Canterbury
Christ Church
University

Salomons Institute for Applied Psychology

DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL)

ASSESSMENT HANDBOOK

The British
Psychological Society
Accredited Clinical Psychology

Academic Year 2021/22
(2018 and 2019 Intakes)

**CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)**

ASSESSMENT HANDBOOK

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CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

ASSESSMENT HANDBOOK
(2018 INTAKE ONWARDS)

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LIST OF RELEVANT INFORMATION CONTAINED ON Blackboard

Document	Location on Assessment Blackboard
Extenuating Circumstances policy as operated by this course	General Info/FAQ
Faculty Quality Committee Constitution	• Assessment Handbook
Major Research Project Declaration	• 2018 Intake
Guidance to examiners for written feedback & writing on scripts	• Other Relevant Information
Ethics Policy on Archival Data	

Document	Location on Placement Blackboard
ECC Form Marking Criteria and Guidance for Supervisors	• Handbook • 2018 Intake onwards
ECC Form	• P L Documents
Example Service User Feedback Forms	• Practice Learning documents 2018 intake onwards
Practice Learning Portfolio	
Practice Learning Feedback Form	
Placement Resource Audit Form	

LIST OF RELEVANT INFORMATION AVAILABLE ON THE INTERNET

Document	Location
University's policies, procedures and guidance, including Fitness to Practise, Plagiarism, Appeals Procedure	https://www.canterbury.ac.uk/our-students/ug-current/policy-zone
DCP Guidelines on Language in Relation to Functional Psychiatric Diagnosis	https://www.bps.org.uk/power-threat-meaning-framework/resources-training/training-materials
Extenuating Circumstances procedures and Request Form	https://www.canterbury.ac.uk/our-students/ug-current/academic-services/assessments/extenuating-circumstances
Turnitin Guidance for Students	https://www.canterbury.ac.uk/our-students/ug-current/academic-services/assessments/plagiarism
University's approach to preventing and dealing with plagiarism	https://www.canterbury.ac.uk/our-students/ug-current/academic-services/assessments/plagiarism
Role Description for External Examiners	https://www.canterbury.ac.uk/quality-and-standards-office/external-examiners/external-examiners.aspx
HCPC Guidance on Conduct and Ethics for Students	http://www.hpc-uk.org/assets/documents/10002D1BGuidanceonconductandethicsforstudents.pdf
CTCP/BPS Criteria for the Accreditation of Courses	https://www.bps.org.uk/psychologists/accreditation/education-providers

Document	Location
Surrey and Borders Partnership NHS Foundation Trust Policies, including Capability, Disciplinary and policy on Consent and Confidentiality for the Use of Clinical Material for Educational Purposes	https://www.sabp.nhs.uk/aboutus/policies
HCPC Standards of Proficiency for Practitioner Psychologists	https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/
HCPC Standards of Education and training	https://www.hcpc-uk.org/resources/standards/standards-of-education-and-training/
University's Student Study Support	https://www.canterbury.ac.uk/students/current-students/study-skills/study-skills.aspx
The Capital Community College guide to grammar and writing	http://grammar.ccc.commnet.edu/grammar/
Purdue University Online Writing Lab	http://owl.english.purdue.edu
APA Style Guide	http://www.apastyle.org/

ASSESSMENT SYSTEM

1. **Introduction**

   Under the regulations for the Doctorate in Clinical Psychology (D.Clin.Psychol.), Canterbury Christ Church University (CCCU), candidates are assessed across the broad range of capabilities and competencies required of a qualified clinical psychologist. The full Regulations and Conventions for the award are attached as Appendices 1 and 2 and the conventions and guidance are detailed in Section 6 of this document. The university's policies, procedures and guidance are available at http://www.canterbury.ac.uk/student-support-health-and-wellbeing/policies-and-procedures/policies-and-procedures.aspx. The Clinical Psychology Course has been accredited by the Health & Care Professions Council, British Psychological Society and validated by Canterbury Christ Church University (CCCU). This means that successful candidates can register with the HCPC as practitioner psychologists, practise as clinical psychologists in the UK and receive the Canterbury Christ Church University Doctorate in Clinical Psychology. The following describes the structures, procedures and processes involved in the assessment of the Doctorate in Clinical Psychology. The Assessment Handbook is distributed to all members of the Board of Examiners and candidates and is available on the course Blackboard board (Virtual Learning Environment) and the Course's website. The handbook provides information and/or direction to all relevant guidelines and marking standards for the award. The Course Director takes particular responsibility for the organisational arrangements for the Assessment System and is Deputy Chair of the Board of Examiners.

2. **The Salomons Institute for Applied Psychology Organisational Structures**

   The Salomons Institute for Applied Psychology is part of the School of Psychology, Politics and Sociology within the Faculty of Social and Applied Sciences, Canterbury Christ Church University, and is based on Meadow Road in the centre of Royal Tunbridge Wells. The Institute is accountable to CCCU for ensuring the delivery of high quality courses leading to University academic awards, some of these through the Research Degrees Subcommittee (RDSC). The Course Director, or their nominated course team member, is a member of the RDSC. The RDSC has responsibility for monitoring and ensuring the effective operation of the quality processes and procedures of courses governed under the Research Degrees Academic Framework, under which the Doctorate in Clinical Psychology sits. All Research degrees are approved by the Academic Board. Discussion of the progress and developments in the Doctorate course is also held at the Faculty Board.

   The Board of Examiners for Clinical Psychology is chaired by a senior member of Canterbury Christ Church University not involved in significant course delivery. Appointments to the Board follow the usual CCCU protocols and procedures, in that the Chair is appointed by the Dean of Faculty .

   The Board of Examiners has the responsibility to organise the assessment procedures and set, conduct and examine Course assessments within the framework of the CCCU General Regulations, the Research Degrees Academic Framework and of the Regulations and Conventions specific to this Course. The Board of Examiners has authority delegated to it by the Research Degrees Subcommittee to reach final decisions on candidates' results (see Figure 1).
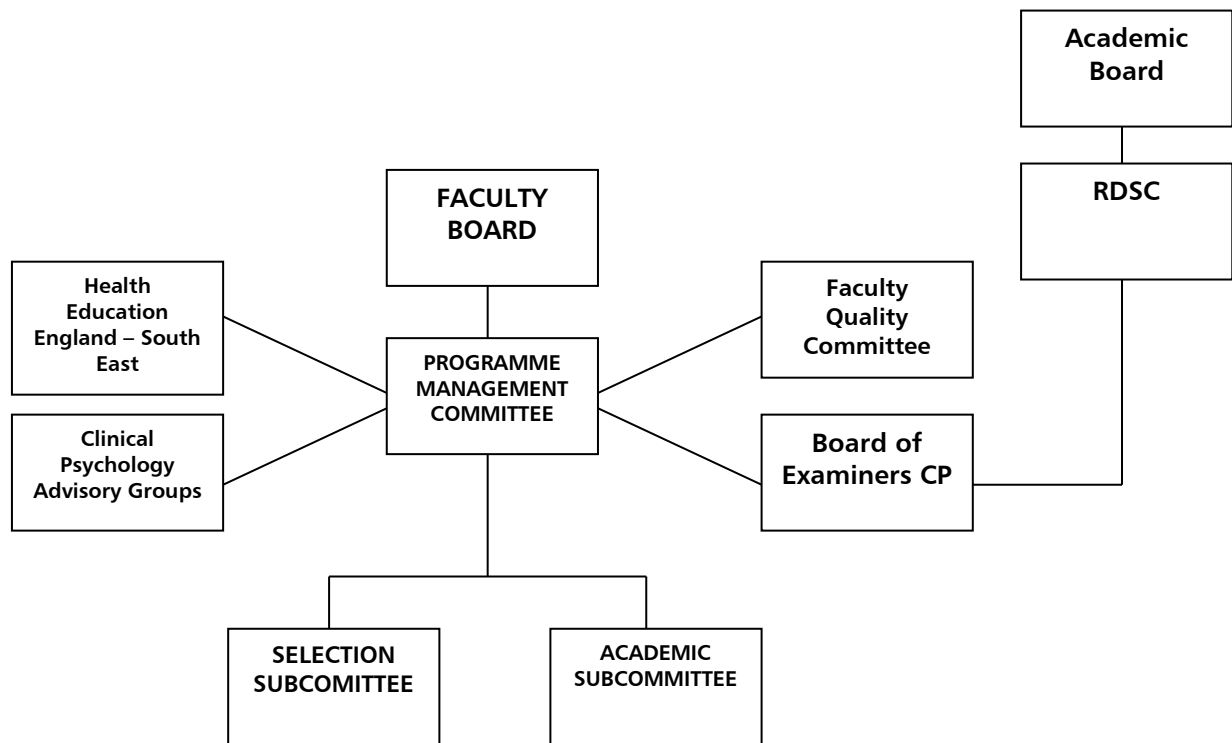
Figure 1.   Organisational Chart Illustrating Relationships between the Committees and Boards Related to the Course

3.   Assessment of the Doctorate in Clinical Psychology

3.1   Registration and Time Limits

The Regulations and Conventions for the award of the D.Clin.Psychol. are attached as Appendices 1 and 2 and the conventions are detailed in Section 6. The minimum time limit for the completion of the full course is three years. A full time candidature shall normally lapse after a period of five years from the date of registration. This time limit may only be extended in exceptional circumstances. This means that, in effect, all submission and resubmission of work must normally be completed within five years of beginning the Course.

3.2   Assessment Requirements

To be eligible for the Award of Doctorate in Clinical Psychology, according to the regulations and conventions set out, candidates must pass:

Across all years:
- Pass all Evaluations of Clinical Competence (ECC) detailed in the forms completed by supervisors (a minimum of five evaluations are undertaken which must cover all required placement-based work and meet in full the competency requirements of the Health & Care Professions Council and British Psychological Society). A copy of the ECC Form and the Marking Criteria and Guidance for Supervisors can be found in the Practice Learning Handbook.
- Successfully complete Practice Learning Log Books for all placements to achieve a confirmed and cumulative record of clinical experience (a minimum of five log

books which must cover all required placement-based work and meet in full the requirements of the Health & Care Professions Council and British Psychological Society). A copy of the Practice Learning Portfolio can be found in the Practice Learning Handbook.
- Pass written evaluations for each of the core experiences (Adult, Children and Families, Disability and Older People).
- In *addition* to all of the above - successfully complete a minimum number of 333 placement days overall, or a greater number of days where this is necessary to achieve the required professional competencies.

Year 1 assessments:
- Pass the Assessment of Clinical Skills which consists of two parts evaluated independently:
  - Part 1: Formulation and Evidence for Intervention Review of 3,000 words, excluding reference lists and appendices.
  - Part 2: Basic Therapeutic and Professional Skills assessment, consisting of a visual or audio tape of a therapeutic session (max 50 mins), an annotated transcript of this session and a clinical viva.
- Pass the Quality Improvement Project of 4-5,000 words, excluding reference lists and appendices;
- Pass a Team Policy Report of 5,000 words, consisting of a team review (3,500 words) and an individual reflective account (1,500 words), excluding reference lists and appendices;
- Satisfactorily provide a Team Policy Report Presentation (formative assessment only).

Year 2 assessments:
- Pass two Professional Practice Reports of Direct Work of 5,000 words, excluding reference lists and appendices;
- Pass one Critical Review of the literature of 5,000 words, excluding reference lists and appendices.

Year 3 assessments:
- Pass one Professional Practice Report of Direct Work of 5,000 words, excluding reference lists and appendices;
- Pass all assessments of the Major Research Project:
  - a Research Proposal (maximum 2,500 words) must be approved by the deadline set in the Research Handbook (Guidance on preparation for the MRP proposal is in the Research Handbook);
  - the report of the Major Research Project, which will comprise,
    i) a Literature Review Paper (minimum 6,000 – maximum 8,000 words)
    ii) an Empirical Paper (minimum 7,000 – maximum 8,000 words)
    iii) all word counts exclude reference lists and appendices.
- Satisfactorily undertake a Community Engagement Project Report (formative assessment)
- Provide a satisfactory Reflective Professional Development Report (formative assessment) of 4,000 words, excluding reference lists and appendices.

The following sections provide an overview of the assessment requirements for the Doctorate. More details on the timing of assessments are described in Appendix 4.

3.3 Fitness to Practise and Codes of Conduct

Trainees are required to meet the Health & Care Professions Council standard:

"1a.1   be able to practise within the legal and ethical boundaries of their profession

- understand what is required of them by the Health & Care Professions Council"[1]

Trainees are advised that they should read thoroughly the HCPC guidance on these issues at the following link: http://www.hpc-uk.org/assets/documents/10002D1BGuidanceonconductandethicsforstudents.pdf.

All university students are expected to adhere to the university Code of Professional Conduct, which can be found at:
http://www.canterbury.ac.uk/support/student-support-services/students/student-procedures.asp

If there are concerns with regard to a trainee's fitness to train or practise they may be taken through the university 'fitness to practise' policy (http://www.canterbury.ac.uk/support/student-support-services/students/student-procedures.asp). Such concerns will also be raised with their employer, Surrey and Borders Partnership NHS Foundation Trust, who may choose to take them through their Capability/Disciplinary or other associated policies (https://www.sabp.nhs.uk/aboutus/policies).

3.4 Submission Deadlines

Deadlines for submission of all assessments will be published at the start of each academic year. A Schedule of Deadlines for the year will be available on Blackboard. Failure to submit assessments by the date required, without following the Extenuating Circumstances Policy (see below), will normally result in a fail mark being recorded for that piece of work.

3.5 Extenuating Circumstances Requests procedures

Please see the information on Blackboard specific to this course; there are different arrangements for some assessments, e.g. Major Research Projects and Reflective Development Reports.

Students are expected to complete assessments, including examinations and other time-constrained assessments, on time. However, there are occasions when there might be a short-term disruption to studies because of an unexpected occurrence or event outside your control that arose through illness or through misfortune. This unexpected occurrence or event is one that prevented completion of an assessment. If there are problems that are likely to affect a student for a longer period of time, which lasts for several weeks or more, students should talk to their Manager or Course Director as soon as possible.

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[1]Standards of Proficiency: Practitioner psychologists (2009), Health & Care Professions Council

To make an extenuating circumstances request, you the request must be emailed to the Assessments Administrator following the procedures which are set out at https://www.canterbury.ac.uk/our-students/ug-current/academic-services/assessments/extenuating-circumstances. On this webpage there is a form for you complete, and for evidence-based requests students will have to make a personal statement about the circumstances and provide supporting independent evidence to accompany the request. There is a list of the circumstances that are considered acceptable for extenuating circumstances.

3.6   Copying and Plagiarism
Plagiarism policy
The University is committed to fair assessment procedures for all students. Our Plagiarism Policy is designed to help you in understanding what plagiarism is and how to avoid it in your work. For the policy and guidance on avoiding plagiarism please see: www.canterbury.ac.uk/plagiarism. Potential instances of plagiarism will be considered under the University's plagiarism policy and not under the Research Misconduct Policy.

Through the Blackboard virtual learning environment you will be asked to routinely submit your coursework (with occasional exceptions) through an online service called Turnitin. By comparing your work with information on the Internet, with databases of journal articles and other published work the service can help you and your tutors to identify where your writing needs to be refined to acknowledge the work of others. You will have the opportunity to submit at least one draft, and check the results from Turnitin yourself, for each piece of work you submit. To help you check your own work, your tutors will give you advice on what to look for. Your tutors will also explain how Turnitin will be used to help detect plagiarism in your assessed work, this is referred to as 'Originality Checking'. For more information and guidance please see: www.canterbury.ac.uk/plagiarism

PLAGIARISM is the act of presenting the ideas or discovery of another as one's own. To copy sentences, phrases or even striking expressions without acknowledgement in a manner which may deceive the reader as to the source is plagiarism; to paraphrase in a manner which may deceive the reader is likewise plagiarism. Where such copying or close paraphrasing has occurred, the mere mention of the source in a bibliography will not be deemed sufficient acknowledgement; in each such instance it must be referred specifically to its source. Verbatim quotations must be directly acknowledged, either in inverted commas or by indenting.

DUPLICATION OF MATERIAL means the inclusion in course work of a significant amount of material which is identical or substantially similar to material which has already been submitted by the candidate for the same or any other course or short course at the university or elsewhere. Candidates should not duplicate material in this way. Where candidates are permitted to choose the title of a piece of coursework, they should be careful to avoid making a selection which might result in overlap between that and any other submitted work. Candidates who feel that they might need to cover similar ground in two pieces of submitted work should consult their supervisor and manager.

If a candidate has been found to be guilty of plagiarism or duplication of material through the University's procedures, normally the trainee will also be taken through the employer's disciplinary procedures as this constitutes an infringement of expected professional practice.

3.7   Presentation
Word counts should be exact and must include **all free text as well as quotations, footnotes etc**. Word counts should exclude title page, abstract, contents page, figures, diagrams, tables and reference list **at the end of the report**. If an examiner believes a piece of work may be over the word limit, they are expected to inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit it will be automatically referred.

Candidates should submit electronic copies of all work (except where vivas are required when hard copies must also be submitted). Work should be typed with double line spacing and the font size should be a minimum of 12. All work should be paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Candidates are encouraged to use double-sided printing where possible.

Please note that the DCP has developed a short document "Guidelines on Language in Relation to Functional Psychiatric Diagnosis" (https://www.bps.org.uk/power-threat-meaning-framework/resources-training/training-materials)   and   the principles detailed here are expected to be followed in all communications, written and verbal. Clinical placements may have their own guidelines for these matters with regard to their own communications, which should be respected and followed for placement reports and other communications within placement. The DCP guidelines are, however, the required ones to be followed for all academic submissions.

4.   The Board of Examiners
The Board of Examiners is responsible for the assessment of candidates. This Board comprises the Chair, who is a senior member of the University, the Course Director (Deputy Chair) or the Deputy Chair's nominee, a representative from Registry, the External Examiners, Course Team and clinical psychologists selected to examine the assessments.

4.1   Course Team
All members of the Course Team are members of the Board of Examiners. Members of the Course Team cannot examine work where they have provided significant advice and support.

4.2   Selection and Role of Non-Team Examiners
All work is marked by two examiners; some of these examiners may not be course team members but local, practising clinical psychologists, often clinical supervisors. All of these examiners are full members of the Board of Examiners. These examiners will meet the following criteria:

Examiners should not examine assessments where they have supervised or played a significant role in assisting trainees in the production of those reports.

4.3 Recruitment and Training of Examiners

Non-course team Examiners are recruited by the Course and must supply a CV which demonstrates that they meet the relevant criteria. Once appointed, examiners, who are full members of the Board of Examiners are expected to attend Board meetings where work they have assessed is being discussed. All new examiners are required to attend an Examiners' Training Workshop and are usually paired with an experienced examiner when they begin marking.

4.4 Recruitment and Role of External Examiners

External Examiners are nominated by the Board of Examiners and approved and appointed by the university's Academic Board. The university's Role Description for External Examiners can be found in the University's Assessment Procedures Manual:

http://www.canterbury.ac.uk/quality-and-standards-office/regulation-and-policy-zone/regulation-and-credit-framework.aspx.

All external examiners will normally be HCPC registered, unless only marking research reports, and this will be checked at the point of recruitment. The role of the External Examiner usually includes the responsibilities detailed below.

a)   Membership of the Board of Examiners.

b)   Commenting on the examination, marking and feedback of the course assessments. A sample, and all fails and referrals from each assessment, will

be sent to external examiners prior to the relevant meeting of the Board of Examiners.

c)   Assisting the Course's Board of Examiners and Internal Examiners resolve significant disagreements in marking course assessments.

d)   Commenting on the course's overall assessment strategy.

e)   Contributing to the consideration of mitigating circumstances and concessions where required.

f)   Contributing to the assessment of all cases of fail and referral performance across all assessments with the exception of referral on one placement competency.

g)   Commenting on individual research proposals, if required, for the Major Research Project through the Research Director.

h)   Marking the Major Research Project.

i)   Conducting a viva voce on the Major Research Project with an Internal Examiner.

j)   Signing and authorising the recommendation made to CCCU on the relevant Board paperwork.

k)   Producing an annual report for CCCU about the assessment process and a final report at the end of each cohort of trainees/candidates.

l)   Producing a report about the course to the British Psychological Society's Committee on Training in Clinical Psychology at the time of any accreditation or review process, if required.

All external examiners are expected to follow the most recent relevant QAA Guidelines for External Examining.

5.   **Procedures and Timing of Assessments**
The table in appendix 4 details the general timings of submissions of the assessments. Detailed schedules of assessments are provided to all trainees and examiners at the start of each academic year. This schedule specifies the submission date for each assessment and the dates of the Board of Examiners.

6.   **Course Regulations including Failure**
The Course operates under the conventions detailed below.

a)   To be eligible for the award of the Degree, candidates must pass all assessments.

b)   Assessments will be graded as follows:
Pass

Pass with Conditions
Not passed (leading either to a Referral or a Fail)

Definitions of each grade category for each assessment are included in the marking criteria contained within the Assessment Handbook, or the Practice Learning Handbook for placements. The grade categories for the Major Research Project are different and outlined in appendices 21 and 22.

c)   A candidate who fails to submit coursework by the date required without good prior reason will receive a mark of a fail for that piece of work.

d)   The consequences of referral and fail marks for coursework are specified below.

i)   All assessments except the ECC and placement assessments and the Major Research Project

Candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a student has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure (see section 7). If any assessment is not passed at second reassessment attempt, this constitutes course failure.

ii)   *ECC and Placement Assessments*

Candidates receiving a referral on their evaluation of clinical competence form will be required on the next placement to achieve a pass on the specific competencies for which they received a referral, i.e. they can only be assessed as having achieved a pass or fail *on this specific competency*. In the rare event a 'Not applicable' rating has been given to the competence previously rated as a referral the candidate will be required to meet this competence on the subsequent placement. Referral of an Evaluation of Clinical Competence constitutes referral of one assessment.

In the event of a candidate receiving a fail on their Evaluation of Clinical Competence, this will constitute failure of one assessment. Candidates receiving a Fail on their Evaluation of Clinical Competence will be required to be reassessed in the specialty placement concerned and achieve a pass on completion of this reassessment. In the event of a placement reassessment, candidates will not be able to be awarded a referral on this assessment; they can only achieve a pass or a fail. In the event of a candidate failing the Evaluation of Clinical Competence on a placement reassessment, or a second placement, this constitutes course failure.

iii)   *Major Research Project*
Upon resubmission of a revised and resubmitted MRP, in order to pass the course (subject to all other requirements also being met) and receive the Doctorate, the candidate must receive a mark of Pass, Pass with Minor Corrections or Pass with Major Corrections. Failure to obtain one of these three marks will result in course failure.

f)   All candidates for the degree will receive a viva voce examination which will include an External Examiner, the focus of which will normally be the Major Research Project.

g)   A candidate will normally be deemed to have failed the Course if:
i)   receive a fail on two Evaluation of Clinical Competence assessments (Placement); or
ii)   do not pass a second reassessment (see (5) above); or
iii)   receive a Referral or Fail on six assessments (including both first attempts, first reassessment attempts and placements);
iv)   fail to complete the work required for the degree within the time limits laid down in the regulations for the course; or
v)   are dismissed from their employment.
vi)   demonstrate unsatisfactory progress or attendance, when the Board of Examiners may recommend that Research Subcommittee should terminate the candidate's registration and require him/her to withdraw from the University.

h)   The Course Handbook contains information about Progress Reviews and Capability meetings, which will be arranged as required to consider progress on the course and any support required.

7.   **APPEALS PROCEDURE**
An Academic Appeal is defined as a request for a review of the decision-making of a body (such as a Board of Examiners, or panel established to investigate plagiarism or other academic misconduct) charged with making academic decisions on progression, assessment, academic conduct or awards. A Fitness to Practise Appeal is defined as a request for a review of the decision-making of a body (such as a fitness to practice panel) charged with making decisions relating to the student's conduct, competence and capabilities in relation to professional practice, taking into account the requirements of any relevant regulatory or statutory body. Students are able to seek the support and representation of the Student Union when making an appeal. The full policy is available from the following web link: https://www.canterbury.ac.uk/our-students/ug-current/academic-services/assessments/initiating-an-academic-appeal

8.   **BOARD OF EXAMINERS' MEETINGS**
The Board of Examiners meets normally on four occasions each academic year. These meetings are in November, February, May/June and September. Each Board may consider submissions relating to progression and outcome.

9. **AWARDING THE DOCTORATE**

At the September meeting of the Board of Examiners, normally all completing candidates' marks will be considered and the candidates eligible for the award will be referred to a Progression and Award Board of Examiners. These candidates will receive their results and confirmation of the award by email normally by mid-October. Candidates will not be eligible for graduation until the final copies of the candidate's work are submitted to the Programme. The distribution of awards will take place at Canterbury Christ Church University's Awards ceremony at Canterbury Cathedral, in the following year.

Once the candidate is informed of confirmation of the award, having completed all placements and academic work including conditions, their name will be forwarded to the HCPC and they may then apply to be registered as a clinical psychologist.

10. **EXIT AWARD**

10.1 A degree of a Postgraduate Diploma in Applied Psychology-Mental Health may be awarded to a candidate if they have completed and passed specified assessments in year one and two of the D.Clin.Psychol., if for whatever reason they discontinue their studies before completion of the doctorate.

10.2 The award of PGDip. in Applied Psychology-Mental Health does **not** confer any eligibility to practise as an applied psychologist and does **not** make the award bearer eligible to apply to the HCPC for registration. It is in recognition of the accomplishment of a period of advanced study in the field of applied psychology and mental health.

10.3 The exit award marks the achievement of the following defined learning outcomes at level 7. Upon successful conclusion of the PGDip. in Applied Psychology-Mental Health, the candidate will be able to demonstrate:

10.3.1 The ability to critically review and evaluate policy within the professional, political and social context of health and social care delivery.

10.3.2 The capacity to contribute effectively and work productively in a team context to achieve shared academic and professional goals.

10.3.3 Self direction and originality in applying the principles of service evaluation and quality improvement including the stages of design, ethical consideration, data collection, interpretation and dissemination within an active service context.

10.3.4 A conceptual understanding that enables the design and conduct of advanced literature reviews conducted to address specified questions about areas of professional knowledge or practice.

10.3.5 The ability to critically evaluate current research and academic publications within a defined area and to draw independent conclusions about the relevance of this to professional practice and to future research.

10.3.6 A understanding of the principles and practice of assessment, formulation and intervention within the context of supervised work with a service user, or group, in a specified domain of clinical work.

10.3.7 The capacity to critically reflect on work undertaken from a psychological perspective and thus learn and develop independently in the context of practice.

10.3.8 The ability to summarise and present work undertaken effectively, both orally and in written form.

10.4 To demonstrate achievement of the above learning outcomes, and thus to complete this award, the candidate must have submitted and passed the following elements of the course:

	Assessment	Word length	Submission due

1	Team Policy Review
	    a) Team review
	    b) Individual report
	    c) Presentation
		
		3,500
		1,500
		n/a
			
			May/June year 1
			May/June year 1
			July year 1

2.	Quality Improvement Project	4,000-5,000	September year 1
3	Critical Review	5,000	May/June year2
4	Professional Practice Report (Child or Disability)	5,000	July year 2

10.5 Guidance regarding these assessments is contained in the appendices of the D.Clin.Psychol. Assessments Handbook.

10.6 The decision to award a PGDip. in Applied Psychology-Mental Health will be made by the Board of Examiners of the Doctorate in Clinical Psychology.

10.7 Should the candidate discontinue their employment with the NHS, which is a requirement for the continued registration on the D.Clin.Psychol, they may, at the discretion of the Board of Examiners, complete the Diploma but they may be charged tuition fees in line with other self-funded Diploma candidates.

Ref: Assessment Handbook//2018 updated 10/21

CANTERBURY CHRIST CHURCH UNIVERSITY

REGULATIONS FOR THE DOCTORATE IN CLINICAL PSYCHOLOGY (D.Clin.Psychol)

1.   PREAMBLE & DEFINITION OF TERMS

1.1   Candidates may proceed under these Regulations to the Degree of Doctor in Clinical Psychology. This is an approved course under the Health & Care Professions Council (HCPC) and only those graduating from this course can use the protected title 'Clinical Psychologist'.

1.2   No aegrotat award of the Degree of Doctorate in Clinical Psychology shall be given as this is an approved award which confers professional status under the HCPC.

1.3   Where the words 'examination' or 'assessment' appear in these Regulations, they shall be taken to refer to any examined or assessed component of the Degree including a viva voce examination.

2.   ENTRY REQUIREMENTS

2.1   The Research Subcommittee may approve the registration of a candidate for the Degree of Doctor in Clinical Psychology providing that it has been satisfied that he/she usually possesses a first class or good second class honours degree in Psychology which confers Graduate Basis for Chartered (GBC) Membership status from the British Psychological Society (BPS). Holders of other qualifications in Psychology will be considered individually.

2.2   All candidates must be in employment which permits them to practise as a trainee.

Note 1: All candidates should be reasonably assured of the financial support needed to complete the course proposed.

Note 2: Applicants are advised that registration for courses involving formal coursework can normally only take effect from the starting date given in the published particulars of the course in question.

3. *CREDIT EXEMPTION*

    3.1   There is no credit exemption on this course.

4. *PROGRAMME OF STUDY*

    4.1   A candidate registered for the Degree of Doctor in Clinical Psychology is required to follow a programme of advanced clinical study and research approved by the Research Subcommittee and under the supervision of a member or members of staff of the University and to be assessed according to the requirements set by the Research Subcommittee for that qualification.

5. *PERIODS OF STUDY*

    5.1   A candidate must be registered on full-time basis.

    5.2   The period of registration for the course is a minimum of 3 years and a maximum of 5 years following initial registration.

6. *ATTENDANCE*

    6.1   Candidates will attend the Salomons campus, or other designated centres, for the whole period of the course except that, with the approval of the Research Subcommittee, part of the prescribed period of registration may be spent elsewhere.

7. *DISCRETIONARY POWER*

    7.1   In cases of illness or other good cause the Research Subcommittee may permit a candidate to interrupt the prescribed period of study for a stated length of time. A candidate may apply to the Research Subcommittee to vary the conditions attached to his/her registration. The Research Subcommittee shall, if the application be approved, determine the length of the course, any further period of attendance required and any other conditions attached to the registration.

    7.2   In the event of unsatisfactory progress or attendance, the Board of Examiners may recommend that Research Subcommittee should terminate the candidate's registration and require him/her to withdraw from the University.

> ***Note:*** *The power to vary conditions attached to registration (paragraph 7.1) and termination (paragraph 7.2) will normally be delegated to the Board of Examiners.*

7.3   If the student is supported through employment by the NHS and this employment is terminated then their registration with the University shall also be terminated.

7.4   Any student whose registration is terminated under the provisions of paragraph 7.2 of these Regulations, may request a review of his/her case by the Research Subcommittee. The decision of the Research Subcommittee in the matter shall be final.

8.   *EXAMINATION*

8.1   A candidate must:

8.1.1   fulfil all the requirements of such written, practical or clinical work as the Research Subcommittee or the Board of Examiners concerned may require by such dates as may be prescribed;

8.1.2   present for examination two comb bound copies of the Major Research Project and three copies of the other work that is required for the Course. At the end of the course work should be submitted in accordance with the instructions issued to candidates;

8.1.3   present himself/herself for viva voce examinations unless specifically exempted from this requirement by the Board of Examiners;

8.2   The composition of the Major Research Project must be wholly the candidate's own work and must embody the results of the candidate's research during the period of registration. A candidate is required to show in the Major Research Project appropriate ability to conduct an original investigation, to test ideas, whether the candidate's own or those of others, and to understand the relationship of the theme of his/her investigation to a wider field of knowledge. The Major Research Project should be relevant to the form of clinical practice studied and describe the links with the relevant literature; candidates should demonstrate within the Major Research Project their capacity to understand the link between their research and clinical practice. The candidate is also required to show

appropriate ability in the organisation and presentation of his/her material in the Major Research Project.

Where a Major Research Project is based in whole or in part on collaborative work, the extent of this collaboration must be clearly indicated in the Major Research Project. Any material which repeats the ideas or discoveries of another must be clearly identified and the author acknowledged.   Failure to do so will be regarded as plagiarism.   Potential instances of plagiarism will be considered under the University's plagiarism policy and not under the Research Misconduct Policy. Any material which the candidate has previously presented and which has been accepted for the award of an academic qualification, at this University or elsewhere, must be clearly identified in the Major Research Project. Such material will be ignored by the Examiners in deciding whether the candidate is worthy of the award of the Degree.

8.3   A candidate shall remain eligible to present a Major Research Project for such further period after the completion of the prescribed period of registration as may be determined by the Board of Examiners provided that during this period he/she pays such annual fees as may be prescribed and submits such reports on progress as may be required by the Board of Examiners. Upon completion of this eligibility, a candidate may, if for good and sufficient reason the Board of Examiners so decides, remain eligible to present a Major Research Project for one or more further periods of not more than 12 months on payment of a prescribed fee.

8.4   If a candidate provides evidence satisfactory to the Board of Examiners of illness or of other urgent and reasonable cause which prevented him/her from submitting assessments, required for an examination, by the due date, then the Board of Examiners shall allow the candidate a deferment to submit such assessments as it may require at a time not later than one year after the normal time of examination.   Such evidence shall be submitted in writing, through the Deputy Chair of the Board of Examiners together with supporting evidence (including, in the case of illness, a medical certificate) not later than the day prior to the submission deadline of the part of the assessment to which it relates.   In exceptional circumstances, the Academic Board may extend this time limit if he/she is satisfied that it is appropriate to do so.

8.5   After examining all assessments presented by the candidate and considering the results of the viva voce examination, the Examiners, at their discretion, may recommend to the Research Subcommittee:

8.5.1   that the degree of Doctorate be awarded (Pass) subsequent to all other marked submissions being passed;

8.5.2   that the degree of Doctorate be awarded subject to certain minor corrections being carried out to the satisfaction of the Internal Examiner within three months of the official notification to the student of the recommendation of the Examiners and subsequent to all other marked submissions being passed;

8.5.3   that the degree of Doctorate be awarded subject to certain major corrections being carried out to the satisfaction of the Internal Examiner, and the External Examiner in cases where both examiners feel this necessary, within six months of the official notification to the student of the recommendation of the Examiners and subsequent to all other marked submissions being passed;

8.5.4   that the degree of Doctorate be not awarded at present but that the student be permitted to resubmit the thesis in a revised form not later (except in cases of illness or other good cause) than twelve months after the decision to allow resubmission has been made by the Research Degrees Sub-committee. A new viva voce examination will be required;

8.5.5   in cases where the student submits a thesis judged satisfactory by the Examiners for the award of the degree of Doctorate but fails to satisfy the Examiners in the oral examination, that the degree be not awarded at present but that the student be permitted to take a further oral examination, normally not later than six months after the decision to allow this has been made by the Research Degrees Sub-committee;

8.5.6   that the degree of Doctorate be not awarded but that the degree of PGDip. in Applied Psychology-Mental Health be awarded if the Board of Examiners considers that the candidate has met the criteria for this award;

8.5.7   that no degree be awarded.

8.6   *Fees*

8.6.1   The fee for the first examination of a candidate is included in the tuition fees.

8.6.2   A candidate who repeats a written or viva voce examination in whole or in part or resubmits an Major Research Project must pay the fee prescribed and in force for the time being.

8.6.3   A candidate who submits a Major Research Project later than the date specified by the Research Subcommittee must pay the fee prescribed and in force for the time being.

8.6.4   The Research Subcommittee, on the recommendation of the appropriate Board of Examiners, may waive or reduce the payment of these fees in special circumstances.

8.6.5   The award of the Degree may be withheld where a student owes money to the University.   Such students will not normally be informed of the recommendation of the Board of Examiners concerning them.

9.   APPEALS

9.1   A candidate may appeal against a decision by the Board of Examiners in the following circumstances only:

9.1.1   where a resit or repeat has not been offered to a student following failure, without good reason

9.1.2   where a student believes their extenuating circumstances request was rejected without proper consideration

9.1.3   where a material administrative error has led to a particular negative academic outcome

9.1.4   where exams or coursework have not been conducted according to the current rules and regulations

9.1.5   where evidence can be provided from a qualified professional that has not previously been provided but shows that recent performance may have been impaired and the ability to apply for extenuating circumstances affected

a) shows the student's performance to have been materially affected; and

b) is, for demonstrable reasons, of a sort which the student could not reasonably have been expected to submit at the appropriate time under the University's extenuating circumstances procedures; and

c) has not previously been received and reviewed by the University; and

d) relates to one or more assessment/s recent enough to have been considered when the Board of Examiners or other academic body last made a decision relating to the student.

9.2   Evidence will not be accepted which:

9.2.1   calls into doubt the academic or professional judgement of the Examiners; or

9.2.2   relates to the candidate's failure to fulfil the requirements of paragraphs 8.1.1 and 8.1.2.

Note: *The University's Appeals Procedures are set out in detail on the following website*

http://www.canterbury.ac.uk/student-support-health-and-wellbeing/policies-and-procedures/policies-and-procedures.aspx

10. PROCEDURE & DELEGATION OF POWERS

10.1   The Academic Board, Research Subcommittee and Committees that have been charged with responsibilities under these Regulations may delegate such of their powers as they may from time to time see fit. The exercise of such delegated powers shall on each occasion be reported to the next following meeting of the delegated body as that body shall from time to time direct.

11. POWERS OF DISPENSATION

11.1   On the recommendation of the Board of Examiners the Academic Board may in special circumstances dispense a candidate from any of these Regulations.

EXPLANATORY NOTES

These notes are provided for the guidance of candidates and do not form part of the Regulations.

1. Candidates are required to submit two comb bound copies for examination and are advised that they will require a further copy of their Major Research Project for use in the viva voce examination.

2. Once candidates have been informed by the Board of Examiners that they have passed the course, they are required to submit their work for access in the library according to the instructions provided by the course.

3. Candidates are advised that they may, if they wish, submit for publication material which is to be included in their Major Research Project before submission of their Major Research Project.

4. (a) Candidates should note that conciseness of presentation, consonant with the prescribed length of the assessments, is an essential part of "appropriate ability in the organisation and presentation" of their material which they are required to demonstrate in accordance with Regulation 8.1.2.

    (b) Unless approval has been obtained from the Board of Examiners, the length of assessments must not be less than the specified minimum.

    (c) Examiners are entitled to refuse to examine assessments where the maximum length specified has been exceeded.

5. Detailed specifications relating to assessments and the examination of particular elements of the course are set out in the Validation Document and in the Assessment Handbook.

6. If a candidate submits an appeal under the terms of section 9 or requests a review of his/her case under the terms of section 7 of these Regulations, a final decision may be delayed until the term following the request.

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Ref: Assessment Handbook/Name of Assessment/2018

CANTERBURY CHRIST CHURCH UNIVERSITY
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Course Regulations Including Failure

The Course operates under the Regulations detailed below.

1.   To be eligible for the award of the Degree, candidates must pass all assessments.

2.   Clinical placements will be assessed on a pass/referral/fail basis. Marking Criteria and Guidance for Supervisors are contained in the Practice Learning Handbook.

3.   Assessments (except the Major Research Project) will be graded as follows:
- Pass
- Pass with Conditions
- Not passed (leading either to a Referral or a Fail)

The Major Research Project will be graded as follows:
- Pass
- Pass with Minor Corrections
- Pass with Major Corrections
- Revise and Resubmit
- That no degree be awarded.

Definitions of each grade category for each piece of work are included in the marking criteria contained within the Assessment Regulations Handbook.

4.   A candidate who fails to submit coursework by the date required without good reason will receive a mark of a fail for that piece of work.

5.   The consequences of referral and fail marks for course work are specified below.

5.1   *Professional Practice Reports: Direct Work, Assessment of Clinical Skills Parts 1 and 2, Team Policy Reports, Critical Reviews and Quality Improvement Project*

Candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a student has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure (see section 7). If any assessment is not passed at second reassessment attempt, this constitutes course failure.

5.2   *Evaluation of Clinical Competence (Placement)*
Candidates receiving a referral on their evaluation of clinical competence form will be required on the next placement to achieve a pass on the specific competencies for which they received a referral, i.e. they can only be assessed as having achieved a pass or fail *on this specific competency*. In the rare event a 'Not applicable' rating has been given to the competence previously rated as a referral the candidate will be required to meet this competence on the subsequent placement. Referral of an Evaluation of Clinical Competence constitutes referral of one assessment.

In the event of a candidate receiving a fail on their Evaluation of Clinical Competence, this will constitute failure of one assessment. Candidates receiving a Fail on their Evaluation of Clinical Competence will be required to be reassessed in the specialty placement concerned and achieve a pass on completion of this reassessment. In the event of a placement reassessment, candidates will not be able to be awarded a referral on this assessment; they can only achieve a pass or a fail. In the event of a candidate failing the Evaluation of Clinical Competence on a placement reassessment, or a second placement, this constitutes course failure.

5.3   *Major Research Project*
In the event of Major Corrections being resubmitted and not obtaining a Pass with Minor Corrections or a straight Pass, the case should be referred to the Research Degrees Sub-committee.

Upon resubmission of a revised and resubmitted MRP, in order to pass the course (subject to all other requirements also being met) and receive the Doctorate, the candidate must receive a mark of Pass, Pass with Minor Corrections or Pass with Major Corrections. Failure to obtain one of these three marks will result in course failure.

6.   All candidates for the degree will receive a viva voce examination usually in their third year which will include an External Examiner, the focus of which will normally be the Major Research Project.

7.   A candidate will normally be deemed to have failed the Course if they:

   i)   receive a fail on two Evaluation of Clinical Competence assessments (Placement); or
   ii)   do not pass a second reassessment (see (5) above); or
   iii)   receive a Referral or Fail on six assessments (including both first attempts, first reassessment attempts and placements);

   iv)   fail to complete the work required for the degree within the time limits laid down in the regulations for the course; or
   v)   are dismissed from their employment.
   vi)   demonstrate unsatisfactory progress or attendance, when the Board of Examiners may recommend that Research Subcommittee should terminate the candidate's registration and require him/her to withdraw from the University.

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Learning Outcomes and Assessment Methods

No.	Learning Outcome	Assessment Methods
1	An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.	ECC Form Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Team Policy Report Quality Improvement Project PPR: Direct Work Critical Review Major Research Project Community Engagement Project Report Reflective Development Report
2	An advanced and critical understanding of the scientific methods involved in research and evaluation, including the evidence base for psychological therapies, and to have developed the complex skills required to use this understanding in practice through carrying out original research and advanced scholarship.	ECC Form Assessment of Clinical Skills Part 1 Quality Improvement Project Critical Review Major Research Project
3	A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.	ECC Form Assessment of Clinical Skills Part 2 Team Policy Report PPR: Direct Work Critical Review Community Engagement Project Report Reflective Development Report
4	An advanced and critical understanding of, and ability to apply, at least three theoretical models on which clinical psychology draws (in particular, behavioural, cognitive, systemic and psychoanalytic) and to be able to adapt the therapeutic model to work effectively in highly complex and novel contexts occurring across the lifespan.	ECC Form Practice Learning Portfolio Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 PPR: Direct Work Critical Review

No.	Learning Outcome	Assessment Methods
5	A high level of competence in assessment, formulation, intervention and evaluation across a range of theoretical models (one of which must be Cognitive Behaviour Therapy), client groups and organisational contexts, with appropriate attention to any factors relating to risk and to have the transferable skills to apply these in complex and unique circumstances.	ECC Form Practice Learning Portfolio Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Team Policy Report PPR: Direct Work
6	An advanced level of creative and critical thinking in relation to the development of clinical practice and services as well as the personal and organisational skills to implement, or facilitate the implementation of, these ideas in unique and complex situations.	ECC Form Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Quality Improvement Project PPR: Direct Work
7	A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.	Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Team Policy Report Team Policy Presentation Quality Improvement Project PPR: Direct Work Community Engagement Project Report
8	A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.	ECC Form Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Quality Improvement Project PPR: Direct Work Major Research Project
9	An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.	ECC Form Assessment of Clinical Skills Part 2 Team Policy Presentation PPR: Direct Work Quality Improvement Project Major Research Project
10	The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.	ECC Form Team Policy Report Team Policy Presentation Quality Improvement Project PPR: Direct Work Community Engagement Project Report Reflective Development Report

No.	Learning Outcome	Assessment Methods
11	An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.	ECC Form Assessment of Clinical Skills Part 1 Assessment of Clinical Skills Part 2 Team Policy Report Community Engagement Project Report Reflective Development Report
12	An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent; which recognises the value of feedback and the importance of seeking this out, and constructively responding to it; and which demonstrates the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge, enabling them to continue to grow.	ECC Form Team Policy Report PPR: Direct Work Major Research Project Reflective Development Report

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Ref: Assessment Handbook//2018

Timeline of assessments (and interim research deadlines)

Submissions due	December	January	March/April	May/June	June	July	August/Sept	September
Year 1		QIP proposal deadline: last Friday in January	Team Policy Report & Reflective Account	MRP proposal deadline: last Friday in May	Assessment of Clinical Skills part 2	Team presentation	Practice Learning Documentation Stage 1	QIP
			Assessment of Clinical Skills part 1		MRP proposal reviews	Clinical vivas		
Year 2			Child or Disabilities PPR (1st 6 month placement)		Child or Disabilities Critical Review			Child or Disabilities PPR (2nd 6 month placement)
			Practice Learning Documentation Stage 2a					Practice Learning Documentation Stage 2b
								*MRP Part A
Year 3			Practice Learning Documentation Stage 3a	MRP vivas	OP/Supp PPR (1st 6 month placement)	Community Engagement Project Report (2nd 6 month placement)	Practice Learning Documentation Stage 3b	
			MRPs				Reflective Development Report (first Friday in Sept)	
Year 4 (in exceptional cases)	Deferred MRP							
Board of Examiners	**February**	**N/A**	**May/June**	**May/June**	**September**	**September**	**September**	**November**

*To be negotiated with MRP supervisors

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ASSESSMENT OF CLINICAL SKILLS:
PART 1- FORMULATION AND EVIDENCE FOR INTERVENTION REVIEW

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Assessment of Clinical Skills Part 1
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The purpose of this assessment is to demonstrate that the trainee has the competencies to formulate case work and make a clinical judgment about the most appropriate intervention given the presenting clinical issues and the service context. The review should demonstrate that the intervention is evidence based and adapted as needed to the individual and service context. Theory-practice links within the formulation should also be evident. The assessment contributes to the following educational objectives of the course:

- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- An advanced and critical understanding of the scientific methods involved in research and evaluation, including the evidence base for psychological therapies, and to have developed the complex skills required to use this understanding in practice through carrying out original research and advanced scholarship.
- An advanced and critical understanding of, and ability to apply, at least three theoretical models on which clinical psychology draws (in particular, behavioural, cognitive, systemic and psychoanalytic) and to be able to adapt the therapeutic model to work effectively in highly complex and novel contexts occurring across the lifespan.
- A high level of competence in assessment, formulation, intervention and evaluation across a range of theoretical models (one of which must be Cognitive Behaviour Therapy), client groups and organisational contexts, with appropriate attention to any factors relating to risk and to have the transferable skills to apply these in complex and unique circumstances.
- An advanced level of creative and critical thinking in relation to the development of clinical practice and services as well as the personal and organisational skills to implement, or facilitate the implementation of, these ideas in unique and complex situations
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.
- A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.

- An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.

More specifically, the assessment will facilitate the following skills to be developed:

a) To be able to search the available literature on a selected topic in a systematic and rigorous way using electronic and manual methods.

b) To be able to focus the review within specific parameters e.g. time available, length of report and level of sophistication necessary.

c) To be able to select and convey the relevant information from a clinical assessment, which underpins the clinical formulation.

d) To be able to construct a clinical formulation that is theoretically grounded and appropriately inclusive, taking into account the developmental and contextual history of the client, and which leads to clear indications for intervention.

e) To be able to describe a specific clinical intervention and provide a rationale for why that approach is the intervention of choice given the specific circumstances of that individual and service context.

f) To be able to link the intervention to the available evidence base and describe the support this literature offers to this clinical judgement.

g) To be able to reference national guidance in relation to general presenting issues.

h) To be able to describe and provide a rationale for any adaptations being made to the intervention to ensure that it best fits the needs of this client within this service context.

i) To be able to be appropriately critical of the existing limitations of the evidence base in reference to intervention proposed.

j) To provide a brief action plan resulting from the chosen intervention.

GUIDELINES ON THE PREPARATION OF THE ASSESSMENT OF CLINICAL SKILLS:
PART 1- FORMULATION AND EVIDENCE FOR INTERVENTION REVIEW

1. Part 1 of the Assessment of Clinical Skills specifically addresses the competencies needed to develop a clinical formulation and make an appropriate clinical judgement about intervention. It is marked as an assessment independent of Part 2.

2. Ideally, the same clinical case should be presented throughout part 1 and part 2. This will usually be therapeutic work with either a single client, family or group.

3.   Candidates are strongly advised to read the guidance relating to **both** parts 1 and 2 of the Assessment of Clinical Skills before choosing the therapeutic work on which to base these assessments and to discuss their choice with their clinical supervisors.

4.   Part 1 of the Assessment of Clinical Skills (maximum 3,000 words) will be submitted in March/April of year 1 and Part 2 in June of the first year.

5.   Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title and the candidate's examination identity number. The candidate's name should not appear anywhere in the submission.

6.   Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
   a.   On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
   b.   On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.
   c.   If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

7.   Part 1 and Part 2 of the Assessment of Clinical Skills will normally be examined by the same examiners. In exceptional cases, where this is not possible, Part 1 will be made available to the new examiners when examining Part 2, for reference only.

8.   Care should be taken that the review is completely anonymised such that neither the client(s), the service nor the trainee can be identified.

        It is required that the candidate will have sought the consent of the client to the work being presented as part of their Assessment of Clinical Skills. Guidance about this should be sought from the Trust or organisation where the work was carried out. Such organisations may have their own guidance regarding the use of clinical material for educational purposes. An example is the Surrey and Borders Partnership NHS Trust policy, which can be found at https://www.sabp.nhs.uk/aboutus/policies.

Usually this will involve written evidence, to be kept in the clinical records of the client. A copy of this should NOT be supplied with the Assessment of Clinical Skills, as this would identify the client, but Part 1 should include a statement by the trainee indicating that:

- consent has been agreed by the client for written information to be presented for examination under these guidelines
- this has followed the organisational guidance where the clinical work was carried out and
- the presented material has been fully anonymised.

9.   Information which could identify a client should not be included. Clients' actual names should never be included or mentioned in the report, but should be replaced by fictitious names. Other information that might identify the client, for example, dates or places of birth, or very specific job titles, should not normally be included in the Assessment of Clinical Skills. If such information is very central to the clinical work being reported, it should not be removed, but it may then be appropriate to disguise some other aspect of the client's identity in order to preserve their anonymity. For example, if information about someone's job is central to their clinical presentation, then it might be appropriate to disguise some other aspect of their personal information (such as changing their nationality from English to Scottish). Such changes should only be made where candidates have good grounds for doing so. In addition, information that might identify other professionals or services should not be included. Candidates should consider issues relating to the prevention of individual clients being identified in discussion with their supervisors. Pseudonyms are recommended on reports referencing people by name. It is not acceptable to employ pseudonyms that reference any well-known person or character (celebrity, actor, fictional person or cartoon character) and any chosen and agreed should be neutral and based on preserving anonymity and not on names associated with particular characteristics (e.g. Amity, Charity, Grace, Joy, BrightBoy, and so on). Pseudonyms employed may be agreed, within these restrictions, with the service-user concerned, or colleague concerned.

10.   Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

11.   Care should be taken that references are complete, in the APA style and should include full details of cited secondary references.

12.   The assessment should be broken down into subsections with headings. The sections should follow logically on from each other and within each section the paragraphs should form a coherent story.

13.   The format or structure of the review will be dependent upon the chosen therapeutic work, but should minimally include:

- Title page (including title of the assessment; candidate number and word count)
- Introduction (this should be a brief introduction to the client and the service context – max 100 words)

- Assessment
- Formulation
- Intervention plan
- References.

14.   Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes. Additional practice-based information can be found in the Practice Learning Handbook.

15.   Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

16.   Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Criteria

The Board of Examiners requires a final mark to be expressed as one of the following grades:

Pass
Pass with Conditions
Referral
Fail

Please provide an overall qualitative assessment of the Assessment of Clinical Skills Part 1: Formulation and Evidence for Intervention Review on the Confidential Report. These comments may help you compare your assessment with your co-examiner and will provide the basis for feedback to be given to the candidate and the Board of Examiners.

Marking Standards for the Grades

Pass. This work has reached an acceptable or above standard. The introduction tells the reader who the client is and what the service context is. The assessment section describes what assessments have taken place, how and by whom, then describes the key findings (including presenting problem and relevant background). The formulation is well written, follows from the Assessment, contains all relevant information and is well theoretically grounded. The rationale for the chosen intervention is clearly described and stems from the formulation. Any adaptations to the approach, due to specific characteristics or history of the client, are well documented. There is a clear description of the intervention plan, followed by an action plan. Any contextual or service limitations are well documented and the actions to be taken described. The review is well written, the content well-structured and easy to follow. The language used is client-centred and respectful, drawing on psychological descriptions rather than diagnostic terms. The review is appropriately critical and evaluative. The sophistication of conceptual material and argument is of a good standard appropriate to a doctoral level award. The presentation of the review should be good with few, if any, typographical errors. References are complete and presented in the APA style.

Pass with Conditions. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that this review has reached a doctoral standard and is suitable to be viewed by others as such. The Examiners must specify these Conditions. These may include typographical errors, errors in the use of language, clarification, the inclusion of missing information and correction. Up to one additional paragraph (approx. 150 words) may be included under Conditions. If more correction than this is needed the work may be considered a referral.

Referral. This work has failed to reach an acceptable standard. A substantial number of the following concerns must be present. The introduction to the client, the description of the assessment and service context lacks clarity or depth, or is missing information later drawn on in the formulation. The formulation is incomplete, poorly written, under/over inclusive or lacking theory. The chosen intervention is poorly described. The rationale for choice of intervention is poor, or does not flow logically from the formulation. The evidence base used to justify this choice is missing or poorly reviewed. The critique of this evidence is missing or insufficient, poorly articulated or inaccurate. Any adaptations made are poorly explained or do not seem appropriate. The intervention plan is missing, poorly articulated or does not follow on coherently. The inclusion of material has been inappropriately selective resulting in a biased perspective. The work is not well presented and references incomplete. However, it seems that the original clinical work is adequate, the main elements are there and the case could be improved considerably with a better write up, and hence this work could meet a pass standard.

Fail. This work is at a clearly unacceptable standard. All or a substantial number of the following concerns must be present. The introduction is unclear and unfocussed. The assessment was poorly planned, and/or is poorly reported, and key findings which inform the formulation are not clear. The formulation is poorly articulated and/or there seems to be a lack of understanding of the concept of formulation. The structure is confusing and provides no clear pathway through the material presented. The intervention is very badly described. The evidence cited is not based sufficiently on appropriate literature; it is not clearly linked to the model or clinical work. The evidence is not evaluated. The inclusion and exclusion of material is haphazard, leading to an incomprehensive rationale. The review is too broad and is not linked sufficiently to the client(s) and context. No, or inappropriate, comment is made on the adaptations needed for the individual and service context. The evidence is over reliant on few sources and the literature is not up to date. No clear, or too vague, an intervention plan is presented. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

Guidance

The following table provides guidance to assist the examiners in evaluating the different dimensions of the review. It is not expected that all the elements in the boxes need to be met, but that this guidance is read in conjunction with the standards above and an overall conclusion reached. Examiners are asked to be familiar with the Guidelines on the preparation of the Assessment of Clinical Skills Part 1 and Part 2.

It must be borne in mind when judging submitted reports that clients presenting to services will not be typical of a 'text-book description'; in addition, some approaches to working may work with the client and their system, without employing a formal systemic

model and the quality of this must be considered outside of usual model specific requirements. Such work may involve working with carers, or with a group, and such clinical work may form the focus of a submission, requiring judgement on generic therapeutic skills and appropriate reflective writing.

	PASS	**REFERRAL**	**FAIL**
Introduction (max 100 words)	Clearly written, introducing the client and the service context.	Not very clearly written and with some information missing.	Does not adequately introduce the client(s) and/or service context.
Assessment	a) The means and range of assessment are adequate and well described (e.g. referral, case notes, observation, clinical interview, psychometrics). b) A sound rationale for the types of assessments selected is provided, or seems inherently relevant, evident in the description and to the particular case. c) The key findings of the assessment are clearly indicated and inform the formulation which follows. d) Information is described in psychological rather than diagnostic language.	a) Some of the means of assessment are excessive and/or irrelevant, and/or are inadequately described. b) The rationale provided and/or assessments selected are of questionable value or relevance to the particular case. c) Key findings are unclear, and/or appear to be of questionable relevance to the formulation that follows. d) Information is missing that later appears in the formulation. e) Information is at times presented in overly medical or diagnostic language.	a) Assessment information is derived from a single source or an inadequate range of sources, and is therefore lacking/ inadequate. b) The rationale for assessments provided is inadequate, or its description seems irrelevant or incorrect to the particular case. c) Key findings are difficult to discern, and clarity or linkage to the formulation is unclear. d) Key information is missing that later sections rely on. e) Language is largely medical or diagnostic.
Formulation	a) There is a clear formulation that makes sense. b) It contains all the relevant information required to comprehend it and the following intervention plan. c) It is well linked theoretically. d) It is about the client and his or her context/story, not a diagnostic label. e) Client is discussed respectfully. A warm and collaborative therapeutic alliance is evident in description.	a) It is poorly written and confusing. b) It is either over or under inclusive. c) Theory practice linking is insubstantial or unconvincing. d) It is questionable whether 'client' or diagnostic label were at the centre of the formulation. e) At times the description of the client seems technical and distant. Collaboration and/or alliance may not be conveyed.	a) It does not read as a formulation, more a description. b) It is unclear why some information is included and other not. c) Theory practice linking is very poor. d) Diagnostic label is at the centre of the formulation, not the client. e) Client is discussed in a disrespectful or condescending manner; a lack of collaboration is evident.

	PASS	**REFERRAL**	**FAIL**
Intervention Plan *a) Description* *b) Evidence* *c) Adaptation* *d) Action plan*	a) The intervention is clearly described and linked to a therapeutic model(s) and follows on from the formulation. b) Evidence is supplied and critically evaluated which gives a rationale for the use of that intervention. c) Any adaptations made to the intervention are clearly described and rationalised. d) This is clearly stated, is client-centred, links with the intervention described, and is concise. General aims across the course of therapy are described, session-by-session or by sets of sessions.	a) The intervention is not clearly described and may be only tenuously linked to a model(s) and/or the formulation. b) The evidence cited is not up to date, not clearly relevant, poorly evaluated and overall does not give robust support to the chosen intervention c) These are vague and general and do not demonstrate in depth thinking about the attributes of the specific client(s) and or service context. d) The linkage to the intervention is not clear. It is poorly structured and/or poorly written.	a) The intervention is vaguely described. It is not clear what model(s) it is attributed to, or to the formulation. b) Irrelevant information is supplied; there is little evidence of literature searching. Evidence is not evaluated. Overall it does not give an appropriate rationale for the chosen intervention. c) Little effort is made to take the specific individual(s) and or context into account. d) The plan is very vague, not clearly linked to the literature. Does not appear to be relevant or useful to the client. It is badly written.
Structure	There is a clear and coherent structure to the review with good linkage between elements. Where more than one model is used to inform understanding, these are brought together in a coherent and logical way.	The material is inadequately structured, making it difficult for the reader to follow any argument. Links are not adequately made between sections. Where more than one model is used to inform understanding, these are not well brought together, leading to a lack of coherence.	There is no clear structure and there is no evidence of any line of argument being followed through. Little or no thought has been given to how best to present the material. Two or more models are drawn on in a haphazard way, lacking any coherent sense of how this helps to understand the client.

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	PASS	**REFERRAL**	**FAIL**
Presentation *a) Adheres to APA guidelines* *b) Grammatical and typographical errors* *c) References*	a) The review adheres to the APA guidelines in terms of style, with only minor errors. b) Few grammatical errors. Spelling largely correct, with only minor omissions that could have been missed by using a computer spell check and by proof reading. c) References are complete and in the APA style.	a) The review deviates from the guidelines in significant ways. b) A significant number of grammatical errors. Spelling errors that should have been picked up. c) There are significant problems with the references in terms of being incomplete and/or not in the APA style.	a) The review does not adhere to the guidelines. b) A large number of grammatical and spelling errors, suggesting the review had not been checked or proof read. c) References are missing completely.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by the two examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates. Examiners are blind to the identity of candidates and candidates are blind to the identity of their examiners.

b) The two examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report. If a fail is given the report will end with a statement about a new piece of work being required or, in the case of all clinical experience being successfully completed, whether a new piece of work is required.

c) In the event of the two examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from both examiners as part of the resolution process and recommend a mark. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the

appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

d) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

e) The assessments and comments will be considered and final decisions made at the Board of Examiners.

f) In the event of extensive typographical errors, significant errors in the use of language, the need for up to one paragraph (approximately 150 words) for clarification, significant referencing errors, or missing appendices, examiners can agree a conditional pass which requires the candidate to correct the identified errors. These 150 words can be additional to the existing word limit. Should meeting specified conditions lead to the submission exceeding the word limit, the total word count on the front sheet should be set out in the following manner: original word count (additional words), e.g. 4846 (120). A letter to the examiners should be included indicating where the changes have been made, including page numbers. It would normally be expected that such conditions would be met within four weeks of receiving the results. If conditions are not met on representation of the work, they will be returned to the candidate for amendment on two occasions. In the event of conditions not being met on a third occasion, the work will be referred to the Board of Examiners for consideration. In the event of very minor typographical errors, candidates will be asked to make corrections before submitting for final binding.

g) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure.

The candidate must inform the Assessments Officer, in writing, of the new submission date within four weeks of receiving their results. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers.

h) Candidates will be informed of provisional results by email and the aim is to give feedback within 40 working days of the submission deadline. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

i) Work that is re-submitted will usually be marked by the two examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

j) At the end of the Course, candidates are required to submit a final copy of the work according to the specifications provided on completion of the course. This should be submitted as soon as possible following formal notification from the Board of

Examiners. The submitted copy must include any amendments required by the Board of Examiners. The title page should contain the name of the candidate. This work will be kept as a record for up to 5 years. Candidates are advised to keep a copy for their own record of work completed.

Ref: Assessment Handbook/Assessment of Clinical Skills Part 1/2018, revised 09/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

ASSESSMENT OF CLINICAL SKILLS: PART 2 – CLINICAL AND PROFESSIONAL REVIEW

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Assessment of Clinical Skills Part 2
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The purpose of this assessment is to demonstrate that the trainee has the basic clinical skills to work therapeutically in a clinical context. It consists of three components which are assessed together to form one assessment.

a. Digital recording (50 mins)
b. Annotated transcript
c. Clinical viva

The assessment contributes to the following educational objectives of the course:
- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- An advanced and critical understanding of, and ability to apply, at least three theoretical models on which clinical psychology draws (in particular, behavioural, cognitive, systemic and psychoanalytic) and to be able to adapt the therapeutic model to work effectively in highly complex and novel contexts occurring across the lifespan.
- A high level of competence in assessment, formulation, intervention and evaluation across a range of theoretical models (one of which must be Cognitive Behaviour Therapy), client groups and organisational contexts, with appropriate attention to any factors relating to risk and to have the transferable skills to apply these in complex and unique circumstances.
- An advanced level of creative and critical thinking in relation to the development of clinical practice and services as well as the personal and organisational skills to implement, or facilitate the implementation of, these ideas in unique and complex situations.
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.

- A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.
- An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.
- An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.

More specifically, these assessments will facilitate the following skills to be assessed:

Generic Skills
a. To be able to demonstrate generic basic therapeutic skills within a real clinical context. Specifically these skills are:
   i. Active Listening
   ii. Empathy
   iii. Accurate Reflections
   iv. Ability to be Responsive to the Client
   v. Exploration of Client Concerns
b. To be able to identify what these skills are and when they occur

Model Specific
a. To be able to demonstrate basic model specific intervention within a real clinical context.
b. To be able to identify which model specific interventions have been used and when they occurred.

Competencies jointly assessed with Service User and Carer examiners
These are defined as:
a. Understanding: Within the therapy session, the trainee should show a willingness to, and demonstrate that, they understand and empathise with the client's experiences of their circumstances (social, family , community and of this therapy session)
b. Hope: The trainee maintains a hopeful approach with humility and sensitivity by identifying the possibility of making small changes and reflecting on the strengths of the client.

The first competency (Understanding) can be demonstrated in any of the following ways:
   i. Responding to any immediate issues that the client may bring;
   ii. Reviewing any tasks or changes the client has been involved in with compassion;
   iii. Reminding clients of things they have said in the past (e.g. small details about social situation etc.); and
   iv. Understanding the client's experience of the session and responding to this with warmth and interest.

The second competency (Hope) can be demonstrated in any of the following ways:

    i.   Using a warm tone, using plain language, not using the words should or must;

    ii.   Acknowledging the possibilities of making changes;

    iii.   Acknowledging the possibility of the client using their strengths and/or reflecting back their strengths; and or/enabling the development of new strengths, and/or inspiring strength;

    iv.   Being affirming and positive without being patronising;

    v.   Recognising that making changes is difficult and reflecting on this with the client;

    vi.   Reflecting on the possibility of hope.

It is to be noted that the above are examples of how to fulfil the competencies rather than concrete requirements and that there are potentially, other ways in which trainees may be able to demonstrate the competencies jointly assessed with service user and carer examiners.

Critical Reflection
To be able to reflect appropriately on clinical work and understand the strengths and limitations of current competencies.

Lifespan and Context
To be able to reflect upon the specific life circumstances and social/cultural context of the client in relation to therapeutic work.

Professional Skills
    a. To be able to abide by ethical and professional standards when presenting and discussing clinical work. Specifically,

        i.   To be able to talk about client work in a respectful way

        ii.   To be able to present and discuss such issues in a way which maintains client confidentiality

        iii.   To be able to demonstrate a professional approach to discussing their work.

        iv.   To demonstrate that the submitted work is representative of their general level of skills and approach to clinical work.

    b. To be aware of further training needs.

GUIDELINES ON THE PREPARATION THE ASSESSMENT OF CLINICAL SKILLS: PART 2 – CLINICAL AND PROFESSIONAL REVIEW

1.   Ideally the same clinical work should be presented for Part 2 of the Assessment of Clinical Skills as for Part 1. If this has not been possible a short letter of explanation should be presented as to why this has not been possible (max 200 words) and a brief description of the client and formulation (max 700 words). This work will usually be therapeutic work with a single client, family or group.

2.   Part 1 of the Assessment of Clinical Skills will be submitted in March/April of year 1 and Part 2 in June of the first year.

3.   Candidates are required to submit three stapled copies of the annotated transcript and one audio recording. The transcript should be typed with 1.5 line spacing, the font size should be a minimum of 13.5 and paginated. The assessment will NOT be marked anonymously, so the title page should include a title and the candidate's name. The candidate's examination number should not appear anywhere on the transcript, title page or Assessment Cover Sheet. Further information on the submission of the audio recording will be provided on the Assessment Blackboard; please note that there may be different submission arrangements for different NHS Trusts.

4.   Part 1 and Part 2 of the Assessment of Clinical Skills will be examined by the same examiners. In exceptional cases where this is not possible Part 1 will be made available to the new examiners when examining Part 2, for reference only.

5.   **Length of recording:** It is recommended that the length of the recording should be 50 mins long. It is recognised, however, that some clients do not engage sufficiently to allow this. Alternatively, trainees may be involved in delivering interventions which call for either longer or shorter sessions. If a recording of longer than 50 minutes is submitted, the entire session should still be transcribed, but only 50 minutes of the recording should be annotated in the transcript and clearly demarcated for the examiners, in one continuous 50 minute section. If sessions of shorter than 50 minutes are being utilised (as may be the case in some CBT or Assertive Outreach interventions, for example) then it may be possible to submit two sessions. Where this occurs, 60 to 80 minutes over both sessions should be transcribed, as more may be required for context, but a total of only 50 minutes of therapeutic activity (over the two sessions) should be annotated and clearly demarcated for the examiners. Trainees should be careful to select their clients carefully, so as to minimise problems, as well as the amount of work required, in this regard.

6.   The clinical recording, transcript and viva will be marked as one assessment.

7.   **The client chosen:** The client chosen should be typical of those found in the service where the work was executed. With the advent of all-age services, it is recognised that people over 65 and previously thought of as 'older adults' may be found in 'adult' services. Similarly, some people who are under 65 and presenting with younger onset dementia may be found in services previously demarcated for 'older adults'. The golden rule is that if a client was seen by the service in which you are working, they can potentially be recorded for examination purposes.

8.   **The Model Chosen:** Trainees can potentially utilise any therapeutic model recognised by the Clinical Psychology profession. It is recommended that trainees access the UCL website http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm so as to make use of model specific competencies outlined for CBT, psychodynamic and systemic work. Trainees who want to utilise other models may do so, but will need to convince the examiners that the specific competencies demonstrated are fundamental to the model utilised. Clear reference points for the competencies should be included so that this can be assessed by examiners. It is not generally recommended that integrative models should be used in first year work, other than 'branded' integrative models such as Cognitive Analytical Therapy (CAT).

9. It is required that the candidate will have sought the consent of the client to the work being presented as part of their Assessment of Clinical Skills. Guidance about this should be sought from the Trust or organisation where the work was carried out. Such organisations may have their own guidance regarding the use of clinical material for educational purposes. An example is the Surrey and Borders Partnership NHS Trust policy, which can be found at http://www.sabp.nhs.uk/foi/policies/.

10. Usually this will involve written evidence, to be kept in the clinical records of the client. A copy of this should NOT be supplied with the Assessment of Clinical Skills, as this would identify the client, but a sheet signed by the trainee should be attached to the transcript indicating that:
    10.1. consent has been agreed by the client for both written and recorded information to be presented for examination under these guidelines,
    10.2. this has followed the organisational guidance where the clinical work was carried out and
    10.3. the presented material has been fully anonymised.

11. Information which could identify a client should not be included. Clients' actual names should never be included or mentioned in the transcript or in the viva, but should be replaced by fictitious names. Other information that might identify the client, for example, dates or places of birth, or very specific job titles, should not normally be included in the Assessment of Clinical Skills. If such information is very central to the clinical work being reported, it should not be removed, but it may then be appropriate to disguise some other aspect of the client's identity in order to preserve their anonymity. For example, if information about someone's job is central to their clinical presentation, then it might be appropriate to disguise some other aspect of their personal information (such as changing their nationality from English to Scottish). Such changes should only be made where candidates have good grounds for doing so. In addition, information that might identify other professionals or services should not be included. Candidates should consider issues relating to the prevention of individual clients being identified in discussion with their supervisors.   Pseudonyms are recommended on reports referencing people by name. It is not acceptable to employ pseudonyms that reference any well-known person or character (celebrity, actor, fictional person or cartoon character) and any chosen and agreed should be neutral and based on preserving anonymity and not on names associated with particular characteristics (e.g. Amity, Charity, Grace, Joy, BrightBoy, and so on). Pseudonyms employed may be agreed, *within these restrictions*, with the service-user concerned, or colleague concerned.

12. Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

13. Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes. Additional practice-based information can be found in the Practice Learning Handbook.

14. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

15. Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

16. All clinical vivas will be recorded by the examiners. This is to allow a sample to be sent to the External Examiner in accordance with the regulations for all submissions. All examiners are governed by the Quality Assurance Agency, the University policies and the Health and Care Professions Council with regard to maintaining confidentiality and professional practice. The recordings will be kept for no more than a year after the clinical viva and will not be used for anything other than sending a sample to the External Examiner without obtaining the candidate's consent. The recording is classified as the equivalent to an examination script, and cannot be made available to the candidate.

17. As this assessment contains sensitive case material it will not be included in the portfolio of assessments submitted at the end of the course. The assessment material must be kept by the trainee until they have received confirmation from the Board of Examiners that this assessment has been passed. The case recording must be destroyed in accordance with the policy of the Trust or organisation.

Guidelines: Digital Recording

a) This may be an auditory recording of a session, or a video recording with soundtrack just showing the trainee, or a video and soundtrack showing client and trainee.
b) It must be of at least 50 minutes duration. Recordings of longer therapeutic interventions may be submitted, but in this case, only 50 minutes of the recording should be annotated in the transcript. Any continuous 50 minute segment can be annotated.
c) The auditory track must be audible for all parties.
d) The selection of the therapeutic work to sample must be made so that the five basic core competencies are able to be demonstrated, in addition to three 'model specific' competencies and the competencies jointly assessed with service users and carers, as set out in the marking criteria.
e) Trainees are strongly advised to discuss this selection of case material with their supervisors and to be able to choose from a number of recordings.

Guidelines: Annotated Transcript

1. The transcript should begin with a brief summary of the client, their main difficulties and the service context. It should contain their age as well as situate the session within the overall context of the intervention. For example, session 6 of 12. No longer than 150 words.
2. This must be a full and accurate transcript of the whole of the session from which the digital recording has been taken.
3. The annotation should only be of the selected continuous 50 minute section presented in the recording. This allows the examiner to see more of the context of the selected 50 mins, if needed. Timings should be included at regular intervals to assist the examiners in locating the annotations on the recording.
4. The annotation should address four issues

4.1. It should identify where each of the 5 generic competencies are demonstrated. It is acceptable (and recommended) to present a few examples of the same competency where possible. This will assist the examiners in assessing whether or not a competency has been adequately demonstrated. No more than a few examples of the same competency need to be presented: not all competencies in the transcript should be marked up as this will be difficult for the examiners to read. The minimum number of required competencies should be adhered to where it is not possible to label more than one example of the same competency.

4.2. It should identify 3 model specific interventions, and state what sort of interventions they were, using the terminology in the http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm website. It is acceptable to present more than 3 model specific interventions, but not so many that it becomes difficult for the examiners to read.

4.3. If three model specific interventions were not identified, it should identify missed opportunities for these in model congruent terms.

4.4. It should identify where each of the competencies jointly assessed with Service User and Carer examiners are demonstrated, indicating where they are showing either Understanding or Hope.

5. The competencies demonstrated must be congruent to the process of the therapy.

6. The use of transcribers is not acceptable for reasons of risk and confidentiality. Indeed, it is unacceptable for trainees to pass the clinical material to any party other than the assessments administrator at hand-in. Trainees should bear in mind that they and their supervisors have clinical responsibility for the material throughout the process.

7. Destruction of transcripts: transcripts must be shredded once the assessment has received a pass grade from the Board of Examiners

Guidelines: Critical Reflection on the Work

At the end of the entire transcript a separate section should make some critique of the therapeutic work, pointing out where interventions could have been made but were not or where improvements could be made (max 500 words). It should also consider lifespan development issues and how these were brought to bear in the therapeutic work. Where competencies have been difficult to identify, you should reflect on the absence of these competencies. It may also be useful to consider elements of the work which could be considered as causing problems in the therapy or being in some other way un-therapeutic. Some reflection on aspects of the session which went well would also be useful.

Guidelines: Clinical Viva

1. The clinical viva has a number of aims:
   a. To share observations on aspects of the sessions that demonstrated strengths on the part of the trainee.
   b. To explore with the trainee areas of competence that might not have been adequately demonstrated within the recording and annotated transcript.
   c. To explore with the trainee their depth of understanding of clinical competencies and therapeutic alliance.
   d. To explore with the trainee their current understanding of the therapeutic model in which they were working, and associated areas for development.
   e. To assess the trainee's ability to reflect on the process of the work and their contribution to it.

2. The viva will last 30-45 minutes and will normally be carried out by the two examiners who have marked Part 1 of the Assessment of Clinical Skills and by one Service User or Carer examiner. Candidates are expected to attend viva with a copy of their Annotated Transcript.

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MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

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General

1. The examiners will review the recording and transcript prior to the clinical viva, independently, and come to a preliminary decision of whether the required clinical competencies have been met.
2. Prior to the viva they will meet and discuss their preliminary assessments in relation to the marking grid (see below), agreeing any areas that require further exploration in the viva.
3. After the viva the examiners will discuss and come to a final recommendation to the Board of Examiners of either a Pass, Pass with Conditions, Referral or Fail.
4. All the competencies to be assessed are summative (i.e. there is a standard to be met) with the exception of model specific interventions which are formative (a missed opportunity must be clearly identified as such, but no standard can be expected).
5. The standard expected is that a trainee at this point in their training should be able to demonstrate the generic, model-specific and service user and carer assessed competencies, as set out in the marking grid. A pass will be awarded when all the competencies outlined in the marking grid below have been demonstrated.
6. It must be borne in mind when judging submitted work that clients presenting to services will not be typical of a 'text-book description'; in addition, some approaches to working may work with the client and their system, without employing a formal systemic model and the quality of this must be considered outside of usual model specific requirements. Such work may involve working with carers, or with a group, and such clinical work may form the focus of a submission, requiring judgement on generic therapeutic skills and appropriate reflective writing.
7. A Pass with Conditions may be awarded if the required competencies appear on the recording, but errors or omissions regarding these have occurred in the annotation and/or critique which, on exploration in the viva are understood by the trainee. Conditions would require the annotation and/or critique to be changed as based on the feedback from the viva.
8. A Referral will be awarded where the required competencies appear to be present on the recording but the transcript is so poorly annotated and critiqued that it's not clear the trainee was aware of what they were doing and that this is still unclear after the viva. A referral may also be awarded if one or more of competencies B, D, E and F are only partially demonstrated in the transcript and not discussed well in the viva. Whilst the assessment of model specific competencies is formative, the trainee is expected to show understanding of how the model might be applied by annotating missed opportunities for use of these skills. They should also be able to reflect on this in the viva in such a way as to demonstrate understanding. In the case of a referral the trainee may opt to resubmit the same case recording, but make improvements on the annotation or submit new case material and an

annotated transcript. It will then be up to the discretion of the examiners if they wish to re-viva after reviewing the resubmission.

9. A fail will be awarded if one or more of the required competencies (A and C) are not present, or if the trainee's understanding of one or more of competencies B, C D, E and F is not demonstrated. Under these circumstances a new recording of case material and annotated transcript should be submitted and a viva will be required.

10. Achieving competency is a mix of writing, acknowledging and reflecting on processes appropriately (with theoretical underpinnings understood and presented) as well as demonstration of skill in the competency area.

Competencies and Assessment methods

Competence	Assessed by

A) Generic skills
 	
   a. To be able to demonstrate generic basic therapeutic skills within a real clinical context. Specifically these skills are:
      i. Active Listening
      ii. Empathy
      iii. Accurate Reflections
      iv. Ability to be Responsive to the Client
      v. Exploration of Client Concerns
   b. To be able to identify what these skills are and when they occur.
	The annotations of the transcript should show the examiner where these 5 specific skills have been demonstrated, and the examiner should be able to see/hear them actively demonstrated in the recording.
	
	This may be further explored in viva, if unclear from the above method.

B) Model specific interventions[1] To be able to identify model specific interventions or appropriate but missed opportunities for them within a real clinical context.	The annotations of the transcript should identify three model specific interventions or missed opportunities for them. The model must be named and the specific interventions identified. Candidates are strongly advised to use the mappings of model specific competencies to help them identify these interventions, e.g. those published by CORE http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm This may be further explored in viva, if unclear from the above method.

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[1] The word 'intervention' here is used to refer to a small action that might demonstrate a wider model specific competency. It is not used to mean a higher level intervention in relation to a formulation and action plan.

Competence	Assessed by
C) **Competencies jointly assessed with Service User and Carer examiners** To be able to identify these competencies within a real clinical context. Specifically: a. Understanding: The trainee should show a willingness to, and demonstrate that, they understand and empathise with the client's experience with regard to their circumstances (social, family etc.) within the therapy session. b. Hope: The trainee maintains a hopeful approach with humility and sensitivity by identifying the possibility of making small changes and reflecting on the strengths of the client.	The competencies showing Understanding and Hope should be 'embedded' within the work and the submitted transcript. This may be explored in viva, if unclear from the above method
D) **Critical Reflection** To be able to reflect appropriately on clinical work and understand the strengths and limitations of current competencies.	A critique should be included at the end of the annotated transcript which may discuss opportunities for interventions[2] that were missed, inadequately carried out, or could have been improved upon. This should be no more than 500 words. This will be further explored in viva.
E) **Lifespan and Context** To be able to reflect upon the specific life circumstances and social/cultural context of the client in relation to therapeutic work.	The reflective account should include consideration of the life circumstances of the individual and how these impacted on the therapeutic work. This may include discussion of what adjustments were, or could have been made in relation to them. It might, for example, include commentary on the therapeutic relationship between client and clinical psychologist. This may be further explored in viva, if unclear from the above method. This reflection must include consideration of how these life circumstances impacted on the therapeutic work and what adjustments were, or could have been made in relation to them. This might include comment on the therapeutic relationship between client and clinical psychologist. This may be further explored in viva, if unclear from the above method

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[2] Here the word 'intervention' is used to mean a small verbal intervention that demonstrates a specific type of model specific competence e.g. an interpretation within psychodynamic work or identifying a specific 'cognitive distortion' in CBT.

Competence	Assessed by

F) Professional skills
  1. To be aware of further training needs.
  2. To be able to talk about client work in a respectful way
  3. To be able to present and discuss such issues in a way which maintains client confidentiality
  4. To be able to demonstrate a professional approach to discussing their work.
  5. To demonstrate that the submitted work is representative of their general level of skill and approach to clinical work.
	This will be explored in the clinical viva.
	This will be explored in the clinical viva.
	
	This will be demonstrated through the recording, transcript and at viva.
	
	This will be demonstrated through the recording, transcript and at viva.
	
	This will be explored in the clinical viva.

Marking Grid

Competence	Formative/ Summative	Assessed by: Recording(R) Transcript (T) Viva (V)	Preliminary Outcome (demonstrated, partially demonstrated, not demonstrated)	Final outcome (demonstrated, partially demonstrated, not demonstrated)
Generic				
i. Active Listening *The trainee is listening closely to what is being said and using what they are hearing to influence their interaction e.g. demonstrates listening cues through sincere interest in the client as well as by means of appropriate verbal and body language. The trainee maintains a neutral stance and asks for clarification at certain points.*	s	R, T, V		
ii. Empathy *The trainee demonstrates the ability to perceive of, and understand the mental state of the client and is able to share in it through compassionate and therapeutic interaction such as reflection and summaries which demonstrate that the trainee is aware of the client's feelings and emotions.*	s	R, T, V		

Competence	Formative/ Summative	Assessed by: Recording(R) Transcript (T) Viva (V)	Preliminary Outcome (demonstrated, partially demonstrated, not demonstrated)	Final outcome (demonstrated, partially demonstrated, not demonstrated)
iii. Accurate Reflections *The trainee demonstrates that they have 'heard' what the client has said by accurately paraphrasing/summarising the content of the client's communication.*	s	R, T, V		
iv. Ability to be Responsive to the Client *The trainee makes every effort to understand the client's point of view, and retains an empathic and neutral stance. The trainee uses open-ended questions and makes appropriate, validating statements that are affirming and non-judgemental.*	s	R, T, V		
v. Exploration of Client Concerns *The trainee demonstrates an ability to use the material presented by the client by exploring it and assimilating it into the therapeutic process where appropriate.*	s	R, T, V		
Model Specific (as identified for the Trainee)				
1.	f	R, T, V		
2.	f	R, T, V		
3.	f	R, T, V		
Competencies jointly assessed with service users and carers				
1. Understanding: The trainee shows a willingness to, and demonstrates that they do, understand and empathise with the client's experience with regard to their circumstances (social, family etc.) within the therapy session.	s	R, T, V		

Competence	Formative/ Summative	Assessed by: Recording(R) Transcript (T) Viva (V)	Preliminary Outcome (demonstrated, partially demonstrated, not demonstrated)	Final outcome (demonstrated, partially demonstrated, not demonstrated)
2. Hope: The trainee maintains a hopeful approach with humility and sensitivity by identifying the possibility of making small changes and reflecting on the strengths of the client.	s	R, T, V		
Lifespan and context				
To be able to reflect upon the specific life circumstances and social/cultural context of the client in relation to therapeutic work.	s	R, T, V		
Professional				
1. To be aware of further training needs.	s	Viva		
2. To be able to talk about client work in a respectful way	s	Viva		
3. To be able to present and discuss such issues in a way which maintains client confidentiality	s	R, T, V		
4. To be able to demonstrate a professional approach to discussing their work.	s	V		
5. To demonstrate that the submitted work is representative of their general level of skills and approach to clinical work.	s	V		
6. To demonstrate benevolence in therapeutic work (i.e. no harm done to client, alliance, etc.) or to demonstrate an awareness of factors and behaviours on the part of the therapist which may cause problems within the therapy and to reflect appropriately on these if they occur.	s	R, T, V		

Format of Annotated Transcript

	These items should be filled in for the entire 50 minutes of the session or only for 50 minutes if a longer session. All competencies can occupy one column.		
Transcript of session This should be a direct, and accurate, transcript of the verbal responses identifying the Therapist (T) and the Client's (C) speech. It should be made clear in the transcript the start and end of the 50 minute segment submitted as the recording. The transcript should begin with a brief description of the client, their main difficulties and service context. It should also contextualise the recording in terms of where it resides within the therapeutic intervention. (For example, session 11 of 16 sessions). This should constitute no more than 150 words.	**Generic** Several examples of the five clinical competences should be identified by naming them opposite the transcript in which they occur.	**Model Specific** Three different examples of model specific interventions or opportunities for intervention should be identified within the transcript. The model and the specific intervention must be identified.	**Service User and Carer** Annotations should be titled as either Understanding or Hope.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by three examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates.

b) Following the viva, the examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report. If a fail is given the report will end with a statement about a new piece of work being required or, in the case of all

clinical experience being successfully completed, whether a new piece of work is required.

c) In the event of the examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from all examiners as part of the resolution process and recommend a mark. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

d) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

e) The assessments and comments will be considered and final decisions made at the Board of Examiners.

f) For work receiving a Pass with Conditions, it would normally be expected that such conditions would be met within four weeks of receiving the results. A letter to the examiners should be included indicating where the changes have been made, including page numbers. Conditions can include discussion of the viva feedback with the trainee's manager. Other conditions may include identifying problems in the transcript which need rectifying, competencies which must be more clearly identified or correctly identified, and typographical errors. For conditions on the Critical Reflection section, no more than 500 words should be added. Where a different client has been used for Part 2 and there are conditions on the description of the client and formulation, no more than 200 words should be added. If conditions are not met on representation of the work, they will be returned to the candidate for amendment on two occasions. In the event of conditions not being met on a third occasion, the work will be referred to the Board of Examiners for consideration.

g) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure. The candidate must inform the Assessments Officer, in writing, of the new submission date within four weeks of receiving their results. As in the case of a Pass with conditions the terms of a referral may include discussion of the viva feedback with the trainee's manager. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers. For a Referral, the examiners will consider whether a further viva voce is required; this decision may be made after reviewed the resubmission. A further viva voce will be required for candidates receiving a Fail.

h) Candidates will be informed of provisional results by email and the aim is to give feedback within 20 working days of the viva voce examination. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

i) Work that is re-submitted will usually be marked by the examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

Ref: Assessment Handbook/ Assessment of Clinical Skills Part 2/2018 updated 10/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

TEAM POLICY REPORT: POLICY REVIEW AND REFLECTIVE ACCOUNT

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Team Policy Report
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The Team Policy Report consists of three elements of assessed work. The first, the Policy Review, requires trainees to work in groups to produce a critical evaluation of a recent policy document. The second, the Reflective Account, requires trainees to work individually to produce a reflective account of how their team went about achieving its task, and the group processes that emerged. The third, the Team Presentation, requires each group of trainees to present their Policy Review to staff and their year group.

The purpose of this assessment is to help trainees develop a more critical understanding of the organisation and functioning of the NHS and Social Care Sector, and to develop their competencies in understanding and critically appraising policy, working as members of teams, reflecting on team and group processes, and presenting material in a clear and concise manner to an audience. The Team Policy Report will assess the following Course Learning Outcomes.

- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- A high level of competence in assessment, formulation, intervention and evaluation across a range of theoretical models (one of which must be Cognitive Behaviour Therapy), client groups and organisational contexts, with appropriate attention to any factors relating to risk and to have the transferable skills to apply these in complex and unique circumstances.
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.

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- An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.
- An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent; which recognises the value of feedback and the importance of seeking this out, and constructively responding to it; and which demonstrates the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge, enabling them to continue to grow.

The Team Policy Report will be submitted in March/April of the first year and a Team Presentation of the Policy Review will be given in July of the first year. The Team Policy Report will be divided into two parts: (i) a 3,500 word Policy Review compiled by a team of four to six candidates that summarises and critically reviews the Policy, and (ii) a 1,500 word Reflective Account by individual candidates about the team process involved in producing the Report. This Team Policy Report will be assessed in the usual way by using the marking standards and a single mark will be awarded. The Team Presentation will be made by all members of the team in July of the first year. The assessment of this presentation will be formative, although each member is required to attend and take part.

GUIDELINES ON THE PREPARATION OF THE TEAM POLICY REPORT: POLICY REVIEW AND REFLECTIVE ACCOUNT

Team Policy Report

General Issues

1.   Policy documents for review will be set by a member of the course team who will gather these from the course team between July and September.

2.   Candidates will be assigned to groups/teams. There will be an attempt to group trainees according to where they live. Each team will consist of four to six members. Individuals can swap places with an individual in another team only if there is a clear rationale for doing so and both trainees agree, and this needs to be approved by the Academic Director. Teams will be allocated documents, although with the agreement of other groups, and the approval of the Academic Director, groups can negotiate to exchange documents. Both these processes must be completed within four weeks of the teams and documents being allocated.

3.   Each candidate is required to undertake both parts of the Team Policy Report; the Policy Review produced by the team and the Reflective Account produced separately by each individual. They are required to submit these in March/April of the first year.

4.   Each team is required to submit one electronic copy of the Policy Review. Each candidate is required to submit one electronic copy of the Reflective Account. The submissions should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and

follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title, the team number and all candidate examination identity numbers. The candidates' names should not appear anywhere in the submission.

5.   Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:

    a.   On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.

    b.   On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.

    c.   If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

6.   The format within each of the parts of the Report is likely to vary, but the following issues should be considered in preparing both of the reports.

    a)   The Report should be divided into two parts, the Policy Review (3,500 words, excluding the Executive Summary/Abstract) which will be produced by the team of trainees who have worked on the Report and which will be the same for each member of that team, and the Reflective Account (1,500 words) which is written individually by each member and which provides a reflective account of the team processes involved in producing the Policy Review. These word counts exclude references.

    b)   The use of subsections with subheadings is usually helpful and makes the work easier to read.

    c)   Care should be taken to ensure references are complete and should include full details of cited secondary references.

7.   Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

8.   Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes.

9.   Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

10.   Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

Policy Review

The Policy Review should be well organised and presentation should be of a high standard. It should include an accurate summary of the major aspects of the policy document and a consideration of the context (e.g. social, political, and/or economic climate) in which it was produced. It should include a critical review of the policy that draws on appropriate literature, and a consideration of the implications of the Policy for the NHS, mental health and social care services, and the profession of clinical psychology. The review should show some originality and/or an awareness of originality in other comments made in the broader literature. In the event of an extensive policy document, the team may wish to provide a detailed critique and consideration of the implications of only part of the policy. If this latter approach is taken, then the aspects of the policy document chosen should be significant and the reasons for the choice clearly justified. It should also include an Executive Summary (abstract) of no more than 300 words. This Summary should be of the whole Policy Review (but not the individual reflective accounts) rather than an Executive Summary of the policy itself. The text and references should follow the guidance in the APA Style Guide in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15).

Reflective Account

The Reflective Account should also be well structured and presentation should be of a high standard. It should include a brief description of how the team went about producing the report, it should use theory to inform reflections on the team processes that arose in producing the Report, and it should include personal reflection on the candidate's contribution to, and role in, the team and the production of the Report. This should include consideration of the relationship between their role in this team and other teams or groups, and also personal reflection on how previous life experiences (in family of origin, for example) may have been pertinent. The candidate should also provide some reflection on what they learnt from the experience. Whilst it is not always possible to maintain complete anonymity when writing about other team members, it is required that they are not referred to by their actual name. The use of pseudonyms is recommended. The text and references should follow the recommendations made in the APA Style Guide in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15). One copy of the Reflective Account will be made available to the trainee's maanger, and may be discussed in their end of year training review.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Criteria

The Board of Examiners requires a final mark expressed as one of the following grades:

Pass
Pass with Conditions
Referral
Fail

The mark for each individual will be based on the lower of the marks on the Policy Review and the Reflective Account. Candidates must achieve a pass mark in both elements before the candidate can successfully pass the Team Policy Report. A referral on either part of the Report will result in an overall referral being given to the individual candidate. A fail level mark on either part of the Report will result in an overall fail mark. The following guidance should be used to prepare your assessment with your co-examiner and to provide the basis for feedback given to the candidate and the Board of Examiners.

Marking Standards for Grades

Policy Review

Pass. This work has reached an acceptable standard and represents at least the level of attainment expected from candidates during the first year of training. The Policy Review is well organised and presented, and the content of the policy document is accurately grasped and summarised. There is some consideration of the social, political and economic climate in which the policy arose. It also contains a reasoned and clear critique of the policy and uses appropriate literature (where possible) to inform this critique. Where possible, it should show some originality and/or an awareness of originality in other comments made in the broader literature. The Review should consider the service implications of the policy in a reasoned manner and show some awareness of the relevant service contexts. It will provide some reflection on the implications of the policy document for the NHS, mental health and social care services, and clinical psychology. The Review, overall, may contain occasional mistakes or errors of omission, but no significant errors in content or presentation. The text and references should follow the guidance in the APA Style Guide in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15).

Pass with Conditions. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that the Policy Review has reached a Doctorate standard and is suitable to be viewed by others as such. The examiners must specify exactly what these conditions are. They may consist of corrections to statements, the inclusion of additional information or clarification of presented information, or the correction of referencing, grammatical or typographical errors, or missing appendices. If additional information is to be included, this must total no more than two additional pages (approx 500 words).

Referral. This Policy Review has failed to reach an acceptable standard. The Review may be badly organised and presented. The content of the policy document may be poorly understood and explained. The critique of the policy may be weak. There may be little consideration given to the service implications and little awareness of the service context. There is an expectation from the examiners that the work could be improved.

Fail. This work is below an acceptable standard. The Policy Review is poorly organised and presented. The content of the policy document may not be understood or may be poorly explained. The critique of the policy may be inadequate and show no originality. There may be a lack of a reasonable consideration of the service implications or awareness of the service context. The examiners feel that the review could not be brought up to an acceptable standard. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

The Reflective Account

Pass. The individual's Reflective Account is well structured and presented. It clearly describes how the team went about producing the report. It contains appropriate reflection on the team processes that arose during the production of the report, and it draws on theory and research to inform this reflection. It will contain some critical evaluation of the candidate's own role within the team, and detail the candidate's personal reflections on the process and what they may have learnt from it. It will include consideration of the relationship between their role in this team and other teams or groups, and also personal reflection on how previous life experiences (in family of origin, for example) may have been pertinent. The Reflective Account may contain occasional mistakes or errors of omission, but no significant errors in content or presentation. The text and references should follow the recommendations made in the APA Style Guide in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15).

Pass with Conditions. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that the Reflective Account has reached a Doctorate standard. The examiners may feel that the candidate hasn't quite grasped certain ideas or concepts, or they may have been inappropriately described or applied. The examiners may also feel that the candidate has failed to sufficiently reflect on something that happened in the group. The examiners must specify exactly what these conditions are. They may consist of corrections to statements, the inclusion of additional information or clarification of presented information, or the correction of referencing, grammatical or typographical errors. If additional information is to be included, this must total no more than one additional page (approx 250 words).

Referral. The Reflective Account has failed to reach an acceptable standard. The Account may be badly organised and presented. It may show a low level of reflection on the team processes and little awareness of the relevant literature that might inform an understanding of them. It may use literature inappropriately. There may be little reflection on the individual's contribution to the work or the individual's own contribution to the team processes. There may be a failure to exhibit a sufficient level of self reflexivity and a failure to describe how the candidate made sense of, or learnt from, their experience. There is an expectation from the examiners that the work could be improved

Fail. This work is below an acceptable standard. The Reflective Account may be poorly organised and presented. It may show an inadequate level of reflection on the team processes and may not relate this to the relevant literature. Literature may not be used to inform the account, or is used very poorly. There may be little or no critical reflection on the individual's contribution to the work, or to the team processes. There may be no or extremely limited self reflection. The examiners feel that the report could not be brought

up to an acceptable standard. Failure to complete the task set will result in the mark of Fail being awarded for that piece of work.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by the two examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates. Examiners are blind to the identity of candidates and candidates are blind to the identity of their examiners.

b) In marking the Team Policy Reports, examiners are required to assign a grade to both parts of the Report. If the Policy Review element of the Report is given a pass with conditions, referral or fail, then this will mean the whole group will need to work on the changes required and will be required to resubmit the Team Policy Report. If the Reflective Account is graded pass with conditions, referral or fail, then only that individual candidate is required to resubmit the Team Policy Report (i.e. both previously submitted Policy Review and the revised Reflective Account).

c) The two examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report.

d) In the event of the two examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from both examiners as part of the resolution process and recommend a mark. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

e) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

f) The assessments and comments will be considered and final decisions made at the Board of Examiners.

g) In the event of extensive typographical errors, significant errors in the use of language, the need for up to one page (approximately 500 words for Review or 250 words for Reflective Account) for clarification, significant referencing errors, or missing appendices, examiners can agree a conditional pass which requires the candidate to correct the identified errors. These 500/250 words can be additional to the existing word limit. Should meeting specified conditions lead to the submission exceeding the word limit, the total word count on the front sheet should be set out in the following manner: original word count (additional words), e.g. 4846 (120). A letter to the examiners should be included indicating where the changes have been made, including page numbers. It would normally be expected that such conditions would be met within four weeks of receiving the results. If conditions are not met on representation of the work, they will be returned to the candidate for amendment on two occasions. In the event of conditions not being met on a third occasion, the work will be referred to the Board of Examiners for consideration. In the event of very minor typographical errors, candidates will be asked to make corrections before submitting for final binding.

h) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure. The candidate must inform the Assessments Officer, in writing, of the new submission date within four weeks of receiving their results. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers.

i) Candidates will be informed of provisional results by email and the aim is to give feedback within 40 working days of the submission deadline. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

j) Work that is re-submitted will usually be marked by the two examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

k) At the end of the Course, candidates are required to submit a final copy of the work according to the specifications provided on completion of the course. This should be submitted as soon as possible following formal notification from the Board of Examiners. The submitted copy must include any amendments required by the Board of Examiners. The title page should contain the name of the candidate. This work will be kept as a record for up to 5 years. Candidates are advised to keep a copy for their own record of work completed.

Ref: Assessment Handbook/Team Reports/2018, updated 09/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

TEAM POLICY PRESENTATION

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Team Presentations
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The presentation is not graded, but assessed formatively. Candidates must, however, take an active part in the presentation in order to complete this component of the assessment system. The assessors will use the criteria detailed below and the Assessor's Form to assess the presentation.

Learning Outcomes
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.
- An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.

GUIDELINES ON THE PREPARATION OF TEAM PRESENTATIONS

1.   Following receipt of the feedback for the assessment of the Team Policy Report, the team of candidates should prepare for a Team Presentation of the Policy Review in July of the first year.

2.   The Team Presentation to the cohort group and Course Team should be of twenty minutes' duration, followed by twenty minutes' discussion. The presentation will be formatively assessed by two assessors working independently using the Assessment Criteria and Guidance for Assessors, paying due regard to the Guidelines on the Preparation of Team Presentations given to candidates.

3.   In preparing for the presentation, the team should take account of the following:

        a)   Each member of the team should make an approximately equal contribution to the presentation;

        b)   The team should ensure that the presentation is limited to twenty minutes and the discussion is brought to an end after a maximum of twenty minutes. The team is required to organise the chairing of the discussion;

    c)   The structure of the presentation should be made clear at the outset;

    d)   Any overheads, flipcharts or handouts should be clear and well presented;

    e)   The presentation should include information about the content of the policy, a critique and some implications for services and psychology.

4.   Each candidate is required to take part in the presentation. The presentation is not graded, but is recorded as being completed. Normally a Team Feedback Report will be sent to the candidates within four weeks of the presentation.

5.   Candidates should read the Assessment Criteria and Guidance to Assessors for information about the Course's expectations of the presentation.

ASSESSMENT CRITERIA AND GUIDANCE FOR ASSESSORS

Assessment Criteria

Assessors will rate and make qualitative comments about the following aspects of the presentation.

Structure	The presentation is clearly structured and the structure is introduced at the start of the presentation. There is a clear logic/rationale for the structure.
Content	The main content of the policy document clearly described and presented. The implications for services and for clinical psychology are highlighted and some critical commentary is provided.
Engagement	The presenters try to engage the audience, and respond to verbal and non-verbal cues. There is an appreciation of the needs of the audience.
Innovation/Creativity	The presentation is interesting and creative.

Time-keeping

i) Presentation:	Each presentation should last 20 minutes. The expectation is that presenters should keep to this. The Chairperson will stop presentations after 24 minutes.
ii) Discussion:	Following their presentation, presenters should chair an audience discussion for 20 minutes. The expectation is that they should keep to this. The Chairperson will stop discussions after 24 minutes.
AudiovVisual Aids	Audiovisual aids are are clear, elucidate the presentation and do not contain more information than is possible for the audience to read.

Handling of Questions

i) Chairing Discussion:	The discussion is appropriately chaired and the audience discussion managed to enable specific questions to be asked and addressed.
ii) Content:	Questions were answered clearly and competently. The presenters demonstrate the ability to "think on their feet".
iii) Interaction:	The presenters are able to manage the interactions and seek further clarification if needed. They are open to being questioned.

PROCEDURES AND OUTCOMES

1.   Following the presentation day, the two assessors will agree a team feedback report that will be sent to candidates, usually within 20 working days. Each member of the presentation team will receive the same report. The Examiners' Report will confirm candidates' participation in the presentation and provide feedback on the quality of the presentation. The feedback report will include half to one page of feedback about the presentation.

2.   The Assessors' Report will be considered at the Board of Examiners and candidates who have taken part in the presentation will be confirmed as having completed the assessment.

3.   Under exceptional circumstances, a candidate can request to defer his/her presentation. The request for a deferred presentation must be made using the University's Extenuating Circumstances procedures. In the event of candidates not taking part in the assessment in July (first year), an alternative date will be arranged and the candidate(s) will be required to present to the examiners individually. The presentation in this instance should be of fifteen minutes duration, followed by fifteen minutes of discussion. The same procedures with regard to assessment as detailed in (b) and (c) above will be followed.

4.   Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

Ref: Assessment Handbook/Team Presentation/2018

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

QUALITY IMPROVEMENT PROJECT

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Quality Improvement Projects
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The learning outcomes to be assessed through this piece of work include:
- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- An advanced and critical understanding of the scientific methods involved in research and evaluation, including the evidence base for psychological therapies, and to have developed the complex skills required to use this understanding in practice through carrying out original research and advanced scholarship.
- An advanced level of creative and critical thinking in relation to the development of clinical practice and services as well as the personal and organisational skills to implement, or facilitate the implementation of, these ideas in unique and complex situations.
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.
- A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.
- An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.

GUIDELINES ON THE PREPARATION OF THE
QUALITY IMPROVEMENT PROJECT

1. One Quality Improvement Project must be presented. No candidate shall be exempt from completing the Quality Improvement Project.

2.   The aims of the Quality Improvement Project are to assess the above learning outcomes and: (i) to promote awareness of quality improvement issues in the current health and social care work context, (ii) to provide candidates with the opportunity of developing the competencies required for designing and conducting quality improvement work, (iii) to evaluate changes in the quality of service provision arising out of a Quality Improvement Project and subsequent dissemination of the findings, (iv) to promote collaboration with respective stakeholders through the process of conducting a Quality Improvement Project, and (v) to understand processes associated with trying to bring about change in a clinical setting, including reference to policies if appropriate.

3.   The Quality Improvement Project should employ a systematic approach to investigate the topic, and should make use of predetermined methods that are underpinned by a clear model for undertaking quality improvement work. The chosen topic should be relevant to the setting in which the Quality Improvement Project is being carried out and should deal with some aspect of quality improvement that is appropriate to the practice of clinical psychology or related disciplines. The extant literature and service related issues should underpin the rationale and justification for the Quality Improvement Project. The primary focus of the QIP should address a clinically relevant quality improvement issue or question arising out of the practice of clinical psychology (or related disciplines) or training or service context, and should be grounded in NHS values. In this regard the project does not need to be an investigation of psychological phenomena. Where there is any doubt about the suitability of a topic area for the project, candidates should first consult their QIP back-up advisor, who may consult the Research Director, who may in turn consult with the External Examiner as required.

4.   The project is intended to be manageable within the parameters of the clinical placement and it should be completed before the end of the placement. The QIP should be completed within a **6 month** timescale. Working on the project should not take more than one half day per week of placement time including time allocated for placement supervision of the QIP. The following are examples of potential projects:

- A clinical investigation or evaluation of an intervention offered on an individual basis or in a group, to examine change over the course of the intervention (e.g. a single case or group design to examine change in outcome measures, or a questionnaire or survey design to evaluate service user satisfaction or perceived outcome).
- An evaluation of a service improvement initiative (e.g. to determine whether a new way of managing referrals has reduced waiting times for a first appointment, to evaluate whether staff training has improved risk assessments).
- An analysis of routinely collected data by a service that is carried out to meet specific aims or objectives (e.g. clinical audit to evaluate whether the service is meeting certain service standards that have been set, such as all case notes having a letter back to the referrer within a month of the first appointment).
- Projects aimed at service user involvement in the planning or implementation of clinical services.

- To initiate, develop, implement and evaluate a training package for practitioners or service users.
- A critical review of a service (e.g. evaluating the service delivery based on its service plans, critical incident analysis).
- An evaluation of the current functioning of a staff team or an evaluation following a consultation provided to a team.
- The evaluation of a training programme delivered to staff within the service.

5. The format and style of the Quality Improvement Project should be consistent with the need to communicate the findings to a multidisciplinary group of colleagues, or other respective stakeholders, few of whom will have extensive research experience. The presentation of the project should normally include the following sections:

(i)   An abstract

(ii)   An introduction to the quality improvement issue or question with critical reference to the extant literature and any relevant evidence base (a comprehensive review is not required but it should consist of sufficient recent literature directly related to the topic or question being addressed). A clear statement of the specific questions or aims being addressed in the project should be provided, and these should be related to the service context in which they arose. It should be made clear what the project was trying to accomplish, and a rationale or justification for the project should be provided. The aims should be grounded in NHS values. For example, much quality improvement work stems from the NHS values of 'Commitment to quality of care' and 'Improving lives'. In some cases, other NHS values may be equally or more relevant.

(iii)   An account of how the project was implemented and the process engaged in to address the questions or project aims should be provided. The project method and sample used, and the ethical considerations should be described clearly and succinctly.

(iv)   A clear style of presentation should be used to communicate the key findings of the project and how the project led to the desired quality improvement in the service, or how the project led to changes in the understanding of the salient quality improvement issues. The emphasis is on the clarity of communication that should be accessible to a broad range of stakeholders rather than on the technical aspects of the methodology and analysis, although the latter should be clearly and well described.

(v)   A discussion of the process and outcome of the project, in the context of the quality improvement questions or aims, should link the findings back to the literature drawn on in the introduction, alert readers to limitations in the design or implementations that may affect the trustworthiness or applicability of the findings, highlight implications or recommendations for the service, describe implementation plans where appropriate, articulate the learning process engaged in carrying out the project, and demonstrate critical self reflection and appraisal of the project carried out.

(vi)   There should be a short appended report that provides feedback to the host organisation and/or service. If the organisation specifies a format for this, please follow this. Otherwise, write a brief report of no more than 750 words. In either case, provide the organisation and/or service with a copy and include a copy in your appendices. If the host organisation requires that you wait until the QIP has passed before providing them with the report, please explain this in the write-up and include a draft report in your appendices. The findings should also be presented back to the organisation and/or service in person. You should either use PowerPoint (or similar software) to produces slides for this or produce a handout to accompany the presentation. A copy of the slides or handout should be included in the appendices. Note that if you use a handout, this should differ from the service-report.

(vii)   Appendices should include copies of all measures used in the project, the service report, and any closely relevant correspondence. <u>All documents in the Appendix must have all identifying names, specific details that could potentially identify the Trust and service and references blanked out: this includes the candidate's own name.</u>

6. All candidates will submit a proposal for the Quality Improvement Project no later than the last Friday of January of their first year to their QIP back up advisor. The proposal should be no longer than 1,000 words. These details need to be sufficient for the back up advisor to judge the viability of the project before it commences and receive feedback.

7. Candidates will submit the Quality Improvement Project (4-5,000 words, excluding abstract, contents pages, references, appended short service report and other appendices) in September at the end of the first year of training.

8. Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title and the candidate's examination identity number. The candidate's name should not appear anywhere in the submission.

9. Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
    a.   On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.

b.   On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.

c.   If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

10. Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

11. Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes. Additional practice-based information can be found in the Practice Learning Handbook, and guidance on undertaking research is available in the Research Handbook.

12. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

13. Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Criteria

The Board of Examiners requires a final mark to be expressed as one of the following grades:
> Pass
> Pass with Conditions
> Referral
> Fail

Please provide an overall qualitative assessment of the Quality Improvement Project on the Confidential Report. These comments may help you compare your assessment with your co-examiner and will provide the basis for feedback to be given to the candidate and the Board of Examiners.

Marking Standards for the Grades

Pass. This work has reached an acceptable or above standard. The introduction clearly articulates the question to be investigated or the aim that is set for the project. The aim or question being addressed in the project is firmly grounded in NHS values, the relevant literature and the service or training context. The need for the project is justified well and clearly related to an issue of quality improvement within the health service within the introduction. The method chosen is appropriate to the aim or questions of interest within that context, and the procedures adopted are well executed. There is a demonstration of ethical procedures having been followed in the conduct of the project. Where aspects of the

project do not come off as anticipated, this is due to circumstances that could not have realistically been foreseen, and steps are taken where practical to compensate for this so as to improve the validity of the results, including implications for continuing quality improvement work within the service. Analyses are carried out that investigate the project aim or questions of interest and appropriate inferences are drawn from the results. The discussion relates the results to the issues set out in the introduction and to previous literature, outlines the limitations of the project and implications of these limitations, provides a description of the feedback and suggestions for quality improvement given to the interested parties, and offers an evaluation of the impact of the dissemination of the findings and any improvements that have occurred. The candidate shows a capacity for critical self-evaluation and an ability to articulate the learning process that was engaged in carrying out the project. There is a clear sense that the project is seen as part of an on-going process of quality improvement. The sophistication of conceptual material and argument is of a high standard appropriate to a Doctorate level award. Presentation of the report should be good with minimal typographical errors. References should be complete and presented in the APA style in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15).

Pass with Conditions. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that the report has reached a doctoral standard and is suitable to be viewed by others as such. The examiners must specify exactly what these conditions are. They may consist of corrections to statements, the inclusion of additional information or clarification of presented information, or the correction of referencing, grammatical or typographical errors, or missing appendices. If additional information is to be included this must total no more than two pages (approximately 500 words).

Referral. This work has failed to reach an acceptable standard. The area of inquiry may not be clearly articulated, the questions of interest not adequately justified, or the structure may not be sufficiently coherent. The methods used may not be adequately explained or the results not presented to an acceptable standard, probably giving rise to questions about the candidate's own understanding. There may not be an appropriate context provided for interpreting the findings and for understanding any limitations of the study. The depth and sophistication of argument is lower than expected at this level. The work is not well presented or references are incomplete.

Fail. This work is below an acceptable standard. The aims and objectives of the project are unclear or unfocussed or the theoretical, value-based or empirical grounding is weak. The structure of the write-up is confusing in a number of places.   The description of the methodology is very difficult to understand or the methodology itself does not appear to follow from the research question being posed. The presentation of the method or results contains mistakes and does not demonstrate a firm grasp of the relevant material or makes it very difficult to be confident of what was done and why. Mistakes are made in the interpretation of the findings, which are not properly placed in the context of their limitations. The candidate does not demonstrate a level of self-criticalness or insight that

would ameliorate any of the other difficulties that are present. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

Guidance

All reports must be between 4,000 and 5,000 words, excluding abstract, contents pages, references, appended service report and other appendices. Examiners are asked to be familiar with the Guidelines on the Preparation of Quality Improvement Projects. The following table provides guidance under the specific headings of the Confidential Report to assist the Examiners in evaluating the different dimensions of the report.

	PASS	**REFERRAL**	**FAIL**
Abstract	Clearly written, provides an adequate summary for someone not reading the full report.	Not very clearly written and does not manage to convey the gist of the full report.	Not adequate as a summary of the full report.
Critical Review Of Extant Literature And Other Relevant Quality Improvement Work	A concise but critical review of the extant clinical, theoretical, and empirical literature that is relevant to identified aim of the project and model of quality improvement adopted. The literature and reporting of other quality improvement work is used to provide a basis for the project.	Falls short of providing a conceptual framework for the project. The literature cited is not well summarised, too narrow, or not clearly relevant to form the basis of a rationale for the project.	Fails to provide a grounding for the project in the literature through irrelevance or sparseness of the literature cited or through serious difficulties in either understanding or written communication.

	PASS	**REFERRAL**	**FAIL**
Rationale And Outline Of The Quality Improvement Aim Or Question	A clear and readily understood justification is provided for addressing this particular quality improvement aim or question and a description is provided of the overall service context so as to show why this was an important area to address, and what the project was trying to accomplish. The aims are explicitly grounded in NHS value(s).	No rationale is provided or the rationale fails to justify why this particular aim or question was worth pursuing.	No rationale is provided for why the particular problem was worth investigating or the rationale provided raises serious concerns about the candidate's under-standing of the area or the process of developing practice evaluation.
Method And Procedure	Choice of methodology is well explained and follows from the nature of the aim or question stated for the project. It represents a sensible approach that should provide useable and valid results. Key measures are identified (e.g. of change, outcome, satisfaction, performance), are appropriate and adequate justification of their use given. A reasonable effort is made to implement the plan. Where practical, appropriate steps are taken to compensate for unanticipated factors so as to maximise the validity and applicability of the results obtained. Good attention is paid to ethical concerns.	Why a particular method was chosen why key measures were selected is not made clear. Candidate does not demonstrate adequate insight into advantages and limitations of the method chosen. Either the implementation of the project plan or its description falls short of the expected level of competence. Candidate has failed to respond flexibly to developing circumstances. Ethical considerations are missing or dealt with superficially.	Choice of method or key measures appears to be arbitrary or due to factors other than their appropriateness to the problem at hand. Serious difficulties with description of the method suggest a lack of either understanding or practical competence. The implementation of the plan or its description clearly suggests that the candidate has not attained the expected level of research competence. Surmountable obstacles are not responded to appropriately. Evidence of unethical practice and/or failure to appreciate what important ethical considerations should have been taken in to account.

	PASS	**REFERRAL**	**FAIL**
Analysis And Results	The chosen analyses are appropriately carried out. The presentation of the results is readily understandable, adheres to style conventions (e.g., in the presentation of statistics, graphs, or tables), and relates to the questions of interest.	Either implementation or presentation of results falls short of the expected level. Conclusions drawn may not be appropriate or not well linked to the aims or questions being addressed in the quality improvement project.	Description of analyses and results raise serious doubts about the candidate's understanding. Inferences made are incorrect or unsubstantiated or are not appropriate to the analysis used. Analyses do not provide answers to aims or questions set for the project.
Interpretation And Dissemination Of Results	The discussion convincingly relates the results to the issues set out in the introduction and to the previous literature. Limitations to the procedures used and the conclusions that can be reached are included. A capacity is shown for critical self-evaluation, as well as an ability to reflect on the learning process. Feedback is effectively disseminated to interested parties and appropriate recommendations are made for further quality improvement work within the service context.	The discussion does not manage to tie all of the threads of the project together and relate them back to the issues covered in the introduction or previous literature. There are significant concerns with the interpretation of the results in terms of inappropriate inferences or lack of insight into limitations. The candidate does not critically self-reflect to an appropriate degree. Feedback to interested parties is lacking in some way.	The discussion gives rise to definite concerns about the candidate's level of understanding. The thread of the investigation started in the introduction may have been lost. Insight is lacking into mistakes made in previous sections, which may instead be magnified. Limitations of the project are not well addressed. Critical self-reflection is either lacking or off the mark. Dissemination of findings back to the service is either absent or ineffective.

	PASS	REFERRAL	FAIL
Presentation *a) adheres to APA guidelines* *b) Grammatical and typo-graphical errors* *c) References*	a) PASS: References are complete and presented in the latest APA style. PASS with CONDITIONS: References are incomplete and/or not in the latest APA style.. b) PASS: Few grammatical errors. Spelling largely correct, with only minor omissions. PASS with CONDITIONS: A large number of grammatical and spelling errors, suggesting the review had not been adequately checked or proofread.	a) The report deviates from the guidelines in significant ways. b) References are mostly missing	a) The report does not adhere to the guidelines.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by the two examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates. Examiners are blind to the identity of candidates and candidates are blind to the identity of their examiners.

b) The two examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report.

c) In the event of the two examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from both examiners as part of the resolution process and recommend a mark.   The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

d) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

e) The assessments and comments will be considered and final decisions made at the Board of Examiners.

f) In the event of extensive typographical errors, significant errors in the use of language, the need for up to two pages (approximately 500 words) for clarification, significant referencing errors, or missing appendices, examiners can agree a conditional pass which requires the candidate to correct the identified errors. These 500 words can be additional to the existing word limit. Should meeting specified conditions lead to the submission exceeding the word limit, the total word count on the front sheet should be set out in the following manner: original word count (additional words), e.g. 4846 (120). A letter to the examiners should be included indicating where the changes have been made, including page numbers. It would normally be expected that such conditions would be met within four weeks of receiving the results. If conditions are not met on representation of the work, they will be returned to the candidate for amendment on two occasions. In the event of conditions not being met on a third occasion, the work will be referred to the Board of Examiners for consideration. In the event of very minor typographical errors, candidates will be asked to make corrections before submitting for final binding.

g) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure. The candidate must inform the Assessments Officer, in writing, of the new submission date within four weeks of receiving their results. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers.

h) Candidates will be informed of provisional results by email and the aim is to give feedback within 40 working days of the submission deadline. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

i) Work that is re-submitted will usually be marked by the two examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

j) At the end of the Course, candidates are required to submit a final copy of the work according to the specifications provided on completion of the course. This should be submitted as soon as possible following formal notification from the Board of Examiners. The submitted copy must include any amendments required by the Board of Examiners. The title page should contain the name of the candidate. This work will be kept as a record for up to 5 years. Candidates are advised to keep a copy for their own record of work completed.

Ref: Assessment Handbook/Quality Improvement Projects/2018, updated 09/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

PROFESSIONAL PRACTICE REPORTS: DIRECT WORK

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Professional Practice Reports
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- An advanced and critical understanding of, and ability to apply, at least three theoretical models on which clinical psychology draws (in particular, behavioural, cognitive, systemic and psychoanalytic) and to be able to adapt the therapeutic model to work effectively in highly complex and novel contexts occurring across the lifespan.
- A high level of competence in assessment, formulation, intervention and evaluation across a range of theoretical models (one of which must be Cognitive Behaviour Therapy), client groups and organisational contexts, with appropriate attention to any factors relating to risk and to have the transferable skills to apply these in complex and unique circumstances.
- An advanced level of creative and critical thinking in relation to the development of clinical practice and services as well as the personal and organisational skills to implement, or facilitate the implementation of, these ideas in unique and complex situations.
- A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.
- An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.

- An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent; which recognises the value of feedback and the importance of seeking this out, and constructively responding to it; and which demonstrates the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge, enabling them to continue to grow.

GUIDELINES ON THE PREPARATION OF
PROFESSIONAL PRACTICE REPORTS: DIRECT WORK

Three Professional Practice Reports: Direct Work must be presented. These should be selected to demonstrate the candidate's clinical competence. They should cover a range of ages, types of problem and clinical procedures and should include cases involving direct work with individual clients or groups of clients and/or work with clients, carers or staff involved. Evidence of knowledge of more than one psychological model is required. It is crucial that issues of confidentiality are addressed and, in those cases where appropriate, full attention should be given to the matter of consent, or capacity to consent (citing up to date legislation where relevant e.g. Mental Capacity Act 2005). Some examples of suitable clinical activities are individual and group work with clients (including extended assessments), working with families, working with clients' carers, or staff involved with clients' care. When working therapeutically some examples of the model specific competences that the candidate used and how they were applied should be provided. (Candidates may wish to refer to the UCL competence frameworks for specific therapy modalities at http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks).

1. One Professional Practice Report: Direct Work must be presented from each of the following three areas of supervised experience: Child, Disabilities (across the lifespan), and Older People or other specialty. Trainees are encouraged to write up an extended assessment, for one of their Professional Practice Report submissions.

   All PPRs, regardless of whether they are an extended assessment or not, should report on the use of at least one psychometric test with the client and/ or members of their support network or reasons given as to why this was not possible/appropriate. The definition of a psychometric test has been interpreted broadly to encompass any of the following:
   - Questionnaires, self-report scales or outcome measures
   - Neuropsychological tests
   - Session by session monitoring
   - Projective tests

2. The trainee, in liaison with their line manager, is responsible for ensuring that an appropriate range of work is submitted.

3. It is not appropriate to include material that has been submitted for another examination unless the prior agreement of the Board of Examiners to do so has been obtained. Work published (but not submitted for another examination) may be included when the candidate is sole author or, in the case of multiple authorship, when the candidate's responsibility can be, and is, clearly specified. Although candidates are

encouraged to undertake joint work, there are constraints on the submission of some kinds of joint work for examination because of the problem it raises in evaluating a candidate's personal clinical competence. The Board accepts the following categories (a) joint work for which the candidate took the primary responsibility, and (b) joint work in which the candidate shared equal responsibility with another professional. Work undertaken jointly with another trainee clinical psychologist or in which the candidate took a subsidiary role should not be submitted. In all cases it should be made absolutely clear which procedures were carried out by the candidate and which by the collaborator, though candidates will be expected to take responsibility for the whole of what is submitted. Examiners are asked to ensure that candidates meet these requirements.

4. The Reports submitted should enable the examiners to have a clear idea of the problem to which the Report refers and of the way in which it was tackled. Examiners will be looking for a systematic approach to the problem which integrates theory with practice and addresses the issue of outcome. The examiners will attach particular importance to the application of psychological knowledge in the formulation of the problem, the competent use of psychometric measures to assess the nature of the problem, the candidate's understanding and ability to demonstrate therapeutic competence and the candidate's demonstrated ability to evaluate clinical work critically and to learn from it.

5. Reports should normally be structured using the following framework. Variations to this structure are acceptable but candidates should provide a brief rationale for this and present their work in a coherent way which takes into account the content of points (i) to (viii) below as fully as possible.

   (i)   A brief statement of how and/or why the problem came to the candidate or their supervisor.

   (ii)   An initial assessment that might include information from interviews, case notes, meetings, telephone calls, observation or daily diaries. The use of at least one psychometric measure should also be evident where this is possible, or reasons given for not including a measure. Such assessment should form the basis for subsequent action and review of outcome. Which measures are appropriate to use may be dependent on a number of factors including the theoretical model informing the work, the service context, the presenting problems being brought to the service, the acceptability of the use of such measures to the client, and the aims of the work to be undertaken. This thinking will need to be demonstrated.

            When writing up the ways in which the psychometric measures were used, it will be important for the trainee to convey critical thinking regarding the results, and ethical practice in how the measures were administered and conclusions discussed with the client.

            For all Reports, evidence of consideration of issues of consent, confidentiality, assessment of risk and its management, responsibility around appropriate recording of information gathered, and use of supervision, would be important to demonstrate.

(iii)   An initial formulation which consists of hypotheses about how the problem may be understood after the assessment phase or during the early stages of assessment (if the whole intervention was an extended assessment). Such an initial formulation could require significant amendment as a result of knowledge gained during the extended assessment and/or intervention, but should at this early stage be well-grounded in the assessment information presented and lead coherently to the action plan.

(iv)   An action plan following logically from the initial assessment and formulation of the problem. This action plan might involve further detailed assessment, an outline of therapeutic intervention, proposals for service development, and/or an outline of a teaching programme. Where relevant it should refer to the professional, diversity and ethical issues raised. In the case of an extended assessment, what further assessments are proposed to be undertaken and why needs to be clear, as well as a brief description of the tests, with reference made to their appropriateness for use for the purposes outlined.

(v)   A description of how the action plan was implemented (the intervention). Although not a verbatim account, this should provide enough detail and/or examples to enable their examiners to have a clear picture of which procedures were adopted. If the work involved a therapeutic intervention, candidates should give explicit examples of the therapeutic competences they were using and what effect they had by giving examples or using quotations. For example, if a candidate was using a psychodynamic model they could explain how they worked in the transference, or how they recognised and worked with defences. It is important to demonstrate the link between theory and practice in this section and relate procedures to established research findings and competency frameworks.

(vi)   A description of what was achieved. This will need to include reference to any change in outcome measures used, and might also include qualitative accounts and/or measures of change in psychological functioning or wellbeing, skills, settings, management practice, or effectiveness of teaching programmes. Service user or carer feedback should also be included. Follow-up details should be described in this section. In the case of an extended assessment, an outline of the assessment results, showing an ability to synthesise the material gathered into a meaningful, coherent summary and proposed further action plan/ intervention, will be required. In addition, critical thinking in the interpretation and formulation of the findings will need to be demonstrated, evidencing sensitive feeding back of the results to the service user, his/her network and other professionals involved.

(vii)   Reformulation.   If, at the end of the work, candidates considered that a reformulation using a different theoretical model is important to include, it is usually better presented as a separate section. In addition, if a significant development of the existing formulation is required, strong consideration should be given to writing the reformulation as a separate section. Such a section should include both some rationale for why a reformulation was important as well as the reformulation itself. It is not essential to include a

reformulation section but if it is omitted then some comment on the initial formulation needs to be made in the critical reflections section.

(viii)   Critical Reflections. This should provide a reflective review of the clinical work that has been presented and demonstrate what has been learnt as a result. It should indicate clearly the understanding of the problem that was achieved by the end of the episode of work and provide a critical appraisal of the outcome. This would include reference to the role of the supervisor as well as theoretical, practice, contextual and ethical considerations. It is important to consider, as part of the context, the issues of diversity raised by the work.

6. Information which could identify a client to someone who knew them should be removed. Clients' actual names should never be included, but should be replaced by fictitious names or initials.   Other information that might identify the client, for example, dates or places of birth, or very specific job titles, should not normally be included in the Report. If such information is very central to the clinical work being reported, it should not be removed, but it may then be appropriate to disguise some other aspect of the client's identity in order to preserve their anonymity. For example, if information about someone's job is central to their clinical presentation, then it might be appropriate to disguise some other aspect of their personal information (such as changing their nationality from English to Scottish). Such changes should only be made where candidates have good grounds for doing so. In addition, information that might identify other professionals or services should be removed (including from the Appendices). Candidates should consider issues relating to the prevention of individual clients being identified in discussion with their supervisors.   Pseudonyms are recommended on reports referencing people by name. It is not acceptable to employ pseudonyms that reference any well-known person or character (celebrity, actor, fictional person or cartoon character) and any chosen and agreed should be neutral and based on preserving anonymity and not on names associated with particular characteristics (e.g. Amity, Charity, Grace, Joy, BrightBoy, and so on). Pseudonyms employed may be agreed, within these restrictions, with the service-user concerned, or colleague concerned.

A statement declaring that changes have been made to the Report to prevent the identification of the client/s should be included in the title page.

It is expected that normally the candidate will have sought the consent of the client to the work being written up as a PPR. A brief indication should be provided in the Report of the process for obtaining that consent. If there are compelling clinical reasons why it is not possible or appropriate to obtain such consent, then these reasons need to be outlined, along with an indication of any relevant discussions about this issue with the candidate's supervisor. Trusts may have their own guidance regarding the use of clinical material for educational purposes. It is important that you check what procedures are in existence for the Trust in which you were on placement and follow these. An example is the Surrey and Borders Partnership NHS Trust policy, which can be found at https://www.sabp.nhs.uk/aboutus/policies.

7. Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories.   Tone and language should be

respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

8. Normally, relevant letters and reports written by other professionals should be attached as appendices to a PPR in order to document the information drawn upon. If this is done, the trainee must show how they considered and acted upon the consent and /or confidentiality issues raised by using documents written by a third party. How this was addressed should be documented in the PPR. If consent has to be sought but was not granted for whatever reason, reference to material from third party sources might still be incorporated in the body of the PPR text as part of the account of the psychological work, and an explanation provided for the absence of the document.

    Trainees should always consult and seek advice about local NHS policies on the use of third party information and discuss the issues with their supervisors.

    Each Report should include, as an appendix, copies of any letters or official reports written by the candidate, as report writing is a professional communication skill. With this in mind, trainees are required to include a therapeutic letter or summary report as an Appendix. This may be addressed to the service user, family member, carer or another professional in recognition that the nature of clinical correspondence will vary in different contexts. Trainees must include a reasonable explanation for the absence of such a letter or report, given that this would normally be considered good practice.

    Copies of cognitive and/or psychometric assessments included in the appendix should be initialled by the supervisor to confirm they have been checked.

9. Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title and the candidate's examination identity number. The candidate's name should not appear anywhere in the submission.

10. The Reports submitted may vary in length. However individual reports must not exceed 5,000 words. The Reports should be able to be read without constant reference to the appendices. An exact word count for each report must be included on the cover of the report along with a statement specifying that, for reasons of confidentiality, all names (individuals, units and places) are fictitious.

11. Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:

a. On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
b. On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.
c. If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

12. Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes. Additional practice-based information can be found in the Practice Learning Handbook.

13. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

14. Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Criteria

The Board of Examiners requires a final mark expressed as one of the following grades:

>   Pass
>   Pass with Conditions
>   Referral
>   Fail

Marking Standards for Grades

Pass. This report has reached an acceptable or above standard. It represents at least the level of attainment expected from an adequate candidate appropriate to their stage of training. It is well organised and presented. The clinical argument is easy to follow and justified, demonstrating a clear integration of theory, practice and evidence. Where applicable relevant psychometric measures are included and relevant therapeutic competences are illustrated. The report provides critical evaluation of the clinical issues and outcomes, and demonstrates specific learning, including reflection on self in the work, from supervision and from the work conducted. Where possible it shows a capacity for the original application of clinical techniques, and their adaptation to different service users and contexts. Awareness of issues around confidentiality, consent, capacity to consent, risk, sensitive and ethical handling and interpretation of data from psychometric measures and other relevant ethical issues (e.g. diversity) are considered where relevant. The report reflects the values of the NHS constitution in relation to service users, carers, families, colleagues and others. The work described may have shortcomings or inherent limitations but these are appropriately reviewed and critiqued in the report with learning from them clearly demonstrated. The report may contain occasional minor mistakes or

areas of omission but otherwise be good, with no significant errors in content or presentation. References are complete and presented in the APA style.

Pass with Conditions. This report meets nearly all the above criteria required for a pass but with errors or omissions that require rectification or clarification for it to reach a Doctoral standard and to be suitable to be viewed by others. For example, Conditions could include: significant typographical errors or in the use of language; referencing errors; omissions such as missing appendices or other errors of content, information or presentation. The Examiners must specify these Conditions. They should be readily corrected within two additional pages (500 words approximately). If more correction than this is needed, the work may be considered a Referral.

Referral. This report fails to reach an acceptable standard. A significant number of the following concerns may be present. The work is not described in a logical or systematic manner or the structure of the report lacks coherence. Clinical thinking may be limited or unclearly articulated, and there is insufficient justification of the psychological arguments presented. There is poor integration of theory and practice, and reference to evidence (research evidence or clinical information relevant to the work) is scant. There is an unsystematic approach or no original adaptation of clinical technique to the particular work and the people involved. There is limited evaluation of the work and its outcomes, and minimal critical appraisal or evidence of learning. The depth and sophistication of argument is lower than expected for this stage of training. The report does not appear to reflect NHS values or to be actively informed by ethical thinking. The work is poorly presented, with extensive typographical or referencing errors.

Fail. This report is of an unacceptable standard. All or a substantial number of the following concerns may be present. There is a serious lack of integration of theory and practice, with no or insubstantial use of information from assessment, research or other sources. The approach appears to be unsystematic with no rationale, and uninformed by coherent clinical thinking or planning. Psychological argument is lacking or completely unsubstantiated. There is little or no critical appraisal of the work and its outcomes, and no clear evidence of the candidate's learning.   There is evidence of unethical or unprofessional methods of working, including lack of respect for service users, carers or colleagues. The presentation makes it difficult to comprehend the report, through consistently poor use of language and grammar, lack of organisation of material into a structure or a very high number of typographical errors. A section may be missing or incomplete: failure to complete the set assignment will result in the mark of Fail being awarded for that piece of work.

Guidance

1. The following table provides guidance under specific headings to assist the Examiners in evaluating the different dimensions of the Professional Practice Report.

	PASS	**REFERRAL**	**FAIL**
Initial assessment	The person(s) is introduced and described to the reader holistically and respectfully, and situated within their life context and strengths. A clear account of assessment procedures used in early stage of work, and rationale/context for choosing them is provided. The properties of psychological tests are described and accurately interpreted. Information is inclusive but succinct, well organised and reported descriptively. The perspectives and preferences of the service user(s)/other stakeholders are included.	The person(s) is described minimally with limited reference to their wider lives, concerns or strengths. The reporting of assessment procedures is not systematic, leaving the reader unsure what was done, why, or what information sources were used. No context for the work is given. Psychological tests are insufficiently described or interpreted. No explanation is provided for information that is missing, or it is interpreted rather than reported. Minimal consideration of service user / other stakeholder perspectives.	The service user(s) is described narrowly with a focus upon their deficits and without a life context. Little information is provided about the assessment procedure, its structure or rationale. There are Significant gaps in information provided. There are significant errors or gaps in reporting the use of psychological tests. There is no mention of service user(s') and/ or stakeholder perspective (e.g. carers).
Psychologist's Initial formulation	Provides summary of relevant theoretical propositions. Draws coherently and systematically on assessment information and relates it in appropriate way to psychological theory, thus developing a tentative explanatory narrative to account for the psychological difficulties reported to inform action planning.	Provides limited account of a theory/model and of rationale for its application to the work. Is theory-led rather than data- driven and person-led, and presented as fact instead of hypotheses. Theory-practice links are weak, confused or unjustifiable. There is inconsistent or erroneous use of assessment information and the formulation may introduce new information not reported in assessment.	Very little or no psychological theory. No rationale given for adoption of theory or model and no account of it provided. Few or no theory – practice links. Theoretical assertions not grounded in assessment data or a person-centred perspective. Assessment information is not used to drive formulation. Formulation consists of unjustifiable and overly firm claims to understanding.

	PASS	**REFERRAL**	**FAIL**
Action plan	Explicit reference to key propositions of formulation is made and then used to build a reasoned action plan for the work. Service user/stakeholder views and goals inform the plan, as do the evidence base, national guidelines and ethical considerations. The plan reflects the service user's and their network's strengths. A clear rationale for a more in-depth assessment or for the planned approach to intervention is provided. In the case of an extended assessment consideration is given to the appropriateness and aims of any further testing. Where a therapeutic intervention is being planned, examples are given of the model/theory driven techniques the candidate intends to draw upon. The action plan includes plans for evaluation of the intervention.	The rationale for the action plan is not explicit or only weakly justified with reference to evidence, guidelines, ethical issues or service user/stakeholder views. Links between the hypotheses of the formulation or assessment information and the action plan are weak. The action plan is not clear. The theoretical model or aims and methods of further assessment are not clear or only loosely inform the approach and techniques proposed. Outcome evaluation is not adequately attended to.	Little or no reason is given for the assessment or intervention approach(es) chosen. Ethical issues and service user/ carer views are not considered. Description of the proposed intervention/ further assessment is very limited, partial or conveys lack of understanding of the model's approach and techniques. No identifiable argument links the formulation with the proposed course of action. There is an absence of theory. Attention to how the work will be evaluated is lacking.

	PASS	**REFERRAL**	**FAIL**
Intervention	The reader is given a respectful sense of the people involved in the work, their relationships(s) and responses. An underlying person- centred approach is apparent from the account. The account is clear, transparent and organised coherently chronologically, by theme or other structure. Ethical matters are appropriately considered. The narrative conveys continuing psychological thinking informing decisions within the work. Whilst broadly congruent with the formulation, action plan and the values framework, necessary flexibilities and adaptations are also demonstrated. Where an extended assessment has been written up, there is an awareness of ethical practice in how measures are used, for example consideration has been given to issues of consent, how tests are administered and how results are interpreted. Assessment results are presented in a meaningful and coherent manner. In the case of a therapeutic intervention, selected examples appropriately illustrate techniques, processes or significant episodes in the development of the work (and make reference to relevant therapeutic competency frameworks where appropriate).	The description of the relationships, responses and people involved in the work is thin. The account is not systematically structured. It may be abstract or dominated by techniques employed, with little grounding in the interpersonal nature of the work. Examples of practice episodes may be limited or inappropriate, and the application of techniques shows little understanding of the theory underlying them. In the case of extended assessments, the conduct of the assessments may indicate limited understanding of measures/ tests administered and their interpretation. Ethical considerations are not actively considered. There is limited evidence of continuing psychological thinking guiding the work. The approach appears weakly informed by the initial formulation or shows lack of responsiveness to new information and circumstances	The reader has little or no sense of the service user(s) or the psychologist and how they relate together in the work or the description is not respectful. The account is disorganised and it is difficult to see any clinical logic or purpose to what is reported. The practices bear little relationship to the initial formulation or action plan (or changes are not explained). Few or no examples are given of exchanges or techniques, which may be misapplied or ill-informed. In the case of extended assessments, competence in administration and interpretation of measures/ tests is lacking. There may be unconsidered breaches of ethical practice. There is evidence of inflexibility of thinking and practice and a failure to learn from emerging or changing information and circumstances.

	PASS	**REFERRAL**	**FAIL**
Outcome evaluation	A multi-perspectived, balanced and critical approach to evaluation is taken and appropriately reported, for example drawing on evidence from some of the following: self-report/monitoring, psychological and psychometric tests, outcome measures, service user/stakeholder goal attainment, service user/stakeholder feedback forms, carer/professional/other reports, candidate's observations, behavioural evidence, assessment of impact upon family or organisational systems. In the case of extended assessments there should be evidence of the sensitive feeding back of the assessment results.	There is restricted, inadequate, unbalanced or inaccurate evaluation. There may be over-reliance on a narrow approach or limited evidence. Conclusions drawn are not well based in evidence. Psychological tests are not fully or accurately reported, or critically interpreted in the light of other information. Sharing of results to relevant parties in the case of an extended assessment is limited or shows a lack of sensitivity to the needs of the recipients. Inconsistent findings are not discussed. Limitations to the evidence and its evaluation are not considered.	Evaluation is very limited or lacking, or the approach is serendipitous. Evaluation tools are used inappropriately. No critical analysis of evidence is provided. No reference is made to the service user/stakeholder aims or goals. Discussion around feeding back results in the case of an extended assessment is absent or raises questions around whether recipients' needs were met in the reporting of findings. Potentially erroneous conclusions are drawn.
Reformulation (where relevant)	A reformulation outlining a different or more developed framework for psychological understanding is provided, taking into account new information or ideas arising from the experience of the work. Whilst this may be fairly brief, it should still demonstrate clear linking of theory, evidence/information and practice, and illustrate new ways of thinking derived from hypothesis-testing and feedback, or go some way to explaining key issues arising in the course of the work. It may appear as a separate section, as part of the intervention account or of the critical reflections.	The reformulation is not consistent with the information it is based upon, is not data-driven or draws upon information not previously mentioned. It contains limited or inaccurate theory-practice links, or does not address key issues in the work or add to psychological understanding of it.	A reformulation is not provided when one is clearly needed because the hypotheses of the initial formulation are unsupported or irrelevant to how the reader can understand the psychological issues and development of the work. The reformulation contains few or no coherent links between theory, evidence/information and practice.

	PASS	**REFERRAL**	**FAIL**
Critical Reflections	The review shows good understanding of the work undertaken, and a reasoned, balanced appreciation of its strengths and limitations from diverse perspectives. Key issues and themes (clinical, ethical, personal, interpersonal) have been identified and thought about, reflectively and critically. There is evidence of critical thinking in the use of measures, and possible alternatives, in the case of extended assessment. Consideration is given to what has been learnt and how (e.g. through supervision, personal reflection on experience, feedback from others). The candidate demonstrates a constructive and appropriate depth of thoughtfulness, including capacity to reflect on own impact on the work.	Key issues and problems in the work are not substantially considered. Its strengths and limitations are superficially reviewed or inappropriate conclusions are drawn. The review contains limited reflection or critical thought about clinical, personal, interpersonal or ethical issues, and critical thinking around the use of measures in the case of extended assessments is limited. There is restricted evidence of significant learning from the experience of the work or from feedback.	The review does not convey a good understanding of the work, the processes and people involved in it. Key issues and problems are not identified or considered. Little or no awareness of ethical and important personal and interpersonal issues is shown. There is little or no critical thinking or reflection in the review, and little or no evidence of significant learning from experience.

	PASS	**REFERRAL**	**FAIL**
Theory/practice links	At various places in the report, there is evidence of competence in making useful sense of clinical material by drawing on relevant psychological theories that then guide practice. In addition to the formulation and action plan, the way that theory informed the work may be demonstrated in other sections e.g. in thinking about and responding to issues as they arise in the intervention/ extended assessment, showing understanding of the theoretical principles underlying specific techniques through their appropriate and creative application, and by critical reflection on use of models with different service users/stakeholders in the review section.	There is some limited evidence of theoretical knowledge and thinking informing practice. This may be inconsistent or absent from key areas of the report. Weak understanding of theory is apparent in some areas, e.g. in the application of ideas, or practice is at odds with theoretical propositions and no explanation is offered. Application of theory may be very rigid and lacking in adaptations to the service user. The action plan contains ideas and aims that do not appear to be well and consistently grounded in the assessment material. Psychological theory or empirical research drawn upon to make provisional sense of this material in the formulation is limited.	Theory is only weakly articulated throughout the report. The formulation lacks explicit description of theoretical principles informing the way that the assessment data is interpreted. Little or no theoretical rationale is provided for action planning and intervention/ extended assessment, or is used incorrectly. The intervention is not clearly guided by considerations and responses to new material or occurrences are not underpinned by theory or psychological thinking. No attempt to reflect on theory-practice links is made in the critical reflections.
Structure	A coherent and systematic structure that reflects the progression of the particular psychological work undertaken is evident. The narrative leads the reader through different stages in thinking and practice. Headings are used and sections contain appropriate information, building and flowing logically from one to the other.	Although some evidence of structure, it is difficult for the reader to understand the development of the work, the rationale for it and the candidate's psychological thinking, or the structure used does not appear to reflect the actual work undertaken. Significant amounts of information may appear in the wrong place, confusing the logical flow (e.g. a lot of new information appearing for the first time in the Formulation section).	The report is largely unstructured in its argument and development, without a clear narrative to guide the reader or to communicate coherent psychological thinking and practice. Important sections are extremely short, missing, or may contain large amounts of irrelevant or misplaced information.

	PASS	REFERRAL	FAIL
Presentation *a) adheres to APA guidelines* *b) Grammatical and typographical errors* *c) References* *d) Appendices*	a) The review adheres to the APA guidelines in terms of content and style, with only minor errors. b) Few grammatical errors. Spelling largely correct, with only minor omissions that could have been missed by using a computer spell check and by proof reading. c) References are complete and in the APA style. d) Appendices are well ordered, anonymised and include the necessary information to support the main text, including clinical correspondence written by the trainee.	a) The review deviates from the guidelines in significant ways. b) A significant number of grammatical errors. Spelling errors that should have been picked up. c) There are significant problems with the references in terms of being incomplete and/or not in the APA style. d) Appendices are numbered in the wrong order or are missing or contain breaches of confidentiality	a) The review does not adhere to the guidelines. b) A large number of grammatical and spelling errors, suggesting the review had not been checked or proof read. c) References are missing completely. d) Required Appendices are missing completely and/or contain serious breach of confidentiality.

2. Examiners should bear in mind that the Reports are a vehicle for the assessment of clinical competence in the context of the services in which placements and professional work take place. They should seek to make an assessment of the candidate's competence from the information available to them. The appropriateness of the clinical procedures used (for example the use of psychometric measures, or therapeutic techniques) and the competence with which they were executed are thus important issues, but need to be understood in context. The candidate's ability to learn from any mistakes, shortcomings or limitations of the work they carried out is also a crucial feature of competence. Examiners should bear in mind that in some cases there are legitimate differences of view between qualified psychologists about the appropriateness of alternative procedures and candidates should not be penalised for not following the assessor's own preferences or for offering legitimate criticisms of them.

Candidates are required to include an example of their own clinical correspondence as an Appendix to the main report. This would most commonly be an assessment or discharge report or a therapeutic letter, but could reasonably take different forms depending on context. Although the content of these letters are not formally marked, examiners may wish to comment on the appropriateness or otherwise of the letter. Absence of any such letter, or an explanation for its absence, should be made a condition for pass.

Candidates should also include service user or carer feedback where this is possible.

3. In evaluating the Reports, the examiners should consider: the adequacy of the rationale for the procedures used, the application of psychological knowledge in the formulation of the problem, the capacity to use initial hypotheses to guide a plan of action and its

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implementation whilst at the same time being responsive and flexible to new developments, integration of theory and practice and the assessment of outcome as well as demonstration of the skilled use of therapeutic competencies and interpretation of data from psychometric assessments. The examiners should also consider the candidate's demonstrated ability to reflect on the work they have undertaken, evaluate it critically and to learn from it and should hold in mind the ways in which the report conveys respect for service users, carers and colleagues and other NHS values.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by the two examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates. Examiners are blind to the identity of candidates and candidates are blind to the identity of their examiners. For core specialties, i.e. Child, Disabilities and Older People, at least one examiner will be a supervisor working in the specialty appropriate to the work submitted for examination. The person who supervised the candidate in the work reported will not be one of the Examiners. Specialists on the course team can be available to examiners for consultation on any queries, particularly on PPRs from Supplementary placements.

b) The two examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report. If a fail is given the report will end with a statement about a new piece of work being required or, in the case of all clinical experience being successfully completed, whether a new piece of work is required.

c) In the event of the two examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from both examiners as part of the resolution process and recommend a mark. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

d) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

e) The assessments and comments will be considered and final decisions made at the Board of Examiners.

f) In the event of extensive typographical errors, significant errors in the use of language, the need for up to two pages (approximately 500 words) for clarification, significant referencing errors, or missing appendices, examiners can agree a conditional pass which requires the candidate to correct the identified errors. These 500 words can be additional to the existing word limit. Should meeting specified conditions lead to the submission exceeding the word limit, the total word count on the front sheet should be set out in the following manner: original word count (additional words), e.g. 4846 (120). A letter to the examiners should be included indicating where the changes have been made, including page numbers. It would normally be expected that such conditions would be met within four weeks of receiving the results. If conditions are not met on representation of the work, they will be returned to the candidate for amendment on two occasions. In the event of conditions not being met on a third occasion, the work will be referred to the Board of Examiners for consideration. In the event of very minor typographical errors, candidates will be asked to make corrections before submitting for final binding.

g) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure. The candidate must inform the Assessments Officer, in writing, of the new submission date within four weeks of receiving their results. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers.

h) Candidates will be informed of provisional results by email and the aim is to give feedback within 40 working days of the submission deadline. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

i) Work that is re-submitted will usually be marked by the two examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

j) At the end of the Course, candidates are required to submit a final copy of the work according to the specifications provided on completion of the course. This should be submitted as soon as possible following formal notification from the Board of Examiners. The submitted copy must include any amendments required by the Board of Examiners. The title page should contain the name of the candidate. This work will be kept as a record for up to 5 years. Candidates are advised to keep a copy for their own record of work completed.

Ref: Assessment Handbook/Professional Practice Reports/2018, updated 10/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

CRITICAL REVIEWS

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Critical Reviews
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The purpose of this assessment is to help the trainee to develop the necessary competencies that will allow them to develop new or existing services, areas of practice or research initiatives. Whilst the review may be of a publishable standard, the level set here is that it should be written to inform a professional team but not necessarily an expert group. The assessment contributes to the following educational objectives of the course:

- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- An advanced and critical understanding of the scientific methods involved in research and evaluation, including the evidence base for psychological therapies, and to have developed the complex skills required to use this understanding in practice through carrying out original research and advanced scholarship.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- An advanced and critical understanding of, and ability to apply, at least three theoretical models on which clinical psychology draws (in particular, behavioural, cognitive, systemic and psychoanalytic) and to be able to adapt the therapeutic model to work effectively in highly complex and novel contexts occurring across the lifespan

More specifically the assessment will facilitate the following skills to be developed:

a) To be able to search the available literature on a selected topic in a systematic and rigorous way using electronic and manual methods.

b) To be able to describe how this search was completed in a way that would allow it to be replicated.

c) To be able to focus a review of literature within specific parameters, for example length of report and level of sophistication necessary and to give a rationale for this focus.

d) To be able to succinctly and clearly present this literature to the audience by including:

    I.   the current cutting edge of research, theory and/or debate;
    II.   a sense of how this literature has developed;
    III.   a review of any methodological issues;
    IV.   a synthesis of the material which results in a convincing and reliable overview of the topic, and a balanced conclusion reached on the basis of reasoned argument.

e) To be able to adequately discriminate between the existing critiques of the topic and their own critique.

f) To demonstrate an in depth knowledge of a specific area of interest within a specified area of clinical psychology.

GUIDELINES ON THE PREPARATION OF CRITICAL REVIEWS

1. The trainee can choose to write their Critical Review (maximum 5,000 words) on a topic relating to working with either children and families or people with disabilities and will be submitted during the second year (June). Only one Critical Review will be submitted during training.

2. Critical Review Topics will be set by a member of the course team in liaison with other members of the course team and external partners who are either examiners in the area, or who are experienced in the relevant specialty.

3. From the topic headings provided by the Course, candidates will develop their own specific titles to reflect the work they have chosen to undertake. These titles are best developed after some preliminary reading in the area and may be further refined as more literature is reviewed. A rationale must be given linking the title to the topic and explaining the reason for addressing this topic.

4. Titles should be no more than 30 words in length.

5. Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title and the

candidate's examination identity number. The candidate's name should not appear anywhere in the submission.

6. Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
    a. On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
    b. On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.
    c. If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

7. In deciding a Critical Review title, there should not be any substantial overlap in content area with other pieces of assessed work including Professional Practice Reports, the Major Research Project or the Team Policy Review.

8. Trainees may consult their manager in the development of their title and area with a skeleton plan of their review.

9. The literature search(es) carried out must be appropriate to the review title. In some instances more than one search will need to be carried out, for example, to provide a general overview of the area and then to focus in detail on one or more specific issues. A description of search methodologies must be included. Some searches will be very systematic and focussed, others less so dependent upon the focus of the review.

10. Summaries of the relevant literature may be given by by referencing previous papers and meta-analyses. Where there is a large literature, papers that are representative of the literature may be presented, but this should be stated clearly and a rationale given for the choice of the material presented. Where little literature is available a fully comprehensive review is appropriate.

11. Tables and figures may be used to summarize, illustrate or present material that would be less clearly or succinctly presented in textual form. Tables are a useful way to briefly summarize the results of a number of similar papers. A flow chart summarising the search strategy and a table summarising the included papers or studies are also strongly recommended.

12. Care should be taken that references are complete, in the APA style and should include full details of cited secondary references.

13. Critical reviews should be broken down into subsections with headings. The sections should follow logically on from each other and within each section the

paragraphs should form a coherent narrative. Each paragraph should make one general point, perhaps made up by a number of sub-points. Avoid multi-clausal sentences.

14.   The format or structure of the review will be dependent upon the chosen area, but should minimally include:
   • title page (including title of Critical Review; topic name; candidate number and word count);
   • abstract;
   • contents page;
   • an introduction;
   • the main body of the review;
   • conclusions;
   • references.

15.   An introductory summarising abstract of up to 200 words should be included and does not form part of the word count.

16.   Reviews must reflect the title as stated and attend to all the issues raised therein. This will usually include a clear explication of the topic to be reviewed and key issues, an understanding and critical evaluation of the work already carried out, a critical review of the research, and any relevant implications for clinical, professional and research work.

17.   Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

18.   Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes.

19.   Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

20.   Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Criteria

The Board of Examiners requires a final mark to be expressed as one of the following grades:
                    Pass
                    Pass with Conditions
                    Referral

Fail

Please provide an overall qualitative assessment of the Critical Review on the Confidential Report. These comments may help you compare your assessment with your co-examiner and will provide the basis for feedback to be given to the candidate and the Board of Examiners.

Marking Standards for the Grades

Pass. This work is at an acceptable or higher standard. The topic of the review is clear and the content well-structured and easy to follow. There is a clearly described and appropriate method to the literature search ensuring the important literature in the area has been included. The review is appropriately critical and evaluative of both the evidence it presents and the research methods that led to this evidence. The arguments presented are adequately justified from the material presented and an unbiased and open-minded stance has been adopted at the outset. The sophistication of conceptual material and argument is of a good standard appropriate to a Doctorate level award. The review should demonstrate an in-depth knowledge of the topic area and there should be synthesis of the material such that the candidate has developed new understanding in the area. Any clinical or research implications should be clearly stated. Clear conclusions are reached at the end of the review. The presentation of the review should be good with few, if any, typographical errors. References are complete and presented in the APA style.

Pass with Conditions. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that this review has reached a Doctorate standard and is suitable to be viewed by others as such. The Examiners must specify these conditions. These may include extensive typographical errors, significant errors in the use of language, clarification, the inclusion of missing information and correction. Up to two additional pages (approx 500 words) may be included under conditions. If more correction than this is needed the work may be considered a referral.

Referral. This work has failed to reach an acceptable standard. A substantial number of the following concerns may be present. The topic area may be unclearly articulated and the structure may lack some coherence. The methods used to review the literature may be inadequately explained or not rigorous enough to ensure that the majority of the appropriate literature has been included. There is insufficient justification of the arguments presented. The depth and sophistication of argument is lower than expected at this level. The evidence presented is insufficiently evaluated. The material is not adequately synthesised and the conclusions are too repetitive of previous reviews. The inclusion of material has been inappropriately selected resulting in a biased perspective. The work is not well presented and references incomplete.

Fail. This work is at an unacceptable standard. All or a substantial number of the following concerns may be present. The topic is unclear and unfocussed. The structure is confusing and provides no clear pathway through the material presented. No methodology to the review is described or it is clearly inadequate. The inclusion and exclusion of material is haphazard, leading to an incomprehensive review. Material is

accepted with little or no critical analysis. The review is too broad and lacks an in-depth understanding. Information is presented without clear linkage to a coherent argument. Little justification is given to the arguments presented and bias is evident. The material presented is reliant on few sources and the literature is not up to date.   No clear conclusions are reached and the review has failed to confidently inform the reader about the chosen topic. In addition, failure to complete the task will result in the mark of Fail being awarded for that piece of work.

Guidance

The following table provides guidance under specific headings of the Confidential Report to assist the Examiners in evaluating the different dimensions of the review. All reviews must be no more than 5,000 words.   Examiners are asked to be familiar with the Guidelines on the Preparation of Critical Reviews.

	PASS	**REFERRAL**	**FAIL**
Abstract	Clearly written, setting out the purpose or objectives of the review, the methods used, results and conclusions. Sub-headings may be appropriate.	Not very clearly written and with some information missing.	Does not adequately describe the review.
Title	Informs the reader what the focus of the review will be and this is matched by the content. Is succinct but clearly focussed.	Only provides a vague idea as to the content of the review. Is too broad and unfocussed.	Provides little information about the focus of the review. Topic area inappropriate or ill-defined.

	PASS	**REFERRAL**	**FAIL**
Introduction *a) Explanation of the title* *b) Scene setting* *c) Route map*	a) Makes explicit what the review will be about and raises the issues mentioned or implied in the title. b) Provides a clear and convincing rationale for the choice of focus of the review. Key concepts and terms are defined in an informed and useful way. There is an understandable and convincing rationale for the inclusion and exclusion of material. c) Adequate directions are given that enable the reader to make sense of what is to follow.	a) Fails to adequately elaborate on the title leaving the reader unfocussed as to the content of the review. b) There is some rationale given for the choice of topic but this is unclear or unconvincing. Significant key terms or concepts are inadequately defined. Insufficient justification is given for the selection of material. c) Confusing or insufficient directions are given to the reader about what follows.	a) Does not elaborate on the title and leaves the focus of the review unclear. b) No rationale is given for the choice of this topic. Little or no attention is paid to defining key terms or concepts, or they are defined wrongly. No comment is made about selection of material. c) Directions were absent or wrong.
Methods	How the literature review was carried out is adequately explained, including which and what type of searches were made, exclusion/inclusion parameters, the resulting literature and its analysis. Demonstrates explicit knowledge about how to carry out literature surveys.	Insufficient information is given about how the literature was reviewed. The method described was not rigorous enough to provide comprehensive inclusion of the majority of the relevant literature. Demonstrates a limited knowledge of literature searching.	No systematic method was employed or described and the literature reviewed was either serendipitous or selected on other criteria not leading to a comprehensive inclusion of all relevant material. No apparent knowledge demonstrated about literature searching.
Structure	There is a clear and coherent structure to the review with good linkage between elements. Sub-headings are used effectively.	The material is inadequately structured, making it difficult for the reader to follow any argument. Links are not adequately made between sections.	There is no clear structure and there is no evidence of any line of argument being followed through. Little or no thought has been given to how best to present the material.

	PASS	**REFERRAL**	**FAIL**
Literature	A thorough review of the relevant literature, which is systematically analysed and all the main variables and arguments identified. Demonstrates the ability to select key material to support the argument presented. The writer relies on high quality, up to date, primary sources which are cited appropriately.	The literature not reviewed systematically, and biased in its presentation. Over-dependence on some sources and a lack of judgement about the quality of literature used to support arguments. High use of secondary sources and out of date references. Sources are cited poorly.	A serendipitous approach to the literature leaving the reader unconfident that the most appropriate literature has been reviewed, and may not have been reviewed in an impartial and thorough way. The literature is outdated, poorly cited and there is over reliance on some work.
Critical Analysis	Material is critically evaluated in a rigorous but balanced way. The review uses this critical analysis constructively to draw out clinical, professional and/or research issues. The most important flaws in previous research are identified.	There is little evaluation of the evidence presented, or the evaluation is not balanced, accurate or informed. Few links are made to the research/clinical or professional implications. Some obvious flaws in presented research are not identified.	No critical analysis is undertaken. Evidence is accepted with disregard to quality. No links are made with the implications of the evidence. No research flaws are identified.
Synthesis of material and originality	The review shows a good understanding of the topic. Material has been drawn together in an original way to provide an overview. Material is reviewed in an appropriate depth. The vast majority of literature is relevant and all parts of the title are addressed.	Material is presented in a list-like way with no synthesis drawing it together. Conclusions reached are not supported by the evidence. Previous formats have been too closely followed, resulting in a lack of originality. Only a proportion of the literature seems relevant and is reviewed in either too much or too little detail.	Material is presented with little effort made to link it together and fails to address the title fully. Seemingly irrelevant material is included. The conclusions are not linked or supported to the material presented. There is a consistent lack of method to reviewing the material. The review lacks any original conclusions.

	PASS	**REFERRAL**	**FAIL**
Clinical/ research/ professional implications	Clinical, research or professional implications are drawn out and are firmly grounded in the evidence presented.	The implications are unclear, not specified or unjustified from the material presented. They may be poorly thought through.	Implications are not specified, unjustified, confusing or grandiose. They may be practically impossible and naïve.
Conclusion	The conclusions flow clearly from the material and ideas presented and provide a reasonable and useful conclusion.	The conclusions are unclear and do not flow clearly from the presented material. The conclusions may be unjustified.	There are no clear conclusions or they seem unrelated to the material presented.
Presentation *a) adheres to APA guidelines* *b) Grammatical and typographical errors* *c) References*	a) The review adheres to the APA guidelines in terms of content and style, with only minor errors. b) There are few grammatical errors. Spelling largely correct, with only minor omissions that could have been missed by using a computer spell check and by proof reading. c) References are complete and in the APA style.	a) The review deviates from the guidelines in significant ways. b) A significant number of grammatical errors. Spelling errors that should have been picked up. c) There are significant problems with the references in terms of being incomplete and/or not in the APA style.	a) The review does not adhere to the guidelines. b) A large number of grammatical and spelling errors, suggesting the review had not been checked or proof read. c) References are missing completely.

PROCEDURES AND OUTCOMES

a) Submitted work will be sent to and marked by the two examiners (the list of examiners for each group of submissions is provided on Blackboard) independently using the Marking Criteria and Guidance for Examiners, paying due regard to the Guidelines on the Preparation of this submission given to candidates. Examiners are blind to the identity of candidates and candidates are blind to the identity of their examiners.

b) The two examiners will confer and agree a mark for each piece of work. The coordinator/lead examiner is responsible for preparing the Confidential Report which contains qualitative comments about the pieces of work. The Confidential Report can reflect legitimate differences of perspective that may exist between examiners about the work. The coordinator/lead examiner will send the Confidential Report, independent and resolved marks to the Course at least four weeks before the Board meeting. The Confidential Report should contain positive feedback as well as criticisms. It is helpful if the final sentence provides an overall general conclusion about the quality of the work. If the work is given a conditional Pass the conditions should be made clear and listed after the summary sentence. Similarly if the work is awarded a Referral or Fail the major issues that need to be taken into account in the resubmission should be listed at the end of the report. If a fail is given the report will end with a statement about a new piece of work being required or, in the case of all clinical experience being successfully completed, whether a new piece of work is required.

c) In the event of the two examiners failing to agree a mark the work will be passed to a third internal examiner for resolution. The third examiner will receive comments from both examiners as part of the resolution process and recommend a mark. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results. In the event of a fail or referral grade, the submission will be sent to the External Examiner for comment about the appropriateness of the grade. The External Examiner's comment should be available for the relevant meeting of the Board of Examiners.

d) A sample of work and all marks/grades for the assessment will be sent to the External Examiner for comment on the examination process prior to the relevant meeting of the Board of Examiners.

e) The assessments and comments will be considered and final decisions made at the Board of Examiners.

f) In the event of extensive typographical errors, significant errors in the use of language, the need for up to two pages (approximately 500 words) for clarification, significant referencing errors, or missing appendices, examiners can agree a conditional pass which requires the candidate to correct the identified errors. These 500 words can be additional to the existing word limit. Should meeting specified conditions lead to the submission exceeding the word limit, the total word count on the front sheet should be set out in the following manner: original word count (additional words), e.g. 4846 (120). A letter to the examiners should be included indicating where the changes have

been made, including page numbers. It would normally be expected that such conditions would be met within four weeks of receiving the results. In the event of very minor typographical errors, candidates will be asked to make corrections before submitting for final binding.

g) In the event of a candidate receiving a referral or fail for the submission, candidates will receive two reassessment attempts and may submit either a revised piece of work or a new piece of work. If a candidate has a referral or failure on a first submission or first reassessment on six occasions (including Evaluation of Clinical Competence) this constitutes course failure. If any assessment is not passed at second reassessment attempt, this constitutes course failure. The candidate must inform the Deputy Chair of the Board of Examiners, in writing, of the new submission date within four weeks of receiving their results. A letter to the examiners should be included with each copy of the resubmitted work indicating where the changes have been made, including page numbers.

h) Candidates will be informed of provisional results by email and the aim is to give feedback within eight weeks of the submission deadline. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

i) Work that is re-submitted will usually be marked by the two examiners who originally marked the work and only in exceptional circumstances will different examiners be used.

j) At the end of the Course, candidates are required to submit a final copy of the work according to the specifications provided on completion of the course. This should be submitted as soon as possible following formal notification from the Board of Examiners. The submitted copy must include any amendments required by the Board of Examiners. The title page should contain the name of the candidate. This work will be kept as a record for up to 5 years. Candidates are advised to keep a copy for their own record of work completed.

Ref: Assessment Handbook/Critical Reviews/2018 and 2019 intakes, updated 09/21

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

MAJOR RESEARCH PROJECTS (MRP)

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Major Research Projects
3. Marking Criteria and Guidance for Examiners
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The Major Research Project shall consist of an extensive investigation that has clinical relevance. The MRP (thesis) is to be an original contribution to knowledge or understanding in the field under investigation and should demonstrate the student's ability to test ideas, whether his/her own or those of others, and to understand the relationship of the theme of the investigation to a wider field of knowledge.

Learning Outcomes
- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- An advanced and critical understanding of the scientific methods involved in research and evaluation, including the evidence base for psychological therapies, and to have developed the complex skills required to use this understanding in practice through carrying out original research and advanced scholarship.
- A commitment to services and the development of inclusive services which seek to empower service users and their family and supporter, consistent with NHS values.
- An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships, compassionate dynamics and strong working relationships, which enables, if possible, service users to influence research that may affect them.
- An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent; which recognises the value of feedback and the importance of seeking this out, and constructively responding to it; and which demonstrates the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge, enabling them to continue to grow.

GUIDELINES ON THE PREPARATION OF THE MAJOR RESEARCH PROJECT (MRP)

A research proposal must be submitted and approved by an MRP Review Panel. Once approved by the MRP Review Panel, the candidate must seek appropriate R&D and ethics approval (if relevant) before commencing the project. Candidates will be expected to provide evidence that their work has been subjected to, and approved by, the appropriate R&D department (if in the NHS) and ethics panel.

Note on clinical relevance:
The course views the term "clinical relevance" broadly and wishes to convey that a range of topics related to human development will be considered appropriate in order to fulfil the requirement for the MRP. Research projects based on clinical and/or non-clinical populations, or using archived data, are welcome as are comprehensive meta-analytic studies involving a clinically relevant topic. Projects should demonstrate the application of psychological theory to a well defined problem or issue that concerns human health and wellbeing and is seen to potentially have an applied benefit to healthcare.

1. Candidates must give careful consideration to ethical issues raised by the research which they undertake and must adhere to the "Ethical Principles for Conducting Research with Human Participants", BPS Code of Conduct, and the University's Research Governance Framework and adhere to HCPC ethics regulations for students (see http://www.hpc-uk.org/publications/brochures/index.asp?id=219). A Major Research Project that does not meet these principles will not be approved.

2. Research design, execution, analysis and interpretation should be of a doctoral level standard and appropriate to the research aims/questions/hypotheses that have been identified. Candidates should be able to justify their work at the oral (viva voce) examination.

3. Word count for Sections A and B of the Major Research Project are required and must be a minimum of 13,000 and a maximum of 16,000 words. Candidates are required to state on the title page an exact count of the number of words in each of these two sections. The appendices will be referred to only at the discretion of the examiners. Therefore, candidates should not include in the appendices material that they wish the examiners to read and mark. Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
   a. On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
   b. On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.

    c.   If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

4. The Major Research Project must be presented for assessment typed with double spacing, in Times New Roman or Arial font, with a font size of 12, on A4 paper and comb bound. Where possible, work should be double-sided. An electronic copy must also be submitted. The Major Research Project should be fully and appropriately referenced according to the most recent APA Style Guide. Citations within the text, tables and figures should be organised following APA Style guidance.

5. Language used should be client-centred, when relevant, and draw on psychological descriptions rather than diagnostic categories. Tone and language should be respectful to all parties presented and discussed, avoiding the use of flippant or casual terms.

6. The Major Research Project will be examined independently by an internal examiner and an external examiner. Candidates should keep a third copy, which will be required in order both to prepare for the viva voce (oral examination) and to refer to during the examination. Participant consent forms should also be submitted in an envelope for confidential storage by Salomons Institute (Consent forms will be checked and then stored but your work will not be marked if these are not received). If, however, consent was via an online questionnaire, you should email the Assessments Administrator confirming that this is why no consent forms are being submitted.

7. The sections of the Major Research Project should be presented in the following order:
- Title page (overall title of the MRP, titles for sections A and B, word count for each section, overall word count for the MRP)
- Author's declaration/copyright statement
- Acknowledgements (up to 100 words)
- Summary of the MRP (briefly summarises content of sections A & B, up to 200 words)
- List of Content
- Lists of tables, illustrations, etc.
- List of appendices

- Text, divided into three main sections including:
  a) Section A: title page, abstract, literature review paper, with references list
  b) Section B: title page, abstract, empirical paper, with references list
  c) Section C: Appendices of supporting material

It should contain the following elements:

a) Section A: Literature Review Paper (minimum 6,000-maximum 8,000 words)
Section A is meant to provide a comprehensive and structured review of the literature that (1) addresses one or more research questions *that can be answered by a literature review* and (2) provides, as a result of the review, broad-based questions for future empirical research, one of which may form the overarching question used in Section

3

B. We recommend that you read several reviews published in different journals, including *Clinical Psychology Review*, to help in planning your review.

Section A should set out the wider context to the subject matter of Section B. It should demonstrate competencies of methodically searching the literature and being able to evaluate the merit of this literature/evidence. It should provide for the reader a synthesised description of the landscape relating to this topic. It should be structured such as to be able to describe what has contributed to the knowledge in this area, be that policy, research evidence, organisational frameworks, history and or methodological limitations. It should be clear within Section A where the edges of understanding lie, such that the next areas that require researching can be described. This edge will also be shaped by methodological issues pertaining to this topic, which may also be explored.

Structure of Section A

A Title Page for section A: to include the title of the review paper and a word count (required for all submissions).

The clinical psychology course does not require a specific structure for Section A as this may vary somewhat depending upon the topic under investigation. The section should, however, provide a clear and concise discussion of the topic. What follows is a suggested structure:

Section titles should be centred, as below, with subsections, Tables and Figures adhering to APA style.

Abstract and keywords
An Abstract on a separate page: this should provide a succinct and clear summary of the literature review paper, adequate for someone not reading the full paper.   It should be no longer than 200 words. Up to five keywords should be added immediately below the abstract on the same page.

Introduction
An introduction to the topic, its importance and the research question(s) that the trainee seeks to address within the review. Relevant psychological theory should be discussed in order to help develop the background and rationale for the review. As needed, please provide definitions to key terms.

Methodology
The following should be included within the body of the text: A concise description of the methodology used in the literature review should be provided. This should be limited to one to two paragraphs where the methodology is clearly described. Often within a literature review you may need to conduct different searches (e.g. anxiety and cardiovascular disease; personality factors and cardiovascular disease). If this is the case please include them in this section.

A rationale describing the inclusion/exclusion criteria for reviewed articles is required. The rationale should also address how was quality assessed for these articles.

The decision-making process to seek additional references and/or reduce the number of references from the initial search should be clear to the reader. Search resources (e.g. ASSIA, Cochrane Library, ERIC, MedLine, JSTOR, PsycInfo, Google Scholar, etc.) should be listed along with search terms and how they were combined.

Also provided within the main text should be (1) a flow chart with specific details as to number of references encountered at each point within the literature search and the decisions made to exclude references and (2) a table that lists all papers reviewed and provides relevant information about what data was extracted from each paper.

Main body of the review

This will be organised differently depending upon your topic area and type of literature review undertaken. *Clinical Psychology Review*, for example, offers different ways to consider how this section might be structured, as do many other journals. Consideration should be given to how subsections within the main body of the review might help to focus your writing and form your arguments. Generally speaking, it is not advised to present a list of individual studies followed by a critique of that study but, rather, to organise the review by thematic content, methodology, theoretical contributions or historical narrative in a way that seeks to critically appraise, integrate and summarise.

Discussion

The discussion should bring together the main findings from the review and provide an overarching critical appraisal of the research in this area, which in turn leads to *recommendations for future research and implications for clinical practice*. One of the recommendations for future research must be the study undertaken in Section B.

References

b) **Section B: Empirical Paper based on the findings of the study (minimum 7,000-maximum 8,000 words).**

Section B should be prepared as a publication-ready manuscript follow the APA Style Guide in terms of references and conventions, but not structure. Structure should follow the guidance in this document (appendix 15). Please note: We require all submissions to include the name of a potential journal that the work might ultimately be submitted to. This should be included on the title page of Section B.

For qualitative studies, there should be "evidence of reflexivity concerning the ways the researcher and the research process have shaped the collected data" (e.g. Pope & Mays, 2000, p. 51); this can be incorporated at any point in the text as the author deems appropriate.

Section B should demonstrate adherence to one or more NHS values regardless of whether the study was completed within the NHS; this should be briefly articulated at a point in the text that the author deems appropriate.

The main sections should be as follows:

Title Page

A succinct and appropriate title for the empirical paper should be given, along with a word count. The name of the chosen journal should also be specified (e.g. for submission to British Journal of Clinical Psychology).

Abstract

This should follow the guidelines provided by the journal chosen and be on a separate page. It should provide a succinct and clear account of the context for the research carried out, information about participant numbers and characteristics, the methodology, an adequate summary of the key findings, and implications of the study for someone not reading the full report.

Key words: Immediately below the abstract on the same page 5 key words that describe important aspects of your study.

Introduction
(about 1,000 to 1,500 words)

- The introduction should be succinct and to the point. It should address the salient issues arising out of the extant literature, and provide the context and rationale for the study. Whilst there may inevitably be some overlap with the literature review, it is not expected that there should be significant duplication from Section A. The introduction should conclude with an exposition of the research aims and questions/hypotheses.

Methods
(about 1,000 words)

- This should include the following subsections: Design, Participants (including R & D and ethical approval and assurances as relevant to the study), Data Analysis and Procedures. For example, details of participant numbers and characteristics, drop out rates, study procedures, selection, methodology, quality assurance checks undertaken (e.g. reliability, validity), ethical considerations, a description of the type of data analysis carried out, measures (names of psychometric tests and validity/reliability data) details about the interview schedule, statistical power (if it was a quantitative study).

Results
(about 3,500 to 4,500 words; quantitative results sections are likely to be shorter than qualitative ones)

The results should be clearly presented. The chosen analyses should be appropriately carried out to a high level of quality. They should be presented in a readily understandable way. The presentation of the results should adhere to style conventions (e.g., in the presentation of statistics), and should clearly relate to the research questions or hypotheses. Descriptive statistics should be described and results noted prior to describing the main statistical analyses. **Note that although most journals require tables and figures to be at the end of the submission, these should be presented in the body of the report for examination purposes. Please also note that some journals will prefer a shorter results section and a longer discussion section, hence requiring you to make some changes prior to submitting to the selected journal.**

Discussion
(usually between 1,000 and 1500 words)
The findings should be systematically discussed in terms of their strengths, potential meanings, <u>their theoretical, research and clinical implications</u>, and their limitations, including a brief methodological critique. The discussion should convincingly relate the results to the issues set out in the introduction. There is a need to consider how the findings relate to previous clinical or research literature. Implications arising out of the study in relation to future research and clinical practice should be identified within a subsection of the Discussion.

Conclusion
(usually no more than 250-500 words):
A succinct summary of conclusions resulting from the study should be provided.

c) Section C: Appendix of Supporting Material

- This section is different to a standard appendix in that some of the material contained **in it may not be referred to in the text of any of the preceding sections (e.g. ethics approval letter) whereas other material might** (e.g. research diary referred to in Section B). In some cases, material contained in this appendix might need to be included in one of the other sections at the stage of publication (e.g. appending a new measure to an empirical paper reporting the development of said new measure).

- In Section C, the candidate should include appendices of materials pertaining to the research (e.g. one completely coded transcript or parts of multiple coded transcripts, abridged research diary, distribution graphs and tests, ethics materials (consent form, information sheet, ethics approval letter, R&D approval letter (if applicable), copies of measures (questionnaires, surveys, interview schedule and/or experimental stimuli, etc.), feedback to ethics/R&D). In general, it is not appropriate to include raw data in the appendix. For a qualitative project, there should be appendices that allow the examiner to carry out a quality check and audit of how the final themes were arrived at (e.g. tables showing a progression of theme development, sections of coded transcripts with identified theme heading or

codes). **However, due to ethical considerations, any appendix containing transcripts <u>or measures which have copyright </u>should be removed from the Major Research Project after the has been passed by the Board of Examiners and before the work is presented for final submission to the Canterbury Research and Theses Environment (CReaTE).**

- Author guideline notes for contributors of the journal chosen for the empirical paper submission must be included in the appendix.

Major Research Projects that are not submitted in the required format or those that exceed the specified word limit will not be examined.

8. The Major Research Project must not have been submitted in fulfilment of the requirements of any other examination.

9. The internal examiner shall not be the candidate's research supervisor.

10. The candidate will also be examined in a viva voce by both examiners in May/June of the final year of training. Prior to the viva voce, the examiners will meet to discuss their provisional marks and comments and to agree the issues to be discussed with the candidate at the viva voce.

11. Wherever possible, candidates are requested to present the findings of the Major Research Project to professional and non-specialist (including service users) colleagues. Candidates should consider how they would disseminate their work in order to inform good practice in any of the following areas: health and/or social care, public mental health, government policy, charitable sector work.

12. Trainees must show evidence that they have provided appropriate feedback (300-500 word summary) of their research to the ethics panel that approved their research project, and if the study took place in the NHS, to all R&D committees that approved the study. <u>Copies of letters, along with one copy of the summary, must appear in the appendices</u>.

13. Candidates should read the Marking Criteria for Examiners for further guidance, and information on available grades and outcomes.   Additional guidance on undertaking research is available in the Research Handbook.

14. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

15. Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

MARKING CRITERIA AND GUIDANCE FOR EXAMINERS

Marking Standards for the Grade

Pass. This work has reached an acceptable standard. The research represents an original contribution to the broad and ever developing base of clinical psychology. This can include to theory and/or clinical/health care practice, consultation practice, community engagement, health/social care policy, and public mental health, among others. The sophistication of conceptual material and argument is of a standard appropriate to a Doctorate level award. Presentation of the report is good throughout with minimal typographical errors. The Major Research Project should be fully and appropriately referenced according to the most recent APA Style Guide. Citations within the text, tables and figures should also be organised following APA Style guidance unless stated otherwise (e.g. essential tables and figures are generally contained within the text for ease of marking). Both sections should adhere to APA style guidelines for preparation of manuscripts.

In Section A the literature review is sufficiently critical and demonstrates confidence that relevant literature has been sufficiently addressed. The search methodology is well articulated and inclusion/exclusion criteria are made evident. The section has been used to identify pertinent issues or gaps in relation to a defined area of enquiry. Relevant broad research questions in the defined area of enquiry are clearly articulated and grounded in the extant literature. The paper should be able to stand alone as a review of a topical area. The word limit for Section A should be 6000-8000 words.

In Section B the introduction of the empirical paper sets the context for the study. The method chosen is appropriate to the research aims, questions or hypotheses, and clearly described. The study is well executed. Consultation with service users and carers, and their influence on the research, is discussed, if relevant to a specific project. Pertinent ethical considerations and how these have been managed is succinctly described. Relevant NHS values are identified even if the research was not carried out in the NHS. Analyses are carried out appropriately to investigate the research aims, questions or hypotheses, and appropriate inferences are drawn from the findings. The discussion relates the findings to the issues set out in the introduction and outlines the limitations of the study, and the clinical and theoretical implications of the work. Section B should be prepared as a publication-ready manuscript and adhere to APA Style guidance as stated above with the exception of placing figures and tables, which should be in the body of the text rather than at the end of the report. The word range for the paper should be 7000-8000 words. The quality of the paper would merit submission after additional preparation, to a journal for peer review.

Pass with Minor Corrections. Nearly all of the above criteria have been met. However, there are errors or omissions that need to be corrected before the examiner is satisfied that the report has reached a doctorate level standard and is suitable to be viewed by others as such. As a guide, these errors or omissions should reasonably be able to be corrected within a three-month time period and may include: Confidentiality gaps in written work, extensive typographical errors, significant errors in the use of language, significant referencing errors, missing data, reanalysis of a portion of the data, amendments to analyses, limited re-writing

of one or more parts of the MRP, missing feedback to ethics/R&D panels or missing appendices. The Examiners must specify exactly what these conditions are. Up to an additional 600 words of text is permitted. These 600 words can be additional to the existing word limit (16,600 maximum word count). Failure to complete the set task within 3 months will result in the MRP not being passed and the doctoral degree not awarded (except in cases where a concession is granted on the basis of illness or other good cause).

Pass with Major Corrections. This work has required additional improvements that go beyond Pass with Minor Corrections.   The area of inquiry may not be clearly articulated and the level of argument and critical appraisal of previous research may be poor. The structure across the whole report may not be sufficiently coherent. The methods used may not be adequately explained or the results not presented to an acceptable standard, possibly giving rise to questions about the candidate's own understanding of the area or aspects of the research process, adherence to ethical principles or NHS values; confidentiality gaps in data collection procedures are noted; significant re-writing of several parts of the MRP are required; substantial data re-analyses is required; additional data collection is needed to meet acceptable methodological standards. There may not be an appropriate context provided for interpreting the findings and for understanding any limitations of the study. The depth and sophistication of argument is lower than expected for doctoral work. The clinical and theoretical implications of the work are not sufficiently articulated. As a guide, these errors or omissions may require up to six months to be corrected. Examiners should provide detailed information as to the areas requiring additional work. Up to an additional 1,200 words of text is permitted. These 1,200 words can be additional to the existing word limit (17,200 maximum word count). Failure to complete the set task within 6 months will result in the MRP not being passed and the doctoral degree not awarded (except in cases where a concession is granted on the basis of illness or other good cause).

Resubmit. This work is below an acceptable standard and requires more revision than is possible within a six-month timeframe. This may include several of the following issues: The aims and objectives of the project are unclear or unfocussed or the theoretical or empirical grounding is weak. The structure of the write-up is confusing in a number of places.   The description of the methodology is very difficult to understand or the methodology itself does not appear to follow from the research questions or hypotheses being posed or the aims that have been set. A different methodology is required with a subsequent re-analysis of data and reinterpretation. The presentation of the method or findings contains significant mistakes and does not demonstrate a firm grasp of the relevant material or makes it very difficult to be confident of what was done and why. There are significant questions about the candidate's adherence to ethical principles or NHS values in conducting the research. Significant errors are made in the interpretation of the findings, which are based on a faulty analysis of data. The work is not sufficiently self-critical or insightful so as to ameliorate any of the other difficulties that are present. Failure to complete the set task within 12 months will result in the MRP not being passed and the doctoral degree not awarded (except in cases where a concession is granted on the basis of illness or other good cause). If it is not possible to revise the project to a sufficient standard, a new project may be undertaken.

Guidance

In marking Major Research Projects, Examiners should ensure that they are familiar with the Guidelines on the Preparation of Major Research Projects (MRP). The MRP should be a minimum of 13,000 and a maximum of 16,000 words excluding abstracts, tables, figures, reference lists and appendices. The MRP should include a title page that gives the candidate's name, date of submission, overall title for the Report plus separate titles for the 2 sections. A word count of the number of words, excluding abstract, tables, figures, reference lists and appendices for each section should be given, along with a total word count for the overall MRP.

The following should be considered in awarding a Pass:

Section A Literature Review Paper *6000-8000 words*	Pass[1]
Abstract *a) Enables the reader to grasp the key facets arising out of the literature review.*	Clearly written, provides an adequate summary for someone not reading the full paper.
Review Of The Extant Literature demonstrating: *a) Coverage of relevant literature* *b) Critique of literature* *c) Synthesis of key issues and organisation of material* *d) Ability to identify research gaps*	The extant literature is reviewed critically in order to identify key issues or gaps in relation to a defined area of enquiry. The review is sufficiently broad and the material well synthesised.
Question(s) for Future Research: *a) Are Clear* *b) Set within the literature reviewed* *c) Have clinical and theoretical importance*	The research question(s) is/are clear and flow from the review of the literature. A good case is made for why research on these questions is timely and important clinically and theoretically.
References	References are mostly complete and presented in the latest APA style.

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[1] In cases where the student submits a thesis judged satisfactory by the Examiners for the award of the degree of Doctorate but fails to satisfy the Examiners in the oral examination, that the degree be not awarded at present but that the student be permitted to take a further oral examination, normally not later than six months, which they must pass successfully.

Section B *Empirical Paper* *7000-8000 words*	**Pass**
Abstract a) Enables the reader to grasp the key facets of the study.	Clearly written, provides an adequate summary for someone not reading the full paper. Gives key information about the context of study, methods, participant details, key findings, and main conclusions.
Introduction *a) Highlights key literature to set the empirical and theoretical context for the study* *b) Attends to key issues and critique arising out of the literature*	A focused and tightly argued background is provided of the theoretical and/or empirical literature, the relevance of which is made apparent. The context for the study is described. The clinical and theoretical relevance of the study is made clear.
Methodology a) *Participants* b) *Design* c) *Measures* d) *Procedure* e) *Quality assurance checks* f) *Ethical considerations*	Choice of methodology is well explained and follows from the nature of the research aims, questions or hypotheses. It represents a sensible approach that should provide valid findings, as far as is reasonably possible. a) Participant numbers, characteristics, and the basis for inclusion or exclusion of participants are adequately specified and justified. b) A concise and informative overview is provided of the basic scheme of the study. c) Choice of data collection tools are explained and justified. Basic properties are described so as to enable the reader to understand the findings of the study. d) Description gives clear picture of what took place for each participant and across the sample. The research plan is competently executed. e) Steps taken to ensure validity, reliability or other quality checks have been stated. f) Ethical considerations are addressed and the overall project design adheres to NHS values.
Data Analysis and findings/results a) *Are appropriately analysed* b) *Are presented clearly*	The chosen analyses are appropriately carried out. The presentation of the findings is readily understandable, adheres to style conventions (e.g. in the presentation of statistics or presentation of qualitative analysis), and relates to the research aim, question, or hypothesis. Trainees must show evidence that they have provided appropriate feedback (300-500 word summary) of their research to the ethics panel that approved their research project, and if the study took place in the NHS, to all R&D committees that approved the study. Copies of letters, along with one copy of the summary, should appear in the appendices.
Discussion a) *States how findings relate to the literature* b) *States limitations of study* c) *Clinical and theoretical implications of study are highlighted*	The discussion convincingly relates the findings to the issues set out in the introduction. Limitations to the procedures used and the conclusions that can be reached are included. Reference is made to further research questions arising out of the work, and the theoretical and clinical importance of the work discussed.
References	Paper follows APA style. References are complete.

Section B *Empirical Paper* *7000-8000 words*	**Pass**

PROCEDURES AND OUTCOMES

1. MRPs will be marked independently by an Internal Research Examiner and an External Examiner using the Guidance and Marking Criteria for Examiners, paying due regard to the Guidelines on the Preparation of MRP given to candidates. Examiners should not write comments directly on the submitted MRP but can circle grammatical and spelling errors. The two examiners will produce independent reports, which will be incorporated into the Confidential Report following the viva voce.

2. The candidate will also be examined in a viva voce by both examiners in **May/June** of the final year of training. Prior to the viva voce, the examiners will meet to discuss their provisional marks and comments and to agree the issues to be discussed with the candidate at the viva voce. Following the viva voce, the examiners will agree a mark that takes into consideration the written and oral components of the MRP examination and provide a report of the strengths and weaknesses on the Confidential Report, to the Course. The marks/grades are then considered and final decisions made by the Board of Examiners. Confidential reports are used to inform discussion at the Board and are sent to candidates with a letter informing them of the results.

3. A report of this viva voce and MRP will normally be considered and final decisions made at the May/June meeting of the Board of Examiners.

4. After examining the thesis the Examiners will inform the Board of Examiners of their final mark and, at their discretion, may recommend to the Research Subcommittee of the Academic Board of the University, via the Chair of the Quality and Standards Committee:

   (a)   that the degree of Doctorate be awarded (Pass) subsequent to all other marked submissions being passed;

   (b)   that the degree of Doctorate be awarded subject to certain **minor corrections** being carried out to the satisfaction of the Internal Examiner within three months of the official notification to the student of the recommendation of the Examiners and subsequent to all other marked submissions being passed;

   (c)   that the degree of Doctorate be awarded subject to certain **major corrections** being carried out to the satisfaction of the Internal Examiner, and the External Examiner in cases where both examiners feel this necessary, within six months of the official notification to the student of the recommendation of the Examiners and subsequent to all other marked submissions being passed;

   (d)   that the degree of Doctorate be not awarded at present but that the student be permitted to **resubmit the thesis in a revised form** not later (except in cases

of illness or other good cause) than twelve months after the decision to allow resubmission has been made by the Board of Examiners.

(e)   in cases where the student submits a thesis judged satisfactory by the Examiners for the award of the degree of Doctorate but fails to satisfy the Examiners in the oral examination, that the degree be not awarded at present but that the student be permitted to take a further oral examination, normally not later than six months after the decision to allow this has been made by the Board of Examiners;

(f)   that the degree of Doctorate be not awarded but that the degree of PGDip. in Applied Psychology-Mental Health be awarded if the Board of Examiners considers that the candidate has met the criteria for this award;

(g)   that no degree be awarded.

5. Examiners should provide an overall qualitative assessment of the Major Research Project (MRP) on the Confidential Report in addition to above marked recommendation. These comments may help you compare your assessment with your co-examiner and will provide the basis for feedback to be given to the candidate and the Board of Examiners.

6. Candidates will be informed of provisional results by email and the aim is to give feedback within 5 working days of the viva voce examination. Official confirmation of results will be sent by the University in due course after the Board of Examiners.

7. When the candidate is submitting revised work, a letter to the internal examiner should be included with work that required minor or major corrections indicating where the changes have been made, including page numbers. It would normally be expected that minor corrections be made within 3 months and major corrections within 6 months of receiving the results (except in cases where a concession is granted on the basis of illness or other good cause). Viva voce exams are normally not required for minor or major corrections. In the event of Major Corrections being resubmitted and not obtaining a Pass with Minor Corrections or a straight Pass, the case should be referred to the Board of Examiners.

8. When the candidate is submitting revisions requiring more than major corrections (between a 6 and 12-month time period) a letter to both internal and external examiners should be included indicating where the changes have been made, including page numbers. A new viva voce examination will be required.

9. In the event of either Minor or Major Corrections not being submitted on time and/or to the satisfaction of the examiners, the examiners should in the first instance request the approved work from the candidate. The examiners will agree on a date for the work to be submitted in consultation with the deputy chair of the board of examiners. If the candidate is not able to produce the required work, the case should be referred to the Board of Examiners, which has the power to withhold the degree.

10. Upon resubmission of a revised and resubmitted MRP, in order to pass the course (subject to all other requirements also being met) and receive the Doctorate, the candidate must receive a mark of Pass, Pass with Minor Corrections or Pass with Major Corrections. Failure to obtain one of these three marks will result in course failure.

11. The final copy of the MRP, after all corrections are made and the supervisor has signed it, should be submitted electronically as a Word or PDF document (guidance on this will be provided after passing). Some appendices and the declaration will, however, need to be scanned and submitted as a PDF document. This should be submitted as soon as possible following formal notification from the Board of Examiners. The copy will be kept as the public record by the Library <u>and available on the Internet.</u> Due to the Research Governance Framework and data retention requirements, the candidate must submit an electronic copy of their data (e.g. SPSS data file or anonymised interview transcripts), where possible, with their electronic copy of the MRP. The candidate will continue to hold the primary responsibility of retaining their data, but we will archive the copy you give us.

Ref: Assessment Handbook/Major Research Projects/2018 updated 12/20

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

Community Engagement Project Report

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of the Community Engagement Project Report
3. Marking Criteria and Guidance for Assessors
4. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The purpose of the Community Engagement Project Report assessment is to provide trainees with the opportunity to:

- Develop skills in the promotion of clinical psychology as a valuable knowledge-base for the general public
- Develop, demonstrate and articulate outreach, leadership, systemic, community engagement and public education competencies.
- Generate experience of a community health, lifespan approach and of the cultures and competencies of different organisations and groups.
- Assist in the building of links and understanding between NHS and other organisations through exchange of knowledge and collaborative practices
- Consider potential roles a clinical psychologist could take in helping to build community capacity for health
- Reflect on their own developing professional roles and identity in relation to this work.

The assessment contributes to the following educational objectives of the course:
- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals, including self and own practice, and the delivery of psychological services.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.

- An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.

The Community Engagement Project Report has two elements, the practical Project itself and the Report about the Project.

Background and rationale for the Community Engagement assessment

Community engagement practices draw upon a range of competencies and values relevant to the work of clinical psychologists, overlapping with important professional competency frameworks (e.g. leadership).

In his seminal review of the processes involved in health inequalities, Marmot (2010) clearly identified the wider role of communities in mediating health and the importance of addressing social factors to effect change.   Thompson, Tribe & Zlotowitz (2017) contextualised the significance of community engagement in health policy and for psychologists as follows:

"There is widespread agreement on the need for community engagement to improve health outcomes (NICE, 2008; 2016). Despite this, it can be difficult for psychologists working in the diverse settings in which they are employed to bring a more community based or community driven stance to their work.

In addition, recent national health policy emphasises the importance of co-production and prevention in healthcare, as well as the importance of reducing stigma and discrimination and equitable access to services (Mental Health Task Force , 2016). To achieve these aims and develop solutions, proactive engagement with communities and community groups is essential." (p.2, Thompson, Tribe & Zlotowitz).

The benefits of community engagement may be both diffuse and broad, relating to positive health indicators and to the indirect benefits of wider civic engagement:

 "… *community engagement approaches used to inform (or consult with) communities may have a marginal impact on their health. Nevertheless, these activities may have an impact on the appropriateness, accessibility and uptake of services…(and) on people's health literacy*" (NICE, 2008, p.6)

The relationship between health and the qualities of networks (for individuals and their families, and between organisations and systems that seek to support them), is both important and complex (e.g. Smith & Christakis, 2008).   Psychologists have sought to develop ways of understanding and intervening to enhance social processes such as networks. For instance, in his ecological theory, Bronfenbrenner (1979) mapped out the ways in which human development is shaped by the inter-relationships between personal and multiple systems contexts. Similarly, Hagan and Smail (1997) centred upon the role of power relationships, both distal and proximal in people's lives, in the generation of health and distress.

In summary, the links between community involvement, corollary psychosocial processes and individual health, can be seen as including:

"enhancing the sense of belonging of a particular group (social capital), empowerment (increasing confidence, self-esteem and self-efficacy) and a feeling of greater control over key decisions, increased trust in government or statutory bodies (democratic renewal) and so forth."   (Thompson et al., 2017,p.5)

Given the diverse nature of the role of clinical psychologists and their relevance in contributing to building community capacity and public health, the Course therefore seeks to support the development of understanding of community engagement work and the associated practitioner skills and competencies.

Trainees are required to carry out a **small** community engagement project in their final year, in order to create an opportunity to develop competencies relevant to this kind of practice. A 2,000 word Report, describing the trainee's work and his/her learning from it, is to be submitted in July of the final year. The report will be **formatively** assessed.

Brief summary of Community Engagement Project assessment

- Submitted during the final placement in the third year (Older People/Supplementary specialism)
- **Formatively** assessed through submission of 2,000 word report and critical reflection in July of the final year
- Broad scope, usually positively oriented, collaborative and about capacity-building, public/community health focus, involving trainee initiative and outreach
- Most relevant competency frameworks are Leadership, Critical/Community Psychology, Systemic.
- Must be small and do-able without unbalancing the main learning opportunities of a placement
- Usually generated with supervisor on placement but if the trainee is on a Supplementary placement, it may arise from own interests or other Salomons Institute community connections
- Can be done in a pair with another trainee if there are two of you on the same or related placements or do a project related to the widening access work.

Bronfenbrenner, U. (1979).*The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Hagan, T., & Smail, D. (1997) Power-mapping – 1: Background and basic methodology. *Journal of Community and Applied Social Psychology, 7,* 257-267.

Marmot, M. (2010) *Fair society, healthy lives: The Marmot Review.* UCL: London.

NICE (2008) *Community Engagement to Improve Health*. Nice Public Health Guidance 9. February 2008.

NICE (2016) *Community Engagement: improving health and wellbeing and reducing health inequalities.* Nice guideline 4 March 2016.

Smith, K.P, & Christakis, N.A. (2008) Social networks and health*. Annual Review of Sociology, 34,* 405–29.

The Five Year Forward View for Mental Health (2016). The Mental Health Task Force: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

Thompson, K., Tribe, R. & Zlotowitz, S. (2017) *Guidance on working with community organisations for psychologists*. Internal BPS Consultation document, personal communication.

GUIDELINES ON THE PREPARATION OF THE COMMUNITY ENGAGEMENT PROJECT

The whole **Community Engagement** assessment aims to provide trainees with learning opportunities and experience through which they develop key professional competencies. The **Community Engagement Report** on the project assesses the candidate's understanding and application of the competencies, values and principles involved in community engagement work by clinical psychologists, and their ability to relate their learning to their own developing professional roles and identity.

AIMS

The Community Engagement Report aims to assess candidates formatively in the following areas:

- Application of understanding of a community engagement approach to developing resources for health in the community
- Skills in the promotion of clinical psychology as a valuable knowledge-base for the general public
- Outreach, leadership, systemic, community engagement and public education competencies.
- Understanding of the cultures and competencies of different organisations and groups
- Ability to build links and understanding between NHS and other organisations through exchange of knowledge and collaborative practices
- Appreciation of potential roles a clinical psychologist could take in helping to build community capacity for health
- Capacity to reflect on their learning and own developing professional roles and identity in relation to this work.

1. All trainees must complete at least one written assessment on a piece of clinical psychology practice that relates to older people. It may be a Professional Practice Report (PPR) or a Community Engagement Project Report. Which of these it is will largely be determined by the order of placements in the final year of the Course.

2. The Community Engagement Project and Report should normally be carried out in relation to the client group of the final placement. For trainees on an Older People placement, it must be relevant to the health and wellbeing of older people. For

trainees on their Supplementary placement who have done an Older People PPR, the Project may relate to the supplementary placement client group, older people or a community health/wellbeing issue of interest to the individual trainee.

3. The project will be identified through discussion with the trainee's supervisor. The trainee's manager may also be consulted.

4. Trainees should approach their supervisors as soon as possible to discuss possible projects. This is particularly important where trainees are on an Older Adult placement in April as when this is the case, trainees must complete a project relevant to the OA population and Older Adult speciality supervisors may have ideas for possible projects.

   However, for trainees on a supplementary placement in the cases when the supervisor does not already have a project in mind, there will be more flexibility in project choice. In these cases, projects can be set within any voluntary or third sector services within the geographical area associated with the course (e.g. Kent, Sussex and South London). These services should have an ethos and mission that is in keeping with the broader work of the Salomons Institute (for example in supporting mental health or inclusion).

   Another option would be for the project to be associated with the widening access project work of the Institute, for example in linking in with local schools to promote more diversity in the profession.

5. If a trainee negotiates with the supervisor to do a non-placement generated project, then this could take place on study days, lunchtimes/evenings (if appropriate) or on placement days, according to what works best for the supervisor and trainee. As much of the initial work may involve finding out information, emails, phone calls and so on, this could be done from placement anyway, though clearly face – to – face meetings could not.

6. The advantages of the project arising from the placement context are: supervisor knowledge of the community profile and landscape, at risk groups, referral patterns, strengths and needs of the potential client group and local organisations in the area, supervisor interest and support including possible direct involvement with the trainee on the project, and a perhaps clearer containment of the work involved in the project within the placement.

7. An advantage of the Project being developed away from the placement context is being able to start planning it earlier. For instance, a Salomons-based Schools Project could be carried out earlier in training. Trainees may also already be involved with voluntary or third sector organisations external to the course, or have carried out community projects in previous placements which are suitable for writing up as a CEPR in the third year. Write ups of these projects would often be suitable for submission, **but** final placement needs should come first.

8. Trainees, therefore, may end up having done suitable community work earlier in training and then also end up doing a further supervisor-led community project on their final placement. Where this is the case, as long as the placement community project is carried out to a standard with which the supervisor is satisfied, trainees could write up their previous community work for the actual assignment if they wish (as long

as they meet the older adult criteria if they are on an OA placement). This may mean that there is some doubling of work for trainees, but the Course does encourage trainees to get involved with third sector or voluntary organisations throughout training (as being in line with the ethos of the programme.) So it may be that trainees may be involved in multiple community activities throughout training only one of which is written up for the assignment. Trainees should also keep in mind that they will not know until the beginning of the third year which placement they will have for their last placement so that non older adult projects carried out earlier in training may end up not being suitable for the submission.

9. Either way, trainees are advised and encouraged to think about, discuss and plan their Projects during the first half of the third year, particularly if their final placement is a Supplementary placement.

10. **Joint working** Collaboration, partnership and generally working together to include diverse and sometimes under-represented viewpoints to generate new ideas, connections and practices are at the heart of community engagement work. It is expected that the trainee will often work with another person (trainee, supervisor, colleague) in planning, initiating and progressing a project, for the whole project, or in part. Therefore two trainees may work on the same project, although they should each write their own report. It should be clear in each of the reports who did what and some comment on the skills, benefits or disadvantages of working together should be provided and related to the competencies involved in the project. Some reflection on the strengths or difficulties of joint working may also be appropriate.

11. Candidates should read the Marking Criteria and Guidance to Assessors for information about the Course's expectations of the Report.

12. Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

13. Failure to comply with the criteria set above will result in the project being sent back to the trainee to re-write within the guidelines. If this happens, trainees will be given an extra 150 words to meet the criteria set by their reviewer.

14. Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

15. **Description of the Community Engagement Project**

A Community Engagement Project could be about almost anything that involves promoting psychology and public engagement, building networks with local community groups or agencies, or prevention and resource building. It should give you the opportunity to develop community, systemic and leadership competencies, and should include at least some elements of the Aims listed above, but not be restricted by them.

In addition to geographic location, communities are also understood and framed by commonalities of interest, affiliation, experience, health need, disadvantage etc.

The project will usually be identified and planned through discussion with a placement supervisor who knows the local communities, services and social health issues. You may have to do some initial liaison with local groups or networks too. Your supervisor may or may not be directly involved but you will need to make opportunities to discuss your work with them.

The project should be **small and manageable** within the usual placement frame. It should not have undue impact on the rest of the work and learning on placement. So, an evening event could be considered for example, so long as time can be taken back without compromising other work. It could be very small, for instance, an hour's talk about a psychological issue to a community group, such as speaking about ways of supporting wellbeing at a local memory café, so long as the trainee has had to initiate, plan, liaise, build relationships and so on (i.e. draw on and develop particular competencies) in order to do it. Supervisors may have larger ideas which could be broken down into smaller cumulative components for successive trainees.

Social media projects will need to be creatively conceived (e.g. facilitating the use of online mental health resources by older people or carers, or helping to set up an online forum which home-bound older people contribute to, through collaboration with a voluntary organisation) in order to be informed by the outreach and community development principles underlying the Project and to draw on the clinical psychology competencies involved.

It is unlikely that an activity such as giving a psychologically informed talk to a group of professional staff will really be in keeping with the spirit of the task or map on to the aims of the assessment: such work is often part of placements anyhow.

Projects could include some aspect of inquiry or evaluation (e.g. carrying out a community needs assessment such as regarding ways to address social isolation and loneliness in the local population, or helping a community group/organisation develop a plan for evaluating an aspect of their work). However, the Community Engagement Project should **not** be like a Quality Improvement Project (QIP): the focus for the Community Engagement Project is upon trainees developing community, systemic and leadership skills through setting up and carrying out small pieces of community liaison work, as opposed to the development of research-related competencies.

Trainees should evaluate the project, at least through reflecting with their supervisors using different sources of feedback in order to promote learning and development. It may (or may not) be less appropriate to use more conventional evaluation measures given that much community work often requires a longer term, more ecological and systemic approach to effects and outcomes. Relationship- and capacity-building outcomes are not easily captured in the short term and may occur in unanticipated places. The project therefore needs to be modest in its aims and evaluation of them.

16. **Examples of community engagement projects**

- Finding out from local funeral directors what psychological support issues they encounter in their work and providing a talk and/or information about resources

- Developing links with Citizens' Advice to identify possible projects, such as around educating older people around benefits and other support available to them, that could be taken up and developed by future trainees for older people or another potential client group
- Having a meeting with a local voluntary sector provider such as the local Men's Sheds, to find out about their needs and issues with a view to both providing some one-off input and taking information/ideas back to placement
- Producing some cost-free information, e.g. around domestic abuse or opportunities to engage in exercise, with a service user or voluntary group, for distribution to GP surgeries, pharmacies or other "hotspots" for contact with certain "at risk" groups.
- To provide sessions for volunteers, older people or their carers, on issues that might be relevant to them, for example, understanding why people neglect themselves, or around end of life issues.
- To meet with theatre groups/ art centres/ museums/ adult education centres to help adapt their meetings/ performances/ exhibitions/ classes for certain client groups to make them more available for people such as those with autism or a dementia.
- To meet with third sector organisations locally such as Age UK and the Alzheimer's Society to find out what they do and bring that information back to mental health services to aid signposting.
- To set up a community initiative to break down barriers between generations, such as a reading group for isolated older people and college students in the local college.
- To convene a meeting with local GPs alongside a representative from the third sector to educate regarding the mental health needs of older people and what is offered by the voluntary sector and statutory services to meet these needs.

17. **The Community Engagement Report**

The Report should provide the reader with a clear and succinct account of the project, from conception through to its conclusion, so that what the candidate did and the thinking, values and principles shaping the actions can be understood.

It should also provide evaluation and critical reflection on the project work, considering how it may contribute to community capacity for health, some of the competencies involved, what was learnt, and consideration of the candidate's personal relationship to community engagement roles as part of professional identity.

Where possible, the Report should also consider sustainability, for instance by including a couple of pointers for "Where to next?" so that future trainees could pick up a thread and develop it.

The Report should be no longer than 2,000 words excluding tables and references.

Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents

pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The submissions are marked anonymously, so the title page should include a title and the candidate's examination identity number. The candidate's name should not appear anywhere in the submission.

Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
a. On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
b. On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.
c. If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

Reports should usually be structured using the following framework.

Context and rationale for the project - covering reasons for choosing this project based on appraisal of systems opportunities/possible openings, epidemiological information or service knowledge about people at risk of health problems, relationship to meeting health need or promoting health gain in the community, and resource needs (information, support, communication) of local groups or organisations.

Example: if the project was to find out about the needs of carers' groups that meet on third sector premises, you might mention that your placement service usually only has extended contact with carers if they develop significant mental health difficulties themselves, and that there were already some links between your placement and a person within this voluntary organisation. You could present some statistics about carers and their health and (very briefly) describe the local landscape of support for carers. In effect, you have some initial hypotheses from the literature about health need, and your assessment of the local situation suggests that meeting up with local carers and associated organisation(s) could lead to some developments in the relevant community network that would benefit local carers.

Description of the project – describing what you and anyone you were co-working with did, what happened and very broadly, what outcomes there were. Where possible and so long as it does not over-determine the account, the narrative should articulate some of the competencies (and especially "beyond therapy" competencies) that the trainee needed to draw on and develop in the work.

Example: you describe an initial meeting between you, your supervisor and the person in the charity who explains how she sees the challenges facing carers in the groups. It is agreed that you will meet members from a couple of the groups for a discussion about their wellbeing and needs. You do this and they would like you to come back and talk about anticipatory grief. You tell the reader about some of the things you noticed and

thought about in terms of well-being. In addition, you had told the carers a bit about your service and they were particularly interested in the impact on carers of a new diagnosis for their relative. Someone suggested that having a befriender who had been through it might be very supportive at that time: they felt this would have helped them to cope. You do the talk/workshop with a carers group, discuss with your supervisor and team about carers with relatives with a new diagnosis, and finish up meeting again with the person at the charity for a closing conversation which included some exploration of the befriending idea. You gave her a recent review article to read. The charity worker told you she thought she had seen a grant somewhere that funded on line befriending projects relating to health conditions. You also sought some feedback from her about your involvement and what had been done so far. You told your supervisor about the funding idea, and discussed feedback from the charity worker and the team, and possibilities for the future.

Future potential – describing how you think the project could be moved forward in the future, with reference to contextual constraints and opportunities, and how this may contribute to community capacity and/or public well-being. (This section could be used as a starting place for a subsequent trainee on placement).

Example: you might put forward some ideas here about how carers who already have many demands upon them could be enabled to take up valued helping roles and how this may enhance their well-being. You could flag up a lack of knowledge about funding applications but then consider how a psychologist could learn about the process through supporting the charity worker to make an application that included some research literature and proposed a useful evaluation of a project. You might refer to the possibility of engaging another team member in the future with carers' group talks/workshops or to exploring with the charity worker collaborations with other organisations that may help promote carer health and well-being.

Critical reflection on the project and the clinical psychologist's role – commenting on 1) whether the project was useful and for whom, what was learnt by the trainee (and possibly others) and how, what helped (supervision, reading, framing with particular psychological theory), any difficulties, dilemmas, personal challenges, ethical or power issues and how they were thought about and managed, unintended or surprising consequences, and 2) how doing the project shaped the trainee's understanding of "beyond therapy" competencies, reflections on community engagement roles for clinical psychologists and the trainee's own personal and professional development and identity.

Example: this section includes some thoughts about the carers', the charity worker's, and perhaps the supervisor's/team's learning but mainly focusses on your own. You illustrate a challenge with the example of how you used supervision to work out how to use your initiative to move things forward at a particularly frustrating point in the project whilst also allowing things to emerge through conversations in which you took a one-down position, and personally, were also experiencing this indeterminate process work as anxiety-provoking. An aspect of the project that was not very useful is explored. You describe some of the "beyond therapy" leadership and community competencies you used and how they stretched you out of your comfort zone initially, especially in relation to your own power positioning and sense of professional expertise. You close with some reflections on the relationship of community engagement work to the kind of clinical psychologist you will be.

Presentation

The Report should succinctly and clearly expressed with few typographical or grammatical errors. It should follow a coherent structure and uses accurate APA referencing.

MARKING CRITERIA AND GUIDANCE FOR ASSESSORS

The Community Engagement Project Report is not graded, but assessed formatively. The assessors will use the criteria detailed below.

Assessment Criteria

Assessors will make qualitative comments about the following aspects of the Report:

Understanding of community engagement and community health principles, practices and theory, including appreciation of the cultures and competencies of different organisations and groups

- The project is informed by community engagement principles, with a relevant rationale, aims, and consideration of potential health or community resource gains. The description shows attention in application to processes of empowerment, respect (for learning, expertise and diverse perspectives), communication, knowledge exchange and collaboration.

Articulation of "beyond therapy" competencies in the project work, and consideration of their relationship to potential roles of clinical psychologists

- The trainee appropriately describes their actions (and/or the thinking behind them) with respect to leadership, critical community psychology, systemic or other relevant clinical psychology competencies. They are able to recognise such competencies, reflect on their own development of them and consider their use in professional work.

Suggestions for further community engagement project work

- The Report contains modest and realistic suggestions for the next few steps forward in developing the work the trainee has been engaged in, illustrating an ability to evaluate the opportunities and constraints afforded by the local context. If the Project being reported worked out to be quite limited in practice, then this aspect of the Report should be prioritised so that the principles and values of community engagement are evident in the thinking about further developments.

Critical reflection on strengths, limitations and effectiveness of community engagement work

- The Report contains critical thinking and evaluation of the practice and consequences of the project work for the various stakeholders involved, including an understanding that effects are rarely direct but may be small, cumulative over

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the longer term or unanticipated when intervening into the "ecology" of the complex systems involved in communities and public health. If the Project did not quite go to plan or met particular barriers, these should be reflected on in such a way as to convey the candidate's understanding of community engagement principles and processes.

Personal/professional reflection on own development and identity as a clinical psychologist of the future

- The trainee demonstrates capacity to be thoughtful and curious about their own responses to community engagement work and associated competencies, and about their learning, and to think about their own professional development as they progress in their career. In particular, the trainee is able to reflect on their own impact on the progress and process of the project and their own contribution to what went well and what did not go so well.

PROCEDURES AND OUTCOMES

The Report will be read by one reviewer who will offer up to half a page of formative written feedback based on the six areas outlined in the assessment criteria above. Reviewers will usually be course team members, though regional practitioner colleagues with specialty expertise may also be employed to review projects. Should the report be considered by the reviewer to be unclear or lack necessary detail or reflection, or contain substantive errors, the report will be returned to the trainee for the required revisions and reviewed once more by the examiner. At this point the reviewer may allow for 150 extra words to meet the criteria that was considered to be missing.

Ref: Assessment Handbook/Name of Assessment/2018 updated 10/21

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THE REFLECTIVE DEVELOPMENT REPORT

Contents
1. Introduction and Learning Outcomes
2. Guidelines on the Preparation of Reflective Development Reports
3. Procedures and Outcomes

INTRODUCTION AND LEARNING OUTCOMES

The Reflective Development Report provides an opportunity for candidates to review and articulate the key features of their professional development throughout the course in an integrated and imaginative manner. It is intended to be a tangible expression and culmination of the personal and professional reflection that is encouraged throughout the Course in keeping with the Course's aim of developing reflective practitioners.

- An ethical and compassionate approach to the work centred on the goals, needs, rights and strengths of service users, which is grounded in NHS values and demonstrates a high level of professional behaviour, including reliability; responsibility for actions; ability to challenge where necessary and respect for colleagues and other professionals, for service users and their families and supporters, for openness and an awareness of the limits to competence.
- A reflective approach to practice and for this to be evident in terms of a high level of self-awareness, including own impact on others (personal reflection) and an advanced awareness of the perspectives of other individuals, groups and organisations (context reflection); and to the interpersonal issues with particular regard to the dynamics of power in working relationships, including one's own potential contribution to this dynamic.
- The capacity to work effectively in multi-professional teams in partnership with other professions and, when appropriate, to provide leadership, consultation, supervision and training to other staff in the provision of psychologically informed services.
- An advanced capacity to reflect on, manage and respond constructively to the personal and professional pressures and constraints encountered during the course of training and thereby demonstrate a readiness for practice, including demonstration of openness to, and good use of, feedback on self and own work.
- An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent; which recognises the value of feedback and the importance of seeking this out, and constructively responding to it; and which demonstrates the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge, enabling them to continue to grow.

GUIDELINES ON THE PREPARATION OF
THE REFLECTIVE DEVELOPMENT REPORT

1.   The Report is required to be submitted for the Award of the Degree, but is not formally graded. The Report will be read by one member of the Course Team (the candidate's Manager). It will be discussed with the candidate at their final review meeting where feedback will be provided.

2.   The Report should be between 3,500 and 4,000 words in length. Word counts should be exact and must include all free text as well as words and numbers contained in quotations and footnotes etc. Word counts should exclude title page, contents page, abstract, tables, figures and the reference list at the end of the report and appendices. If an examiner feels a piece of work may be over the word limit, they should inform the Assessments Administrator who will check the word count of the electronic copy. If the work is found to be over the word limit, the following will apply:
     a.   On the first occasion that a trainee declares work to be over the word limit, the work will be returned to be revised within 7 days of notification.
     b.   On subsequent occasions, the work will be automatically referred, although the work would be marked and would receive qualitative feedback.
     c.   If work is declared to be under the word limit but the examiners judge the work to be over the word limit, the work will be automatically referred if this is verified.

3.   The Report is more personal and individual than most other pieces of written work submitted on the Course. This can be reflected in the style of writing and the structure chosen for the Report which will need to reflect the themes and issues that arise for each individual rather than follow a pre-determined framework. Inclusion of imaginative or creative styles of writing will be welcome as long as there is some associated commentary.

4.   The Report is not meant to be a one off exercise but should draw on a continuous reflective approach to the experience of training. This could include for example:
     •   previous dialogue with peers, Course Team, supervisors and others
     •   use of a reflective journal during training
     •   self-appraisals/feedback from placements and at training reviews
     •   particular experiences on clinical placements and the course programme
     •   the experience of the reflective practitioner group
     •   other personal development or therapeutic activities
     •   the impact of personal life on professional work and vice versa
     •   a consideration of the impact of self on any of the processes above, reflecting on one's own contribution to one's training and development experience.

     The Report will be much easier to write if some form or written record of experience and reflections is kept on a regular or occasional basis throughout training.

5.   The Report can include some discussion of relevant theoretical ideas or indeed make use of theory reflexively. For example in understanding the experience of

working in an organisation or team. However, this is not mandatory. Reference to other work may or may not be necessary but should be acknowledged where appropriate.

6.   The Report should provide a stepping stone to future developments and therefore should include some reflections on future career direction, training and personal development needs.

7.   The Report is a highly personal document and will remain part of the candidate's confidential Course records. Individuals need to consider their own boundaries with regard to this and write as openly as possible within them. Any reference to clients should ensure their anonymity.

8.   The Report must be submitted in accordance with the published schedule of deadlines.

9.   Candidates are required to submit one electronic copy of the submission. The submission should be typed with double line spacing and the font size should be a minimum of 12. Each submission should adhere to the maximum word limit (excluding abstract, contents pages, references and appendices), paginated and follow the APA Style Guide in terms of references and conventions, but not structure. Structure and presentation should follow the guidance in this document (appendix 15). Exact word counts are required for all submissions. The candidate's name should be on the report.

PROCEDURES AND OUTCOMES

10.   To be accepted the Report must meet normal standards of presentation. In addition the content must be appropriate to the self-reflective task and coherently and respectfully written.

11.   Should the report be judged by the examiner to lack necessary detail or reflection, or contain substantive errors, the report will be returned to the trainee for the required revisions and reviewed once more by the examiner.

12.   Failure to complete the set task will result in the mark of Fail being awarded for that piece of work.

13.   Assessments must be the candidate's own work. Copying and plagiarism is unacceptable and the procedure described in Section 3 of the Assessment Handbook will be used in such cases.

14.   Receipt of the Report will be confirmed at the Board of Examiners meeting in September and candidates will be notified of its acceptance in the letter informing them of their final results.

15.   A copy of the Report will be kept with the Candidate's confidential records but will not be open to wider access.

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PRESENTATION GUIDE FOR WRITTEN ASSESSMENTS

The ability to present written material in a clear and well-presented manner, to a range of different readers, is a key competence for clinical psychologists. One means by which the Course assesses this competence is through the evaluation of the presentation style of all the written assessments.

All pieces of written work submitted for assessment should: be presented in a manner appropriate to the piece of work being assessed; be laid out in a format that is clear and easy for the reader to follow; use the common rules of English in an appropriate way; follow the normal rules for the presentation of academic material such as citations, statistics and tables.

It is not uncommon for potentially strong pieces of work to receive lower marks than they could have achieved because of serious flaws in their presentation. The most common errors relate to: mistakes in the presentation of references (both in the body of the text and the references section); incorrect presentation of statistical results; and the misuse of various elements of English, such as colons and semi-colons, apostrophes and abbreviations. Some of these errors can be simply avoided by the use of the spell checking and grammar checking facilities on most word processing programs.

The Course expects candidates to follow the advice given in the APA Style Guide, which can be downloaded from the APA website. This guide is regularly updated and the latest version should be used. The Style Guide covers: abbreviations; capitalization; italics; lists; numbers; statistical and mathematical copy; punctuation; quotations; citation of sources; word selection; sentence construction; spelling; tables; and figures and graphs.

There are now a large number of Internet sites which provide helpful advice on matters of English grammar, presentation, spelling, and so on. For example, CCCU provides short guidance notes on topics such as the use of colons, punctuation, apostrophes, etc. This can be found at:
http://www.canterbury.ac.uk/students/support-services/develop-your-learning/develop-your-learning.aspx

Other useful sites are: The Capital Community College guide to grammar and writing: (http://grammar.ccc.commnet.edu/grammar/) and the Purdue University Online Writing Lab (http://owl.english.purdue.edu).

The use of APA style guidelines for marked work

APA style guidelines are oriented toward two areas: The first, manuscript style (how a manuscript is organised and prepared prior to submission for publication) and the second, reference style (how references are cited within the text and in the reference section at the end of the text).

APA reference style is required for all marked submissions in the doctoral course.

From the 2018 cohort onwards, *all* pieces of written work should adhere to a modified APA style for manuscripts.

"Modified" means that not all APA guidance needs to be followed; only the essential aspects should be adhered and include the following:

1. Page numbers on the upper right-hand corner of all pages except title page.
2. 12-point Times New Roman font for all papers except title page which could be 14 point.
3. Lines to be double-spaced.
4. Section headings to follow APA style (and *not be underlined or numbered*): https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/apa_headings_and_seriation.html
5. In text citations in APA style: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/in_text_citations_author_authors.html
6. Tables in APA style: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/apa_tables_and_figures_1.html
7. Figures and photographs in APA style: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/apa_tables_and_figures_2.html
8. References in APA style including doi numbers for all journal articles: https://www.mendeley.com/guides/apa-citation-guide
9. *Unlike APA referencing style*, please provide journal issue numbers for all references to journal articles in the reference list.
10. *Unlike APA style guidance*, key tables and figures should usually be embedded in the text and not in the appendix; they are not included in the word count.

The University library supports RefWorks, which is a software programme to help organise references across all pieces of work; it also adjusts references to APA style, 6th edition. Please go here to find more information about RefWorks including a YouTube video on how to use it (takes 20 minutes to learn): https://www.canterbury.ac.uk/library/citing-references/reference-management-tools.aspx

Further support for APA style can be accessed without charge from OWL at Purdue University: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html and also, without charge from APA: https://www.apastyle.org/

Anonymising confidential information in appendices

If anonymising a variety of names and locations in appendices, do not replace every identifier with "XXX" or similar, as the remaining text will make no sense. You should use different substitutes for different people and places. Consider using the following format:

[Staff member] at [University] advised all trainees studying for the [course name] to avoid replacing all identifiers with "XXX" in order to ensure that sentences remain comprehensible.

Anonymising documents to be circulated electronically

Use of black highlighting/white text
Please be aware that some information can sometimes still be read by holding the cursor over it; it may also be found using the search function.

E.g. the search function will find the word 'Salomons' in the examples below, and the hyperlinks will work in the bottom row.

Black highlighter and black text	White text
███████	Salomons
████████████████ ███	salomons.appliedpsychology@canterbury.ac.uk

The full version of Adobe, available on University PCs, can 'redact' words and remove hidden information. These will appear blacked out as above but will not be found through the search function. You should still check that these have been applied correctly.

Text boxes
The formatting of Word documents can change from one computer to another, and even when converting to a pdf on a different computer. This is a particular issue with text boxes, which can move or change colour when viewed by another person.

E.g.

Submitted version

████████ at ████████ advised all trainees studying for the [course name] using text boxes.

Version received:

[Staff member] at [University] advised all trainees studying for the [course name] to be ca██████████g ██████
████████████

[Staff member] at [University] advised all trainees studying for the [course name] to be careful when using text boxes.

If using text boxes, it would be best to submit the document as a pdf so that you can check they are in the correct place prior to submission.

Alternatively, anonymise the information in a different document and insert as a screenshot or screen clipping.

If inserting a photograph, e.g. of a consent form, you could cover up the information before taking the photo or edit the photo prior to inserting in the document.

Ref: Assessment Handbook/2018 updated 12/20

CANTERBURY CHRIST CHURCH UNIVERSITY
DOCTORATE IN CLINICAL PSYCHOLOGY (D.CLIN.PSYCHOL.)

MARKING PRACTICES FOR TRAINEES WITH DYSLEXIA (or other Specific Learning Difficulties) – GUIDANCE FOR EXAMINERS[1]

There are usually several trainees with dyslexia on the Salomons Doctorate in Clinical Psychology Course at any one time. The Special Education Needs and Disability Act (2002) requires that the Course should not treat a disabled person less favourably than others for a reason that relates to their disability. The Course needs, therefore, to both ensure that the assessment process does not disadvantage dyslexic trainees whilst also ensuring that the Course's academic standards are maintained.

Context
Writing reports and other professional documents is a very important competence of clinical psychologists and, for the protection of the users of psychological services, it is important that all trainees are able to demonstrate their ability to meet the usual professional standards. Evaluation of an appropriate level of presentation is therefore written into the guidelines for all the Course's written assessments.

All of the trainees on the Course will have already obtained a good undergraduate degree (and many will also have a further degree). This suggests that many trainees with dyslexia will have already developed some strategies for coping with the academic demands of the Course. However, this may be less true for those trainees who do not receive the diagnosis prior to commencing the Course, or for whom they have not completed any academic study for several years. Furthermore, given that this is likely to be the trainees' first experience of doctoral level study, the academic requirements of the course may be more demanding or rigorous than they have experienced in their previous university study.

Canterbury Christ Church University processes for dyslexic trainees
The current processes relating to trainees with dyslexia, based on the University's guidelines, include the following:
1. Trainees are encouraged to disclose their dyslexia (or any other specific learning difficulty) to a member of the course staff at the earliest opportunity. Such disclosure could take place through a statement on the trainee's application form indicating that they have a diagnosis of dyslexia or by their informing a member of the Course staff (such as their Manager) before or after starting training.

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[1] This guidance draws, in some sections, on the Association of Dyslexia Specialists in Higher Education (ADSHE) (2004) document "Guidance for Good Practice: Institutional Marking Practices for Dyslexic Students".

2. After letting a member of the staff team know that they have dyslexia, trainees are advised to inform the Student Support Health and Wellbeing Team at Canterbury Christ Church University. This is to ensure that consideration can be given to what support they might need and to what reasonable adjustments might need to be made to ensure that they are not disadvantaged. Trainees are also encouraged to inform the University's Academic Administration Department, in relation to the assessment process. In order for this to happen the trainee will need to provide a report that provides information about a formal psychological assessment, which has been undertaken since they were an adult.

3. The Academic Administration Department will then supply the trainee with a cover sheet to attach to all academic submissions, indicating that they have dyslexia. The cover sheet states that *"Consideration should be given for the spelling, grammar and structure of written work."* These cover sheets have primarily been designed for students undertaking undergraduate exams and would be attached to their examination scripts. It is clearly a rather different situation with non-examination forms of assessment and it would be up to the trainee to decide whether or not they attach this cover sheet to their submission. (One reason for not doing so might be because of the possibility that the trainee believes that it could it increase the likelihood that an examiner will be able to identify the candidate, though this has never happened.)

4. Trainees with dyslexia are also advised to seek support through the university's Student Support Health and Wellbeing Team based in Canterbury, for advice about applying for the Disabled Students' Allowance (DSA). Trainees can use this funding to access assistive technology (such as computer programmes) to help with written work, or to pay for one to one sessions with a specialist Dyslexia Consultant. They may also be able to access funding for the use of proof readers.

Managing trainee submissions
These processes mean that examiners may get submissions from trainees with dyslexia: (a) where this is *not* identified on the piece of work and when the trainee has or has not had the piece of work read by a University proof-reader; or (b) where there is a cover sheet to indicate the trainee has dyslexia and where, again, it may or may not have been proof-read. This is clearly a complex situation and it is suggested that examiners use the following guidance when undertaking their marking:

1. Academic standards
   There must be no difference in the requirements for trainees with dyslexia to provide evidence of their learning compared to their peers – the academic standards required of dyslexic trainees are the same as for all other trainees.

2. <u>Marking with due consideration for the effects of dyslexia</u>
    It is important that examiners are aware of the potential manifestations of dyslexia by trainees and how this could affect their submissions.

    The Guidance for Good Practice: Institutional Marking Practices for Dyslexic Students document (2004) states *"People with dyslexia typically experience difficulty producing written work as quickly as other people; they are likely to make more spelling errors, even in word-processed work; their punctuation and grammar may be weak and they often omit, repeat or insert small function words or word endings. While not without structure, dyslexic trainees' written assignments may lack the "polish" demonstrated by their peers. Examiners might reasonably, in normal circumstances, consider such work "shoddy" or careless."*
    Therefore in the case of dyslexic trainees, some consideration needs to be given to how such errors should be understood and how they will be taken into account when examining a piece of work. However, the fundamental principle remains that the work should not be given a Pass until it meets the usual professional standards in terms of content and presentation.

    Options available to examiners include:
    A. *Where there is a cover sheet indicating that the trainee is dyslexic*, the examiners will need to mark the work in the normal way but then consider the extent of the presentational problems and how likely it might be that these relate to the candidate's dyslexia. (The cover sheet may not specifically mention dyslexia, but will indicate that the candidate has difficulties with their written work that have been identified to the University Registry.) Where the work is recommended to receive a Pass and there are only minor presentational problems, the examiners will need to ask the candidate to correct any presentational problems before binding. Where the work is recommended to receive a Pass with Conditions, correcting the presentational problems can appropriately form part of the conditions that the candidate is required to meet. If the work is being recommended for a Referral, then the examiners will need to ensure that presentational problems, potentially related to the candidate's dyslexia, do not form a substantial part of the reason for a Referral. If the examiners feel that this may be the case, then it may be appropriate to recommend to the Board that the work receives a Pass with Conditions, whilst indicating that the candidate's dyslexia has been taken into account in making this recommendation.
    B. *Where there is no cover sheet indicating that the trainee is dyslexic,* then clearly the piece of work will have to be assessed without any consideration being given to the candidate's dyslexia. However, it will then be important for the Board's attention to be drawn to the candidate's registered dyslexia, so that the Board (along with at least

one of the examiners who would be present) can consider whether any modification needs to be made to the recommended mark for the candidate. It is the responsibility of the Assessments Administrator to ensure that the relevant members of the Board are aware when pieces of work from dyslexic trainees are to be examined.

3. Qualitative feedback
In making their qualitative feedback to candidates about presentational problems, examiners need to bear in mind that these could be a result of the candidate's dyslexia. Examiners should therefore, avoiding making inferences about the reasons for such problems (e.g. "the work seems to have been produced in a careless way" or "the work seems to have been completed at the last minute") as these might be very inappropriate in relation to dyslexic trainees.

4. Oral Examinations
Typically trainees are required to complete two oral examinations (viva voce exams) over the course of the training courses. One of these is related to the 'Assessment of Clinical Skills' assessment, and the other forms part of the examination of their Major Research Project.

In relation to their performance in oral examinations, trainees with dyslexia may have word finding and/or verbal fluency difficulties. This means that they may struggle to think of a particular word (even if the material is very familiar to them), may take longer to respond to questions, or may give answers that are a little unclear. This is likely to be exacerbated if they are very anxious (as most trainees are in the viva), or if they lose their train of thought.

As with written assessed work, the academic standards required of dyslexic trainees in oral examinations are the same as for all other trainees. However trainees with dyslexia are allocated oral examination slots before a break, so that the length of the examination can be extended slightly if this would be helpful. When examining trainees who have special considerations, examiners are advised that it may be helpful to give some reassurance to the trainee (e.g. 'take your time') or to remind them that they can refer to their written MRP (or transcript in the case of the assessment of clinical skills) if that would be helpful.

David Sperlinger, November 2005
Amended by Celia Heneage, January 2011
Amended again by Rachel Terry, January 2018