Past medical and psychiatric history**<br>• **Systemic review**<br>• **Family history**<br>• **Socio-cultural history**<br>• **Developmental history** | |
| | 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.<br><br>Individual elements can be assessed through MiniACE |
| **2 Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses** | |
| | This will be demonstrated through CBDs, at least one with a rehabilitation accredited Consultant |
| **4 Competence in risk assessment in a rehabilitation setting and in the employment of a positive risk taking approach.** | |
| | This will be demonstrated |

| | |
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| | through CBDs with a rehabilitation accredited Consultant |
| **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** | |
| | Wherever possible there should be an ACE covering observation of the trainees assessment and handling of a crisis, for instance in a residential home. 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 |

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| | should be reflected in the supervisors' reports. |
| **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 supervisors report |
| **10 Develop appropriate leadership skills** | |
| | One round of Mini-PAT<br><br>Supervisors' reports |
| **16 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. |
| **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 | Supervisors' reports |

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