Canterbury Christ Church University

Salomons Institute for Applied Psychology
School of Psychology and Life Sciences
Faculty of Science, Engineering and Social Sciences

DOCTORATE IN CLINICAL PSYCHOLOGY
(D.CLIN.PSYCHOL.)

PRACTICE LEARNING HANDBOOK

The British Psychological Society
Accredited Clinical Psychology

March 2022
(2018 Intake onwards)

Contents

LIST OF APPENDICES 1

1. INTRODUCTION 2

2. OVERVIEW OF THE PROGRAMME 3
- 2.1 The Salomons Institute for Applied Psychology: Canterbury Christ Church University 3
- 2.2 Historical background to the Course 3
- 2.3 Position Statement 3
- 2.4 Structure of the Programme 6
- 2.5 Assessment and Submission Framework 10

3. MODELS OF LEARNING AND PRACTICE 14
- 3.1 Competence and Capability 14
- 3.2 Experiential Learning and Reflective Practice 14
- 3.3 Reflective Journal and Reflective Practitioner Group 17
- 3.4 A Complex Responsive Processes Perspective 17

4. THE PROVISION OF PLACEMENTS 19
- 4.1 Introduction 19
- 4.2 Placement Framework 19
- 4.3 Partnership Arrangements 20
- 4.4 Placement Information / Placement Outline Forms 21
- 4.5 Collaboration with Trusts 21
- 4.6 Placement Organisation and Allocation 22
- 4.7 Travel and Staying Over 24
- 4.8 Specific health and learning needs and placements 24

5. SETTING UP AND MANAGING PLACEMENTS 25
- 5.1 Introduction 25
- 5.2 Placement preparation: Resources, Communication and Information 25
- 5.3 Pre-placement Contact 28
- 5.4 The Placement Contract 30
- 5.5 Supervision Contract 31
- 5.6 Starting the placement: Induction and Observation Week 31
- 5.7 Process for managing placement changes 34
- 5.8 Management Roles and Responsibilities 34
- 5.9 Health and Personal Safety at Work 35
- 5.10 Placement Days, Leave, Sickness and Study Time 37
- 5.11 Fitness to Practice 38
- 5.12 Administration and Record Keeping 39
- 5.13 Advice and Support 40

6. SUPERVISION 41
- 6.1 Introduction 41
- 6.2 The Health and Care Professions Council (HCPC) and Supervision 41
- 6.3 BPS Accreditation Through Partnership and DCP policy 43
- 6.4 The Division of Clinical Psychology's View 43
- 6.5 The Role of Co-ordinating and Clinical Supervisors 44
- 6.6 Definition of supervision 47
- 6.7 Models of supervision 47
- 6.8 Some Suggestions for Supervisors Regarding Good Practice 49

6.9 Some Suggestions for Trainees Regarding Good Practice ... 49
6.10 Supervisor Training and Development ... 50
6.11 Suggested Reading ... 51

7. LEARNING OUTCOMES ... 52
7.1 Introduction ... 52
7.2 Overall Learning Outcomes and Metacompetencies ... 52
7.3 Core and Model-Specific Competencies ... 54
7.4 Breadth of Experience ... 56
7.5 A Note on Workload ... 57

8. ASSESSMENT & MONITORING ... 59
8.1 Introduction ... 59
8.2 Placement Visits ... 60
8.3 Formal Evaluation ... 62
8.4 Placement Referral or Failure ... 63
8.5 Withdrawal from Placement ... 64
8.6 The Evaluation of Clinical/Professional Competence (ECC) Form ... 65
8.7 Practice Learning Feedback Form & Placement Audit Form ... 67
8.8 The Practice Learning Portfolio (PLP) ... 68
8.9 Recording Placement Days ... 74
8.10 Ensuring competency development between placements ... 75
8.11 Additional Assessment Support ... 75

9. PROFESSIONAL PRACTICE REPORT: DIRECT WORK ... 76
9.1 Introduction ... 76
9.2 Course Requirements ... 76
9.3 Selection of Cases ... 76
9.4 Client and Third Party Consent and Confidentiality ... 80
9.5 Structure and Content of Reports ... 81
9.6 Writing Reports on Different Kinds of Work ... 88
9.7 Support Systems for Writing Professional Practice Reports: Direct Work ... 97

10. ASSESSMENT OF CLINICAL SKILLS ... 99
10.1 Guidance for completing the Assessment of Clinical Skills ... 100
10.2 Support for the preparation of the Assessment of Clinical Skills ... 103

11. COMMUNITY ENGAGEMENT PROJECT REPORT ... 104

12. PROFESSIONAL PRACTICE REPORTS: QUALITY IMPROVEMENT PROJECT ... 105
12.1 What is a Quality Improvement Project? ... 105
12.2 Why is a QIP part of the Course Requirements? ... 106
12.3 What Sorts of Topics Form the Basis of a QIP? ... 106
12.4 How is the QIP supervised? ... 107
12.5 How Does the Course Team support the QIP? ... 108
12.6 How Should Trainees and Supervisors Work Together on the QIP? ... 108
12.7 Ethical Approval and QIPs ... 109
12.8 How are QIPs Assessed? ... 109

13. FEEDBACK AND QUALITY IMPROVEMENT ... 110
13.1 Practice Learning and Quality Assurance ... 110
13.2 Process for Managing Trainee Placement Concerns ... 114
13.3 General Review Processes ... 114

LIST OF APPENDICES

4.1	Placement Outline Form	**120**
4.2	Guidance for approval of placements	**123**
4.3	Trainee Placement Allocation Form	**124**
4.4	Practice Learning Support Plan	**126**
4.5	Guidelines for managers on completing Placement Allocation Forms with trainees	**129**
5.1	Practice Learning Feedback Form	**131**
5.2	Placement Audit Form	**133**
5.3	BPS Accreditation through Partnership – Additional guidance for clinical psychology training courses: Guidelines on clinical supervision (2010)	**137**
5.4	Trainees with Dyslexia and Placements – Guidance for Supervisors	**144**
5.5	Pre-placement meeting checklist	**146**
5.6	Example of Placement Contract	**147**
5.7	Examples of Observation Week Tasks	**148**
5.8	Feedback on Observations	**152**
5.9	Guidance on video and audio recording	**154**
5.10	Consent Form for audio-video taping	**156**
5.11	GMC Guidelines on making and using visual and audio recordings	**159**
5.12	Guidance for the management of serious concerns and problems with supervision on placements	**161**
5.13	DCP Policy on Supervision	**169**
5.14	Trainee Risk assessment form CCCU & SABP	**192**
5.15	Placement Risk Assessment Process	**198**
6.8	Suggested template for Clinical Supervision Contract	**200**
7.1	BPS (2017) Core competencies	**203**
8.1	Evaluation of Clinical Competence Form	**209**
8.2	Service User Evaluation Form	**224**
8.3	Practice Learning Portfolio	**227**
8.4	Mid-Placement Visit Record Sheet	**299**
8.6	Evaluation of Clinical/Professional Competence Marking Criteria	**306**
8.7	Placement Log of Clinical Experience	**318**
8.8	PLP Individual Record of Client Contact	**319**

1. INTRODUCTION

Practice learning is the cornerstone of clinical psychology training. Trainees are required to spend approximately half of their three-year course of doctoral training working on placement in service settings under the supervision of appropriately qualified staff.

The importance and influence of this clinical and professional learning experience is hard to over-estimate. The current course specification for the doctoral course at Salomons (Canterbury Christ Church University) is based on partnership with supervisors and ownership within NHS Trusts for practice learning and placement provision. This is achieved through formal agreements with Trusts about placement provision, linking with Trust Representatives to ensure the quality of placements provided. Also by developing future placements and to sustaining positive, collaborative working relationships and communication between the Course and Trust staff.

In recognition of the changes in the NHS structure arising from the Health and Social Care Act (2012), the Course seeks to reflect the diverse organisational contexts within which future clinical psychologists may work. Therefore, a number of carefully selected placements from the independent sector (charitable and private) are also available. These placements are governed by the same quality standards and formal agreements as Trust-provided placements.

This handbook attempts to bring together in one place the most salient information needed by supervisors and trainees with regard to practice learning on placements under current course arrangements. This ranges from general background information on the course at Salomons (CCCU) and the design of the doctoral course to specific guidelines for the setting up of placements, the supervision of clinical practice and the evaluation of learning.

In addition to this handbook trainees will need to make reference, as appropriate, to the course Handbook and the Assessment Handbook. Supervisors should however find most of the information they need here. If not please let us know and we will endeavour to rectify any omissions in future editions. It is of course impossible to cover every eventuality and the provision of a handbook should not deter contact with members of the course team to clarify specific questions as they arise.

The course has been developed to meet in full the standards for postgraduate training courses in Clinical Psychology set out by the Health and Care Professions Council (HCPC) and by the British Psychological Society (BPS) in their Accreditation Through Partnership scheme. In addition, the practice learning and placement arrangements have been developed in line with the Quality Assurance Agency's code of practice and precepts for placement learning. The philosophy and values underlying the course are, however, those that have evolved over many years at Salomons (CCCU) drawing on the active contribution of many individuals across the South East, as well as course staff and previous trainees. Some aspects of this are articulated in sections 2 and 3 of this document.

2. OVERVIEW OF THE PROGRAMME

2.1 The Salomons Institute for Applied Psychology: Canterbury Christ Church University

The Doctoral Course in Clinical Psychology is part of the Salomons Institute for Applied Psychology, based at Lucy Fildes Building, 1 Meadow Road, Canterbury Christ Church University's location in Tunbridge Wells.

In 2017, the Course moved from the nearby Salomons estate where it had been based since 1986 when the estate was used as the conference and training Centre for the South East Thames Regional Health Authority. In 1996, the estate was sold to Canterbury Christ Church University College (later Canterbury Christ Church University) who took over the validation of the Course. When the University sold the Salomons estate in 2013, the Salomons name was retained in our Institute's current title.

The Institute for Applied Psychology runs a range of other mental health trainings including Low and High Intensity Programmes for the Improving Access to Psychological Therapies Initiative (IAPT), and is involved in Practice Consultancy, Research and Knowledge Exchange, and Continued Professional Development programmes within the health and social care sector.

The Institute for Applied Psychology is part of the School of Psychology and Life Sciences, which in turn is part of the Faculty of Science, Engineering and Social Sciences. The Faculty includes a range of other Departments including Centre for Sport, Physical Education and Activity Research, School of Law, Policing and Social Sciences, and the Business School, plus others. Most of these Departments are based at the Canterbury campus.

2.2 Historical background to the Course

The Pre-Qualification Course was originally developed by a group of senior Clinical Psychologists within the South East Thames Region. The first intake took place in 1972 with four trainees. Trainees on this three-year Course, completed the British Psychological Society's Diploma in Clinical Psychology, assessed by the Board of Examiners of the British Psychological Society (BPS).

Between 1972 –1993, the Course remained an In-Service Scheme with trainee numbers gradually increasing to 12 by 1992 and rising to 18 in 1994. In 1993 a decision was made to move from the association with the BPS, (i.e. with trainees qualifying via a BPS diploma), to a temporary arrangement first with the University of Wales and then with the Open University. This enabled the Course to make the transition to offering a training which resulted in the award of a Doctorate in Clinical Psychology. This degree is now validated by Canterbury Christ Church University.

Each year, the number of places is governed by the number of NHS commissions. Since 2018 there has been a steady increase which is projected to continue until 2024. From then the numbers will once again reduce.

2.3 Position Statement

The aim of the Course is to make a significant contribution to the NHS and the wider social care context by delivering a high quality and responsive training course that provides able, committed and reflective clinical psychologists.

In addition, the Course is committed to ensuring that trainees' values and behaviour are at all times rooted in the core values of the NHS Constitution

The training and design of the Course is based on the following broad principles and values.

2.3.1 Broad Knowledge Base

A broad theoretical/knowledge and experience base underpins the Course. The Course is based on a growing body of psychological knowledge which draws on a range of theories considered of relevance to the work of clinical psychologists including behavioural, cognitive behavioural, psychoanalytic, systemic, humanistic, social constructionist, community, critical and biological. The Course aims to provide trainees with the experience, knowledge and skills necessary to conceptualise a problem from a number of different theoretical viewpoints and to use the practice associated with a range of models in working with individuals, groups and organisations.

Whilst psychology is the main knowledge base for practice, the importance of integrating contributions from other bodies of knowledge, including sociology, politics, organisational theory, ethics, philosophy, education, management, legal/judicial, informatics, economics and anthropology is also recognised. Training, therefore, aims to provide input from these bodies of knowledge when relevant to practice.

2.3.2 Developmental Framework

The process and experience of change, development and diversity throughout the lifespan is seen as a pivotal contextual framework for understanding psychological problems and their relationship to biological, social, cultural, material and spiritual factors. It also provides a perspective for understanding and promoting psychological health and well-being. The curriculum is therefore framed within a biopsychosocial understanding of human development and its challenges across the lifespan. This is seen as complimentary to traditional nosological frameworks and is viewed as an important aspect of person-centered psychological formulation.

2.3.3 Models of Clinical Psychology

The Course adopts an approach which aims to integrate three models of clinical psychology practice and to facilitate the trainee to develop their own position with regard to these and other models. The three models are the scientist practitioner, the reflective practitioner and the critical practitioner. The scientist practitioner promotes an investigatory, evaluative and evidence-based approach to practice and the development of knowledge through research. The reflective practitioner places the study of 'process' as central to practice and emphasis is placed on 'reflection' to develop an awareness of the influence on practice of self and others. A critical approach places value on challenging the construction of knowledge and practice to promote emancipation and social justice and reduce the risk of harm. The Course aims to develop the competence to undertake research and use scientific methods in their broadest sense, including continual reflection and critique of professional knowledge and activity and its impact on individuals and society. This combination of models aims to help the developing clinical psychologist to integrate theory, research and practice and thereby promote a process of continuous clinical inquiry and development.

2.3.4 Service Work and Development

The Course trains clinical psychologists to work in publicly funded organisations and services. This primarily involves working for the NHS, although working in partnership with a range of other organisations including Social Services and the Independent Sector is becoming increasingly important. Essential to this work is the development of an awareness of social responsibility and social justice. In this work emphasis is placed on the need for clinical psychologists to make a contribution to the development of services in a way which listens to, empowers and engages service users, with their safety as a priority, and pays due regard to the evidence base for the psychological work offered.

2.3.5 Multi-Professional/Agency Context

The Course trains clinical psychologists to work effectively in multi- professional/agency service contexts and to contribute positively to the organisation and development of those services. In order to achieve this, the need to understand the organisational context of services is recognised and addressed in the curriculum. The Course seeks to prepare trainees to be able to work flexibly and effectively in multi- professional teams and to develop the capacity for leadership. This involves providing a unique psychological contribution to the work of teams and working in a collaborative manner to meet service goals and priorities. The value of mutual and shared learning with other professional groups is highly valued. Trainees will experience working collaboratively with a wide range of professions. They may receive and share clinical supervision from HCPC registered professions other than clinical psychologists. Within the context of their clinical experience, they will be working with individuals training in other professions and will have shared learning experiences. The outcome of this experience will be that they have an understanding of other professional roles and the need to work collaboratively within teams, whilst maintaining professional boundaries.

2.3.6 Training for Diversity and Valuing Difference

The Course trains clinical psychologists to work with people from all backgrounds, including those for whom services have been traditionally difficult to access. Within this, the value and importance of training clinical psychologists to work in multicultural communities and to use culturally sensitive ways of delivering services is recognised. The Course also recognises that some groups of people have been disenfranchised from services often because of their difference and the prejudice of others. The Course aims to challenge this disenfranchisement and to promote the development of theory, research and practice, which both values difference and seeks to ensure the inclusion of such groups and individuals within services.

2.3.7 Consultation and Involvement

The Course ensures that a wide range of stakeholders are involved in, and consulted about, the organisation and running of the training. This means involving regional clinical psychologists in the Course in a way that allows real opportunity to participate in the organisation and operation of training. The contribution of service users and carers is highly valued and structures have been created to support, develop and evaluate ways in which they can be continuously involved in the design and delivery of the Course. In addition, other contributing stakeholders including service managers and clinicians and service managers are also recognised and active measures are taken to involve them where appropriate. Course participants are actively involved in decisions about the development, organisation, structure and content of training at all levels.

2.3.8 Life Long Learning

The world for which the Course is preparing people is changing rapidly and will require participants to learn continually and develop throughout their careers. In recognition of this, the Course aims to facilitate participants' commitment to a life- long approach to learning and provide them with the skills to recognise and utilise a broad range of development opportunities.

2.4 Structure of the Programme

The general organisation of the Course comprises three year-long stages. These correspond with the organisation of clinical placements, enabling the academic/research teaching to be integrally linked to the trainees' clinical experience, and to the learning structure of the Course as a whole. Within each year-long stage, the teaching content is organized into a number of units that conceptually relate to one of six academic strands. These six strands span the entire three years of the Course and organize the content and structure of the teaching. Each unit of teaching within a strand focuses on a particular area of clinical or professional practice as described by that strand (See Table 1 below). The units are delivered at various points throughout the three years of training, and it is intended that later units will build upon previous units delivered earlier in training. The academic Course as a whole is planned with reference to HCPC and BPS criteria for Clinical Psychology Training.

Table 1: Overview of Structure of Educational Course

	Strand 1 Models & Skills of Clinical Psychology Leader: **Anne Cooke**	**Strand 2** Working with Clients Leader: **John McGowan**	**Strand 3** Working with Groups & Organisations Leader: **Simon Powell**	**Strand 4** Clinical Research, Evaluation & Dissemination Leader: **Fergal Jones**	**Strand 5** Personal & Professional Development Leader: **Margie Callanan**	**Other** Additional Professional Competencies Leader: **John McGowan**
Stage 1 Basic therapeutic and professional competencies	Foundation & the Life-Cycle **Carmel Digman** Clinical Skills **Maria Griffiths & Kathryn Stevenson** Biological & Medical Approaches **Anne Cooke** Service User and Carer Perspectives **Laura Lea** Cognitive Behaviour Therapy **Alan Hebben-Wadey** Psychodynamic **John McGowan**	Adult Development/ Adult Mental Health **Rachel Terry** Forensic **Theresa Connolly** Neuropsychology across the Lifespan **Jennifer Dean** Psychosis & Complex Needs **Paul Wilson** Clinical Health Psychology **Paul Sigel**	Understanding Teams & Groups **Alan Larney** Public Sector Organisation: Adult Services **Kathryn Stevenson &** **Simon Powell**	Research unit covering: Essentials of Design, Methodology & Practice Based Research Advanced Research Design & Methodology Integrating Research Theory & Practice **Fergal Jones, Sue Holttum & Tamara Leeuwerik**	Risk & Ethics **Maria Griffiths** Reflective Group **Margie Callanan** Professional Roles & Identity **Carmel Digman** Difference, Diversity & Social Inequalities **Kamisha Guthrie**	Pre-course meeting **Rachel Terry** Induction & Mandatory Trainings and assessment briefings. **Admin and Academic staff/Surrey and Borders** Trainee/Staff Liaison **Various** Reflective Group **Margie Callanan**

Stage 2 (Year 1&2) Advanced and more specialist competencies	Systemic Thinking & Practice **Kate Daniels** **& Trish Joscelyne** Clinical Skills **Simon Powell** **& Trish Joscelyne** Critical and Community **Anne Cooke** Service User and Carer Perspectives **Laura Lea** Biological & Medical Approaches **Anne Cooke**	Learning, Physical & Sensory Disabilities **Simon Powell** Child & Family **Trish Joscelyne**	Understanding Teams & Groups **Alan Larney** Public Sector Organisation: Child & Disability Services **Kathryn Stevenson** **& Simon Powell**	Research Study Time and Individual Meetings	Risk & Ethics **Maria Griffiths** Reflective Group **Margie Callanan** Difference, Diversity & Social Inequalities **Kamisha Guthrie** Professional Roles & Identity **Carmel Digman**	Trainee/Staff Liaison **Various** Reflective Group **Margie Callanan**
Stage 3 (Year 2&3) Consolidation, additional specialist and further development of transferable competencies	Clinical Skills **Simon Powell** **& Trish Joscelyne** Critical and Community **Anne Cooke** Service User and Carer Perspectives **Laura Lea** Psychology & Society **Anne Cooke**	Older People **Lucy Mills** Clinical Complexity & Therapy Integration **Kathryn Stevenson & Alan Hebben-Wadey**	Understanding Teams & Groups **Alan Larney** Public Sector Organisation **Kathryn Stevenson &** **Simon Powell** Psychodynamic Observation **Peter de Backer**	Research Study Time, Individual Meetings and Project Completion + Viva Preparation	Risk & Ethics **Maria Griffiths** Difference, Diversity & Social Inequalities **Kamisha Guthrie** Professional Roles & Identity **Carmel Digman** Endings Workshop **Margie Callanan**	Trainee/Staff Liaison **Various** Advanced Reading Seminars **John McGowan** Specialist Options **John McGowan** Reflective Group **Margie Callanan**

2.4.1 The Academic Strands

A brief summary of the six academic strands is given below.

Strand 1: Models and Skills of Clinical Psychology
This strand introduces the history and development of clinical psychology models and provides a foundation to the position of different therapeutic approaches within the profession. These include: cognitive behaviour therapy (CBT), psychodynamic therapies and systemic therapies. There are also units in which more generic clinical skills are taught. These are appropriate for the populations with whom the trainees are working in a specific placement. As the course progresses, there is an increasing emphasis on models that address wider service systems and integration. The curriculum also includes teaching on different epistemologies of knowledge and encourages input from non- professional perspectives such as those of health service users and carers.

Strand 2: Working with Clients
This strand commences with a foundation unit introducing the concept of the human lifecycle as an integrating model to be held throughout the course.
This is followed by a series of units that consider challenges in human development and teach competencies specific to working with different clinical population groups across the lifecycle. In year one the focus is on working with adults, in the broadest sense, including working with specialist issues such as forensic work, severe mental health problems, physical health and neuropsychology. The end of the first year and the second year involve consideration of issues affecting children and young adults, and also of issues that affect development and may be more enduring, such as intellectual and physical disabilities. Year three focuses on work with older people and complex therapeutic issues.

Strand 3: Working with Groups and Organisations
This consists of two units that span the three years. The first, Public Sector Organisation, looks at the history and development of the types of services which the trainees will be encountering during that year of placement experience. The second, Understanding Teams and Groups, focuses on the knowledge and skills necessary to function in teams, therapeutic groups and services.

Strand 4: Clinical Research, Evaluation and Dissemination
This strand aims to develop the trainees' competencies to critically evaluate clinical practice, to carry out original research at doctoral level standard, to be able to critically evaluate others' research and disseminate research findings to a variety of audiences. This strand is intimately intertwined with the other areas of the curriculum and is considered central to a meaningful understanding of evidence-based practice and to an understanding of the epistemologies of psychological theories.

Strand 5: Personal and Professional Development
This strand facilitates the personal and professional development of trainees in relation to key issues and experiences that can arise across all aspects of their training. The focus is on their active engagement in a process of personal reflexive learning and integration to support the development of professional capabilities.

Learning is facilitated through a variety of different methods including a reflective practitioner group that continues fortnightly throughout the three years. Additionally, this strand includes units dealing with risk and ethical issues and also diversity and social inequalities.

Strand 6: Additional Professional Competencies
In addition to induction into the practical resources of the Course (e.g. computing, library), this strand includes two later units where the trainees are able to choose from several academic pathways to develop more specialist knowledge in areas of particular interest or training need. The first unit consists of the Advanced Reading Seminars, based around particular clinical populations or issues pertaining to clinical practice. The second unit, the third year Options, provides a choice between a number of more extended subject options intended to provide in-depth instruction on particular therapeutic modalities (such as cognitive behaviour therapy), or a greater depth of knowledge in particular clinical (e.g. neurological problems) or professional areas (e.g. supervision & consultancy).

2.5 Assessment and Submission Framework

Trainees will need to undertake the following assessments during the course of the training. Timings for submissions can be found in Table 2 below.

2.5.1 Assessment of Clinical Skills (ACS)

The Assessment of Clinical Skills has two parts which are submitted separately. Part 1 is a formulation of a client, a review of the relevant evidence base, and a plan for an intervention which adapts the evidence base to the needs of the client and service context (3,000 words). Part 2 consists of a 50 minute digital recording of part of a session with the client, an annotated transcript of the whole session, and a clinical viva. For a full description of this assessment, please consult the Assessment Handbook for the Guidelines on Preparation and the Marking Criteria. https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/docs/resources/Assessment-Handbook-2018-intake-2018-19.pdf

2.5.2 Professional Practice Reports (PPR)

Trainees will need to submit four Professional Practice Reports (PPRs) of a maximum of 5,000 words each. Three of these must be related to direct work with clients (one with children, one with people with Disabilities, and one either with older people or in the area of the trainee's supplementary experience). Details about these PPRs can be found in Section 9 of this Handbook. The fourth PPR must be a Quality Improvement Project (QIP) undertaken during the first year. Details about the PPR: QIP can be found in Section 12.

2.5.3 Team Policy Report and Presentation

The trainees work in teams to produce a 5,000-word critique of a policy document relating to the service and/or profession and an individual critical reflection on the team processes to emerge in the producing of the report. A formal presentation of the Team Policy Report is also made to the entire year group and members of staff.

2020 intake onwards 09/21

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)		Critical Review			Child or Disabilities PPR (2nd 6 month placement)
			Practice Learning Documentation Stage 2a					Practice Learning Documentation Stage 2b
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

2019 intake

Approximate Timing of Submissions (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 Assessment of Clinical Skills part 1	MRP proposal deadline: last Friday in May	Assessment of Clinical Skills part 2 MRP proposal reviews	Team presentation Clinical vivas	Practice Learning Documentation Stage 1	QIP
Year 2			Child or Disabilities PPR (1st 6 month placement) Practice Learning Documentation Stage 2a		Child or Disabilities Critical Review			Child or Disabilities PPR (2nd 6 month placement) Practice Learning Documentation Stage 2b *MRP Part A
Year 3			Practice Learning Documentation Stage 3a MRPs	MRP vivas	OP/Supp PPR (1st 6 month placement)	Community Engagement Project Report (2nd 6 month placement)	Practice Learning Documentation Stage 3b 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

2.5.4 Critical Review

Trainees will need to submit a critical review of the literature of 5,000 to 8,000words. It will usually be on a subject area related to the Major Research Project.

2.5.5 Major Research Project (MRP)

Trainees will need to undertake an independent research project which will comprise of the following submissions: a 2,500 word research proposal to be approved, a literature review of between 6,000 and 8,000 words, and a research report in a journal format of between 7,000 and 8,000 words.

2.5.6 Community Engagement Project Report

Trainees will submit an account of a small project, usually conducted on one of the third year placements, illustrating a contribution to community outreach, promoting clinical psychology for wider benefit, and leadership. (2,000 words).

2.5.7 Reflective Professional Development Report

Trainees are encouraged to keep a journal reflecting on their professional development throughout their training and are required to submit a reflective report (4,000 words) on their experience at the end of training. It is to be read by and discussed with their manager and is a formative assessment only.

2.5.8 Placement Learning

Placement learning will be assessed and monitored by the trainees' supervisors and line manager with the aid of placement visits from the trainee's manager, using Evaluation of Clinical/professional Competence (ECC) forms, and Practice Learning Portfolios.
Details about these can be found in Section 8.

2.5.9 Training Reviews

Individual meetings to monitor and review the trainee's development across the whole of the training are held with their manager at the beginning and end of the first year, and at the end of the second and third years. Details of this are documented in the Course Handbook. Training Reviews and the Placement Allocation forms completed by managers are the main ways of monitoring trainees' competency development, and they inform placement allocation decisions.

3. MODELS OF LEARNING AND PRACTICE

3.1 Competence and Capability

Whilst recognising the central place of competencies in practitioner training and their role in specifying required standards and outcomes, the preferred model adopted by the Course at Salomons is that of capability. The ultimate aim is to produce not only competent practitioners, but also capable practitioners. As such, capability subsumes competence. The difference between the two has been defined as:

Competence – what individuals are able to do in terms of knowledge, skills, and attitude.

Capability – extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance.

Capability has been further defined as including the following dimensions:

- A performance component which identifies 'what people need to possess' and 'what they need to achieve' in the workplace;
- An ethical component that is concerned with integrating knowledge of culture, values and social awareness in to professional practice;
- A component that emphases reflective action in practice;
- The capability to effectively implement evidence-based interventions into the service configurations of a modern health system; and
- A commitment to working with new models of professional education and responsibility for Lifelong Learning.

As can be seen this model puts a very high priority on workplace or practice learning and the integration of this with the academic and research elements of training. The combined 'critical-reflective' and 'scientist-practitioner' emphasis of the course aims to ensure that trainees integrate the theory, practice and research components of the course towards becoming capable practitioners. This model underpins the competencies framework and every effort is made to ensure that there is continuity between placement and academic learning. In particular, the course aims to weave research activity across all aspects of placement and academic learning to avoid the unhelpful split between theory, practice and research.

3.2 Experiential Learning and Reflective Practice

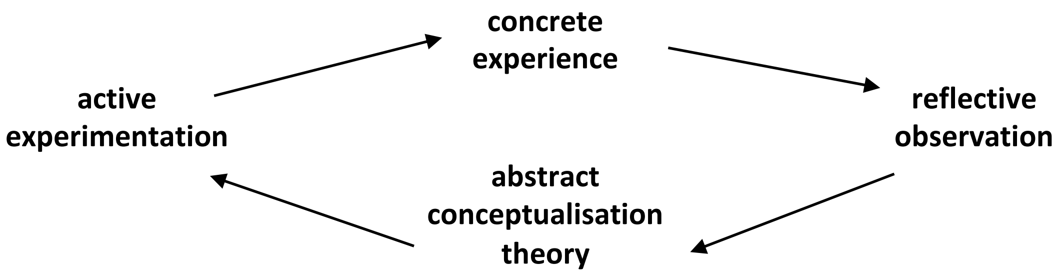
The Course attempts to adopt key ideas from Experiential Learning Theory (Kolb 1984), and from Schon's (1983, 1987) concept of reflective practice in planning trainees' learning experiences on placements and academic days. Kolb's model has been adopted in order to address the division that can arise between theory and practice, when theory occurs on academic days and practice on placement. Such a division means that the learning opportunities in both settings are restricted. The following extract from Gibbs (1988) provides the rationale for the adoption of this model.
"It is not sufficient simply to have an experience in order to learn. Without reflecting upon this experience, it may quickly be forgotten or its learning potential lost. It is from the feelings and thoughts emerging from this reflection that generalisations or concepts can be generated, and it is generalisations, which allow new situations to be tackled effectively.

Similarly, if it is intended that behaviour should be changed by learning, it is not sufficient simply to learn new concepts and develop new generalisations. This learning must be tested out in new situations. The learner must make the link between theory and action by planning for that action, carrying it out, and then reflecting upon it, relating what happens back to theory.

It is not enough just to do, and neither is it enough just to think. Nor is it enough to simply do and think. Learning from experience must involve links between the doing and the thinking. The four-stage model of learning, which is elaborated below, is that of Kolb. Quite a few theorists have proposed cyclical models to explain how people learn from experience but they all share the important features of Kolb's model."

Learning from experience involves four stages which follow each other in a cycle, as in the diagram below:

Fig. 1: The Experiential Learning Cycle



The terms used here as labels for the four stages come from Kolb's Experiential Learning Theory and placed in this sequence they form the experiential learning cycle. The cycle can be entered at any point, but its stages are then typically followed in sequence.

Kolb's model is based on a structuralist model of learning and is influenced by the work of John Dewey and Jean Piaget. In this model learning is defined as the process whereby knowledge is created through the transformation of experience. Kolb identified two separate learning activities: perception and processing. Perception has two distinct aspects Concrete Experience and Abstract Conceptualisation. Processing also has two aspects Reflective Observation and Active Experimentation. Gibbs suggests that in order to learn effectively from experience it is necessary to utilise the abilities associated with each of the four learning styles in turn. These abilities are illustrated below:

Fig. 2: Abilities associated with each stage of the learning cycle (Gibbs 1988)

Experience

Can carry out plans Interested in action and results Adapts to immediate circumstances Trial and error style Sets objectives Sets schedules	Imaginative, good at generating ideas Views situation from different angles Open to experiences Recognises problems Investigates Senses opportunities
Experimentation	**Reflection**
Good at practical applications Makes decisions Focuses efforts Does well when there is one answer Evaluates plans Selects from alternatives	Ability to create theoretical models Compares alternatives Defines problems Establishes criteria Formulates hypotheses

Conceptualisation

In addition to the Adult Learning Model the Course is committed to providing a wide range of opportunities for trainees to develop skills to become reflective practitioners. Reflective practice is an important aspect of learning on placement and in teaching. Schon (1987) described the concept of Reflective Practice as a counterbalance to the model of professional practice based on a positivist epistemology of practice.
Schon developed an alternative epistemology of professional practice grounded in observation and analysis of the artistry competent practitioners bring to the indeterminate zones of their practice. The four processes of Schon's reflective practice are:

- Reflection in action;
- Reflection on action;
- Reflection about impact on others;
- Reflection about self.

A primary purpose of facilitating trainees' development and competence in these processes of reflective practice is to enable them to be prepared for what Schon (1987) describes as the 'indeterminate world or swampy ground of clinical practice'. Reflection in action is a process of reflecting cognitively and emotionally while in the process of acting. Learning to think while 'in practice', and later 'on practice', are important aspects of reflective practice development. Placement supervision, which may use a number of reflective practice development processes (for example, observation, tape/video recording, live supervision and process notes) is a crucial important aspects of reflective practice learning. Learning to reflect about one's impact on others through group and team working facilitates the development of self-awareness in relation to and recognition of others and this can be fostered by group, peer or individual supervision.
The teaching model of the Course integrates Kolb's experiential learning cycle and Schon's concept of reflective practice to ensure continuity between placement learning and the teaching course. In bringing together the Adult Learning Model and Reflective Practice the Course aims to

prepare trainees for the complexities of working in NHS and public sector organisations that are constantly changing.

3.3 Reflective Journal and Reflective Practitioner Group

In addition to placement supervision, personal tutoring and peer discussion the Course provides two particular means for trainees to maintain a reflective engagement with their own experience and development throughout the course. These involve the use of a reflective journal and attendance at a reflective practitioner group.

Trainees are encouraged to maintain some form of reflective journal throughout the three years of their training that is private to them but can be used as a basis for discussion in supervision and line management. It can also provide the basis for the written submission at the end of the third year, which consists of a reflective account of their personal learning and development during the course of the course.

Guidelines are provided on keeping such a journal but it is recognised that this is a highly individual matter and trainees are encouraged to be as creative with this as they wish.

Every trainee attends a fortnightly reflective practitioner group that maintains the same membership from within individual year groups throughout the period of training. These groups are facilitated by trained practitioners who are independent from the Course. The reflective practitioner group provides a forum for reflective discussion and dialogue throughout the experience of training. The aims of the group are:

- To promote self-reflection and personal awareness;
- To promote learning about working with and within groups/teams;
- To provide a forum for reflection on issues relating to the interface between the experience of individuals in the group, the year groups, the course and the wider context.

The intention is that by providing a space for issues and experiences to be voiced and explored, the group will help trainees fulfil their major task of completing and learning from the Programme and becoming more effective reflective-scientist practitioners.

3.4 A Complex Responsive Processes Perspective

In addition to Kolb’s Adult Learning Model and to Schon’s concept of Reflective Practice, both based in structural approaches to learning, the Course is keen to emphasise that the process of learning is not simply the activity of autonomous individual learner’s, but learning is the activity of interdependent people. This perspective draws on the work of Stacey, Griffin & Shaw’s (2000), theory of complex responsive processes. The theory of complex responsive processes draws on some analogies from the natural complexity sciences interpreted in the human sphere in accordance with the thought of George Herbert Mead (1934) and Norbert Elias (2000/1939). Complex responsive processes is a theory of social selves which is based on a phenomenological approach that focuses on one’s experience as the starting point for learning and reflection.

By focusing on experience there is no attempt to stand outside of experience and there is no expectation that the future can somehow be controlled, rather the future arises as continuity and potential transformation in experience with others. Attention is focussed on the cognitive and affective aspects of experience as they occur together. Particular attention is paid to the relationships one has with others and to processes of power relating as aspects of all relating. Learning from a complex responsive processes perspective is seen to involve the potential transformation of identity with all of the potential for anxiety that this entails. Competence is seen to arise in experience and this experience always takes place at a social level.

4. THE PROVISION OF PLACEMENTS

4.1 Introduction

Placement experience is organized to enable trainees to achieve the practice elements of the Course's learning outcomes (see Section 7) in a balanced and progressive way during the course of the course. To achieve this, optimal use has to be made of available clinical placements and close integration maintained between placement learning, the academic and research curriculum, and monitoring of individual progress and competency pathways through training. Placement arrangements are therefore designed to balance clarity of structure and outcome with sufficient flexibility to ensure the maximal use and integration of an increasingly diverse range of learning opportunities within NHS and related services. Placement arrangements are specified to meet HCPC and BPS criteria and the precepts and guidance of the QAA code of practice and the Commissioning for Quality (CFQ) criteria for placement learning.

4.2 Placement Framework

Placement provision is organized in parallel to the academic and research curriculum in three approximately year-long stages designed to ensure that experience is gained across the lifespan with problems representative of all stages of development and in a variety of contexts and forms of service provision.

Table 3: Placement Framework

	Placement experience:
Stage One – First year	• Working age adults • Quality improvement project
Stage Two – Second year	• Children and families • People with Disabilities
Stage Three – Third year	• Older people (age 65+) • Supplementary clinical/service area

In each of these stages three days per week (normally Monday, Tuesday and Wednesday) is spent on placement. During the third year, Thursdays can also be a placement day so trainees and supervisors negotiate which three out of the possible four days will be spent on placement. During July and August, trainees are on placement four days a week. The remaining days of the week are either academic days or private study/research time. The academic syllabus running alongside placements is designed to map on to the knowledge and skills needed for those particular placements. Thus, in Year Two, the two main taught units are Children and Families and People with Disabilities, and in Year Three, the academic focus is upon Older People.

It is important to note that placement experience in year one includes work with adults across a range of adult specialties in addition to mainstream mental health provision (e.g. health psychology, forensic services and neuropsychological assessment/rehabilitation). Adults with disabilities and older adults may also be seen in the first year within the context of some generic services but further work with these groups would still take place in years two or three within more specialist service settings.

Trainees must meet in full the competency requirements of the Health and Care Professions Council and British Psychological Society. This means developing competencies in CBT and at least one other therapy model as well as achieving the core competencies through successfully complete a minimum of 333 placement days overall during the course, or a greater number of days where this is necessary to achieve the required professional competencies. This necessitates careful monitoring and planning by each trainee through training reviews and articulating training needs for placement allocation purposes. Futhermore, good organisational planning is required by trainees as there are more teaching days (and fewer placement days) in the first year, and annual leave needs to be spread across academic days, placement days and study days.

4.3 Partnership Arrangements

Clinical placements are largely provided in the geographical area covered by South East London, Kent and East Sussex. The main host trusts are South London and Maudsley, Oxleas, Kent and Medway, and Sussex Partnership NHS Trusts. The setting up and monitoring of clinical placements involves a close collaboration and shared responsibility between the Course, the trainee's employing NHS Trust (Surrey and Borders Partnership NHS Foundation Trust) and the host NHS Trusts or other organisations providing placements. The main responsibilities undertaken by Trusts or other placement provider, the Course and the trainees' employer are specified in a Service Level Agreement (SLA) that has been drawn up between all parties in conjunction with the training commissioners, Health Education: South East England and London. In particular this specifies responsibilities for trainee management, employment checks, occupational health screening and health and safety procedures including appropriate indemnities. All placement providers have copies of the SLA to which supervisors can refer. Placements for independently funded trainees are covered in a similar manner by an adapted version of the SLA or an honorary contract.

In addition, a number of placements with independent providers may be used, in recognition of the diverse organisations that the clinical psychologists of the future may work in following the introduction of the Health and Social Care Act (2012).

Close liaison between Course and Trusts and other placement providers is also required in order to identify and co-ordinate appropriate placements, to enhance placement provisions and maximise use of available resources, to support supervisor development, to facilitate quality assurance and improvement, and to ensure that Trusts and practitioners from other placement providers contribute to the running and development of the whole Course (e.g. by taking part in admissions procedures, by suggesting new practice-based knowledge that needs to be included in the syllabus to meet workforce needs). To this end, Trust Representatives work to establish and develop placement provision in a coherent and sustainable way within local psychology services and to strengthen mechanisms for the quality assurance and improvement of placement provision. Where the placement is provided by an independent organisation (e.g. a charity, a private organisation providing services to NHS clients), the same close liaison and co-ordination about placement availability and quality is maintained through Course staff.

Where a Trust provides placements to more than one clinical psychology training course (e.g. SL&M, Sussex Partnership Trust), the Trust Representatives or nominated Trust staff member are essential in ensuring good collaboration regarding use of placements.

Service user and carer collaboration and the Placement Advising Scheme
This scheme aims to create specific opportunities for trainees to learn from local service users and carers whilst on placement during the first year. Trainees meet once a month with a member of a

local service user or carer group to discuss issues arising from both parties' experience of (delivering or receiving) services.

However, over and above this scheme, trainees are expected to gain experience and competence in learning from and working with service users and carers outside of the traditional client-professional definition of relationship on most placements. This may mean linking up with community and self-help organisations or systems for involvement established within Trusts.

4.4 Placement Information / Placement Outline Forms

All potential supervisors who have been identified and show an interest in holding this role, are sent Placement Outline Forms (Appendix 4.1) to complete or update as appropriate. Trust Representatives use these forms to collate necessary information about placements (e.g. nature of experience, service setting and competency development opportunities). The Placement Outline Forms are used for the identification, organisation and allocation of placements. Trainees and their managers are given access to the Placement Outline Form once the confirmation email is sent.

4.5 Collaboration with Trusts

The Trust Representatives or other Trust staff who have been nominated represent the responsibility that Trusts have to provide the quality-assured placements required for the number of training places that have been commissioned on the Course. Trust Representatives or their substitutes and Course staff keep the Professional Heads in each Trust informed about placement needs, availability and quality issues (for instance, by attending Trust-based meetings about training, and at the Programme Management Committee). Trust Representatives or other Trust staff work to identify the suitable placements available in their Trust, and if there is any shortfall relative to changing needs, they work closely with their supervisors and with each other to find the additional placements between them. When there have been increased numbers of training places, or a Trust has been going through a major reorganisation impacting on placement provision for instance, this collaborative approach has been very helpful. It has been found to provide the flexibilities needed and to be more effective than having a formally agreed number of placements provided by each Trust.

The Trust Representatives or nominated Trust staff, as well as helping in the identification and allocation of placements, also have an important role in areas such as providing support to supervisors, ensuring placements are of appropriate quality and acting as a liaison point between the Trust and the Course. Guidance is available to Trust staff to help them to decide whether a placement is of sufficient quality to make it suitable for use by trainees on the Course (see Appendix 4.2, Guidance for approval of placements for use by Salomons trainees).

In recent years, there have been times of pressure in relation to placement needs in Learning Disabilities, Older People and Child and Family areas. In contrast, potential supervisor availability exceeds placement requirements for supplementary placements of a more specialist nature (e.g. forensic, neuropsychology). However, the establishment of a year-long Adult placement has enabled fuller use of the range of Adult services that clinical psychologists now work into in the NHS (e.g. Assertive Outreach, Health Psychology) to configure placements underpinned by a competency plus experience approach to training.

The Course is committed to providing as much good quality experience as possible for trainees in all areas within available supervisory resources. The role of Trust Representative in working with supervisors and Trusts to ensure optimal use of these resources is crucial, as is the development of good third sector and independent placement opportunities. The current flexible system of working collaboratively with all contributing Trusts combined with use of alternative appropriate placement providers is seen as fit-for-purpose for meeting future demands in the context of services and needs that are likely to continue to change over the foreseeable future.

Independently provided placements are identified and quality assured by members of Course staff who liaise with independent partner organisations and supervisors.

4.6 Placement Organisation and Allocation

4.6.1 Placement identification and allocation

Trust Representatives, in conjunction with the Course staff who have responsibility for particular specialisms associated with each of the three years, are responsible for identifying placements and for facilitating the organisation and configuration of placements. All supervisors, from Trusts or other provider organisations, are required to complete a Placement Outline Form (Appendix 4.1) which (along with information provided by the Trust Representative, and feedback from managers and trainees when available), is used to determine whether the placement meets the requirements.

Placements for the year are allocated to individual trainees in June/July before placement commencement in October of each year. Prior to this, each trainee has an individual meeting with their manager at Salomons to review and identify their training needs, model-specific competency development priorities, interests, and any personal circumstances that should be taken into account for the next placement. This information is recorded on the Trainee Placement Allocation Form (Appendix 4.3).

Guidance on how to complete and use this form can be found as Appendix 4.5. In addition, trainees with specific health or learning support needs should also complete the Practice Learning Support Plan (PLSP) with their managers so that this information can be considered at allocation and with supervisors (see **4.8** below and Appendix 4.4).

The placement allocation takes place through day-long meetings involving the Trust Representatives and the members of the Course team for that year. The Trust Representatives provide the Placement Outline forms which are then summarised and posted around the room. The Course Team bring the Trainee Placement Allocation Forms detailing the trainees' needs and priorities. Starting with trainees who have special needs due to health or personal circumstances, each trainee is considered in turn and matched to a placement that best meets their needs. Often several trainees' needs will appear to be best met by the same placement. In these situations there is a discussion as to which trainees' needs could be met elsewhere and who should have a priority for that particular placement.
Consideration is also taken to ensure that any requirements of particular placements/supervisors are also met.

Every effort is made to ensure that a good proportion of the needs of each trainee are met by the allocation, although it is not usually possible to meet all of the needs of every trainee. A record is kept on the Trainee Placement Allocation Form of which learning needs are met by the placement allocated.

For some placements which are six months long, it is necessary to hold a second allocation February in order to either allocate or check the April placements. This is particularly true in the second and third year of the Course.

Travel (see 4.7) - It should be noted that as it is required that all trainees will be able to make appropriate arrangements for travel during the Course. Whether or not they have access to a car is not taken into consideration at Placement Allocation meetings, except when there are relevant health issues.

Every effort is made to be as equitable as possible with regard to the amount of travel required to get to placements across the duration of training. In this respect, special consideration is given to trainees with disabilities or dependents but in the context of the need to balance the travel demands for all trainees. However, significant travel is usually involved in undertaking at least some placements. Travel costs are reimbursed according to the NHS handbook, Agenda for Change mileage rates.

4.6.2 Placement and supervision organisation

The way placements are organised maximises the range of supervisors who can offer placement experience and support for development of specific competencies, and involves a broad range of possible placement configurations that fit with local service arrangements. All trainees will have a **co-ordinating clinical supervisor** (an HCPC registered psychologist or related professional governed either by the HCPC or an appropriate professional body) who will be responsible for co-ordinating the placement, undertaking formal reviews with the trainee and for completing the end of placement Evaluation of Clinical Competence form. In addition, there may be a range of other supervisors who provide input (**clinical supervisors**) – this might, for example, be supervision on a single case, using a particular theoretical model, across the whole year of a year-long placement or offering a three-day a week involvement in a particular service over a period of a few weeks. Clinical supervisors may come from a range of professional groups (e.g. psychotherapists) who are suitably qualified and experienced to provide supervision in relation to the development of particular competencies.

If neither the co-ordinating or clinical supervisor is a clinical psychologist, there is a requirement that the trainee has access to professional liaison and supervision during the placement. It is generally expected that the trainee and a clinical psychologist will meet on a minimum of three occasions towards the beginning, middle and end of the placement in order to provide a professional context for thinking about the trainee’s experience and learning. Such discussions may include how clinical psychology roles and responsibilities may be both similar and different to those of their supervisors, how clinical psychology and professional structures “sit” within local services and the Trust, development of professional identity, and opportunities for organisational influence and leadership for instance. It is also recommended that the trainee attends a couple of professional clinical psychology meetings during the placement if possible. Sometimes there may be opportunities for a piece of joint work with a clinical psychologist and the arrangement for supporting professional development may then be a more informal process, but adequate opportunities for relevant discussions should still be made available to the trainee.

4.7 Travel and Staying Over

The Course makes use of placements throughout South East London, Kent and East Sussex and is under an obligation to send trainees to all Trusts within this area. All Trusts and qualified NHS providers contribute to the funding of training. As a result, trainees are required to undertake significant journeys to some placements. Trainees are expected to make their own arrangements for all travel. This normally necessitates the use of a car. However, it should be noted that the mode of travel used will not influence placement allocation except in exceptional circumstances, e.g. where a trainee is unable to drive through disability.

In addition to commuting to placement, many community services also require significant travel on placement. This can be extremely difficult without at least regular access to a car. Rural public transport is unlikely to enable trainees to carry out their work in a timely manner, and taxi bills could run into several hundred pounds over the course of a placement in a rural area. Taxi costs are **not** reimbursable travel expenses. Use of taxis is not encouraged or routinely supported. If particular circumstances suggest the need to use a taxi for any reason, this needs to be discussed with the Surrey and Borders Trainee Manager and agreed in advance. Similarly the congestion charges payable in London are not normally reimbursed unless exceptional circumstances arise which make them unavoidable in order to complete placement work. Once again this should be anticipated and agreement reached with the Surrey and Borders Trainee Manager and agreed in advance before submitting a claim.

Where travel is particularly lengthy it may be more convenient and less stressful for trainees to arrange to stay over in Bed and Breakfast accommodation for one or two nights a week on some placements. By prior agreement with the Surrey and Borders Trainee Manager it may be possible to claim reimbursement for these expenses, in accordance with the NHS handbook, Agenda for Change subsistence allowances. For further information see the Course Handbook.

4.8 Specific health and learning needs and placements

In order to assist staff in making good placement allocations for trainees with particular health and learning needs, trainees to whom this applies should complete a Practice Learning Support Plan (PLSP - see Appendix 4.4). This form provides brief information about the health (including pregnancy) or disability issues (including dyslexia) that may need to be taken into account when selecting an appropriate placement for the person. Sometimes it may be necessary to make reasonable adjustments to a placement or its physical environment. Therefore, when signing the PLSP, the trainee gives his or her permission for information to be shared. This makes it possible for the Trust Representative or other Trust or course staff member to explore and discuss with a potential supervisor how the trainee's learning needs may best be accommodated in a service.

5. SETTING UP AND MANAGING PLACEMENTS

5.1 Introduction

The aim of this section is to outline the framework of resources, processes and responsibilities involved in setting up and starting a placement. The audit items in the Practice Learning Feedback Form (Appendix 5.1) and the Placement Audit Form (Appendix 5.2) may be useful to refer to as they indicate some of the key features of placement management.

Year-long competency-based placements mean that more than one supervisor and service setting may be involved in providing trainees with a range of learning opportunities. The guidance in this section applies to all contributing placements making up the overall configuration. The learning design and configuration of placements will normally have already been established with Trust Representatives and Course staff. However, communication between different supervisors involved in a placement, and between supervisors and trainees about how the practicalities of placement components and the aims of different placement components work together, is crucial to the success of placement arrangements. The co-ordinating clinical supervisor's co-ordinating role is particularly important in this respect.

5.2 Placement preparation: Resources, Communication and Information

Supervisors are encouraged to begin planning and organising the placement well before the trainee arrives, especially in respect of the permissions involved in gaining access to IT and record keeping.

5.2.1 Physical Resources

The HCPC Standards of Education and Training require that practice placement settings must provide a safe and supportive environment (HCPC SET 5.3). Furthermore, the BPS Accreditation through Partnership (2019) Course Standard 7.3 states that:

"When trainees are on clinical placements, they must have access to (at least) a shared office and telephone. There must be adequate arrangements for secretarial and IT support for their placement work and trainees must be given guidance on the facilities available."

Access to secure filing/storage space, photocopying, test materials and space to see service users will also be needed, and will need to be negotiated locally in advance. A rule of thumb for thinking about practical matters is that trainees should have broadly the same access to resources as other psychologists.

5.2.2 Supervision

Supervisors must be HCPC registered or be appropriately qualified and experienced members of another profession who are registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures.
All supervisors need to be aware of the following documents and use them for guidance.

Placements generally should meet the criteria set out in Standards for the accreditation of Doctoral courses in clinical psychology https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf

Particular guidance for supervisors of clinical psychology trainees can be found at https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Guidelines%20on%20clinical%20supervision.pdf (or see Appendix 5.3).

Supervisors should also be familiar with the DCP Policy on Supervision (2014), which can be found at https://hull-repository.worktribe.com/preview/369313/CAT-1556.pdf (see Appendix 5.13).

It is stipulated that the total "contact" time between supervisor(s) and trainee(s) must be at least three hours per week. The Course expectation is that as part of this, the trainee will have a *minimum* of one full hour of scheduled supervision per week. If a group, or pairs, supervision model is being used, an appropriate amount of individual supervision time should also be offered to address any issues that may be harder to raise in a group. The remaining time may comprise joint work together and informal contact e.g. in the office, telephone or email contact. The amount of additional scheduled supervision time provided by the co-ordinating clinical supervisor should be proportionate to the amount of clinical practice they are directly supervising; however weekly supervision time should be protected for the trainee regardless of how many people they have started work with. In addition, some allowance should also be made for the time required to maintain an overall view of the trainee's experience on placement and to co-ordinate their evaluation. It is our view that an hour a week will often not be enough, and we recommend a minimum of 90 minutes scheduled weekly supervision time, particularly for trainees at an early stage of their training and/or at the beginning of a new placement.

Where there is more than one supervisor, the actual supervision time made available should be a pro rata reflection of the BPS guidance, in keeping with the proportion of time spent by the trainee working with a given supervisor. Supervisors will therefore need to incorporate this time when planning their workload management. Each placement should have a designated co-ordinating clinical supervisor and may have one or more clinical supervisors responsible for specific aspects of the placement. Further details of the respective roles of co-ordinating and clinical supervisors can be found in section 6.3.

Supervisors are expected to attend a three day BPS accredited supervisor induction training organised by Salomons (CCCU) prior to becoming a supervisor, and are encouraged to undertake further supervisor training organised by the Course or externally as appropriate to address their own developmental needs and interests and to comply with HCPC expectations. Trust Representatives and Course Staff are available to provide on-going support and guidance as required.

Where a supervisor is experienced and has already engaged with another course's training but is new to the area, web resources exist to support their adaptation to Salomons requirements

Trainees should normally have opportunities to observe their supervisor's work and plans should be made for this to occur early in the placement. Ideally, this should incrementally progress to joint work and then independent work.

It is required that trainees will have their practice directly observed by their supervisors to facilitate specific feedback and learning and to enable valid assessment of clinical practice. It is also helpful to make use of indirect forms of observation such as audio tape or video recording (see 5.5.4). The number and breakdown of observations (25 across three years) is specified on the Evaluation of Clinical Competence (ECC) form. One of these observations of trainees should be devoted to a piece of work involving a focus on model-specific competencies, and followed by a supervision session designed to facilitate model-specific learning, which also supports the trainee to evaluate and record their progress (in the relevant sections of the Practice Learning Portfolio) in this respect.

Further guidance about supervision is provided in Section 6.

5.2.3 Communication

Preparation of staff and teams for the arrival of a trainee is important, contributing to a welcoming learning context. Whilst some services may be used to having students around, not all of them will be familiar with clinical psychology trainees, so preparing the ground by informing colleagues of when the trainee will start and the kind of work they will be doing is strongly recommended.

Status and title - Trainees are called Trainee Clinical Psychologists, not students, probationers, or assistants. When a trainee writes letters or reports, it is of course inappropriate to use the title "Clinical Psychologist". Service users have the right to know if they are being treated by trainees and to ask to be treated by a qualified practitioner if they wish. Whilst trainees do already have a psychology degree, they are not entitled to practise as Chartered Clinical Psychologists. The title that is recommended by the BPS Division of Clinical Psychology is “Trainee Clinical Psychologist”.

Consent - It is also worth bearing in mind that trainees will need to seek consent from clients to write about them for their Assessment of Clinical Skills (ACS) and Professional Practice Reports (PPRs - see section 9) so it is worth agreeing a way that trainees can introduce themselves and their role that routinely covers this at the outset and is suitable for the placement.

Furthermore, in accordance with the local NHS policies operating in the placement Trust, trainees may also have to seek consent from other professionals in order to include third party letters, reports etc. in the appendices of PPRs.

5.2.4 Preparing for Induction

An appropriate induction orienting the trainee to the placement, the supervisor’s work context(s), the service, the Trust and relevant policies should be provided during the initial weeks on placement. As trainees may be based in more than one service, each placement component will need to be covered in the induction.

It can be very helpful if an information pack is developed in advance and trainees very much appreciate one. It usually includes:

i) A list of key people, their jobs and contact details; an organisational chart
ii) Maps of the area with units clearly marked
iii) Health and Safety information and other relevant Trust staff policies (e.g. harassment, equal opportunities policies)
iv) Client group policies, local protocols, operational policies, referral criteria etc.
v) Descriptions of administrative procedures, secretarial support

vi) Information about where to get lunch, drinks, parking, nearby facilities such as banks and chemists

vii) An induction timetable for the trainee to meet key people and visit places of importance to the service (See 5.4)

viii) Resource directory information about services provided by the Trust, Social Services, self-help and service user groups, and voluntary agencies in the community.

Observation week - Please see Section 5.5.2 for a full description of the Observation Week at the beginning of the placement in the first and second years. The trainee will be required to carry out some work (an "observation task) during the placement induction period, which they will then feed back into particular academic sessions. The tasks are designed to complement the induction process. Some advanced planning by supervisors may be necessary about how the learning task can be facilitated (e.g. thinking in advance about induction visits or meetings that would fit with the tasks, ensuring enough time is left in the first week's induction course for the trainee to pursue them) and the best ways of achieving them given the particular local circumstances of the placement. Supervisors may also find it interesting to read the small number of articles set to support the trainees' work.

5.3 Pre-placement Contact

Confirmation email to co-ordinating clinical supervisor - Trainees and co-ordinating clinical supervisors are normally notified of the placement allocation by email in July/August. For six month placements commencing in April some communications may take place at a later date, usually by early March. The email contains the following information:

- Contact information for the designated member of Course staff who will be monitoring and supporting the trainee's placements throughout the three years is provided. This person is the trainee's manager.
- Details of the academic course related to the placement.
- For first year placements, a copy of the Observation Week tasks the trainee will be expected to carry out with the supervisor's support as part of the placement induction. Second year placements the supervisors will be briefed by the trainees.
- Details of important placement/course dates. It is helpful to check these carefully as, for instance, the induction arrangements can involve trainees attending placement for a week and then having a further week of course - based induction at Salomons.

There is a teaching break at Salomons during July, August and early September which means trainees have four days available to be on placement during this period. It is normally necessary for some annual leave to be taken at this time. If there is any difficulty accommodating a trainee on placement for four days a week this should be raised with the Trust Representativeor the trainee's line manager.

5.3.1 Pre-placement telephone call

The trainee's manager will telephone the co-ordinating clinical supervisor to discuss:

- Details of the placement being offered.

- Any planning, preparation, practical, design or support issues the supervisor may wish to raise.
- The learning needs of the trainee.
- The arrangements for supervision and induction, and preliminary considerations for the placement contract.
- The date for the placement visit.

This conversation also provides an opportunity for the Course to provide some information about a) the trainee and their development, and b) support for supervisors e.g. workshops, information.

5.3.2 Trainee – Supervisor Pre-Placement Meeting.

As far as possible in advance of the starting date for the placement, the trainee contacts the supervisor to arrange a pre-placement visit. (For placement components that will not start till later in the year, trainees may either meet their future supervisor during their general induction at the beginning to orient them to the whole year, or nearer the time that part of the placement will start). This visit has several important functions:

- Trainee and supervisor getting to know each other.
- Supervisor finding out about the trainee's previous experience before and during the Course.
- Supervisor finding out about the trainee's strengths and learning needs, and any expectations or special interests for the coming placement.
- Trainee finding out what is on offer at the placement and any particular requirements or expectations that the supervisor has (e.g. attendance at certain times).
- Any special needs that the trainee has and how the placement can support these. In particular, approximately 10% of Salomons' trainees have a diagnosis of dyslexia either before they arrive or while they are on the course and this can have implications for placements. A brief guidance for supervisors about this is available in Appendix 5.4.
- Clarification of the placement configuration and supervisory relationships and responsibilities (when trainee will be with whom for what during the year).
- Start date, also dates of holidays, study and teaching times, major deadlines.
- Discussion of the main points to be included in the Placement Contract (see section 5.4 below).
- Discussion of a potential Supervision Contract

The three most important purposes of the Pre-Placement Visit are probably meeting each other personally for the first time, planning exactly how the placement will be spent and beginning to establish the “contract” for the placement including supervision.

It is a good idea to schedule the first supervision session during the Pre-Placement Meeting, and if possible, to set a regular time and day for it to occur thereafter.

A Pre-Placement Meeting Checklist is provided as Appendix 5.5.

5.4 The Placement Contract

The earlier configuring of placements with Trust Representatives means that supervisors will already have a framework of the main experiences and competencies the placement will seek to offer. Further information on learning outcomes for the Course and practice learning can be found in Section 7.

Placement Contracts contain the agreed aims, learning outcomes and more detailed specification of each placement component, developed through discussion with the trainee and tailored to their particular needs and interests. A template for the Placement Contract is available in Appendix 5.6. This provides an outline of the issues that need to be agreed between the trainee and the supervisor. Usually for placements with multiple components and supervisors, one contract is agreed to cover all aspects of the placement.

The Placement Contract is constructed at the time of the pre-placement visit, or very shortly after the start of the placement. The template can be adapted to meet the needs of the trainee and the opportunities available on that particular placement.

Attention is given to the range of opportunities available in the placement and to the needs, interests, and previous experience of the trainee in order to combine them in a set of aims. Particular efforts are made to fill any major gaps in the trainee's experience, and to describe any particular competencies, including model-specific competencies, they will be developing. The contract contains the following key features:

- A brief description of the placement and setting(s), name of supervisor and trainee, dates of placement.
- A statement of main aims of placement, including the goals for the clinical competencies to be developed.
- An outline of ways in which it is intended to achieve those aims.
- A statement of specifically what work will be done, with whom, and some estimate of how much.
- A brief description of any special experience which will be offered.
- An outline of any quality improvement research to be undertaken.
- How the supervisor will support the trainee’s assessed written work arising from the placement i.e. the Assessment of Clinical Skills/ Professional Practice Report (PPR)/Community Engagement Project Report/ and Quality Improvement Project (QIP).
- Details of supervision.
- Opportunities for the trainee to observe the supervisor(s).
- Details of how the trainee’s work will be observed.
- An outline of what will be achieved by the end of the placement.
- Plans for how annual and study leave will be taken during the placement.

The contract should be agreed between the supervisor(s) and trainee, written, signed by all parties, and returned to the Placements Officer at Salomons **within four weeks of the start of the placement**. They forward it to the trainee’s manager who checks it to ensure it covers key competency areas and provides for adequate supervision time. A copy is also kept by both the supervisor and the trainee.

The process of arriving at a contract is as important as the contract itself. It is also a document that helps the trainee, supervisor and manager to monitor the placement and reflect upon expectations, aims and achievements. It is referred to formally at placement visits for review purposes.

5.5 Supervision Contract

It is good practice to have an open discussion of how supervision will proceed to consider the expectations both parties may bring to the working relationship. As with all relationships, there are sometimes implicit assumptions of clinical supervision that if not made explicit, may lead to misunderstanding.. A negotiated agreement on different aspects of the supervisory relationship and process allows the needs of both parties to be considered and models good practice with regard to attending with humility to each other's core values, world view and aspects of social identity such as 'race' and gender. Investment of time at the start is likely to help things progress more smoothly and contribute to a good supervisory relationship Therefore, supervisors are encouraged to discuss a supervision contract with the trainee at the beginning of placement.

For guidance on areas to include in developing a Supervision Contract, please see Appendix 6.8 for a suggested template which can be adapted and used to suit the specific needs and preferences of the individual trainee and supervisor. This is for the supervisor's and trainee's own use and the Course does not require a copy.

5.6 Starting the placement: Induction and Observation Week

5.6.1 Induction

A good induction process creates a context for a successful and enjoyable placement. The early stages of the first year Adult placement make a particularly important contribution to trainees' overall orientation and adjustment to the expectations and demands of training in general. Placements and relationships with supervisors are usually a particularly significant part of settling in and making the transitions from old identities and roles to new ones.

Ordinarily, trainees are expected to be "operational" within a week or two of starting a placement, but this will vary with the complexity and number of settings they are working across in year-long placements. Being plunged straight into clinical work without any knowledge of people, settings and issues is usually anxiety-provoking for trainees, though long inductions can be experienced as frustrating.

Information packs have already been mentioned as part of the placement preparation. Reading them and clarifying/finding out further information is a useful induction task. In addition, it is good practice for supervisors to construct a schedule of visits, meetings and observations that the trainee can follow in the early weeks of the placement to orient them to the contexts of their work. Induction timetables typically include:

- "Mapping" of key personnel, their jobs/roles, position in organisational structure, and of geographic and organisational location of services.
- Locating and reading local and national policies, key documents etc.
- Visiting local services, settings, teams, community agencies
- Meeting and talking to psychologists and other professionals

- Observation of/ sitting in on groups, clinics, sessions
- Familiarisation with referral and administrative systems, record keeping etc.
- Observation of / sitting in on professional, team and multidisciplinary meetings
- Reading or finding out about local databases, audits, service evaluation etc.
- Familiarising themselves with the Trust's Health & Safety and staff procedures

5.6.2 Observation Week

The first week of the Adult placement and of the Child or Disability placement at the beginning and end of the first year is designated as an "Observation Week". That means that the three placement days during this week will be focused on placement induction and the completion of some placement-based learning tasks required by the Course. These tasks are designed to bridge and integrate practice, academic work and research during the early months of the placement. They are set by academic unit tutors and each one should take no more than half a day to complete. They will involve activities based on common induction experiences (e.g. observing a team meeting, talking to different professionals, finding out about the population characteristics, referral patterns, community resources), and will contain elements of reflective practice and systematic inquiry. Trainees will be required to feed back, develop and reflect on their learning during subsequent academic sessions. Supervision obviously has an important role to play in this process.

Examples of two learning tasks and their associated methods of inquiry are given in Appendix 5.7. The first is derived from the syllabi for the Community Psychology, Adult Mental Health and Diversity Units, and the second one is derived from the Child Unit.

Co-ordinating clinical supervisors will be sent descriptions of the tasks when they are notified of the placement allocation so that they can incorporate them into their plans for the induction, and ensure that trainees will have access to opportunities to pursue the inquiries necessary to complete their learning tasks. The ways that trainees can approach their tasks in the context of their particular placement should be discussed at the Pre-Placement Meeting, with due regard to the constraints and opportunities afforded by the given service setting, team and organisational backdrop.

5.6.3 Required Induction Training

A number of Trusts have introduced requirements for the induction training of their employees. Unfortunately Trusts have established different specifications for what they consider to be "mandatory" training and have generally not drawn up guidelines for groups of staff like Clinical Psychology trainees who are centrally employed and may be working within particular Trusts for only a limited period. Therefore, a three day NHS focussed induction training package for all trainees commencing the Course is provided by Surrey and Borders Partnership NHS Foundation Trust on behalf of all NHS placement providers. The induction has been designed in light of data gathered from individual Trusts about their induction requirements and covers all recognised "statutory" induction requirements. This includes vulnerable adults, data protection, manual handling, child protection, and fire training. Trainees will have written details of the areas covered in this induction so that they can clearly inform host Trusts of the areas covered. In addition, trainees are required to engage in on-line mandatory training during training, and the employing Trust, SABP, ensures that trainees are up-to- date with all requirements. This enables host Trusts to know that trainees have already completed core mandatory training, and to identify and tailor any additional induction requirements to those specific to work within the local Trust setting or specialism (for example to local health and safety procedures or clinical policies).

5.6.4 Observation of Each Other's Work

It is generally good practice for trainee's to be able to observe their supervisors' work before beginning their own clinical work. A process which progresses from the trainee observing the supervisor, to joint work between the trainee and supervisor, to the supervisor observing the trainee, and ending with trainee working independently is ideal. While this may not be possible in every placement, it is expected that supervisors will observe trainee's work directly to enable them to both give feedback to the trainee and to accurately assess their clinical competence. Guidance that may be useful in providing feedback to the trainee is available in Appendix 5.8. Observation could be in the room, via a screen, or through joint work or shared professional activities such as meetings, by video/camcorder or audio tape, or using process notes if no other options are suitable.

The Course requires trainees to be observed on a minimum of 25 occasions during the three years (10 times in first year, 10 times in second year, and five times in the third year). They should reflect a combination of assessment and on-going therapy sessions, and should be achieved by a range of methods across the whole of the training. Numbers of observations are recorded in Section A of the ECC form.

Observation of model-specific competency development One (or more) of the observations on every placement should be devoted to observation of competencies that are more model-specific, in order to help the trainee complete the relevant model- specific competency records in their Practice Learning Portfolio (see Appendix 8.3).

Specific supervision time needs to be devoted to discussion of this observation, to provide feedback and support further development. The trainee will then be in an informed position in order to complete the relevant model-specific competency framework in the Practice Learning Portfolio at the end of placement. The supervisor will sign off the trainee's recording of their model specific experience and development to indicate their agreement with the trainee's self-evaluation. Further information about this process is available in Section 8.8.

Equipment for video and audio recording is available at Salomons for trainees to borrow for this purpose. For further guidance on consent, data protection and confidentiality issues when making recordings, see Appendices 5.9 and 5.10. Excerpts from the General Medical Council's guidelines on making and using visual and audio recordings of patients can be found in Appendix 5.11.

Summary guidance for audio and video recording

- Trusts maintain their own separate protocols with regard to the production, storage and removal of audio and video recordings. It is the responsibility of the trainee to establish the protocol for the use of recordings within the placement or clinical settings and to strictly adhere to it.

- The HCPC/BPS codes of conduct also impinge on recordings made in clinical settings. For use in non-clinical settings e.g. recording practice interviews with another trainee, it is sufficient to gain the usual permissions as well as to follow the HCPC/BPS codes of conduct.

For further information with regard to the making of recordings, see Appendix 5.9. Additional information on how this issue relates to making recordings for the Year 1 Assessment of Clinical Skills can be found in Appendices 5.10 and 5.11. Further details can also be found in the Assessment Handbook. https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/docs/resources/Assessment-Handbook-2018-intake-2018-19.pdf

5.7 Process for managing placement changes

Occasionally it may be necessary to make changes to the placement configuration after the placement has been allocated or even after it has started, due to service changes or supervisor movements. In such situations the Trust Representative (or Course staff member if an independent placement) should be involved in exploring options which would meet the trainee and/or service needs. It would normally be desirable for them to also involve the trainee's manager in this discussion and the Placements Officer should be informed of any changes.

In the extremely rare circumstances of there being serious recurrent and unresolved problems with the quality of a placement, a trainee may be allocated to a different placement. This only occurs after all reasonable attempts have been made by the trainee, manager and Trust Representative to improve the learning opportunities provided by the placement.

Very occasionally it may be necessary to withdraw a trainee from a placement. See section 8.5 for further information.

5.8 Management Roles and Responsibilities

Unless independently funded, the trainee is a full-time employee of the NHS, with terms and conditions in accordance with national agreements concerning the profession, and the policies and codes of practice in operation at Surrey and Borders Partnership NHS Foundation Trust. All trainees, however they are funded, are required to abide by the HCPC Standards of Conduct, Performance and Ethics, the HCPC Guidance on Conduct and Ethics for Students, the BPS Code of Conduct, and, Salomons (CCCU) and the placement Trust at all times.

Supervisors are clinically responsible for the trainees' work on placement and undertake day-to-day management of the trainee on the placement on behalf of the placement Trust. Trainees are expected to be working under supervision at all times although the closeness of this will clearly vary according to the nature of the work and the level of competence reached by the trainee.

A service level agreement (SLA) specifies the responsibilities of host Trusts and other placement providers, the trainees' employing Trust and the Institute for Applied Psychology at Salomons (CCCU). This agreement supersedes individual honorary contracts, which are not required except occasionally and then only for independently funded trainees. Among other things this agreement specifies the indemnity arrangements to cover the professional work of trainees on placement with regard to both clinical and research activity.

Professional indemnity insurance Although trainees are indemnified in a similar way to other health service employees, the Course strongly recommends that in addition to this, for their own protection, they seek personal professional liability insurance. This is because in respect of NHS work, any claim by a patient or their family arising from the work of an employee – e.g. for negligence - will normally be made against the employer of the psychologist concerned, i.e. Surrey and Borders NHS Trust for a trainee. The supervisor, their employer and insurer may also carry a liability. It is sensible for trainees to have their own insurance to provide legal cover in the case of a dispute because the supervisor's insurance does not cover a trainee, and the employer's legal representation will not be aimed at protecting the interests of employees (e.g. trainees). Therefore, trainees are either obliged to take out insurance or to sign a form to say they have decided not to.

The professional indemnity insurance cover arranged by the BPS has discounts for trainees. The costs should also be tax deductible. Union membership also accords protection to members in the case of complaints or disputes, and trainees are strongly encouraged to join the union. The union which represents psychologists in the NHS is Unite.

It is good practice for work with potential legal implications to be particularly carefully monitored and for reports relating to this to be counter-signed by the supervisor. If court appearances are required it is generally best if these can be undertaken by the supervisor, although it is recognised that this is not always possible and that trainees can be asked to appear.

Management Trainees are managed throughout the Course by a member of the Course Team. The manager is responsible for line management, all matters relating to trainees' progress on the University course and liaises closely with the trainees' employing Trust, Surrey and Borders Partnership NHS Foundation Trust (SABP), about employment matters for which they are responsible. Additionally, SABP employs their own manager to support the line management of trainees. Trainees' course managers are responsible for supporting and monitoring placements, and are the second examiner for the formal Evaluations of Clinical Competence, the supervisor being the first examiner.

Trust Representatives are usually senior psychologists employed by Trusts. They are responsible for working with supervisors to identify and configure placements of a suitable standard within Trusts, for supporting and developing both placements and supervisors, for advising both supervisors and the Course about placement quality and providing detailed information for allocation purposes, and finally, contributing to the operation and periodic review of the Course as a whole. Both Trust Representatives are invited to engage with the Course in multiple ways as well e.g. through Committee attendance, contributing to supervisor training etc., in order to facilitate the necessary Course – Trust collaboration.

5.9 Health and Personal Safety at Work

Employers have a duty under law to ensure, as far as is reasonably practical, people's health, safety and welfare at work. Employees have a responsibility to look after themselves and others by taking reasonable care, reporting potential risks or incidents and co-operating with all relevant policies and procedures.

Trainees who are employees of Surrey and Borders Partnership NHS Foundation Trust, should abide by their Health and Safety Policy, a copy of which is available at Salomons and on Blackboard. However, as trainees spend most of their working time within other trusts and also at Salomons, they also need to be aware of and abide by the specific health and safety arrangements that apply locally. Independently funded trainees should abide by the host Trusts' Health and Safety policies. In practice this constitutes part of the purpose of the service level agreement. This places both Trusts offering placements and trainees on placements under a mutual obligation regarding issues such as health and safety. On placement it is trainees' responsibility to familiarise themselves as much as possible with all relevant policies, procedures and local practices. In addition trainees should be clear about reporting arrangements in the event of identifying a risk, or for any kind of accident or incident that might occur.

It is obviously particularly important to consider issues concerning personal safety carefully while on placement, as trainees will constantly be working in new environments with differing requirements regarding specific practice. If uncertain about the safety of any course of action it is vital that trainees seek guidance on it from their supervisor.

General guidance and principles will be provided on personal safety at work in one of the early teaching sessions in the Course. The following factors should be actively considered by trainees on each placement to ensure personal safety and professional responsibilities to others, including service users:

- Fire safety arrangements/procedures
- Environmental safety – e.g. waiting arrangements, consulting areas, car parks, lighting, potential hazards, calling for assistance.
- Safety when moving or handling (e.g. heavy test materials).
- Risks and management of potential violence or aggression
- Working out of hours or in unoccupied/isolated buildings
- Conducting home visits
- Personal information on the internet

As a rule, trainees should not work in buildings on their own, conduct visits to unknown clients on their own, or go on visits without informing people of their whereabouts and expected time of return. Trainees should make sure they are familiar with all local arrangements for fire safety and evacuation and other potential physical risks.

The Course requires trainees either take out professional liability insurance to ensure all aspects of the work they undertake as trainees are adequately covered, or that they sign a waiver document which will be kept on record by the Course. They are also made aware of the benefits of union and BPS/DCP membership.

Coronavirus and risk mitigation

At the start of each placement, trainees and supervisors are required to discuss, complete and sign a form concerning the trainee's personal health/caring risk factors and any potential exposure to environmental risks associated with the placement. This form should provide the basis for discussion between trainee and supervisor about any adaptations needed to mitigate risks. The trainee's manager will review the form and sign it off. If necessary, the manager will discuss any risk issues identified with the trainee and supervisor, and if appropriate, refer the trainee to SABP occupational health service for further advice.

It is recommended that the joint SABP/Salomons form is used as it covers some specific issues associated with training. However, the SABP form may be used, as may the host placement Trust's coronavirus risk assessment form if preferable, so long as it covers the same potential areas of risk, including caring responsibilities and travel. The joint SABP/Salomons form can be found in Appendix 5.14, and it should be read in conjunction with the flow chart in Appendix 5.15 which describes the procedure for assessing and recording coronavirus risk for trainees on placement.

5.10 Placement Days, Leave, Sickness and Study Time

Trainees must meet in full the competency requirements of the Health Professions Council and British Psychological Society and successfully complete a minimum of 333 placement days overall during the course, or a greater number of days where this is necessary to achieve the required professional competencies.

It should be noted that there are more academic days in the first year than in other years, and correspondingly fewer placement days. Therefore, trainees will probably not do the same number of placement days for each year of training and should factor the different proportions of placement, academic and study time in each year of the Course into their calculations and plans.

It is the responsibility of the trainee to keep a record of the days spent on placement and to submit this information as part of each six month placement evaluation. Supervisors are required to check and countersign this so it is helpful if they also keep a record of any days absent from placement.

What can be counted as a placement day – If trainees are required to, or obtain permission to attend course meetings or conferences on placement days, they can normally still be counted as placement days. Study and annual leave **do not** count as placement days.

In the case of sickness, the first three days of a period of sick leave on a maximum of two occasions in a six month placement can be counted as placement days. For the longer first year placement, the first three days of a period of sick leave may be counted on a maximum of three occasions. Emergency leave days (e.g. for caring responsibilities) may also be counted as placement days in this way as well **but must** be included with any sick days so that together the maximum limits of the allowance outlined above are not exceeded. The number of such days included in the total should be indicated for monitoring purposes.

Annual leave – Discussions about when annual leave will be taken should be part of the discussions that take place between trainee and supervisor at the pre-placement visit and during the contracting process at the beginning of the placement. All annual leave should be well planned by supervisor and trainee. It is the trainee's responsibility to gain the **supervisor's permission** to take days off placement at least **four** weeks in advance. Once approved trainees email their relevant Salomons Year Group Administrator for processing.

Given the multiple demands of the academic, practice learning and research elements of the Course and the limitations on when annual leave may be taken, it is vital that throughout training, trainees plan their leave carefully and well in advance for the year, and that the permission of supervisors and managers is also sought well in advance.

Leave should be spread across academic days, placement days and study days. (N.B. Please note that a maximum of **four** academic days may be taken as annual leave in any academic year). No leave may be carried forward into the following leave year except under exceptional circumstances. In the third year, as a result of multiple competing deadlines and the ending of the Course, it is essential that annual and study leave is discussed with placement supervisors at the outset, and trainees are required to include their leave in the placement contract.

This guidance applies equally to NHS and independently funded trainees. For a fuller explanation of the framework governing annual leave, please see Section 2, Leave Arrangements of the Course Handbook.

Sickness - In the event of sickness, the trainee must notify both the placement supervisor and the Administration Office at Salomons by 10am at the latest. In circumstances where it is necessary for a trainee to have an extended period of sick leave, individual arrangements are made to take into account individual trainees needs.

Emergency leave - Trainees must apply directly to their manager for special leave for domestic, personal or family reasons. Liaison with supervisors will also be necessary.

Conferences and Courses - If a trainee wishes to attend an external course or conference on a placement day, they must consult the supervisor before applying to the line manager. If approved this would usually be additional to their allocated study days and would be treated as a placement day.

Placement study days - In each of the first, second and third years, six allocated study days can be taken from placement at any point during the year but should always be taken paying due care and attention to the needs of the clinical work and in discussion with the placement supervisor. Taking study leave in a way that is disruptive to the overall running of the placement, (for example, taking one day a week for a six week period) will not normally be acceptable. If you have two six month placements within a year, three study days are allocated to each placement. Some of these study days may need to be taken in the Christmas, Easter and Summer Teaching Breaks. These study days cannot be "carried over" and taken on the next placement. If they are not taken they are lost. Third year trainees must plan all of their study leave with their supervisor at the start of their placement(s).

In all cases, trainees should always approach the taking of placement study leave in a professional manner and consider the requirements of their clinical work as paramount. Study leave should not normally be combined with annual leave to extend the period of time taken away from placement.

Placement study leave must always be agreed with your supervisor and signed off by the line manager ***before the leave is taken*****. Taking unauthorised leave is a disciplinary matter.** Trainees are expected to be contactable during these periods.

Placement-related preparation and administration - The placement week should include adequate time for placement-related preparation and administration, including placement-related reading and report writing. Trainees are not encouraged to routinely undertake practice-based work in their own time or during scheduled study time with the exception of preparing for assessed submissions. Therefore, adequate time will need to be scheduled during placement time for placement related tasks such as preparation and administration. The amount of time for this will vary according to the stage of the placement and will normally be flexibly integrated across placement days. Trainees have designated study days throughout the course as described above. There is ***no additional designated study time while on placement*** other than necessary preparation for clinical activities – for example, for familiarization with the procedures for administering a new test.

5.11 Fitness to Practice

Trainees are required to abide by the BPS and HCPC codes of conduct at all times. This includes being responsible for monitoring their own fitness to practice. The HCPC defines fitness to practice as individuals having "the skills, knowledge and character to practise their profession safely and effectively". For Canterbury Christ Church University, it refers to trainees' "good conduct, health and character that impacts on public safety, professional practice or ability to conduct themselves in line with the requirements of their regulatory body".

If trainees have any concerns about their fitness to practice, they should raise them with their supervisor and manager. If supervisors have concerns about a trainee on placement with them they should discuss them with the trainee and contact the trainee's line manager.

A major fitness to practice concern may mean that a trainee is neutrally withdrawn from placement whilst it is investigated. Information regarding potential sources of support for trainees is made available to all trainees at Salomons (CCCU) (see for instance https://cccu.canterbury.ac.uk/student-support-health-and-wellbeing/docs/FHWB-SFTP-Policy-v7.2-Jan-2018.pdf

University procedure is available at https://www.canterbury.ac.uk/quality-and- standards-office/docs/FHWB-SFTP-Procedures-v3-Sept-2018.pdf

Further useful guidance on supporting and valuing trainees' lived experience is available in this BPS publication:

https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Lived%20experience%20of%20mental%20health%20difficulties%20in%20clinical%20psychology%20training.pdf

For NHS funded trainees, where the concerns relate to conduct, attendance or health issues, the employer, Surrey and Borders Partnership NHS Foundation Trust, needs to be involved at the earliest stage, either through contacting the Trust manager of the Trainee Clinical Psychologists or the nominated Human Resources representative. For independently funded trainees, the matter will be investigated through CCCU procedures.

5.12 Administration and Record Keeping

Writing up reports, letters and assessments is an important aspect of placement experience. Trainees should get into the habit of writing routine letters and reports promptly and getting early feedback from supervisors about any conventions or requirements that exist in the setting.

All patient records are the property of the National Health Service. Trainees should find out from supervisors about any conventions or requirements that exist for the setting, and ensure that they are aware of local policies and practices regarding their completion, management and storage of records. In particular it is not acceptable to keep records at home or to leave them unattended e.g. in a car. Trainees should obtain permission from their supervisor before removing records from their usual place of storage and ensure their return as soon as possible.

It is also important to be aware of service users' rights to seek access to their records at any time. Furthermore, service users should be provided with copies of relevant correspondence in line with current policy. All notes and letters should be written with this fact in mind, and host Trust procedures and guidelines should be observed. Records and other returns (e.g. activity data) should be completed according to local requirements and quality standards.

As noted above trainees should keep a careful record of the number of days worked on placement. They should also keep a log of all their clinical work and professional activities in the Practice Learning Portfolio. This is aggregated information: no individual records should be kept electronically. Supervisors should be in a position to confirm the Portfolio records at the end of each six-month placement period.

5.13 Advice and Support

Supervisors are encouraged to contact the trainee's manager at times outside the placement visits if they have difficulties or issues they wish to discuss about the placement. This informal contact is often most helpful when supervisors are concerned about an issue which, if not dealt with at an early stage, could become problematic.

Managers also offer support at the pre-placement telephone call, to first time supervisors in particular. In addition, supervisors can contact the other members of the Course Team for guidance about specific issues.

Trust Representatives have a key role in providing advice and support to supervisors, and some are involved in Trust-based developments to enhance supervisory competencies. In particular, Trust Representatives should be used by supervisors where there are any questions about assessment of trainees' practice learning competencies so that they can form a considered judgement independent of the manager who is second marker of the ECC forms.

Supervisors are always encouraged to discuss the supervision they provide to trainees in their own supervision, and to include their supervisory role in appraisals. In Trusts where there is no Trust Representative, support for supervisors and opportunities to discuss any placement issues in their own supervision or line management meetings is particularly important.

A stepped approach is taken to difficulties raised by trainees about placements. Where a trainee has concerns about their placement, they should first be discussed with the supervisor (the trainee may wish to discuss the issue with their manager beforehand to check out expectations or for support). If difficulties persist, the trainee should either contact the manager directly or raise them at a placement visit. With the trainee's permission, the manager will then contact the supervisor. Various actions may be taken, for instance, the Trust Representative/Trust representative may be involved if further learning opportunities need to be sought outside the placement or additional supervisory support is needed.

A full description of the steps that would be taken to address and manage serious concerns about supervision and placements is given in Appendix 5.12.

As with any aspect of the Course, trainees may make a formal complaint according to the CCCU complaints procedure (https://www.canterbury.ac.uk/our-students/ug-current/student-voice/complaints) , further details of which are provided in the Course Handbook.

6. SUPERVISION

6.1 Introduction

Amongst Health and Social Care Practitioners clinical supervision is increasingly acknowledged as an important mechanism to facilitate personal and professional development. Clinical supervision can also be seen as part of a wider quality improvement framework, which is linked to clinical governance in that supervisors and supervisees should be offered appropriate support from their organisations and the Clinical Psychology Training Course with a view to delivering best practice.

This section of the handbook will start with the position of the Health Professions Council, the British Psychological Society's and the Division of Clinical Psychology regarding supervision. This will be followed by a section on the role of co-ordinating and clinical supervisors, definitions of supervision and the description of a number of models of supervision. Some suggestions for both clinical psychology supervisors and trainees will be presented and the section will conclude with some information about supervisor training and development.

6.2 The Health and Care Professions Council (HCPC) and Supervision

As the profession is regulated by the HCPC, the Course and its partners (i.e. Trusts and supervisors) are required to meet the Standards for Education and Training (SETs) set out by the HCPC. Table 4 shows the Standards most relevant to placements and supervision.

Table 4: HCPC SETs for practice placements

5 Practice placements
5.1 Practice placements must be integral to the course.
5.2 The number, duration and range of practice placements must be appropriate to support the delivery of the course and the achievement of the learning outcomes.
5.3 The practice placement settings must provide a safe and supportive environment.
5.4 The education provider must maintain a thorough and effective system for approving and monitoring all placements.
5.5 The placement providers must have equality and diversity policies in relation to students, together with an indication of how these will be implemented and monitored.
5.6 There must be an adequate number of appropriately qualified and experienced staff at the practice placement setting.
5.7 Practice placement educators must have relevant knowledge, skills and experience.
5.8 Practice placement educators must undertake appropriate practice placement educator training.
5.9 Practice placement educators must be appropriately registered, unless other arrangements are agreed.
5.10 There must be regular and effective collaboration between the education

provider and the practice placement provider.
5.11 Students, practice placement providers and practice placement educators must be for placement which will include information about an understanding of: • the learning outcomes to be achieved; • the timings and the duration of any placement experience and associated records to be maintained; • expectations of professional conduct; • the assessment procedures including the implications of, and any action to be taken in the case of, failure to progress; and • communication and lines of responsibility.
5.12 Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.
5.13 A range of learning and teaching methods that respect the rights and needs of service users and colleagues must be in place throughout practice placements.

From Table 4 it will be seen that it is of great importance that:

- there is good communication and information flow between the Course, the supervisor and the trainee
- roles and responsibilities are clearly set out and understood
- procedures for assessment of clinical competence are clearly set out and understood, including for the possibility of placement failure
- placements are approved and their quality monitored
- supervisors are appropriately registered, trained and experienced, and engage in continuing development as a supervisor
- the learning outcomes of the placement are clearly specified in the placement contract and supervisors facilitate learning appropriately
- supervisors support safe, ethical practice, good professional behaviour, the rights of trainees and respect for service users and colleagues
- supervisors ensure that practice settings are safe, adequately staffed places of work for trainees to learn in

All these points are covered in this Handbook. For instance, the monitoring of placement quality is covered in Section 13, assessment of clinical competence is described in detail in Section 8, and practice learning outcomes are given in Section 7, with guidance on writing learning outcomes into the placement contract in Section 5. The qualification of supervisors, and their roles and responsibilities will be elaborated further in this chapter.

Supervisors should also be familiar with the HCPC Standards of Proficiency, not only for themselves, but in order to know the required outcome criteria for the Course in terms of trainees' learning and competence. These can be accessed at https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf?v=637106257690000000

The DCP and the BPS provide much more detailed guidance on good practices for psychology supervisors and this will be outlined next.

6.3 BPS Accreditation Through Partnership and DCP policy

The BPS Accreditation Through Partnership scheme is a quality enhancement process complementing the approval of the Course by the HCPC. Combined with the supervision guidance that follows below, it ensures that expectations of placement and supervision standards are clear.

All supervisors are expected to be familiar with the DCP policy on supervision https://hull-repository.worktribe.com/preview/369313/CAT-1556.pdf , or see Appendix 5.13). The additional guidance for clinical psychology training courses: Guidelines on clinical supervision (2010) (see Appendix 5.3) is a valuable resource that covers key areas of supervision of trainees, including time required for supervision, setting up a placement, contracting and feedback).

6.4 The Division of Clinical Psychology's View

The Division of Clinical Psychology's (DCP) policy since 1995 has been that supervision should be organised for trainees and qualified clinical psychologists irrespective of grade and levels of experience. Green and Youngson (2003) cite the five important related components highlighted within the DCP Professional Practice Guidelines (1995) which are linked to maintaining quality of performance and extending an individual's range of skills. There are:

- Best practice in relation to clients
- Best practice in relation to other professionals and service delivery
- Best practice in relation to professional development
- Best practice in relation to personal development
- Best practice in relation to organisational objectives

Green and Youngson (2003) note that this underlines and emphasises the various stakeholder objectives involved in maintaining quality and increasing skills – service users, employers, individual clinical psychologists and professional bodies (p3).

The significance of supervision to clinical psychology as a profession has been even further highlighted following developments in the NHS such as Agenda for Change and the Knowledge and Skills Framework (KSF) policies (DOH, 2004) entailing taking on responsibility for supervising both trainees and colleagues in our own profession and others. Other such developments are the Layard Report (Layard, 2004), New Ways of Working in Applied Psychology (BPS, 2006) and the NHS Long Term Plan (2019) all of which indicate that clinical psychologists need to take on greater leadership roles, with greater emphasis on supervision and consultation.

Supervision is thus seen as not only an essential part of clinical training but a component of on-going professional development and quality improvement. The delivery and experience of supervision during clinical training can be seen to lay the foundation for the use of supervision after training and for the development of the trainees' own supervisory competencies and capability. At the same time, it is important for supervisors to have specific support, training and supervision from their own employing organisation, for their own supervisory practice as part of their own continuing professional development.

6.5 The Role of Co-ordinating and Clinical Supervisors

Although clinical psychologists and other related professionals may undertake a number of supervisory roles, what distinguishes supervision of trainee clinical psychologists is the necessity of ensuring that the requirements of an accredited course of professional training are met, and that the trainee's performance is adequately monitored and evaluated. This is a responsibility shared with the Course team and requires overall planning and co-ordination in addition to the supervision of specific aspects of practice. For this reason, it is important that each placement has a designated co-ordinating clinical supervisor with the relevant knowledge, skills and experience to lead on this role.

All supervisors must be:

(i) A clinical psychologist who is registered with the Health & Care Professions Council, and/or who holds Chartered Membership of the Society and full membership of the Division of Clinical Psychology, who has at least two years' post-qualification experience, and who has clinical responsibilities in the unit in which the work is carried out; or

(ii) Any other appropriately qualified and experienced psychologist who is registered with the Health & Care Professions Council, and/or who holds Chartered Membership of the Society; or

(iii) An appropriately qualified and experienced member of another profession who is registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures.

In case of (ii) or (iii) above, the quality and quantity of supervision that is received by the trainee must be monitored carefully by a Course Director or trainee manager.

It is expected that all trainees will have supervision with a qualified clinical psychologist for the majority of their training.

Extract from BPS (2013) Accreditation Through Partnership Handbook: Guidance for Clinical Psychology Programmes.

Where no qualified clinical psychologist is involved in supervision arrangements for a trainee on placement, alternative arrangements will need to be made for the trainee to have contact with a qualified clinical psychologist with the specific purpose of discussing clinical psychology aspects of the placement work and the trainee's development, in addition to broader professional issues. It is recommended that the trainee meet with a clinical psychologist on at least three occasions during a placement, at the beginning, middle and end, and that opportunities are created for the trainee to attend at least one professional meeting.

6.5.1 The Co-ordinating clinical supervisor

As indicated above, each placement should have a designated co-ordinating clinical supervisor. In some instances, this role may be undertaken jointly by two supervisors if the placement arrangements make this desirable and practical. The co-ordinating clinical supervisor should normally have at least two years' post qualification experience.

If a supervisor has less than two years' post-qualification experience, it may be possible for them to take on the co-ordinating clinical supervisor role as long as they have at least one year's experience and can be provided with an adequate level of support and mentoring. This would normally be set up and monitored by the Trust Representative in conjunction with colleagues and the Course team.

The co-ordinating clinical supervisor is the designated point of contact for the placement with the trainee's manager and Course team, Placement Officer and Trust Representative. Therefore all correspondence from the Course team will normally be sent to the co-ordinating clinical supervisor who should forward information to any other supervisors as necessary. Similarly, placement induction and the negotiation of an overall placement contract is normally the responsibility of the co-ordinating clinical supervisor although this may be shared or delegated in part to other supervisors where this is more appropriate.

The co-ordinating clinical supervisor takes primary supervisory responsibility for the overall co-ordination and monitoring of a placement and assessment of the trainee's performance. In some instances, the co-ordinating clinical supervisor may be the only or major supervisor of the trainee's clinical practice, but in other cases they may provide only one element of the clinical supervision with specified, and sometimes significant, aspects of supervision being undertaken by one or more other clinical supervisors.

While each supervisor has responsibility for the designated area of supervision they provide, the co-ordinating clinical supervisor has the additional responsibility of ensuring that the overall balance of the placement is appropriate and co-ordinated. They are also central to the overall evaluation of the trainee's performance on placement. To do this they need to be in good communication with any other supervisors. The co-ordinating clinical supervisor will normally complete the trainee's Evaluation of Clinical Competence (ECC) form at the end of placement drawing on the feedback/evaluation of any contributing clinical supervisors. Where the other clinical supervisors have undertaken a substantial amount of supervision they should contribute directly to the evaluation through a combined ECC form. However, the trainee's ECC form and Practice Learning Portfolio must be signed by the co-ordinating clinical supervisor to indicate that they concur with the evaluation. Similarly, placement visits will always include the co- ordinating clinical supervisor but may also include clinical supervisors where this is appropriate.

Co-ordinating clinical supervisors can sometimes be working with clinical supervisors who are senior to them or who have different professional backgrounds. It should be made clear that it is not the responsibility of the co-ordinating clinical supervisor to supervise other supervisors but simply to monitor and co-ordinate the trainees overall experience. Should problems arise in other areas of supervision or with the balance of work undertaken these can normally be discussed directly with the supervisors involved. However, if necessary, support and advice can be obtained from the trainee's line manager or the Trust Representative.

Supervision time - The BPS training accreditation criteria stipulate that trainees should have three hours per week contact time with their supervisors overall, of which *at least* one hour should be in scheduled supervision meetings. An appropriate amount of one-to-one contact should be available to each trainee where supervisors have more than one trainee on the placement. The amount of additional scheduled supervision time provided by the co-ordinating clinical supervisor should be proportionate to the amount of clinical practice they are directly supervising; however weekly supervision time should be protected for the trainee regardless of how many people they have started work with. In addition, some allowance should also be made for the time required to maintain an overall view of the trainee's experience on placement and to co-ordinate their evaluation. It is our view that an hour a week will often not be enough, and we recommend a minimum of 90 minutes scheduled weekly supervision time, particularly for trainees at an early stage of their training and/or at the beginning of a new placement.

If all direct **clinical** supervision is provided by other clinical supervisors (see next section), please note that the co-ordinating clinical supervisor for the placement is required to meet with the trainee at least once in the first part of the placement and once in the later stages, with the specific focus of 1) co-ordinating and monitoring the quality of experiences and opportunities available to the trainee to develop their competencies and achieve the learning outcomes specified in the Placement Contract, and 2) to evaluate their progress and give formative feedback and support.

In summary, the *minimal* expectations of a co-ordinating clinical supervisor are that they should normally:

- Be the point of contact for Course staff in relation to the placement
- Pass on relevant information to the other clinical supervisor(s)
- Co-ordinate the placement and the placement induction
- Liaise with the clinical supervisor(s) to monitor the placement and evaluate the trainee
- Attend the placement visit
- Agree and sign the practice learning paperwork
- Maintain sufficient contact with the trainee to make all of the above possible.

6.5.2 The Clinical Supervisor

An increasingly important role is undertaken by clinical supervisors who provide supervision to trainees in specific competencies that substantially enrich their overall clinical experience and model-specific learning. In some cases, a clinical supervisor may undertake the supervision of a substantial area of clinical work across one or more days of the placement. In other instances, the supervision may be focussed on a few selected clinical cases or on a particular project or service. In all cases the clinical supervisor is responsible for the supervision that they provide so they must be suitably qualified, with the relevant knowledge, skills and experience to provide supervision in that area. They must be HCPC registered or be an appropriately qualified and experienced member of another profession who is registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures.

In the case of clinical psychologists, it is not absolutely necessary to have two years' experience before undertaking a clinical supervisor role although this remains preferable. However, providing clinical supervision that contributes to a placement is an excellent way to develop supervision competencies, start supervising and gain experience before moving to a co-ordinating clinical supervisor role. Thus, it is normally most appropriate for those with less than two years' experience to supervise in a subsidiary capacity in the first instance.

Counselling and other HCPC Applied Psychologists are often well placed to provide clinical supervision and may sometimes undertake responsibility for the supervision of a substantial aspect of a placement, particularly when they occupy key roles that are largely equivalent to those of clinical psychologists. Close professional colleagues such as psychotherapists, family therapists and specialists in areas of psychological practice from other disciplines can make an invaluable contribution to supervision in their own areas of expertise. They also enhance the inter-professional learning available to trainees as part of the course and placement experience.

Clinical supervisors from other professional groups are encouraged to attend supervisor training events, especially those organised by the Course, and they can obtain support and advice from the Trust Representatives and members of the course team about their role. Their input to a placement should be negotiated as part of the overall placement configuration in conjunction with the co-ordinating clinical supervisor.

6.6 Definition of supervision

Many definitions of supervision can be found within the literature. Consider the similarities and differences between the following two definitions. The first definition is cited by Watkins (1977):

“An intervention that is provided by a senior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients they see, and serving as a gate keeper for those who are to enter the particular profession.” (Bernard and Goodger, 1992)

The second definition by Bacon (1992) describes supervision as:

“...a joint experience for the supervisor and trainee, who embark on an exploration or journey during which, if all goes well, they will eventually be travelling together through the same perceived landscape. Since each will have very different starting points, in terms of prior experience, learning and values, the journey primarily involves communicating and understanding their differences in order to create common ground upon which the work of the trainee during the placement can be based.”

The above definitions are useful in that both point to the importance of the relationship, learning and development. The tone of the first definition emphasises evaluation whereas the tone of the second highlights the importance of supervision as a process.

6.7 Models of supervision

Over the years several models of clinical supervision have been conceptualised with a view to helping supervisors and supervisees manage the process of supervision. Most models of clinical supervision can be located under one of the following headings:

- Process models of clinical supervision
- Task models of supervision
- Developmental models of supervision
- A systems approach to clinical supervision

A brief description of each of the above models now follows.

6.7.1 Process Model of Clinical Supervision

Page and Woskett (1994) take as their starting point the notion of a contract between the supervisor and supervisee in terms of what the 'work' of the supervision should be about. This negotiated contract then gives rise to the focus of the work. The third stage relates to supervision providing a space to explore this agreed upon focus with stage four being seen as a way of providing a bridge between the supervising work and the clinical work. The final stage involves a review of the work in relation to the original contract. This stage also serves as a way of checking that the needs of both parties have been met satisfactorily.

6.7.2 A Task Model of Supervision

Michael Carroll (1994) conceptualised clinical supervision in relation to seven 'generic' tasks. Examples of some of the seven tasks include:

Relating or the establishing of a working alliance. This is always seen as the first task. It involves creating a safe, well boundaried and professional relationship so that the maximum learning can take place for both parties.

The evaluation task. Here the giving of positive and constructive feedback is highlighted in relation to the assessment of competence to practice. Particular attention will be paid to the developmental areas of growth for the supervisee.

The other five tasks include teaching, counselling, monitoring, consultancy and administration.

6.7.3 A Developmental Model of Supervision

Watkins (1995), after reviewing the literature that had appeared over a nine-year period in the field of supervision put forward a developmental model that he called 'The supervisor complexity model'. This module involves four stages that begin with role shock, then role recovery, role consolidation and finally role mastery.

6.7.4 A Systems Approach to Supervision

Holloway (1995) configured supervision in relation to four contextual factors notably: the institution, the supervisor, the client and the supervisee (trainee). These four factors were seen to inform the tasks and functions of supervisors with a view to enhancing the understanding of the 'core factors', which Holloway (1995) saw as contextualising the supervision relationship.

The models outlined above offer a good starting point in terms of a framework for clinical psychologists to conceptualize some of the intricacies involved in the practice of supervision. However, far more research is needed in relation to the study of such models in relation to the different specialities within clinical psychology. One recent example of this is work by Beinhart (2004) whose work provided relatively strong evidence that the quality of the supervising relationship is the most central factor involved in a positive outcome for both parties. Beinhart's work cites containment, honesty and trust as examples that are all important in relation to a satisfactory relationship.

6.8 Some Suggestions for Supervisors Regarding Good Practice

- Always organise an appropriate induction course and make sure the responsibilities for this are clear when more than one supervisor is involved.
- The induction course should include the Trust's health and safety policy as well as the different components of the placements and what the primary and clinical supervisors will be responsible for.
- The induction course should also be clear about the resources that are or are not available on the placement.
- Within the first four weeks of the placement a written Placement Contract should be negotiated with the trainee. This Placement Contract should specify the core competencies that will be achieved on the placement. It should also clearly state supervision arrangements in relation to managerial, organisation, clinical and team issues.
- A discussion about mutual supervision expectations is recommended. A written supervision contract such as that suggested in Appendix 6.8 may be used but is not required by the Course. Investment of time in a supervision contract is likely to have a positive influence on the supervisory relationship.
- Supervision sessions (and the placement overall) should be positioned in such a way that the power differentials between the supervisor and trainee are acknowledged, particularly in relation to gender, race and culture, sexual orientation, religion and social class.
- Supervisors should attend to issues of race and culture throughout the placement with all trainees, for the continued development of competencies in cultural humility and responsiveness.
- The supervision space(s) should have clear boundaries, preferably agreed well in advance and free from interruptions.
- It is a good idea to keep written notes of all supervision sessions, as this would make placement evaluation, particularly around assessing competencies easier.
- In placements configured with more than one supervisor, ensure adequate communication occurs and that there is some overall monitoring of trainee activity and sharing of feedback on trainee performance.
- Always keep in mind the importance of continued communication with the Clinical Psychology Course staff as leaving difficult issues until the mid- placement visit can often compound the difficulties.
- Section 8 explains how placements are monitored and assessed.
- Creating a reflective space during supervision where process issues can be explored is seen as good supervisory practice.

6.9 Some Suggestions for Trainees Regarding Good Practice

- It is very important during observation week and during the first few weeks of the placement to be clear with supervisors about previous experience. Both good experiences and unhelpful ones.
- Whilst the power differentials between you and your supervisor should be acknowledged it is important to remember that supervision is a two-way process and that supervisors require feedback to help them meet your needs. If things go well this may not be problematic but it can feel difficult to address issues where you feel particularly vulnerable or perhaps you feel critical of the supervisor. It is a good idea to do some preparation before supervision. This might include discussing difficult or pressing issues

first or asking your supervisor for relevant reading in relation to a particular client.

- Always make notes from each supervision session as this helps with continuity and allows you to reflect on all aspects of your work.
- It is best to get into the habit of writing routine letters and reports promptly and getting early feedback from your supervisor about any conventions or requirements that exist for the setting.
- All client records are the property of the Health Service. It is important to be aware of local policies and practices regarding their completion, management and storage to ensure their protection and availability.
- It is not good practice to keep records at home or leave them unattended e.g. in a car.
- Always obtain permission from your supervisor before removing records from their usual place of storage and ensure their return as soon as possible. It is also important to be aware of client's right to seek access to their records at any time. All notes and letters should be written with this fact in mind.
- Records and other returns (e.g. activity data) should be completed according to local requirements and quality standards.
- Written consent must be obtained from clients for the session to be video/audio taped for the purposes of supervision see Appendix 5.10. Trainees should check with their supervisor about the Trust's position on the legal status of any recordings of clinical work and how they should be subsequently stored. Excerpts from the General Medical Council's guidelines on making and using visual and audio recordings of patients can be found in Appendix 5.11.

6.10 Supervisor Training and Development

The Clinical Psychology Training Course values and recognises the importance of training for supervisors. It also recognises the immense value of their contribution to training for the profession and to trainees.

New Supervisors - Each new supervisor is invited to a two-day workshop to help prepare them for supervision, which will then be followed by a one-day follow-up workshop once they have begun supervising. This includes supervisors from professions other than clinical psychology who contribute to placements. All supervisors who supervise trainees on the Course are normally expected to have completed the two- day training.

Supervisors are strongly encouraged to attend the third follow-up day which includes further input on skills in facilitating learning and an opportunity for supervision on their early supervision experience. The three days of training have been accredited by the BPS and completion of all three days entitles psychologists to apply for entry to the BPS register for Applied Psychology Practice Supervisors. https://www.bps.org.uk/membership/directories/rapps

During initial training, supervisors are asked to identify how their development will be supported back in their Trusts, and in particular how their supervisors/managers will facilitate and monitor this aspect of their professional role.

Continuing professional development - CPD is important for all supervisors and is a requirement of HCPC registration. Supervision is also part of the job description of most clinical psychologists. Some Trusts require clinical psychologists to undertake further Trust-based training in supervision, and the Course sees the CPD of placement supervisors as a professional

responsibility shared between the individual, their employer and the Course. Through Trust Representatives and the practice learning quality assurance procedure, there are discussions between Trust psychology heads of service and the Course about ways to support supervisor development through the supervision and line management systems in place in the workplace. Supervisors are encouraged to use feedback from trainees on their supervision as part of annual appraisals for instance, and the Trust Practice Placement Audit and trainee feedback should also be discussed by supervisors with their managers/supervisors.
In order to provide an opportunity for supervisors to continue to develop their skills and to learn from their own and each other's experiences of the role, the Course organises regular CPD Supervisor Workshops. These are usually facilitated by a recognised expert and all supervisors who have completed new supervisor training are invited. The topics of these workshops are decided through consultation with Trust Representatives and from feedback from supervisors. Recent topics have included difficulties and dilemmas in supervision, process issues such as power in the supervisory relationship, and supervision in different therapeutic modalities (e.g. systemic approaches to supervision). Supervisor workshops are offered free of charge to colleagues currently offering a placement to a Salomons trainee. More recently, an additional annual supervisor workshop has been introduced, with a focus on topics concerning Equality, Diversity and Inclusion (EDI). All placement supervisors will be encouraged to attend an EDI workshop.

Finally, other occasional training events are organised for supervisors by the Course. They may be about related aspects of the Course such as research supervision, or they may involve Trust Representatives and Course staff providing Trust- based workshops on Course developments in relation to placements and supervision.

6.11 Suggested Reading

Falender, C.A., Shafranske, E.P. and Ofek, A. (2014) Competent clinical supervision: Emerging effective practices, *Counselling Psychology Quarterly: Special Section: Current Trends in Clinical Supervision,* 27(4), pp. 393-408. doi: 10.1080/09515070.2014.934785

Hawkins, P. & Shohet, R. (2012) *Supervision in the helping professions. (3rd. Edition)* Milton Keynes, Open University Press

McKenzie-Mavinga, I. (2019) The challenge of racism in clinical supervision. In B. Ababio, & R. Littlewood (Eds). *Intercultural Therapy: Challenges, Insights, Developments.* London: Routledge

McMahon (2020) Five reflective touchstones to foster supervisor humility. *The Clinical Supervisor,* 39, 2, 178-197, DOI: 10.1080/07325223.2020.1827332

O'Keeffe, M. & James, F. (2014) Facilitated group supervision: Harnessing the power of peers. Journal of Paediatrics and Child Health, 50, 944 – 948. doi:10.1111/jpc.12638

7. LEARNING OUTCOMES

7.1 Introduction

The HCPC requirements for the training of Clinical Psychologists are specified both in terms of the development of a range of generic professional competencies and the gaining of an adequate breadth of experience across different client groups, settings and types of problem. The amount and exact nature of the experience to be gained is not tightly specified but it is seen as essential that that courses and placements provide "a holistic experience of training that enables trainees to develop an integrated set of learning outcomes".

In a further statement it is noted that: (emphasis added)

*"It is important to recognise that the scope of clinical psychology is so great that initial training provides a **foundation** of the range of skills and knowledge demonstrated by the profession. Further skills and knowledge will need to be acquired through continuing professional development appropriate to the specific employment pathways taken by newly qualified clinical psychologists. "*

In the light of this, the course has drawn up a set of integrated overall learning outcomes (see 7.2 below). With regard to learning on placement a list of both core and model-specific competencies has been developed (see 7.3) along with an indication of the range of experience it is hoped that trainees will gain across the duration of their training (see 7.4). It is the responsibility of trainees (with their manager) to monitor the competencies and experience they are gaining in the Practice Learning Portfolio (see Section 8). The Practice Learning Portfolio checklists may also be of use to supervisors in planning activities to develop specific competencies and in ensuring as much breadth of experience as possible within the constraints of specific placements.

7.2 Overall Learning Outcomes and Metacompetencies

By ***the end*** of the Course trainees should have achieved the following learning outcomes:

1. An ethical and compassionate approach to the work centered 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.

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.

3. A reflective approach to practice and for this to be evident in terms of a high level of self-awareness (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.

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.

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.

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.

7. A detailed, reflective and critical understanding of developmental, social, cultural, political, legal and organisational contexts and their impact on individuals and the delivery of psychological services.

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.

9. An advanced ability to communicate with service users and other professionals within services in a manner that helps to build effective partnerships and strong working relationships, which enables, if possible, service users to influence research that may affect them.

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.

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.

12. An approach to learning and development which recognises the need for it to be lifelong in order to remain professionally and clinically competent, and the skills necessary to systematically acquire, synthesize and critique complex and detailed bodies of knowledge.

Through working towards these learning outcomes, trainees will have developed generalisable metacompetencies specified by the BPS (2017)
https://www.bps.org.uk/sites/beta.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%20(2017).pdf

As follows:

a. Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.

b. Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations.

c. Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.

d. Being familiar with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision-making without being formulaic in application.

e. Complementing evidence-based practice with an ethos of practice-based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

f. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

g. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.

h. Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.

i. Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice.

j. Demonstrating self-awareness and sensitivity, and working as a reflective practitioner within ethical and professional practice frameworks.

Key aspects of these metacompetencies are operationalised in more detail in the core competencies assessed in the Evaluation of Clinical Competence form (see next section).

7.3 Core and Model-Specific Competencies

In indicating the range of competencies to be developed and demonstrated on placement, a distinction is made between core competencies and model-specific competencies.

Core Competencies - The Course's core competencies are professional competencies, based on those described by the BPS (2017) (see Appendix 7.1). They are relevant across most areas of clinical psychology practice. It is hoped that all placement configurations will enable the majority of these competencies to be addressed to some degree with learning being extended and deepened across different contexts as training progresses. The balance between different competencies will obviously be influenced by the stage of training and the opportunities available within services.

The ten core competencies are as follows:

- Working relationships
- Psychological assessment
- Psychological formulation
- Psychological intervention
- Evaluation and quality improvement
- Communication and teaching
- Organisational and systems influence and leadership
- Personal and professional skills and values
- Reflective practice
- Use of supervision

The Evaluation of Clinical Competence form (Appendix 8.1) completed by coordinating supervisors at the end of each placement is structured around the core competencies.

Model-Specific Competencies

The model-specific competencies relate to particular models or forms of practice that are integral to the course and that may be encountered at different stages of training and on different placements. Some models will be therapy models, some will be models of broader psychological practice with teams, communities and in services, and some will relate to competencies in psychological testing. It is definitely not expected that all of these areas of competence will be developed on every placement: there is likely to be a varied profile of coverage and development of these competencies between trainees at the end of the course.

However, **it is a national requirement that trainees develop competencies in CBT and at least one other therapeutic model.** The Course does not specify what the other non-CBT model(s) should be but they will reflect a balance between trainee interests, current best practices and the placement learning opportunities available during training.

In order for managers and supervisors to monitor trainee progress and training needs, trainees are required to log their development cumulatively in relation to models that they have experienced and used. They do this by means of the condensed competency frameworks in Section B of the Practice Learning Portfolio (see Appendix 8.3).

The condensed competency frameworks can be divided into three types, and what each type currently covers is listed below:

Therapy – currently covering CBT, systemic, psychodynamic and cognitive analytic competencies.

Broader psychological practice (or "Beyond therapy") – currently covering leadership and community/critical psychology competencies

Psychological testing – experience of, and stage of development in administering and interpreting all psychological and neurological tests used on placement is logged by trainees.

7.4 Breadth of Experience

Across the duration of training, trainees will be expected to have achieved a reasonable range of experience with regard to:

- Presenting problems:
  - *acute to enduring*
  - *mild to severe*
  - *challenging behaviour*.

- Underlying dysfunction:
  - *biological*
  - *psychological*
  - *social.*

- Life events and disabilities:
  - *bereavement*
  - *physical disabilities*
  - *communication difficulties*.

- Cultural diversity:
  - *ethnicity*
  - *socio-economic class*
  - *religion and beliefs*

- Modes of intervention:
  - *individual*
  - *family*
  - *group*
  - *carers*
  - *direct and indirect*.

- Length of intervention:
  - *brief/short term*
  - *up to one year*

- Models of therapy: o
  behavioural o
  cognitive
  - *psychodynamic*
  - *systemic*
  - *integrative*

- Service settings:
  - *inpatient/residential*
  - *secondary*
  - *primary care*
  - *community*

- Multidisciplinary working/shared learning:
  - *meetings*
  - *joint work*
  - *observations*
  - *consultation/supervision*
- Liaison and User Involvement
  - *user groups/forums*
  - *voluntary groups/services*
  - *social services/housing*
  - *education/schools*
  - *police/prison/probation*

Clearly, a full range of experience cannot be expected from every placement. Placements within each stage of training should seek to select from the learning opportunities available to achieve as much diversity as is possible without compromising the integrity and coherence of the placement as a whole. In planning placement experience attention should also be paid to the experience each trainee has previously gained, including relevant experience prior to training, in order to maximise the overall breadth of experience achieved by the end of training.

Supplementary Experience - The supplementary placement in the third year is designed to meet any outstanding training needs and so can be used to rectify major gaps in experience and to develop or consolidate specific competencies if this is required. Otherwise, it may be used to extend experience and develop further specific competencies in areas of particular interest to individual trainees, for instance in relation to their third-year options.

Additional Guidance

In some areas additional guidance might be available from the DCP or Special Interest Groups that can help to identify appropriate learning experiences and more detailed competencies relevant to specific areas of work. Such guidance can be used to supplement the overall competency/experience framework provided above.

7.5 A Note on Workload

The workload on each placement needs to be carefully monitored to ensure that trainees have adequate time to complete necessary placement administration and preparation tasks during placement time. As a general principle trainees should not be routinely expected to undertake placement related work, other than writing of Professional Practice Reports, outside of placement time. Therefore sufficient time should be allowed on placement for preparation, administration and report-writing (see also section 5.9).

The precise time required and its scheduling is likely to vary across the life of the placement.

In addition during the first year the equivalent of approximately one session a week over a six month period should be devoted to the planning, conduct and reporting of the Quality Improvement Project (QIP). QIP supervisors should ensure that the project and its write up for submission can realistically be completed within that time frame, and that furthermore, there are opportunities whilst the trainee is still on placement for them to comply with the feedback and reporting procedures required by the host Trust. (For further details see section 12)

A suitable caseload for a trainee depends on the nature and complexity of the work being undertaken but it would generally be expected that trainees would be actively involved in working with about 5 to 7 clients at any one time. Work with groups would tend to increase this number while an emphasis on indirect, team working or interagency liaison would tend to slightly decrease it.

8. ASSESSMENT & MONITORING

8.1 Introduction

The assessment and monitoring of trainee progress and performance on placement is a joint responsibility of the trainee's line manager and the co-ordinating clinical supervisor of the placement, in conjunction with the trainee. The main tools for assessment and monitoring of practice competencies are:

- The Evaluation of Clinical competence form, and
- The Practice Learning Portfolio

Additional formal assessment of practice learning is carried out via the trainee's submission of:

- The Assessment of Clinical Skills, Parts I and II (first year)
- The Quality improvement Project (first year)
- Three Professional Practice Reports in the second and third years
- The Community Engagement Project (final placement)

These reports are marked independently by two examiners who are blind to the identity of the trainee. More details of these reports are provided in sections 9 to 12.

Observation - In order for supervisors to be able to accurately assess and provide feedback to trainees on their work it is expected that they will use direct observation (either in the room, by video or audio recording, or using process notes). Trainees are expected to have 25 sessions of their assessment and on-going therapeutic and professional work observed during the course of the training (10 in the first year, 10 in the second year, and 5 in the third year). See section 5.5.4 for more details.

At least one observation on every placement should be devoted to a model-specific piece of work, which is followed by a supervision discussion focussed on the model-specific competencies involved. This supports the trainee's reporting of their model-specific development in the Practice learning Portfolio, and ensures that the supervisor's sign off of the Portfolio is evidence-based.

Guidance on consent and the use of audio and video equipment is given in Appendices 5.9 and 5.10.

Formative and summative evaluations. Assessment and monitoring on placement should be a continuous process not just left to the point of formal evaluation. It is vital for trainees to seek, and for supervisors to provide, regular feedback so that learning needs can be identified and addressed as part of an on-going process.

Assessment and feedback during the course of the placement may be considered to be 'formative' while that at the end of each placement a formal 'summative' evaluation is required that is submitted to the Course's Board of Examiners.

The formal tools for this summative evaluation are:

the **Evaluation of Clinical/Professional Competence (ECC) Form** (see Appendix 8.1)

- **Appendices to ECC Form (Service User Evaluation Form** (Appendix 8.2), the **Practice Learning Feedback Form** (Appendix 5.1) and the **Placement Audit Form** (Appendix 5.2))

- **Practice Learning Portfolio (PLP)** (see Appendix 8.3)

These evaluation tools also provide a helpful framework for placement planning and 'formative' evaluation throughout the placement. In particular, they provide an important reference point at the **Placement Visit**, which is carried out by the trainee's line manager during each placement to help review and support progress.

8.2 Placement Visits

The trainee's line manager visits each placement at least once. These visits will normally occur during March/April of the first year and December/January *and* May/June/July of the second and third year. The purpose of the visit is to:

- Monitor the clinical work and performance of the trainee through (i) a report from the trainee of work undertaken to date and (ii) a report from the supervisor of their view of the trainee's functioning (including whether the trainee's is meeting the HCPC Standards of Proficiency, Code of Conduct, and Guidance on Conduct and Ethics for Students, see www.HCPC-uk.org).
- Monitor the extent to which the aims and learning outcomes of the placement and more particularly, the placement contract, are being met and to suggest corrective action if necessary.
- Monitor how supervision is working and whether it adequately supports the trainee's learning. The BPS Guidelines for Supervisors are used to facilitate this process.
- Monitor the opportunities provided by the setting in terms of suitability for future trainees.
- Identify gaps in the experience of the trainee which may be rectified during the remainder of the placement or which may need to be considered for future placement planning.
- Negotiate any difficulties that may have arisen at a personal or professional level between supervisor and trainee.
- Facilitate feedback between supervisor and trainee in relation to the trainee's progress and performance and the supervision and training opportunities.
- Facilitate setting an agenda for the remainder of the placement with the supervisor and trainee.
- Monitor the quality of the placement, including how equal opportunities policies are working for the trainee and whether the placement is meeting the HCPC Standards for Education and Training (see https://www.hcpc-uk.org/resources/standards/standards-of-education-and-training/ and Chapter 6 on Supervision in this handbook).

Supervisors and trainees are asked to prepare for the visit by conducting a review of the placement to date with reference to the placement contract, Course guidelines and the placement evaluation and record forms (ECC and PLP). In the first year, co- ordinating clinical supervisors are asked to complete a formative version of the ECC form to be submitted to the trainee’s manager in February. This is not a summative assessment of the trainee’s clinical competence but is used to provide an early indication to the course of any potential areas of difficulty and will be used by the manager as a basis for discussion at the placement visit in March/April. It is not necessary for an ECC form to be actually completed prior to the mid-placement visits in the second and third years but it is helpful if the co-ordinating clinical supervisor identifies at this stage any competencies for which the trainee is at risk of being rated referral or fail and if the trainee updates a working draft of their Practice Learning Portfolio. In this way the trainee should be aware of any concerns the supervisor may have about their practice before the placement visit. If there are significant concerns it is helpful if the supervisor is also able to speak to the manager to alert them to these in advance of the visit.

The normal structure for a placement visit is as follows:

Part 1 - Trainee meets with their manager (45 mins - 1 hour approximately)

Part 2 - Supervisor(s) meets with the trainee’s manager (30 mins)

Part 3 - Joint meeting between trainee, supervisor and manager (15 mins)

The first meeting allows the trainee to give an account of their work and a view of the placement and supervision.

In the session with the supervisor they are encouraged to reflect on the training opportunities offered as well as giving a report on the trainee's progress and any issues that may need addressing.

The joint session is an opportunity to consider any difficulties, facilitate clear mutual feedback and agree any action or changes required. It is also an opportunity to make any necessary amendments to the placement contract, to consider the trainee's progress with regard to the Evaluation of Clinical/Professional Competence (ECC) Form and to confirm the agenda for the remainder of the placement.

The length of time spent in each meeting will depend upon need: however, it is envisaged that the majority of placement visits should take no more than one and a half hours in total.

It is desirable for each individual to keep a note of relevant points arising from the visit for their own reference. The trainee’s line manager will complete their own record during the visit including any agreed action (see Appendix 8.4). The final page noting any agreed action points can be copied and circulated, when necessary, to supplement any notes kept by the trainee and supervisor(s). This is particularly important if there are any significant concerns about the trainee’s progress or performance. In such instances everyone should ensure that the documented action points accurately reflect the nature and level of the concerns or shortcomings identified and clearly specify what is required to rectify them prior to the end of the placement. In some instances, these may be further documented in a letter following the visit with arrangements made for a further visit to review progress prior to the end of the placement. This is particularly relevant where a recommendation of placement failure is an identified possibility.

Normally, in cases of satisfactory progress, no further visit is made at the scheduled points for completing the formal summative evaluations. However, if there is significant concern about the trainee’s progress, the trainee’s line manager may also arrange to visit the placement again to facilitate the completion of these.

8.2.1 Continuous Support and Monitoring

The line manager system is designed so that trainees have the opportunity to develop a relationship with a staff member who is responsible for establishing and monitoring their placements through their training. In addition to the formal review points, the manager will have contact with trainees to assess how placements are progressing and will at an early stage in the placement make sure each trainee is asked how the placement and supervision is working out in practice. The Course encourages trainees to contact staff if they are experiencing difficulties or simply have issues they wish to talk through with somebody outside the placement. Line managers and Trust Representatives are also available to discuss any issues or queries that may arise for supervisors at any point in the placement and will assist in the resolution of any problems they identify with placement learning.

8.3 Formal Evaluation

A formal evaluation must be completed by the co-ordinating clinical supervisor(s), trainee and line manager at the end of each placement. This is a summative assessment which the trainee must pass to demonstrate satisfactory progress on the clinical and professional practice elements of the course. If there is any likelihood of referral or failure this should have been identified beforehand and efforts made to rectify whatever problems were arising. Where progress is satisfactory the evaluation is a means of providing structured feedback on both strengths and progress on the placement and future learning needs as well as ensuring an up-to-date record of experience is maintained across the course.

The formal assessment has three components, which are described in more detail in sections 8.6 to 8.8:

- The Evaluation of Clinical/Professional Competence (ECC) form which is completed by the co-ordinating clinical supervisor.
- The Appendices to the ECC form, which include the Service User Evaluation (completed by a service user who the trainee has worked with), the Practice Learning Feedback and Placement Audit Forms (completed by the trainee).
- The Practice Learning Portfolio (PLP), which is completed by the trainee and has three sections:
  - Section A - containing logs of a) clinical experiences, and b) indirect & strategic organisational influence experiences
  - Section B – containing the condensed competency frameworks for therapies and broader psychological practices
  - Section C – containing the cumulative record of psychological testing competencies

It is good practice for supervisors and trainees to use the completion of the necessary assessment documentation as a vehicle for discussion and reflection on learning to date rather than just as a 'paper' exercise. It is strongly recommended that the co-ordinating clinical supervisor complete the ECC form first, that the trainee reads it, and that it is then discussed ***before*** the trainee gives their completed paperwork to the co-ordinating clinical supervisor to read and discuss. This recommendation is made in recognition of the significant power issues inherent in the assessment process, and the challenges therefore involved for trainees in giving their evaluations and feedback.

The ECC form and Practice Learning Portfolio need to be signed by both the trainee and the co-ordinating clinical supervisor(s) before forwarding to the course by the required deadlines. It is therefore necessary to plan to complete them in advance of the deadlines. This is an examination deadline for the trainee and failure to submit the paperwork on time may mean that the trainee is unable to pass the placement at that stage.

When the placement assessment documents are received by the Course, they are forwarded to the trainee's line manager who reviews them in the light of the course requirements and acts as a 'second examiner' with regard to passing the overall assessment of clinical and professional competence. The line manager makes their recommendation and that is submitted to the Board of Examiners that meets after the completion of each six month stage of training. If at all possible at the end of placement, the co-ordinating clinical supervisor(s) and trainee's line manager should reach agreement on the overall outcome of the evaluation in much the same way as examiners of written work are asked to agree a 'resolved' mark. In rare instances where agreement is not reached the recommendations of both the co-ordinating clinical supervisor(s) and line manager will be resolved by the Board of Examiners, usually following a review and recommendation from one of the course directors. As with all assessment decisions, it is the Board of Examiners who makes the final decision about the outcome of the evaluation.

8.4 Placement Referral or Failure

Please see Appendix 8.6 for a full description of the ECC form marking criteria.

In cases of potential overall placement referral or failure (or failure/referral of one or more of the individual core competencies), it is desirable for this possibility to be clearly identified well before the end of placement in order for a remedial plan to be implemented. Co-ordinating clinical supervisors should make sure the trainee's line manager is aware of their concerns and is involved in supporting this plan. Trainees should be made clearly aware of the areas in which they need to improve. Ideally this should happen at the placement visit, if not before, and should involve

- identification of those competencies in which the trainee is at risk of being referred or failed
- a plan of what opportunities will be provided on placement for the trainee to develop those competencies by the end of the placement
- clear guidance on what needs to be achieved and agreement as to how this will be monitored

In the case of potential placement failure, this would normally involve the manager making a second placement visit to monitor the trainee's progress. Trust Training Co- ordinators are also available to supervisors to support them in making a decision about placement referral or failure and it is recommended that supervisors consult with them or a senior colleague when making this decision.

The consequences of referral of a competency on a placement are that the trainee needs to demonstrate significant improvement on their next placement in those competencies for which they were referred. Referred competencies can only be rated as pass or fail on the next placement. Failure of a referred competency on the subsequent placement means that the placement overall must be rated as a fail (one failed competency always triggers an overall placement failure).

Please note that a referral grade cannot be awarded to a final placement as all competencies must have been met by the end of the course. A final placement with one competency rated as referral, with an overall placement outcome of Pass, would require section F to be completed for the trainee to pass to their new employer. If more than one competency would have been awarded a referral had it been an earlier placement in the course, they must be awarded a fail on this last ECC form and hence the placement given an overall fail mark. All or a proportion of the placement must then be repeated, again without the option of a referral grade. If it is failed again the candidate will have met the criteria for course fail.

The consequences of placement failure could be that the trainee needs to do another placement in the same specialism, or that they need to do a placement that allows them the opportunity to develop certain competencies but that this could be in another specialism. Sometimes this can be achieved within the usual placement structure but sometimes this means trainees need to do an additional placement either at that stage or later in the course. Following the recommendation from the Board of Examiners, the trainee's manager, the Clinical and Academic Tutor for that specialism, and the Trust Representatives will consider what options are possible and discuss these with the trainee. Two placement failures would usually mean Course failure.

Supervisors are advised to read the Evaluation of Clinical/Professional Competence Marking Criteria in Appendix 8.6.

8.5 Withdrawal from Placement

There are a few very unusual situations when it may be necessary to withdraw a trainee from placement. These are:

- A significant low level of competence has been demonstrated such that they are unable to attain the progression needed to reach the expected level with the appropriate amount of supervision for this level. The placement paperwork shall be completed and a recommendation shall then be made to the Board of Examiners of Fail.
-
- Where an irrevocable breakdown of the working relationship between the trainee and supervisor has occurred or the placement and supervision persist in being significantly below required standards, rendering it impossible for the trainee to have fair opportunities for learning and assessment of clinical competence (see 5.13).
- When a trainee (or supervisor) has acted or appears to have acted in a way which requires the employing NHS Trust or CCCU to institute disciplinary procedures at a level where they need to be relieved of their clinical duties pending investigation. Following the completion of the investigation, they may or may not return to the placement dependent on the outcome.
- When a major fitness to practice issue has been raised for the trainee (or supervisor) and needs to be investigated (see 5.11). The university's Fitness to Practice procedures can be found here: https://www.canterbury.ac.uk/quality-and-standards-office/docs/FHWB-SFTP-Procedures- v3-Sept-2018.pdf
-

Where the concerns relate to conduct, attendance or health issues the employer, Surrey and Borders Partnership NHS Foundation Trust, needs to be involved at the earliest stage, either through contacting the manager of the Trainee Clinical Psychologists or the nominated Human Resources representative.

8.6 The Evaluation of Clinical/Professional Competence (ECC) Form

This is the primary evaluation tool completed by the trainee's co-ordinating clinical supervisor(s). One ECC form should be submitted per placement. Information and evaluations from clinical supervisors contributing to the placement are usually best incorporated into the evaluation provided by the co-ordinating clinical supervisor. However, additional information/reports may be attached if desired.

In addition to its formal assessment function, discussion of the ECC form and associated feedback process should also provide an opportunity for reflection and further learning, for both trainee and supervisor, from the whole placement experience. It assists in the closing down of the placement and the working relationship. Because of the inherent structural power inequalities in the supervisor-trainee relationship, the ECC procedure needs to be planned for carefully, given sufficient time and conducted with particular sensitivity so that feedback to the trainee occurs before they gives feedback to the supervisor.

The ECC form has six sections (see Appendix 8.1) and an appendix.

Section A asks supervisors to record how many sessions of the trainee's work have been observed during that stage. Secondly, supervisors are asked to record whether these observations included the required observation of the trainee using model-specific competencies, and whether this observation was discussed in supervision. (This is to enable the trainee to have feedback and reflect on their model-specific development in order to complete the relevant competency framework in the Practice Learning Portfolio at the end of placement.) Finally, supervisors are asked to note key model specific competencies that the trainee has had the opportunity to develop on this placement.

Section B Supervisors are asked to make to ratings of pass, referral or fail in relation to each of the ten core clinical competencies. Qualitative feedback on the trainee's strengths and developmental is optional provided the competence has been rated as a pass. Guidance about what might constitute a pass, referral or fail for each competency can be found in the Evaluation of Clinical/Professional Competence Marking Criteria in Appendix 8.6.

When making these ratings, it is essential to bear in mind that the rating is intended to indicate whether the trainee has reached the appropriate level of competence expected of him/her **at this stage of training**. A rating of "pass" indicates that the trainee is attaining the appropriate level of competence for this stage of their training. They may have areas in which they need to develop but these are not of significant concern. In making rating of "pass" the supervisor is also confirming that, under supervision, the trainee is meeting the relevant HCPC Standards of Proficiency which are outlined on the ECC form. A rating of "referral" indicates that the trainee has not demonstrated the level of competence that would be expected at that stage of training and that there are issues regarding this aspect of a trainee's development which are in urgent need of attention. These have not been sufficiently addressed in the current placement and require immediate remedial action in the subsequent placement.

A rating of "fail" indicates that the trainee's competence is significantly below that expected at their stage in training, and automatically leads to an overall placement fail.

If insufficient activity has taken place to rate any section of the form this should be noted and a rating of "not applicable" be made.

Section C asks the supervisor to comment on the Service User Evaluation form which the trainee will submit as an Appendix to the ECC form. Supervisors may want to comment on why that particular service user was chosen, or on their view of the representativeness of the feedback in terms of the trainee's clinical work in general, or offer clarification of any feedback they may feel is required.

Section D is the overall recommendation made to the course by the co-ordinating clinical supervisor(s) regarding the trainee's clinical competence, and allows for three choices.

1. A "Pass" indicates that the trainee has reached a satisfactory level of competence as appropriate to their current stage of training. Trainees who have been given a pass on every competency or have just one competency referral in Section B of the ECC form should be recommended to pass overall.
2. An overall "Referral" indicates that the trainee is having significant difficulty in developing two of the competencies appropriate to their stage in training. Trainees who have been given a referral on two of the competencies in Section B of the ECC form should normally be recommended a referral overall.
3. A placement "Fail" indicates that the trainee is a) having a significant amount of difficulty in developing three or more of the competencies appropriate to this stage of training which have therefore been rated as referrals, or b) has demonstrated a serious lack of competence in one particular area (i.e. failed one or more competencies), or c) has not shown sufficient progress on one or more competencies since a previous placement referral. Trainees who have received a referral on three or more of the competencies in Section B, or a fail on any one of them, should normally be recommended for a fail overall.
4. It is possible that a trainee shows the required development on a referred competency (if previously an overall "Pass") or two referred competencies (if previously an overall "Referral") but has not met the required level of performance for their stage of training on a different competency on the current placement. In this case, rules 1-3 above would continue to apply. In other words, if a trainee was referred on a new competency, that new competency would be carried forward again to the following placement, as a competency that had to show immediate improvement and could only then be passed or failed.

Section E is completed by the trainee and asks them to comment on their own view of their learning on the placement and of the feedback given by the supervisor(s) on the ECC form.

Section F is the information to be passed on to the co-ordinating clinical supervisor(s) of the next placement and should be completed by the trainee and supervisor together. It is important to pass on enough information about the trainee for the next supervisor to understand important aspects of the trainee's experience and development, but not so much that they will be unduly influenced in forming their own independent judgement of the trainee's competence. If the co-ordinating clinical supervisor has recommended that the trainee receive a referral overall, it is important to list which competencies have been rated as such, as the next supervisor will only be able to rate those as pass or fail.

Appendix 1: Service User Evaluation Form (handbook Appendix 8.2) is completed by a service user with whom the trainee has been actively involved in offering psychological help. This feedback is designed to ensure that practice learning is systematically informed by a service user perspective. The Service User Evaluation must be submitted for the following placements: Adult, Child, Disabilities and Older People (i.e. there are 4 in total). The trainee has a range of options for eliciting such client feedback. They may either use the attached rating form (ECC Appendix 1) if it is considered appropriate to the client group, or amend it in such a way as to make it appropriate, or use an existing client evaluation form used by the service where the trainee is on placement. The key thing is that documented feedback has been sought, received and then considered in supervision. The submission of signed forms provides evidence of this having been done as well as making its contents available to line managers. Whichever form is used must be attached to the ECC form that is submitted at the end of the placement. The process of approaching a particular service user to request such feedback needs to be fully discussed with the supervisor prior to being undertaken.

8.7 Practice Learning Feedback Form (Appendix 5.1) and Placement Audit Form (Appendix 5.2)

There are two further forms to be completed which are separate from the ECC form as they are not to do with formal assessment of the trainee but are concerned with placement quality. They are used to communicate quality information about the placement to the supervisor, the manager, the Trust Representative/representative (and Trust) and for contract monitoring with the education commissioner. These forms should only be completed **after** the ECC form has been discussed between the trainee and co-ordinating clinical supervisor. The reason for this is that it is extremely important that trainees (and supervisors) provide honest and accurate information about the placement so that the Course and Trust can manage any quality issues and place future trainees appropriately. Given the nature of power relations between trainees and supervisors, it would be much more difficult for trainees to provide useful feedback whilst they were still being assessed, hence the need to keep the assessment and feedback processes as separate as possible.

The **Practice Learning Feedback Form** (Appendix 5.1) is completed by the trainee. It provides valuable qualitative feedback about the particular strengths, opportunities and limitations of the placement and supervision. The co-ordinating clinical supervisor has a very short section to provide any comments on the feedback as well and is expected to keep of copy of the trainee's feedback for their own records to discuss in supervision and appraisal. Managers and Trust Representatives review copies of this feedback form after the end of every placement.

The **Placement Audit Form** (Appendix 5.2) is an attempt to capture quantitative information about the placement, supervision, and the support provided for them by the host placement providing organisation. There is a checklist of items to be completed by the trainee, and also a checklist to be completed by the co-ordinating clinical supervisor, relevant to placement and trust matters supervisors would know about.

The checklists incorporate HCPC Standards of Education and Training (SET 5 Practice Placements) and the Core Minimum Placement Providers Indicators (CMPPIs) used to benchmark placement quality standards by the education commissioners. They therefore enable comparison to be made between the quality of Salomons' placements and national standards.

Aggregated statistics derived from the Placement Audit Forms are made available to Trust Representatives and Trusts, to trainees via Blackboard, to the Course Management Committee, and to the education commissioners to inform quality monitoring of their contract with Salomons and the University.

8.8 The Practice Learning Portfolio (PLP) (Appendix 8.3)

8.8.1 Introduction

The Practice Learning Portfolio (PLP) is a record of both a) factual information about work undertaken on a placement and b) of the trainee's self-evaluation of their model- specific competency development, referenced to the condensed competency frameworks provided (or, in the case of models not covered by the PLP, other recognised competency frameworks) and agreed by the supervisor.

The PLP is a tool that will provide the trainee with a record that can be used in three ways:

- to monitor trainee development and track breadth of experience for the purposes of progress reviews and placement planning
- to document skills when seeking employment post-training
- to provide evidence should the trainee wish to seek therapy-specific, or domain- specific accreditation in the future.

It is important that the PLP is maintained carefully and in close consultation with the co-ordinating clinical supervisor and that it is submitted to the course at the specified times as part of the overall assessment procedure. The trainee is responsible for completing the PLP and for sending it in at the required time but supervisors' support will be beneficial to them.

The PLP is an electronic document that is submitted to the course electronically. Supervisors will therefore need to be able to provide their signatures electronically.

For convenience, throughout the PLP each placement is identified by the number of the year which indicates stage of training in the following manner:

1 = first placement (Year 1)
2a = first placement in Year 2
2b = second placement in Year 2
3a = first placement in Year 3
3b = second placement in Year 3

The PLP has three sections which will now be described in detail.

8.8.2 Section A: Logs of clinical experience, and of indirect/strategic organisational influence experiences.

Section A of the PLP provides a record of the trainee's direct work with clients and of their indirect work, both for the current placement and cumulatively across training.

The Log of Clinical Experience provides summary information including every client seen or worked with during the course of training. The Log of Indirect/Strategic Organisational Influence Experiences provides an additional record of the range of meetings attended, liaison work or contacts, teaching/consultation, team, service or community development activities and any training events attended while on practice placements. Both logs are completed both for the current placement, and also to provide a cumulative summary of all the trainee's experience to date, making four log forms in total per placement.

These logs need to be completed/updated in draft form prior to each mid-placement visit (as a tool for review and planning), and at the end of each placement (as a means of formal assessment). At the end of each placement the updated version needs to be signed by the trainee and the co-ordinating clinical supervisor(s) and submitted to the course by the specified deadlines. The logs are then used as part of the overall assessment of each trainee's progress that is submitted to the Board of Examiners.

Completion of the Logs of Clinical Experience

There are three stages to the completion of the Logs of clinical experience.

Individual record of client contact (see Appendix 8.7)
Please note, this is a **paper** record, separate from the PLP and **should not be kept as an electronic record** for reasons of data protection.

Completion of the Log of Clinical Experience starts with the trainee keeping individual records of client contact. Appendix 8.7 provides a simple anonymous paper checklist form which is not submitted to the course but which provides a record for the trainee. From these Individual Records, aggregated general descriptive information concerning each client who has been seen or worked with can then be extracted and entered into the Log of clinical experience in the PLP, thus generating a reliable profile of the *number* and *kinds* of clients seen and the *type* of work undertaken with them by the trainee over the course of the Course. It includes observed work, joint work and indirect work as well as independent work conducted by the trainee. Some categories of information are mutually exclusive, e.g. age, while in others more than one category can be recorded, e.g. disabilities.

It is very important not to record any information on the Individual Record that in any way directly identifies individual clients. Individual Records should never be stored electronically.

Information recorded should be that which is routinely obtained as part of client assessment or from client records. It is not necessary to seek additional information from clients over and above that which arises as an integral part of normal clinical practice. It is therefore acceptable for there to sometimes be some areas of missing data. This is particularly likely to be the case with clients that have only been observed.

Information on client ethnicity, social class and religion should be completed so that the trainee can monitor their exposure to a breadth of backgrounds and influences on clients' lives and psychological problems. Socioeconomic status is based upon the current standards employed by the Office of National Statistics (see below).

National Statistics Socioeconomic Classification (NS-SEC)		
NS-SEC group	**Examples of jobs**	**% of those employed**
1.1 Employers and managers in larger organisations	company directors, senior company managers, senior civil servants, senior officers in police and armed forces	4.3
1.2 Higher professionals	doctors, lawyers, clergy, teachers and social workers	6.8

2. Lower managerial and professional occupations	nurses and midwives, journalists, actors, musicians, prison officers, lower ranks of police and armed forces	23.5
3. Intermediate occupations	clerks, secretaries, driving instructors and computer operators	14
4. Small employers and own account workers	publicans, farmers, taxi drivers, window cleaners, painters and decorators	9.9
5. Lower supervisory, craft and related occupations	printers, plumbers, television engineers, train drivers and butchers	9.8
6. Semi-routine occupations	shop assistants, hairdressers, bus drivers and cooks	18.6
7. Routine occupations	cleaners, labourers, waiters and refuse collectors	12.7
8. Never had paid work and the long term unemployed		

Further background information on this classification scheme is available from: http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html.

1. Log of clinical experience

This summary record can be completed by simply tallying the number of checked boxes on the individual records of client contact completed across each placement. This summary is then counter-signed by the supervisor and submitted to the course as part of the assessment of progress.

3. Cumulative log of clinical experience

The cumulative summary can be completed by adding the tally from each log of clinical experience completed up to the current stage of training. For example, the cumulative summary at the end of the first year is identical to the Log of clinical experience for that period. However, at the end of the second placement it would consist of the tally from the first year the Log of clinical experience added to the new tally from Log of clinical experience for the first placement in the second year, and so forth. The cumulative summary does not need to be counter-signed by the supervisor but should be submitted to the course where it will be checked and counter-signed by the trainee's line manager.

Completion of the Logs of Indirect/strategic Organisational Influence experiences

These logs consist of simple checklists which aim to capture the range of development and leadership work in teams, services and the community in which clinical psychologists are commonly involved as an expected aspect of their professional role. They cover activities undertaken over each placement and a cumulative record of all these activities to date. The number of occasions each activity has been undertaken is recorded along with a record of the total number of placement days completed for each placement and should be tallied to create a cumulative record to date, as with the logs of clinical experience. See Section 8.9 below for details about placement days.

The log of Indirect/strategic Organisational Influence experiences should be countersigned for each placement in turn by the co-ordinating clinical supervisor(s) before submission to the course. The cumulative summary should be submitted to the course where it will be checked and signed by the trainee's line manager. **Please check in particular, that the number of placement days**

completed has been recorded.

8.8.2 Section B: Clinical psychology competencies development

Section B provides a cumulative record of the trainee's model-specific development across training, anchored in condensed competency frameworks derived from established national (and international) frameworks such as those produced by CORE and the BPS. The relevant competency frameworks are completed by the trainee who provides a self-evaluation of their stage of development in relation to the specified model-specific competency areas, based on reflection on observation by, feedback from and discussion with their supervisor who signs the completed competency framework to indicate agreement with it.

It is a national requirement that trainees develop competencies in CBT and at least one other therapy. It is also a requirement that training courses monitor the development of model-specific competencies. The Salomons Course is committed to supporting trainees' development of model-specific competencies as part of the broader range of clinical psychology practice competencies. Therefore, the "other therapy" is not specified but is seen as emerging from a balance between the learning opportunities available on placements, current good practice in services and the trainee's interests.
Furthermore, it seems important to acknowledge competency development in other areas of professional practice, beyond therapy. As a result, competency frameworks for other approaches involved in contemporary clinical psychology practice are also available as part of this section of the PLP.

Section B therefore contains condensed competency frameworks for:

- therapies (currently CBT, psychodynamic and systemic – others may be developed and added as the needs arise), and
- broader psychological practices (critical community psychology, and leadership and organisational influence).
- Supporting your trainee to complete the relevant competency framework(s)
  General guidance

Only the competency framework(s) relevant to the particular placement experience should be completed for each placement. For instance, if the placement has not included any systemic work, pure, integrated or adapted, there should be no entry into the Systemic framework for that placement.

Commonly, clinical psychology practice involves integrated and adapted therapy practices. It is not expected that all or even most skills associated with a model will be covered on a single placement. Nor is it expected that trainees will always work to a strict model with service users. The aim is to provide a record of key areas of competency development that reflects the diversity of practice in clinical psychology across the lifespan. Therefore, trainees may do significant amounts of work informed by more than one therapeutic model and adapted for particular client groups or individual services users. Consideration of model-specific skills used within such work should be included in the records, but trainees may need particular help and guidance through supervision in order to recognise and understand the model-specific skills that they are using in integrated and adapted practice.

If no competency framework is provided in the PLP for the specific therapy used by the trainee on placement, supervisors and trainees should draw upon the literature to identify a relevant recognized competency framework or list of skills which can be reproduced and used instead. Salomons staff would be grateful to be informed about the origins of such frameworks or checklists so that they can be made available as a resource for all supervisors in the future. Supervisors are therefore asked to let the trainee's manager know if their trainee is using a new way of framing competency development in a model not currently available in the PLP.

Both trainees and supervisors may find their discussions are assisted by looking at the detailed frameworks accessible through the following links. These links are available through the Resources for Placement Supervisors page of the Salomons website at https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

Links to national and international competency frameworks

CBT https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/cognitive-and-behavioural-therapy

CTS-R http://ebbp.org/resources/CTS-R.pdf

Psychodynamic https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychoanalytic-Psychodynamic-Therapy

Systemic https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Systemic_Therapy

Systemic Family Practice-Systemic Skills Rating Scale (SFP-SSRS) – see link at bottom of page https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

CAT – Competence in Cognitive Analytic Therapy https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/docs/resources/dclinpsy-new/CCAT-Measure-document-1-1.pdf

Community psychology http://www.scra27.org/what-we-do/practice/18-competencies-community-psychology-practice/

Leadership
https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Faculties/Leadership/Clinical%20Psychology%20Leadership%20Development%20Framework%20-%20BPS%20%282010%29.pdf

Suggested procedure for supporting trainee learning through observation and supervision of model-specific competency development.

Observation and supervision could be seen as a shared responsibility between supervisor and trainee, especially as it is the trainee who has to complete the competency framework(s) in the PLP in the end. However, particularly during the earlier stages of training, it is recommended that the supervisor takes the initiative to plan and discuss arrangements as it will almost certainly be experienced as supportive and containing for the trainee.

The aims of observation and supervision of trainee's model-specific practices are:

- to provide the trainee with feedback and perspectives on their model-specific development
- to support the development of the trainee's understanding and recognition of their competencies, their limits and areas for further learning and practice
- to create an additional and quite structured vehicle for supervisors to use to enhance trainee learning

Suggested procedure

1. Agree that one of the observations of the trainee's work that you will be conducting during the placement will be devoted to observation of their competency development in a particular model. Whilst this may be discussed as part of the placement contract, it is unlikely that it will be clear until later in the placement exactly where and when the opportunity for the model-specific observation will arise. However, ideally, the observation should take place well before the end of the placement so that it provides an opportunity for **formative** feedback and learning with further opportunities for development thereafter. This is the educational aim of this procedure. It is **not** recommended that the observation of the trainee's model-specific competencies in practice should be conducted at the end of the placement as this is likely to suggest it is a formal summative assessment (i.e. akin to the ECC form).

2. Remember that observations may be video, audio, live (sitting in or co-working) or transcript/process notes. Suggest that the trainee reads through the relevant competency framework beforehand.

3. Conduct the observation, in whatever form it takes, using either the relevant Salomons condensed framework or one of the lengthier national ones that can be found in the list of links on the Salomons website (as above) to scaffold your observations. If not using a Salomons framework, do remember that the trainee will need to be able to "translate" whatever you do use back into one when completing the PLP.

4. Arrange that a whole or significant part of a supervision meeting will be used for discussion of the model-specific observation. Again, it is suggested the supervisor and trainee use the competency framework to scaffold the discussion. Supervision should, if possible, include the supervisor providing the trainee with feedback (for instance, missed opportunities for use of model-specific interventions, or elaborating model-specific hypotheses and formulations etc.), discussion of areas of model-specific competence for further development and providing guidance on further reading and identifying opportunities for practice and development on the placement if possible. As is good practice generally, the trainee should be invited to identify, comment and reflect on their areas of competence and development as well. This

could give the supervisor the opportunity to engage in an additional conversation about how well the trainee is recognizing their skills and competencies as development of that narrative is often important for learning. The trainee's ability to engage in a model-specific supervision conversation will also give the supervisor more material upon which to offer feedback.

5. If possible and appropriate, model-specific supervision may be continued or followed up in on-going supervision throughout the placement, so that both supervisor and trainee are aware of progress and development.

6. At the end of placement, **after** the supervisor has given the trainee the completed ECC form and the formal assessment has been discussed, the supervisor will need to read the relevant competency framework(s) of the trainee's PLP and add a signature (if in agreement with the trainee's self-evaluation of their competency development on this placement). The trainee's self-evaluation of model-specific competencies will be based on the work the supervisor observed, but also on other relevant work that the trainee has done in the course of the placement both prior and subsequent to the observation.

Finally, it is clear that if following a way of observing and supervising the trainee's model-specific competency development similar to the one outlined above, the supervisor will have useful evidence to assist in making the summative assessment judgements. Therefore, although the supervisor does not directly assess model specific competencies, the observation and supervision process will inform rating of a number of the core (i.e. not model-specific) competencies they have to rate as pass, refer or fail on the ECC form. These may include, for instance, Psychological Interventions, Reflective Practice, Personal and Professional Skills and Values.

8.8.3 Section C: Cumulative Summary of Development of Psychological Testing Competencies

Section C consists of a form on which the trainee records all performance and pencil and paper psychometric tests and neurological tests they have used, placement by placement. Tests should only be logged where the trainee has utilized the test as a principal or joint lead (not observation only). There is also a competency self-evaluation in respect of test administration and interpretation. Again this self-evaluation will be based on feedback and discussion with supervisors of the trainee's testing experiences and development. The coordinating supervisor should sign it off, and as it is a cumulative record, supervisors of successive placements should follow suit in the spaces provided.

8.9 Recording Placement Days

A record of the total number of placement days must be completed for each placement and recorded on the ECC form and Service Activity and Shared Learning Log. Days which can be counted as placement days include: placement days spent attending external conferences, committees and training reviews at Salomons. In the first year, the first three days of any sickness on a maximum of *three* occasions (or nine placement days) within placement can also be counted. In the second and third years, the first three days of sickness on a maximum of *two* occasions (or six days) within each placement can be counted. If Emergency Leave (e.g. for carer responsibilities) is taken, such days can also be counted as placement days using the same formula, but only in combination with any sick leave taken, not in addition to it (i.e. the same maximum number of days applies for either or both kinds of leave). Days which do not count as placement days include: study leave, annual leave, and additional sick or emergency leave beyond the days specified above. The number of sick and emergency leave days included in the total should be specified on the appropriate form.

The cumulative summary of placement days should be recorded on the Cumulative Placement Days summary sheet. The cumulative summary should be submitted to the course where it will be checked and signed by the trainee's line manager. **Please check in particular that the number of placement days completed has been recorded.**

8.10 Ensuring competency development between placements

Whilst the manager will be monitoring the trainee's development and learning needs across placements, the supervisor's assessment of the areas in which the trainee has developed most and those that it is important for the trainee to continue working on is very valuable. Therefore, the trainee is required to submit two copies of Section F of the ECC form ("Information for the next supervisor"), one of which will be kept by the course and one of which will be sent to the co-ordinating clinical supervisor on the next placement to be used in its planning.

8.11 Additional Assessment Support

In addition to overall placement review and monitoring arrangements, specific support is provided by members of the Course team with regard to the production of the Assessment of Clinical Skills, Professional Practice Reports and Community Engagement Project Report that are required from placements. For details and clarification of the role of supervisors in these assessments see Sections 9 to 12.

9. PROFESSIONAL PRACTICE REPORT: DIRECT WORK

9.1 Introduction

The purpose of the Professional Practice Report on Direct Work is to provide an extensive case study of a piece of work carried out with clients or carers or staff in the clinical setting. It contributes to evaluation of clinical competence.

This section of the handbook aims to give information and advice about writing the Professional Practice Report as well as to outline the Training Course systems that are in place to support the production of these reports. This guidance should be read in conjunction with the information provided in the Assessment Handbook.

9.2 Course Requirements

Trainees are required to submit three Professional Practice Reports on Direct Work throughout the training. The submission times and required foci are as follows:

Year of training	Client group	Month of submission
Second: 2 reports	Children/Families **or** People with Disabilities (report from 2nd placement)	March/April
	Children/Families or People with Disabilities (report from 3rd placement)	September
Third: 1 report	Older People **or** Other specialty*	July

* An account of clinical work carried out on the 4th placement which will either be an older adult or a supplementary/specialist placement

The set of three reports should together represent a range of work that has been undertaken by the trainee. Therefore, trainees would be expected to select cases that show diversity in terms of, for example, client characteristics, presenting problem, theoretical model used and level of intervention. Clearly, each report will be on a different client group. However other variables to be considered when selecting cases include client characteristics, presenting problem and setting, theoretical model, level of intervention, joint work and evaluation of outcome. Section 9.3 gives some more detailed guidance on selecting suitable cases.

The maximum word limit for each report is **5,000 words,** excluding tables and references**.**

9.3 Selection of Cases

9.3.1 General Points

It is important to remember that the main purpose of the Professional Practice Reports is that they should be selected to reflect the trainee's clinical competence and be typical of the kind of work currently undertaken by clinical psychologists. As such, the three reports should be selected to demonstrate breadth and depth in a trainee's clinical work and an effort should be made to avoid presenting pieces of work that are too similar to each other. 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. Trainees are encouraged to write up one extended assessment. Evidence of knowledge of more than one psychological model is required.

For all PPRs, 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, are important to demonstrate.

It is not always necessary to select work in which the intervention has been successful. However, it will be important that the trainee is able to reflect upon the weaknesses of a piece of work and demonstrate what has been learned through the process.

When working therapeutically some examples of the model specific competences that the trainee used and how they were applied should be provided. (Trainees may wish to refer to the competency frameworks in the PLP and on the Resources for Supervisors page of the University website at https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

It is recommended that trainees and supervisors discuss the trainee's needs for their PPR and identify a suitable case as soon as possible in the placement.

9.3.2 Client Characteristics

Client characteristics cover factors such as age, gender, ethnicity, sexuality and so on. The set of reports should be spread across a wide age range and represent people of different genders. It is desirable to present at least one case in which issues of difference and diversity have been significant in the work.

There are a few points to bear in mind when choosing cases that represent the different client groups:

a) Children/Families

You are asked to report work with a child or adolescent as the identified client(age 0-17).. Care should be taken if presenting a child with learning or developmental problems not to overlap with the LD report, so for example if the child report is about a child with a global learning disability, then the LD report should be with an adult with a learning disability, or another example of overlap would be two reports where the primary problem is autism, or two reports where the primary intervention is indirect work for someone with an LD. Do check in with your manager if you are concerned about overlap between your child and LD reports.

b) Children or Adults with a Disability
.You are asked to write a report where a child or adult with a disability is the identified client. This may be a learning, physical or a developmental disability which affects day to day functioning. It is acceptable to write up family, indirect or team work, but care should be taken to retain the client as the primary focus of the report. More guidance about different ways of working is given below.

c) Older People

This usually means people over 65. However, the age is less important than the type of problems presented. Trainees are required to demonstrate competence in working with some of the distinctive problems of older age. These may include later life developmental and adjustment issues, physical/health difficulties, bereavement, social isolation/loss of roles, carer issues, cognitive changes and dementia.

d) Supplementary placement

If this is in the area of child or disability it is particularly important to ensure that a different piece of clinical work is presented to that submitted in the second year.

9.3.3 Presenting Problem and Setting

A variety of psychological problems should be presented. To some degree this will be achieved by having to present cases from at least three different client groups.
However, care should be taken to avoid presenting problems that are too similar. For example, it would be inadvisable to present a child, person with learning disabilities and older person all presenting with low mood, particularly if the same theoretical base was used to understand the difficulties.

Trainees should also consider the severity of the problem they are approaching in making a decision about which cases to write up. As part of a trainee's experience, it is expected that they will work with some people presenting with severe or chronic problems. The severity or chronicity of a problem should certainly be considered and an attempt made to present a range of cases in this respect.

It is reasonable to aim for a spread of work done in different settings. For example, try to avoid presenting three cases that were seen on an in-patient basis. If possible, present cases that have been seen in different settings (e.g. Community Team, school, residential setting etc.).

If any work is carried out in an unusual setting it may be helpful to describe this in a brief section at the beginning of the report.

9.3.4 Theoretical Model

In a set of three reports a trainee is expected to demonstrate their ability to link psychological theory to clinical psychology practice. As our knowledge base is so important to clinical practice, the different reports must show a trainee's ability to work with more than one theoretical model. This may be done by presenting cases where different theories have been used to formulate different pieces of work. Alternatively, more than one theoretical perspective may be taken in a single case and integrated to form a coherent intervention.

It is acceptable to write reports where integrative models are used, however, care should be taken that there is coherence in how they are used. For example, if the models used are from different epistemological positions, or have different theories of change (e.g. CBT and Narrative). In these cases, it is possible that a theoretical model is used from one position, but other therapeutic ways of working are borrowed for their ‘techniques’. Some integrative models such as Cognitive Analytic Therapy are coherent in that the different theories have already been well integrated.

9.3.5 Level of Intervention

The set of reports should aim to represent the trainee's ability to work both directly with clients or groups of clients and at other levels of the system. This means that interventions with staff or carers and work in the organisation may also be written up.
Some examples of suitable clinical activities are: individual and group work with clients, working with families, working with a client's carers, or staff teams involved with clients' care.

9.3.6 Joint Work

Joint working and liaison with colleagues from other disciplines is an important part of clinical practice and trainees are encouraged to submit a piece of work that has involved this kind of activity. However, the importance of being able to assess the trainee's distinct contribution to the work means that there must be constraints on the submission of some kinds of joint work for examination: work undertaken jointly with another trainee clinical psychologist or in which the trainee took a subsidiary role, should not be submitted. Joint work for which the trainee took the primary responsibility or joint work in which the trainee shared equal responsibility with another professional are welcomed.

In any piece of joint work the report should make it very clear what part of the work was the responsibility of the trainee and what part of the work was the responsibility of the other professional.

9.3.7 Approach to Evaluation

The trainee should endeavour to present work for which a careful evaluation can be demonstrated. The range of reports may reflect a range of approaches to evaluation. However, it is expected that at least one psychometric test will usually be involved.
Information about the properties of tests should be given, results clearly presented and interpretation appropriately reported. If tests are not used, then the reasons for this should be provided.

The approach taken to evaluate a piece of clinical work will usually have a relationship to the theoretical model applied in the process of assessment, formulation and intervention. Some theoretical approaches may seem to present themselves more readily for particular approaches to evaluation than others. For example, use of pre- and post- treatment measures to evaluate outcome might seem more straight-forward when a cognitive-behavioural approach is used than in the case of a social-constructionist piece of work. This may lead trainees to mistakenly think that they have not evaluated a piece of work if formal measures have not been administered. This is not the case! It may help the trainee to consider three factors related to evaluation:

Systematic approach - The report should tell a coherent story that demonstrates the trainee's ability to assess a problem, arrive at a formulation, intervene, evaluate and draw conclusions from the intervention. This must be the aim in writing all reports, whatever the theoretical approach. Therefore, a report that does not demonstrate a trainee's ability to evaluate their work in some way is not acceptable.

Integration of Theory and Practice - The ability to link psychological theory to practice should be demonstrated throughout a trainee's thinking about a case. This means that the way a piece of work and its outcomes are evaluated will be linked to the theoretical approaches and ideas used throughout. The trainee should be clear about the justification for, and meaning of, the approach to evaluation that is taken.

Outcome - Where possible the issue of outcome should be addressed objectively, via for example, pre- and post- treatment measures, diary keeping, the use of a single case experimental design etc. Trainees are encouraged to consider well-recognised and validated methods of evaluating clinical change, such as a single case design or calculations of clinical significance, as appropriate. Information that is more subjective should also be considered, for example clients' or carers' reports. Often a good evaluation of outcome will combine different kinds of information.

Evaluation of the case is wider than just outcome and should also include some discussion of the wider issues raised by the case; this will be considered more fully in sections 9.5.6 and 9.5.8.

9.4 Client and Third Party Consent and Confidentiality

9.3.8 Client consent and confidentiality.

The identity of the client/s should be fully protected by changing names and any other identifying information. For example, dates of birth, place names, appointment dates and other very specific information about the person should not be included. If information that is very central to the recounting of the work is unusual or highly specific it may be appropriate to actively disguise this or to alter some other aspect of information to ensure anonymity is retained. A statement stating that changes have been made to protect the identity of individuals should be made on 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. It there are compelling clinical reasons why it is not possible or appropriate to obtain such consent, then these reasons need to be outlined in the report, along with an indication of any relevant discussions about this issue with the supervisor.

It is crucial that issues of confidentiality are explicitly 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).

It is recommended that trainees discuss with their supervisors the issues of confidentiality and consent in relation to the piece of work that has been chosen for writing up. It may be appropriate to refer to the decisions made in the Professional Practice Report. Trainees may find it useful to read a fuller discussion of these issues in article by Sperlinger & Callanan (2002).

9.3.9 Third party consent.

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.

Normally, consent should be sought to include relevant letters and reports written by other professionals. Such letters and reports should be attached as appendices to a PPR in order to document the information drawn upon. The trainees 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 was sought, but was not granted for whatever reason, 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.

9.5 Structure and Content of Reports

This section is intended to describe section by section the structure and content of the reports. The Assessment Regulations Handbook provides a structure for the reports that is intended to be flexible and to allow a wide range of work to be written up. There may be occasions when it is necessary to deviate from this structure and whilst this is acceptable, trainees must present their work in a coherent way that considers the points made in each of the sections outlined below.

9.3.10 Referral

This section should be relatively brief and should state how and/or why the problem came to the trainee or their supervisor and the nature of the service within which they were working.

In many individual cases this will include the information given by the referrer and should state WHO was referred by WHOM and for WHAT reason. In interventions with groups of clients or carers it should state HOW the case came to be identified and by WHOM.

Do not attempt to go into great detail in this section; the aim is to provide the basic information that was available before the work began.

If a referral letter was received this should be included in an Appendix (see 9.4.2 above).

9.3.11 Initial Assessment

This section presents the information that is gathered in the early stages of working with a case. It may include information gathered from a variety of sources used to make an initial assessment of the situation. The aim of this section is to introduce the context of the current difficulties being assessed. The information presented may be gathered from:

a) The first few sessions with a client,
b) interviews with group members,
c) case notes,
d) meetings with relevant people,
e) telephone conversations,
f) initial psychometric assessments,
g) observations of an individual or a setting, diary records,
i) questionnaires.

It is usually helpful to begin this section by describing what the initial assessment of the problem involved, for example, *"Mrs. B. was seen for three assessment sessions and completed a daily diary of her anxiety attacks*". Where possible, the aims of the initial assessment should be made clear. Make it clear who did the assessment and over how many sessions.

The information presented in the Initial Assessment section should summarise any initial investigations of the problem undertaken, include assessment of risk as appropriate, and may include the sort of information described in the following sections.

a) The Initial Presentation

It may be useful to present the way in which the problem is viewed by the client, their carers or the setting in which the work took place. What was their understanding of their difficulties?

In addition, the trainee's initial perceptions of the client or the problem are relevant here. How did the people involved in the assessment behave? How did they relate to the trainee? If more than one person was involved - how did they relate to each other? Did they appear co-operative, shy, upset, anxious? How did they communicate their difficulties? Any difficulties in making contact with the client or assessing the situation could be discussed.

This is the trainee’s opportunity to communicate an initial ‘flavour’ of how the client/s presented and how it was to be with them, so bringing the case to life

b) Background Information

Near the beginning of the assessment section, there should always be a clear and detailed description of the problem, its frequency and duration and the circumstances under which it occurs. It is also important to present any other information that was gathered during the initial assessment and so provide a context for the work. Therefore, the following should usually be included:

- The history and development of the problem to be addressed, including details of any previous interventions or attempted solutions, (including medication, drug and alcohol use).

- Details of an individual’s background, including their family history, their educational or occupational history, details of their relationships with others, their marital/relationship history, any developmental issues, their material circumstances and patterns of daily living and any other information relevant to an understanding of their difficulties.

- Information about individuals assessed for a group intervention.

- Details of the setting if this is relevant to the problem being addressed.

c) Initial Investigations

Details of any formal observations, behavioural records, diaries, psychological assessments or questionnaires should be presented here. All investigations and assessments should be described clearly. With regard to reporting on use of psychometric measures, the following might be helpful to include:

- A description of the psychometric assessment, particularly if it is an unusual assessment tool, including its purported construct(s)
- The rationale for using any formal investigations
- What is known about the reliability and validity of the measure
- Whether inferences regarding the individual can be made on the basis of the norms available as reported in the test manual
- Results appropriately reported on, in the form of a table if helpful.

- Critical interpretation of the test result(s), and evaluation of the particular measure(s), rather than an over-reliance on the score
- Evidence of interpersonal skills in the collaborative, sensitive and ethical handling of the material, as well as in preparing, administering and feeding back the findings to the client.

It is important to remember that assessments form the basis of all subsequent action. This includes the evaluation of outcome. It will not usually be good enough to think about the outcome of the case after the work is completed. Rather it should be carefully planned and develop systematically from the assessment and formulation of the case.

d) Summary

In most cases, it is important to make a clear clinical summary of information gathered during the initial assessment. This section will lead into the psychological formulation of the case and as such should pull together information considered to be of psychological importance at this stage.

9.3.12 Initial Formulation

This section will be central to all reports and as such is probably one of the most important. It should provide a statement about how the problem was understood after the initial assessment phase or during the early stages of the assessment if the whole report is describing an extended assessment. It needs to contain a clear, detailed **analysis** of the information gathered so far and described in the assessment section, in **psychological terms.**

An initial formulation does not have to be correct but does have to demonstrate a trainee's ability to draw on assessment information to inform initial hypotheses and conceptualisation of a problem using **psychological models**, and to link psychological theory to clinical psychology practice. The hypotheses should be explicitly grounded in the assessment information and no information that has not been reported in the assessment should be introduced at this point.

At this stage the material presented in previous sections should be sufficient to make a reasonably clear hypothesis about what is happening in the case.

Although initial formulations will vary from case to case, they should generally include the following.

a) A brief discussion or outline of the psychological theory and literature that is relevant to the case.

   e.g. Smith and Jones (1989) have put forward a model of depression in older people which suggests ......

b) A brief summary of the main clinical aspects of the case - this will usually be information gathered during the initial assessment phase. New information about the client should not be introduced in the formulation.

c) Using the theory as a context and making explicit links to examples from the assessment material - an analysis of the probable psychological mechanisms at work.

The initial formulation is essentially a **working hypothesis** - or a series of connected hypotheses providing some ideas about the origin and maintenance of the problems, based on the information available at the time. The initial formulation may need revision in the light of information gained during the work engaged in with the service user. This can be addressed later, in the re-formulation.

In writing an initial formulation it can be helpful to think about the following questions which need to be addressed within the formulation:

Why does <u>this</u> person have <u>this</u> problem, at <u>this</u> point in time and <u>what</u> is keeping it going?

The most important point about an initial formulation is that it should guide subsequent action and so, by means of the Action Plan, it should lead coherently to any **interventions** made. It is important to remember that this section is a hypothesis about the case and as such may guide further assessment and exploration as well as intervention.

It may be important to continue to consider the issue of evaluation and outcome whilst making an initial formulation. Could this hypothesis be tested?

Formulations will vary in terms of length, amount of theory and analysis they contain. Some cases can be formulated very clearly; others will be much more tentative. It is always important to formulate by using a psychological model as a context but the section should remain grounded in the clinical work. The general rule is to make the theory serve the clinical work and not vice versa i.e. formulations should be assessment – data driven.

You are not expected to make a diagnosis as it draws upon a different professional knowledge base and way of thinking. The priority in formulation is to demonstrate linking of psychological theory to assessment information in order to develop a provisional proposition for understanding the person's difficulties and thus guide subsequent practice.

9.3.13 Action Plan

This section should follow logically from the initial assessment and formulation of the problem.

This section may provide:

a) the rationale for adopting a particular approach - where possible based on research evidence which should be quoted;

b) the aim of any subsequent assessment or intervention;

c) the method by which the action plan may be carried out.

The Action Plan should give a clear idea of the work to be done in the case and may contain quite detailed proposals. For example:

a) an outline of a therapeutic intervention,

b) details of further assessments to be made,

c) the outline of a planned teaching course,

d) proposals made for any service development.

Where possible the Action Plan should refer to any ethical and professional issues raised by intervening in the case.

9.3.14 Intervention

This section should provide a description of the way in which the Action Plan was implemented.

Whilst this is not a verbatim account of the work, it should provide sufficient detail and enough illustrative examples, including examples of the application of therapy model- specific competencies, to give a clear picture of which procedures were adopted and how the client responded. Examples taken directly from the work may include:

a) Short transcripts from a therapeutic intervention to illustrate a point. Descriptions of particular teaching sessions and the issues raised by the participants.

b) Descriptions of the way in which procedures were operationalised in the case.

c) Details of further assessments carried out.

This section should also incorporate some reference to the therapeutic relationship if appropriate: in other words, how the client related, responded and worked with you in relation to the procedures and the model being used is a significant part of the story of what you did, what happened and how it worked.

It is important to continue to demonstrate the **link** between theory and practice in this section and to **relate** the procedures used to establish research findings. Whilst writing this section, do remember that the Examiners are assessing **your clinical competence**. They do not just want to know about your client and the changes they made, but also about how you conducted the sessions and operationalised your action plan.

Care may need to be given to the planning of this section, as there will inevitably be a large amount of information to be summarised. If a number of different proposals were made in the action plan then these may be used to structure the section. Alternative ways of structuring the section would be to consider the main themes of the work or the phases of the work - did it have a beginning, middle and an end?

What is important is to find a way to give the examiners a clear picture of the work that was undertaken - remember it is a clear summary with illustrations - not a blow-by-blow account.

9.3.15 Outcome and Follow Up

This section should provide information about what was achieved in working with this case. This might include:

a) accounts of change - by the client
- by the trainee
- by carers or other professionals involved with the service user

- measures of change in
  - psychological functioning
  - skills
  - settings
  - management practice
  - levels of symptomatology
  - frequency counts of behaviour
  - well being and quality of life

b) evaluations of the effectiveness of teaching courses

c) any follow-up information. Ideally, the groundwork for this section will have been laid earlier in the report as the issue of outcome and evaluation should have been considered in earlier sections - such as the initial assessment or the action plan.

Where this has been done structuring this section is easy as the same structure can follow through the report. For example if the Action Plan proposed individual treatment for a client and a staff training course for their carers the outcome of the case can be described in these two areas.

9.3.16 Reformulation

A reformulation section is not always needed. In many cases, the initial formulation will have been useful in guiding the action plan and intervention. During the course of the intervention, new information will have come to light but the basic approach to the case remained the same. In such cases **do not** make up a reformulation for the sake of it!

In other cases, what was learnt in the intervention phase of the work may lead to a partial or complete reformulation of the work. Information gathered during this phase or the process of the work itself may suggest that the initial formulation was not useful in guiding the work and this section can be used to present another formulation informed by all the information available at the end of the case. This may involve using a different psychological model or combination of models to understand the case. If you do have a reformulation section, also include some rationale as to why this is necessary.

In the case of an extended assessment, it may not have been possible to produce a clear initial formulation. In such a case, this section will provide the **main** psychological formulation based on all the information gathered over the extended assessment.

It may be helpful to look back at the **Initial Formulation** section to think about the important elements of this section and the way in which it might be structured.

9.3.17 Critical Reflection

This section allows you to reflect on the piece of work and your own learning. The examiners do understand that Professional Practice Reports are written up as part of clinical training. They do not expect them to be perfect pieces of work. However, examiners do expect trainees to be involved in a learning process and for this to be demonstrated throughout the write-up. This can often be done quite explicitly in the Critical Review of the work, which is an opportunity to discuss the case more broadly, including what has been learnt from the work.

A Critical Review of the work may consider its strengths and weaknesses together with any general and professional issues raised by the work.

The sorts of questions that could be addressed in this section are as follows:

- why did the case work well?
- why did the work fail to produce change?
- what were the important elements of the intervention?
- how did your use of supervision influence the work and what you learnt from it?
- how can the changes be understood theoretically?
- in the light of the reformulation, how might the problem be approached differently?
- what professional issues does the case raise?

    e.g. multi-disciplinary teamwork liaison

    with other professionals the role of

    the clinical psychologist

- does the case raise any ethical or legal issues?

    e.g. consent to treatment

    problems associated with confidentiality

- how did issues of diversity and context of practice impact on the work?
- how else could the case be evaluated?

The questions that could be addressed in this section are almost endless and it is important to consider what is interesting and important about each particular case. Questions should not be addressed just for the sake of it but should illustrate a thoughtful approach to the work.

This section provides the opportunity to show the examiners what has been learned from the work.

9.3.18 References

References should be cited and listed according to the current APA style guide. This section is not included in the word count for the report.

9.3.19 Appendices

At the end of each Professional Practice Report, there will usually be an Appendix or a set of Appendices. The words in this section are not counted in the word count for the report.

An Appendix may contain a range of information pertinent to, but not vital to the understanding of the case concerned. It is important that the main text should contain all the information necessary to convey a complete account of what happened within the various sections outlined above. Appendices are considered by the examiners as they give further opportunities to evaluate a trainee's professionalism and so their clinical competence but are not a substitute for providing the necessary information in the main report.

Appendices **must** contain the following.

a) Copies of any letters or official reports written by the trainee about the case. It is stressed that report writing as a professional communication skill will also be assessed by the examiners.

Any information that could identify a client, another professional, the institution or specific time and place when and where the work was carried out should be removed. Failure to protect confidentiality will be seen as unprofessional behaviour and could result in disciplinary action.

Trainees' names should also be removed from reports as the Professional Practice Reports are marked anonymously.

Appendices **may** contain some of the following.

a) Copies of relevant reports received from other professionals involved in the case (see 9.4.2)

b) **Examples** of any diaries, behavioural records or details of observations made in the case - it is usually necessary only to include one example

c) Copies of any assessments used:
- Record sheets
- Summaries of repeated measures

Examples of any handouts or information given to a client or other person involved in the case are not usually required. If they are included, they should be strictly limited to a maximum of a couple of pages for illustrative purposes.
It is important to number the Appendices and make clear reference to them in sequence in the text.

9.6 Writing Reports on Different Kinds of Work

9.6.1 Introduction

The aim of the structure provided for the Professional Practice Reports is to make it possible for trainees to write up almost any piece of clinical work. Nevertheless, at first sight the structure does appear more suited to reporting certain types of work than others. It is intended, however, that the Professional Practice Reports should be able to be adapted to represent the full and diverse range of work undertaken by psychologists. The points below address some common problems that trainees mention when trying to write-up different types of interventions. The aim of the following sections is to provide additional advice about writing reports for different pieces of work that may need some extra adapting of the format. However, when adapting the format, do be careful that in doing so, you don't leave out important bits of information, for example how you talked about risk, or consent.

"I had to work this way because of the setting I was in"
If the approach you took (CBT, psychodynamic or systemic) was dictated by the setting (for example, you were a member of a service working exclusively in one therapeutic model), it is generally useful to have a section at the beginning of the report describing the special nature of the setting and the approach. In the Critical Review section, you may wish to reflect on the impact on both yourself and the work of being restricted to one therapeutic approach.

Similarly, this may have been dictated by the setting, and if so it's important to say this, but then to 'step back' and say whether you thought the measures were suitable for evaluating the sort of change you were anticipating, and whether there was the opportunity to use alternative/additional measures. See the later comments about theory of change. In this case, you would also want to be particularly alert to other measures of change (eg self/carer report of mood/behaviour change). You would probably want to reflect on this in the Critical Review as well.

"The work I did doesn't fit the format!"
A point can be made here that may be borne in mind for any report. The format is designed to enable the telling of a story in a way that draws out particular aspects of what happened: it is a tool for highlighting your clinical activity and thinking, and these aspects are likely to have occurred, even though they might have been carried out with different labels attached to them.

In summary, the report writing asks you to 'step back' from the work and narrate your work to readers who are other clinical psychologists. In this way, the **assessment** phase may be seen as the early contacts with the client/s, when you were finding out what they were bringing to you; the introductory conversations that led you to take a particular approach as the work progressed. The **formulation** represents your initial thinking and hypothesizing about the case. It is here that the therapeutic model being adopted can be described and linked to the present case and should include something about your theory of change for that model. In general, try to think about what the report format is asking you to communicate about your practice. In this way, you should be able to tell the story of the thinking and clinical activity through the format provided. The **evaluation** phase is linked to your theories of change and should articulate the change journey that was made in the clinical work.

9.6.2 Types of Theoretical Model and Intervention

Many of the points below apply to whichever model you used and are reporting, but here are some particular issues to bear in mind for particular types of intervention.

a) Psychodynamic Psychotherapy

At first sight the basic structure may appear more suitable for writing up cognitive and behavioural interventions rather than psychodynamic cases. However, psychodynamic cases can be written up successfully if the work has been carried out thoughtfully. Generally, the basic report structure can be used, but the following points should be considered.

- Selection of the model: As with any model, it is important to be clear how the selection of the model was made for that client at that time and what led to a decision to offer psychodynamic psychotherapy. The rationale for this needs to be stated together with some indication of why this approach was preferable to others - this should be backed up with research evidence where possible. An understanding of the importance of what needs to be assessed prior to offering an individual brief psychotherapy is crucial. You may, therefore, choose to have a paragraph in the assessment section presenting how you assessed the client's suitability for psychodynamic work, clearly stating the criteria used and referencing them.

- Because a psychodynamic formulation is often based on unconscious processes affecting the here and now functioning, the initial formulation can end up being quite hypothetical in nature. Unspoken as well as spoken communication can be described during the assessment phase to begin to build up a picture of these unconscious processes and this might include reactions to 'trial interpretations.' A later re-formulation is therefore often helpful as it is likely that more information will become available to the conscious during therapy, and lead to a more in-depth understanding of the 'problem'. Be careful, therefore, to be clear which parts of the initial formulation are hypotheses which guide the work, rather than treating them as if they were 'truths'.

- Both the assessment and the action plan should consider the issue of outcome. As brief psychodynamic work is often around a focus, this can be helpful in thinking about what the client would like to be different and how this can be tracked. Having an end change in mind can also help the client or the system not start with unrealistic goals for therapy. Creative ways of monitoring change can be thought about. For example, for a client who finds engagement difficult, monitoring a change in arrival time for sessions is a good way of noticing a change in trusting others.

- Attempts should be made to avoid lengthy accounts of what happened in treatment session by session. The reader will want to know what was brought up in therapy and how this was understood and dealt with, given the theoretical model. Selecting the main themes of therapy is a good way of structuring the Intervention section.

- Supervision is an important feature of many models of psychotherapy: it may be useful to include a brief account of the role of supervision in the case concerned.

- Given that therapist emotional reaction forms an important part of psychodynamic understanding through the process of transference and counter-transference, it is likely that trainees own feelings will be an important part of the work throughout and not just in the reflective review as is sometimes the case in other models.

A paper that might help in thinking about assessment and formulation is:

Hinshelwood, R.D. (1991) Psychodynamic formulation in assessment for psychotherapy. *British Journal of Psychotherapy, 8* (1).

b) Systemic, Family Therapy, Social Constructionist, Narrative and Solution-Focused Practice

Some general considerations for family-based work in particular:

When writing up a family therapy case the 'identified' client should fit into the client group required for the particular report that is to be submitted (i.e. child/ person with a disability/ older person adult) even if you are not directly working with that person in the room, their needs should be the starting point and should be central to the formulation. It is particularly important to ensure that the 'identified' client's voice is heard and that they are engaged and involved in the family/system work as much as possible. This may mean adaptations to the session (eg language, use of visual aids) or the structure of the therapy (eg separate sessions).

Family Therapy cases can be challenging to write up because of the limited number of sessions and because the process often involves a series of hypotheses being generated and interventions made. One way to manage this is to have a series of hypotheses that guide further questioning and to then use the re-formulation section to draw together what you and the family have concluded are the helpful hypotheses for the family or services to hold in mind for the future. In this way the information that was gathered through interventive interviewing can then be added to the more in-depth formulation.

Family therapy often involves joint working. It is important to be clear about who was responsible for which parts of any joint work and to be aware of the regulations for writing up joint pieces of work. For example, it would not be suitable for a trainee to write up a piece of work in which they were part of a reflecting team as they are unlikely to play a big enough role in the work, but it would be fine if they were joint facilitators with another professional (not another trainee). The intervention section would have to have clear pointers as to what the trainee had done to show their emerging competencies. It is not sufficient to refer to 'we' or 'the team'.

A clear understanding of the theoretical model used is important and particular attention should be paid to ways that change is understood and then evaluated. For example, it would not be within a systemic understanding of change to only monitor one person in the family for their anxiety levels. One validated outcome measure for family work is the SCORE-15. More information can be found at:
https://www.aft.org.uk/page/scoreresourcepack

However, it is also worth thinking about creative ways of measuring change that are based on the theories of change that you are using, and also fit in with the families wishes. For example, using goal-based outcomes with different family members can also be a simple tool that is helpful to track change. This may be particularly important where there are very different goals or where some individuals (eg an identified client with a learning disability) have difficulty articulating their goals at the beginning of therapy.

Formatting and organizing your report:

Some suggestions about how to structure and think about systemic or narrative work are given below. These should not be followed prescriptively but may help in thinking about how to create a case report that really reflects the work from a different epistemological position. In the following sections 'the family' is referred to for convenience, but the points will be relevant to systemic or narrative work with individuals, couples, or professional teams.

Although systemic theory and practice has a long history, more recent models are situated within a co-created practice. Trainees conducting work in these models are likely to have to adapt the traditional assessment-formulation-intervention-evaluation structure of the report. This can be a challenge when one is just getting to grips with the more individualistic therapeutic models and can lead to trainees feeling that it is difficult to report this kind of work in the Professional Practice Report format. This is unfortunate, as use of these approaches is common within clinical psychology practice and make for interesting case reports.

An introduction to the case or problem situation and the referral context

The beliefs that families want to help and have the resources that can promote recovery
How did the family (or care team) discuss coming? What ideas do people have about help? What has been helpful? What are their hopes and worries about engaging? Who or what can be a resource? Talking about talking. Dominant and quiet stories. The professional context of referral or therapy. What is the family's relationship to help? How has the professional context impacted the family's journey so far?

Building up initial hypotheses

The idea that problems can be understood by hearing about the generational patterns and 'community of others' of which people are a part.
For example, who is involved, affected, connected? What do you need to know from family and professionals? How does the family genogram (at least three generations) represent intergenerational and relational themes and patterns? How can the genogram be used to explore a lively representation of family life and relationships over three or more generations?

The idea that context gives meaning to our actions, behaviours and beliefs
Professional context of referral or therapy: How has the professional context impacted thus far? How might the GRAACCES organise the work? Exploring culture, class, gender roles, disability and other contextual experiences and how these impact the family's understanding of therapy and of the problem.

The belief in the centrality of inter-relationships and interactions between people within which distress occurs
How does the family influence the problem and the problem influence the family? What are the helpful and unhelpful patterns of beliefs and behaviours?

The idea that problems arise at transitional points in the life cycle and/or unhelpful patterns, meanings or structures
How does the family life cycle and transitions relate to the problem and/or solution?

An account of the therapeutic work

The belief that open-minded curiosity leads to new ideas and meanings
How do you relate collaboratively? How do you stay non-judgemental and non-blaming? What are your blind spots?

The belief that there is shared responsibility for services and family to work collaboratively together
What are the shared aims and understanding? How do you co-create a therapeutic relationship with family? How do you help all family members to be heard?

Knowledge of systemic therapy models
Be aware that there are many different systemic theories that come from different epistemological positions, so stay true to whichever position you choose. For example, if you are working from a

second order position it is not within model for you to tell the family what you think they should do to change. Describe your theories of change. How do these theories link (or not) with the family's theory of change?

The belief in relational assessment of risk
How do you assess risk relating to different family and service perspectives? How can this be incorporated into the engagement task and establishing of trust – getting alongside the family and having a helpful connection and conversation as distinct from 'top down' checking out of risk.

Reflexivity

The belief that therapists' own personal context and position within system influences how the therapist interacts with the family and how the family interacts with the therapist
What affects how you connect to family experiences? How does your own genogram support self-reflexivity? What do you see/understand or not see/understand because of your own GRAACES?

a) Group Work

Writing up an account of a piece of group work can provide a very interesting Professional Practice Report but it is not always easy. Groups can vary considerably in terms of their structure, purpose, content etc., so it is worth using supervision to discuss ways of writing up the work.

Group work is almost always joint work and so it is important to be clear in the report about the regulations concerning joint work and to be clear in any write up about *who* took responsibility for *what* part of the work.

It is always important to describe the type of group and then relate this to the way in which individuals were assessed for inclusion in the group.

In a group situation, clients are in a process of individual change and in addition there is a change in the group as a whole that must also be recognised. A danger in reporting groups is a tendency to become involved in lengthy descriptions of each group member and their progress through the group. It may be possible to use one individual to illustrate the group process throughout (for example to talk through one formulation in detail) but otherwise details of individuals should be avoided and the process of the group relationships and change should be the main focus.

It is important to be clear about the model being used. It is not sufficient just to run a "group" - the theoretical basis for the work and type of group needs to be made explicit as much as for individual work, and the formulation and evaluation should fit that theoretical model. For this reason, it might be harder to write up groups that are 'psycho-educational' groups unless there is a clear understanding of how that education will change the problem and a linked way of monitoring this change for example by using a behavioral formulation. However, any formulation based on individual models should include a component of theory that suggests why a group rather than an individual format is more likely to produce change. In other words, your theory of change should be group focused.

It may also be useful to discuss the advantages and disadvantages of group work and to consider whether the use of a group achieved more than the use of individual therapy in terms of efficiency or quality. It might be helpful to ask if the group was used to its full potential or if the intervention ended up being individual therapy with an 'audience'. If the primary aim of providing an intervention in a group format was on economic grounds, then was this aim achieved?

9.6.1 Extended Assessments

When writing up an extended assessment the format will need to be changed slightly to fit the work that was carried out. In particular, the following points should be noted:

a) Purpose for the assessment

It is important to clarify what questions are being asked. It may be pertinent to consider whether the questions are appropriate. For example, considering the appropriateness of an intellectual assessment of a person with a learning disability or a cognitive assessment of an older person with dementia. There may be a difference between the referrer's question and what you, as a trainee clinical psychologist, consider the question to be and you may need to clarify this in your report. It is important that the choice of assessment tools and methods reflects the purpose.

b) Consent

It may be important to consider the client's understanding of, and consent for, the assessment. If an assessment is to contribute to the process of making a diagnosis, for example in a neuropsychological assessment for dementia, it is important to consider the potential impact and consequences of reaching a diagnosis. It is good practice to discuss the potential outcomes of such an assessment with a client before carrying it out and clarifying what feedback they would wish to receive. Therefore, consideration should be given to the issue of informed consent in the report.

c) Psychometric instruments and neuropsychological tests.

It will be likely that a psychometric or formal assessment will be presented, and if so, it is important to state what the particular assessment is designed to do. The definition of a psychometric measure has been interpreted broadly to encompass any of the following, with the client and/ or members of their support network:

- Questionnaires, self-report scales or outcome measures
- Neuropsychological tests
- Session by session monitoring
- Projective tests

If it is a commonly used tool like the WAIS, a very brief description will suffice but if it is something less well known it is worth writing a little more, for example about the measure's purported construct(s) and rationale. The aim here is to demonstrate to the examiners that you understand the assessment and its use.

The presentation of assessment results must be done carefully. It is best to give a brief summary rather than go into great detail. However, do include information that is vital to the understanding of the case. For example if the WAIS is being used and the profile of the scores needs to be interpreted the whole profile should be presented. More detailed information and assessment forms can be included in an appendix. In some situations it is helpful to present results in table format as follows:

VERBAL	SS	ASS	PERFORMANCE	SS	ASS

Information Comprehension etc.	Digit Symbol Picture completion etc.
VERBAL I.Q. = FULL SCALE I.Q. =	PERFORMANCE I.Q. =

Whenever a score or result on a test is presented it is vital to give a brief interpretation or explanation of what the result actually means. For example if a Beck Depression Inventory score of 25 is obtained it should be clearly stated what category this falls into.

It is important to convey to the examiners the reasons for choosing particular forms of psychological assessment. 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, might all have a bearing. It will be helpful to consider the theoretical and practical limitations of the tools used, if they are relevant to the case.
You will need to be able to discuss issues of reliability, validity and standardisation insofar as they affect the interpretation of any results presented. Keep in mind the extent to which the tests that you have used are standardised for the client group in question.

Diagnosis *vs.* Formulation

Although referrals for extended assessments may often come from medical practitioners who are seeking to reach a diagnosis, it is important that you, as a psychologist, consider the question from a psychological perspective. To this end, it is helpful to give consideration to your **initial formulation** or **hypotheses,** reached after an initial assessment phase (such as your initial meeting with the client and/or information gathering). It may be appropriate to show evidence of critical consideration of whether inferences regarding the individual can be made on the basis of the norms available as reported in the test manual, and provide appropriate evaluation of the particular measure(s), rather than an over-reliance on the score. On completion of the extended assessment you can then offer your psychological understanding in a fuller **formulation** section. You should write about any recommendations you made or feedback that you gave.

d) Follow-up and Outcome

It is important to demonstrate awareness of the need to follow through the results of an extended assessment and evaluate the outcome. Evidence of interpersonal skills in the collaborative, sensitive and ethical handling of the material, as well as in preparing, administering and feeding back the findings to the client(s), will be looked for.

e) Extended Therapeutic Assessments

Neuropsychological assessments are not the only kind of extended assessment. A prolonged assessment for therapy may also be a suitable piece of work to present, for example when considering suitability for psychodynamic work or working to reach a formulation in a complex case. Points to remember here are to be clear why the work is an assessment rather than therapy *per se*, and, as stated previously, think about both the initial hypotheses/formulation and the final formulation reached. Take care to be clear about the theoretical approach you are using and any criteria that you are assessing by.

9.6.2 Different Levels of Work

Much of this guidance has focussed on reporting work carried out directly with clients. However work with other levels of the system may be reported, provided that the work is related to an identified client. Here are some points to consider in such cases.

a) Working with parents of referred children

In many child cases, the majority of the work is carried out with or through the parents. What is important is that the child was the identified patient**.** It is important that a trainee reports their meeting with the child and that the work remains focused on the child's difficulties. Where relevant the child should be included.

A piece of work with the parents that becomes purely focused on their own adult or marital difficulties would not be suitable for a Professional Practice Report focusing on children and families - although it is acceptable for these issues to form a part of the work.

b) Working with carers

Similar points apply here as above. If work with, for example, a person with a disability or an older person, shifts focus from the referred client to the carers, the purpose and rationale for this must be clearly described. Ethical issues may be important to consider in this situation, for example, consent to treatment.

c) Organisational work

Some pieces of work may focus more on the organisation. In reporting this type of work it is still important to remember the clients involved in the placement. All accounts of institutional work should include some discussion of the importance of this work for the clients involved.

It is important to be clear about why a particular intervention was chosen at this level. Much organisational work is not directly requested by a referrer but is based on the psychologist's decision that this is the most appropriate way of proceeding. Issues raised by this should be discussed in the report.

This type of work involves working with a system rather than an individual but psychological models used to understand this work are just as important.

Work of this nature is usually long term and difficult and a trainee on a six month placement would not normally be expected to produce significant and lasting change. An awareness of this needs to be reflected in the account and it is appropriate to spend time discussing the difficulties encountered in this work.

9.7 Support Systems for Writing Professional Practice Reports: Direct Work

9.6.3 Introduction

There are two systems of report supervision on the training Course. The first is provided by placement supervisors who are directly involved in the supervision of the clinical work being presented. The second system is internal to the Training Course (Practice Learning seminars during the second year) and provides trainees with a series of meetings where Professional Practice Reports (PPRs) on direct work can be discussed and there is the potential to give mutual peer feedback on a draft of the work.

It is hoped that these two systems can work together to provide trainees with the support they require.

9.6.4 Supervision on Placement

It is a good idea to discuss how supervision will support the trainee in writing their PPR when negotiating the Placement Contract at the beginning of the placement. Some time in supervision should be allocated to choosing and discussing the reports. Supervisors should also consider allocating some of their time to reading a draft.

It is the responsibility of both the trainee and the placement supervisor to set some time in the agenda to identify a suitable piece of work, plan the way it can be written up and discuss drafts of the report. Trainees are encouraged to share drafts of their PPR with their supervisor wherever possible and, for instance, to request detailed discussion of formulation or another aspect of the work.

Some important points for both supervisors and trainees to remember when discussing the reports in supervision sessions are as follows.

a) **Be aware of the Assessment Regulations about reports:** Use this Handbook and the Assessment Handbook to discuss suitable cases to write up.

It will also be important to discuss previous work that has been presented in the context of these regulations so that a representative spread of work can be seen across the whole set of Reports.

b) **Be aware of the report format:** On some or all of the cases and pieces of work that are discussed in supervision it may be useful to use the report format as the basis for any discussion of the work. Time could usefully be spent in a supervision session thinking about what is the "Initial Formulation" etc.

c) **Discuss evaluation of the work:** This is particularly important and it is helpful if this can be considered in the very early stages of any work. Discuss the ways in which the work can be evaluated and the strengths and weaknesses of any evaluations. Consider whether the case is suitable for a single case experimental design and be aware of the importance of pre and post treatment measures.

d) **Discuss the relevant literature:** Where possible it is important to think about the link between the clinical work and the theoretical basis for the work. Discuss the theory and the way in which this relates to the particular case.

e) **Discuss the general issues raised by the work:** Remember that it is important to consider the piece of work in a wider context and supervision is a good place to discuss the practical, ethical and professional issues that are relevant to the work. Consent issues should always be discussed in supervision to ensure they are in keeping with local policies.

f) **Discuss what has been learned from the work:** An important aspect of training to become a competent clinical psychologist is continually learning from the work. It is helpful to spend some time in supervision considering this so that a trainee's development is illustrated by the report.

g) **Discuss drafts of the Report:** It is important to remember that the Professional Practice Reports form part of the assessment of Clinical Competence. As such, the person in the best position to provide feedback on drafts of the report is the Placement Supervisor. It is crucial that report writing does not become "removed" from the placement experience. When this happens there is a danger that the exercise becomes an exercise in writing a good report **rather** than in presenting the work that has been done. It is most helpful if some time in a supervision session can be spent in discussing drafts of reports and considering ways in which any feedback can be integrated into future drafts.

9.6.5 Support on the Training Course

The second year Practice Learning Groups include tutorial meetings to support the writing of reports. Each group is facilitated by tutors who are either members of the Course staff or clinical psychologists who practice or have practiced in the region and who are familiar with the relevant client specialism. It is intended that the groups will provide a forum for the trainees to learn from and support each other through the opportunity to both discuss their clinical work within a small group of peers.

9.7 References

Sperlinger, D. & Callanan, M. (2002). Confidentiality, Consent and Reports of Clinical Activity. *Clinical Psychology* (11), 19-22.

10. ASSESSMENT OF CLINICAL SKILLS

In addition to the assessment of clinical competence on placement in the first year, clinical skills will also be assessed by the submission of an Assessment of Clinical Skills. This consists of two parts: Part 1 is a formulation of a client, a review of the relevant evidence base, and a plan for an intervention which adapts the evidence base to the needs of the client and service context (3,000 words). Part 2 consists of a 50 minute digital recording of part of a session with the client, an annotated transcript of the whole session, and a clinical viva. Part 1 is to be submitted in March/April of the first year and Part 2 is to be submitted in June. Part 1 and Part 2 will normally be examined by the same examiners but with the addition of a service user examiner for Part 2.

This guidance should be read in conjunction with the information provided in the Assessment Handbook.

The Assessment of Clinical Skills makes a significant contribution to the assessment and monitoring of the development of trainees' competencies, both generic or core competencies and model-specific competencies.

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.

It aims to assess the following skills:

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 summarise an assessment process clearly and systematically, in a manner appropriate to both the client and the service context.
d) To be able to construct a clinical formulation that is theoretically grounded and appropriately inclusive, taking into account the developmental, social 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 succinctly link the intervention to the available evidence base and to utilise the literature in support of your 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 the intervention proposed.
j) To provide a brief action plan resulting from the chosen intervention.

Part 2 aims to assess the development of the following clinical skills:

a) To be able to demonstrate basic generic therapeutic skills within a real clinical context. Specifically these are:
    i. Active listening

ii. Empathy
iii. Accurate reflections
iv. Ability to be responsive to the client
v. Exploration of the client's concerns

b) To be able to identify or suggest model specific competencies within a real clinical context.
c) To be able to demonstrate competencies as defined by service-users. Specifically these are:
   a. Understanding of the context of the client's situation
   b. Working hopefully
d) To be able to identify what these various skills are and when they occur.
e) To be able to reflect appropriately on clinical work and understand the strengths and limitations of current competencies and those not yet achieved.
f) To be able to reflect on the specific life circumstances and social/cultural context of the client in relation to the therapeutic work.
g) To be able to abide by ethical and professional standards when presenting and discussing clinical work. Specifically:
   i. To be able to talk about the client in a respectful way
   ii. To be able to present and discuss clinical work in a way which maintains confidentiality
   iii. To demonstrate a professional approach to their work
   iv. To demonstrate that the submitted work is representative of their general level of skill and approach to their work
   v. To be able to demonstrate they have obtained consent from the client for use of the work they have done together.
h) To be aware of further training needs.

10.1 Guidance for completing the Assessment of Clinical Skills

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

- Care should be taken that the review is completely anonymised such that neither the client(s), the service nor the trainee can be identified.
- Care should be taken that references are complete, in the APA style and should include full details of cited secondary references.
- 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.
- The format or structure of the review will be dependent upon the chosen therapeutic work, but should minimally include:

    Title page (including 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

10.1.2 Part 2

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) A continuous digital recording of 50 minutes of a clinical session.
b) A transcript of the whole session with annotation of the 50 minutes which is to be assessed, ending with a brief critique and reflection on the work.
c) A clinical viva.

It is expected that normally Part 2 would involve the same client as Part 1. In rare circumstances where this has not been possible, the trainee should also submit a letter explaining the reasons (up to 200 words) and a brief description of the client and the formulation (up to 700 words).

Digital Recording - This may be an audio recording of a session, or a video recording (with soundtrack) showing either just the trainee or both the trainee and the client. It must be of 50 minutes duration and a continuous section of one therapeutic session. Both parties must be audible on the soundtrack. Additional information about the technical production of this material can be found in Appendix 5.9. The trainee should select a 50 minute section in which they demonstrate all of the five basic generic competencies and the service-user assessed competencies. In addition they should be able to comment on three places where they demonstrated model specific interventions. They should also be able to reflect and comment on how the therapy relates to the client's specific life circumstances and social/cultural context at least once. Trainees are strongly advised to record a number of sessions and to discuss the selection of material with their supervisors. They should demonstrate that they have the permission of the client in all cases.

Annotated Transcript - This must be a transcript of the whole of the session from which the digital recording has been taken. The annotation should only be for the 50 minutes presented in the recording. This allows the examiners to see the context of those 50 minutes, if needed. The purpose of the annotation is to highlight the trainee's competencies and demonstrate their awareness of their own competence. The competencies demonstrated must be congruent to the process of the therapy. The annotation should address four issues:

a) It should identify where each of the **five** basic generic competencies are demonstrated at least once. (It will be preferable, however, to label several examples of the same competency where this is possible).

b) It should identify at least **three** model specific interventions and what these were, or, where this is not possible, missed opportunities for model-specific interventions. Mappings of model specific competencies which may help identify some of these skills are available in the Practice Learning Portfolio's competency frameworks, based upon the more extensive frameworks published by CORE (see http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm). Trainees are, however, welcome to work in any recognised model of clinical intervention or psychotherapy, but will need to provide referenced evidence of model specific competencies having been met. Some examples can be found on Blackboard.

c) It should identify at least **two** service-user defined competencies, which will be co- examined by a service user or carer. These are: 1) Understanding – defined as a willingness to, and demonstration that they do, understand and empathise with the client's experience with regard to their circumstances (social, family etc) within the therapy session and 2) Hope – defined as maintaining a hopeful approach with humility and sensitivity by identifying the possibility of making small changes and reflecting on the strengths of the client.

d) These can be demonstrated in the following ways:
Understanding: 1) Responding to any immediate issues that the client may bring;
2) Reviewing any tasks or changes the client has been involved in with compassion;
3) Reminding clients of things they have said in the past (e.g small details about social situation etc); and 4) Understanding the client's experience of the session and responding to this with warmth and interest.
Hope: 1) Using a warm tone, using plain language, not using the words should or must; 2) Acknowledging the possibilities of making changes; 3) 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; 4) Being affirming and positive without being patronising; 5) Recognising that making changes is difficult and reflecting on this with the client; 6) Reflecting on the possibility of hope.

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

e) It should make some critique of the therapeutic work, including where improvements could have been made. The critique should contain at least one reflective comment on how consideration was given to the individual lifespan developmental circumstances of the client (which may or may not have been explicitly articulated in the session).

Clinical Viva - The clinical viva aims to explore with the trainee areas of competence that may not have been adequately demonstrated by the recording and the annotated transcript, to explore with them their depth of understanding of clinical competencies and the therapeutic alliance, to explore with them their understanding of the therapeutic model within which they were working, and to assess their ability to meet the professional competencies related to the presentation of clinical work described above. Additionally the viva will offer the opportunity to reflect on the strengths the trainee demonstrates. The viva will last 30 to 45 minutes and will normally be carried out by the two academic examiners who have marked Part 1 of the Assessment of Clinical Skills, as well as a service-user examiner. It will take place in July of the first year.

10.1.3 Consent

Trainees are required to seek the consent of the client for the work to be presented as part of their Assessment of Clinical Skills. Guidance about this should be sought from the Trust where the work was carried out, as they may have their own policies regarding the use of clinical material for educational purposes. A copy of the Surrey and Borders Partnership NHS Foundation Trust policy can be found in http://www.sabp.nhs.uk/aboutus/policies as an example. Usually this will involve written evidence of consent to be kept in the client's clinical records. A copy of this should NOT be supplied with the Portfolio, as this would identify the client, but the trainee should attach a sheet to the transcript indicating that:

a) Consent has been given by the client for both written and recorded information to be presented for examination under these guidelines.
b) That this has followed the guidance of the organisation where the work was carried out.
c) The presented material has been fully anonymised.

10.2 Support for the preparation of the Assessment of Clinical Skills

The Programme will provide support in the preparation of the Assessment of Clinical Skills in the form of tutorial groups during the first year.

11. COMMUNITY ENGAGEMENT PROJECT REPORT

For details of this assessment please refer to the Assessment Handbook.
https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/docs/resources/Assessment-Handbook-2018-intake-2018-19.pdf

12. PROFESSIONAL PRACTICE REPORTS: QUALITY IMPROVEMENT PROJECT

12.1 What is a Quality Improvement Project?

A Quality Improvement Project (QIP) involves a systematic approach to identifying and attending to an aspect of quality improvement within a health service or related professional context. It forms one of the two pieces of academic work that relate to the trainee's professional practice in the first year of training. The QIP is conducted and completed entirely within the first year placement and, by necessity, should be manageable within the parameters of this first placement. A QIP should integrate clinical, theoretical, research and evaluation issues. The aims of the QIP are:

1. To promote awareness of quality improvement issues in the current health and social care work clinical or training context.
2. To provide trainees with the opportunity to develop the competencies required for designing and conducting a piece of quality improvement work.
3. To evaluate changes in the quality of service provision arising out of the QIP and subsequent dissemination of the findings.
4. To promote collaboration with respective stakeholders through the process of conducting a QIP.
5. To understand processes associated with trying to bring about change in an applied health care or related professional setting.

The QIP should ideally be part of ongoing service activity (e.g. clinical governance and local Research and Development or audit initiatives), thereby not requiring research ethics approval (but see Section 12.7 below).

Additionally, the QIP must be conducted within the placement or related context and, in terms of time commitment, should take about half a day a week for six months (or an equivalent amount of time, organized differently).

Supervision does not have to be provided by the co-ordinating placement supervisor, and could be provided by another supervisor within the trust or related organisation. However, for simplicity, the phrase 'placement supervisor' has been used throughout Section 12.

The project should:

1. Employ a systematic approach to investigate the topic
2. Make use of predetermined methods that are underpinned by a clear model for undertaking quality improvement work.
3. Be relevant to the setting in which the QIP is being carried out.
4. Deal with some aspect of quality improvement that is appropriate to practice or training in clinical psychology.
5. Yield results, conclusions, outcomes, or suggestions that are fed back to the service or relevant parties.

12.2 Why is a QIP part of the Course Requirements?

Clinical governance and audit initiatives provide a framework within which NHS organisations can work to improve and assure the quality of clinical services. Knowledge is needed from research on which clinical decisions may be based. In this regard, trainees require competencies to evaluate existing research evidence and to generate new knowledge upon which practice may be based. In addition to being able to evaluate and collect evidence systematically, trainees also need to develop competencies so that evidence may be disseminated effectively to all interested parties. The QIP is the means by which these competencies can begin to be developed in trainees. The QIP aims to provide trainees with experience of completing a piece of service related quality improvement work or evaluation of this within a clinical context. It also aims to promote awareness of the types of quality monitoring issues that will be increasingly salient in the professional environment that trainees will enter into upon qualification.

12.3 What Sorts of Topics Form the Basis of a QIP?

Quality Improvement Projects can be seen to fall into broad categories. These include:

i. Localised evaluation of treatment efficacy or treatment outcome.
ii. Auditing of routinely collected data to compare the service against locally generated or published benchmarks.
iii. Evaluating the impact of a quality improvement initiative.
iv. A critical review of services.
v. An aspect of service performance, such as team-working.
vi. Service user involvement and feedback on existing services or planning new services.
vii. Evaluating the contribution of clinical psychology to multidisciplinary teams, such as psychology-led training courses.
viii. Evaluating a component of clinical psychology training

Examples of specific QIPs falling into each broad category:

i. A single case or group design to assess the efficacy of an anxiety treatment; a questionnaire or survey design to evaluate treatment outcome for depression.
ii. An audit of case notes having a letter back to the referrer within one month of the first appointment.
iii. A study to assess whether a new way of managing referrals has reduced waiting times for a first appointment; a study to evaluate whether staff training has improved risk assessments.
iv. An evaluation of service delivery based on service plans.
v. An evaluation of the current functioning of a staff team; an evaluation of team functioning following consultation provided to the team.
vi. A questionnaire study to evaluate service user satisfaction.
vii. The initiation, development, implementation and evaluation of a training package for practitioners and service users.
viii. Some of these examples (such as iii, v and vii) indicate that trainees can follow-up on QIP work that has been conducted previously in the placement context.

12.1.1 Examples of previously completed QIPs can be accessed by trainees via the course's online Blackboard system. In addition, each Trust receives an annual report that includes summaries of the QIPs completed within the Trust.

Where there is any doubt about the suitability of the project, the trainee or placement supervisor is encouraged to consult the trainee's QIP Back-up Advisor *(see Section 12.5 below).* If necessary, the QIP Back-up Advisor will consult the Research Director, who may, in turn, consult with the External Examiner as required.

12.4 How is the QIP supervised?

The importance of the integration of research and clinical practice is emphasized for trainees from the start of the Course. The QIP is seen as an essential part of placement activity and, by implication, is primarily driven by the placement supervisor.

On occasion, the roles of QIP supervisor and placement supervisor may be separated and held by two different people: the co-ordinating clinical supervisor of the placement has overall responsibility for ensuring that the necessary communication and integration takes place so that the trainee has appropriate time and support for the QIP in amongst their other duties. The QIP should be seen as a collaborative venture that is negotiated between trainee and placement/QIP supervisor. In addition to overseeing the progress of the QIP, the placement/QIP supervisor should provide guidance in developing the QIP aims and questions and in the planning, design and implementation of the project and in reading a final draft of the QIP.

A contract for the QIP should be negotiated and drawn up between the placement supervisor and the trainee. It should include the following:

- Aims of the project.
- Supervision time allocated per week or per fortnight that is dedicated to the QIP.
- Time allocated for project activity (and when the time is allocated, e.g. Tuesday afternoons).
- An agreed deadline before the end of placement that allows the supervisor to read a final draft of the QIP.
- Description of the feedback to be given to participants and to the service, the form this will take, and the target date for provision of the feedback (i.e. steps demonstrating how the findings from the QIP will be disseminated within the local service setting).
- Evaluation of the impact of the QIP or the changes resulting from it (for the service and the trainee)
- Any reporting requirements of the host Trust.

The negotiation of the QIP contract is an opportunity for the trainee and placement supervisor to examine the trainee's views of practice evaluation and to clarify their needs and strengths with regard to research and evaluation skills. This process may be an opportunity for the supervisor to clarify their strengths and learning needs as well. The impact of the project activity on the trainee and on the context within which the project is taking place should be addressed within supervision, with trainees being encouraged to be aware of their own learning and development during the process.

12.5 How Does the Course Team support the QIP?

Each trainee is assigned a QIP Back-up Advisor who will be a member of the Course team. The QIP Back-up Advisor will give some support to the trainee with respect to the initial proposal, which they will read and provide early feedback on. They are ultimately responsible for evaluating this proposal when the trainee submits it for approval, and will give feedback on any further changes that may need to be made. In addition the Back-up Advisor can read the *plan* for the final QIP write-up, but not full drafts. Trainees can request up to 4 meetings with their Back-Up advisor once their QIP has been approved.

12.6 How Should Trainees and Supervisors Work Together on the QIP?

The conduct and development of the QIP should be seen as a collaborative enterprise.

12.6.1 STAGE 1 - Developing the project idea and planning the investigation

Trainees are expected to work with their placement supervisor to discuss ideas for a QIP and ways of carrying it out. Ideally, trainees will be able to work out a suitable plan of action with their placement supervisor. However, if there are questions or problems at this stage, then trainees should consult with their assigned QIP Back-up Advisor for supplementary advice.

Early in the Course, trainees will be involved in an 'Observation Week'. The idea behind this Observation Week is to set some learning tasks that will link academic, practice and research learning at the start of the Course. For the QIP element of Observation Week, trainees will be asked to identify past QIP work that has been conducted in the placement setting, and future work that might be conducted and that could form the basis of their own QIP. Placement supervisors should facilitate this process and encourage other relevant staff to do so.

In some Trusts, an idea for a QIP will have been allocated to the trainee, which they then need to work up, with the support of their placement supervisor. In some other Trusts, trainees are provided with a range of QIP ideas from across the organization that they need to choose between.

The trainee then prepares and submits a QIP proposal to the backup supervisor for approval. The primary purpose of this is to ensure that the proposed project meets the course's academic and examination requirements. The trainee should also seek approval from the host trust/organization (see Section 12.7 below).

12.6.2 STAGE 2 - Conducting the project

The project, once underway, will be monitored and discussed by the trainee and their placement supervisor. Due to the fact that the QIP must be completed within the first placement year, all project data/material must be collected during the trainee's time on placement in such a way as to allow time for data analysis, writing up the project and disseminating the findings. It is important to bear in mind that details of the dissemination of the findings need to be written into the final report submitted for formal assessment.

Essentially, the project needs to be managed in such a way that it is designed, conducted, analysed, the findings disseminated, and the report written by the end of the first placement year.

12.6.3 STAGE 3 - Writing up

The writing up of the QIP will take place while the trainee is still on placement. The trainee needs to submit a QIP report for formal assessment (see section 12.8 below) and, appended to this, they need to submit the brief report that was disseminated to the service. Teaching specifically regarding writing up a QIP will be given to trainees as part of research teaching in the first year. Support regarding the write-up plan can be provided by the QIP supervisors. The placement supervisor, who may read and comment on a draft QIP, will be a helpful guide to shaping the report and for feeding back the findings to the service.

12.7 Ethical Approval and QIPs

Generally, the QIP should be such that it does not require approval from a research ethics committee. Drawing on guidance provided by the NHS Health Research Authority, quality improvement work, audit or evaluation would not usually require research ethics approval so long as: (a) it is intended to generate locally relevant information rather than new, generalizable knowledge; (b) any intervention offered to participants is a routine part of clinical practice or is well grounded in an existing evidence-base; and (c) there is no random allocation of participants to groups/conditions, but rather any decisions about receipt of treatment are based on usual clinical practice in the service. At the time of writing, a useful tool for check whether NHS ethical approval is required can be found at: http://www.hra-decisiontools.org.uk/research/

If in doubt, the trainee and/or QIP supervisor on placement should consult with appropriate individual(s) connected to the service in question with regard to the need for ethical approval, such as someone working in an NHS Trust R&D department.

While a QIP should be designed such that it does not require research ethics approval, it will require whatever approval and/or registration that is usual for such projects in the host organisation; for example, some NHS Trusts require QIPs to be approved by their R&D Department, while others require approval by their Audit and Effectiveness Department. An anonymous copy of the approval email or letter should be included by the trainee in an appendix of the QIP write-up. Furthermore, all quality improvement work should follow ethical principles and be guided by NHS values, as in any other clinical and research activity (e.g. see most the most recent BPS/DCP guidelines on ethical practice and research ethics). QIPs should not be conducted on topics about which there is a high degree of controversy or political sensitivity within the host organisation or if there is a significant risk that participants might experience distress.

12.8 How are QIPs Assessed?

There is both a formative assessment and a summative assessment. For the formative assessment, trainees must submit a 1000-word QIP proposal by late January of the first year (evaluated by the trainee’s QIP Back-up Advisor). The summative assessment is a 4- 5000-word QIP report. Appended to this should be the brief report that was submitted to the service and a letter or email from the Trust’s R&D or Audit department indicating the project did not require ethical review. The QIP report should be submitted in September at the end of the first year.

Full details of the assessment guidelines and regulations for the QIP may be found in the Assessment Handbook. https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/docs/resources/Assessment-Handbook-2018-intake-2018-19.pdf

13. FEEDBACK AND QUALITY IMPROVEMENT

13.1 Practice Learning and Quality Assurance

As is appropriate for the importance of practice learning in the training of clinical psychologists, a great deal of work (often rather invisible) goes into the setting up and provision of placements and in providing placement supervision. The HCPC, the BPS, the training commissioners and the University all require that trainees have access to good placements with appropriate learning opportunities and support. It is often the case that placements are provided against a significant background of service pressures, changes and constraints during challenging times of uncertainty for supervisors. It is therefore imperative that practice learning placements are reliably monitored, with trainees and others providing regular feedback. It is equally important that supervisors, Trust Representatives and Course staff utilise feedback on the experience of placements both to highlight strengths, to draw attention to any areas that could benefit from improvement and follow up to outcome on any support or other actions. Therefore, there is a quality assurance process, drawing on different kinds of information, including both qualitative placement feedback and auditing against specified standards of good practice. The framework has several feedback loops connecting different parts of the system, an approach which seems most likely to be effective under conditions of complexity of relationships and responsibilities. The diagram below (Fig. 3) summarises the main features of the system.

Fig. 3: Framework for Practice Learning Quality Assurance

SOURCES OF INFORMATION

TRAINEES

- Placement Feedback Form*
- Placement Audit Form*
- Mid-placement visit
- Other contact with manager, staff, Clinical Director(s)

MANAGERS

- Placement Visit Feedback Form*

HOST TRUSTS & PLACEMENT PROVIDERS

- Supervisor Assessment of Placement Quality*
- Trust Representatives

SIX-MONTHLY REVIEW

PLACEMENT CO-ORDINATING MEETING, chaired by the Clinical Director

Information discussed and actioned

Issues raised with Supervisors/ Trusts/Course team, actions taken and outcomes reviewed. Next placement allocation process informed.

ANNUAL REVIEW

PROGRAMME MANAGEMENT COMMITTEE

Placement and Supervisor Report

***Copies/summaries of these forms are sent to the Trust Representatives

NB: Concerns are also dealt with when they arise: see Appendix 5.12 for procedure for the management of concerns on placement

All the above procedures and the information they yield are drawn upon by Trust Representatives and managers when deciding to use placements and when allocating them to trainees.

Approach to using feedback - The quality assurance procedure is designed to gather information about placements from a variety of sources and relationships and thus provide a wide net for the identification of both quality assurance and enhancement issues. These can usually be addressed within the framework illustrated in Fig. 3.
However, more significant issues concerning the quality of individual supervisors or placements can sometimes arise. The manager monitoring the placement retains overall responsibility for ensuring that any problem is addressed and an attempt will always be made to provide direct feedback to the supervisor concerned. It is an important part of Course practice that such feedback is managed sensitively and respectfully, but that it must be provided.

Appendix 5.12, **Guidance on the management of concerns about placements**, provides a full description of the procedure for addressing placement issues collaboratively with the supervisor, the Trust Representative and the host Trust. The aim is to resolve any placement problems through local dialogue involving the people concerned with providing the placement. However, where there are serious concerns, it is important to involve the supervisor's employers and to refer to the BPS and HCPC frameworks for professional practice, ethics and competence.

If supervisors are unable to respond to feedback or a placement repeatedly falls below an acceptable standard after active and supported attempts at improvement, it will no longer be used.

Sources of feedback

12.1.2 Trainee feedback: Practice Learning Feedback Form & Placement Audit Form

A Practice Learning Feedback Form and Placement Audit Form (see Appendices 5.1 and 5.2) should be completed by each trainee at the end of each placement, and signed by the co-ordinating clinical supervisor. One copy should be given to the supervisor for their records, and **two** copies should be handed in to the Assessments Administrator at the same time the ECC forms are submitted. Forms will thus be completed either at the end of six months or at the end of the year depending on the duration of the placement.

The Practice Learning Feedback Form is designed to provide qualitative feedback to supervisors on the trainee's experience of the placement and of the supervision received. Trust Representatives are provided with copies of the qualitative feedback forms for all the placements in the Trust for which they are responsible. It is through these forms and others that they build up a cumulative knowledge of supervisors and placements over time.

The Placement Audit Form lists the general standards for placements expected by the BPS which can be rated as fulfilled, fulfilled in part or not fulfilled. There is also space on the form for supervisors to add their own qualitative comments and observations.
Trust Representatives are provided with aggregate statistics of the audit for all placements in their Trust to assist in their direct monitoring of quality of their placement provision.

It is good practice for the Practice Learning Feedback Form and Placement Audit Form to be completed **after** the Evaluation of Clinical/Professional Competence and to be discussed in supervision. Clearly it can be challenging for trainees to provide feedback to those who are evaluating them but separating the processes should make this easier. Indeed the ability to provide constructive feedback is an important professional competence that is worthy of development in its own right.

However, it is understood that trainees may sometimes raise issues with their managers that they do not wish to put on their forms. Action on this information is taken on a case-by-case basis and may be discussed with Trust Representatives and Clinical Director(s) as appropriate.

12.1.3 Feedback from supervisors

The second part of the Placement Audit Form asks supervisors to assess the quality of the placement and the Trust's and Course's support for it.

This information is discussed and acted upon through the Placement Co-ordination Meeting as described above. In addition, supervisors are encouraged to use their own evaluation and the trainee feedback on their supervision and placement co-ordination as information forming part of their annual appraisal of their work within their Trust.

12.1.4 Feedback from managers

One of the purposes of the mid-placement visit is to ensure that the quality of the placement is adequate to achieve the required learning outcomes, that the trainee is being supported appropriately in their learning and that adjustments to the placement are made if necessary. If there are any significant problems with the placement, either identified from the placement visit or at any time during the placement, the manager should contact the relevant Trust Representative to discuss the problem and decide what action will be taken.

Managers provide written feedback on the placements they have visited that is then circulated to the relevant Trust Representatives.

Using the information - The qualitative and audit information is useful in identifying placement strengths and placement needs and provides data to support developments within Trusts, from supervisor training needs to issues of resource provision.

The Practice Learning Feedback results are discussed six-monthly and the Practice Learning Audit results are considered annually at the Placement Co-ordinating Meeting where it is decided what actions should be taken, for instance, whether an issue should be taken up with a supervisor, Trust manager, the Director responsible for the placement at allocation, or the Course Team more widely.

Trust Representatives usually draw on feedback from both trainees and managers to provide feedback to supervisors. Supervisors are encouraged to incorporate feedback about their placements and supervision into their annual appraisal in order to link quality assurance and performance management processes together within their employing organization.

12.1.5 Quality reporting to the education commissioners and stakeholders

On the Practice Placement Feedback and Placement Audit forms, the items marked with an asterisk correspond to the HCPC Standards of Education and Training (SETs) for placements. Therefore, the extent to which these standards, including the responsibilities for quality and support carried by the host Trusts and the Course, are being achieved by the placement are assessed. In addition, direct data about support and quality is collected from Trusts and the Course. Performance against the SETs is included in the Placement and Supervisor Report made annually to the Course Management Committee and may form part of the quality monitoring data used by the education commissioners.

In addition, placement providers are required to submit returns independently to the training commissioners, providing criterion-referenced information about the quality of the placements they have provided.

13.2 Process for Managing Trainee Placement Concerns

The guidance provided in Appendix 5.12 for the management of concerns about placements should be used. Should concerns about a placement or supervision be raised outside of the formal feedback mechanisms, the trainee would be encouraged to raise these directly with their supervisor in the first instance. If this does not resolve the situation, the trainee's line manager would become involved and would normally arrange to discuss the issues with the supervisor and Trust Representative/Trust representative to attempt to find a resolution. Various actions may be taken, for instance, it may be appropriate for the Trust Representative/Trust representative to be involved if further learning opportunities need to be sought outside the placement or additional supervisory support is needed.

Accountability In partnership with the host placement-providing trusts, the Clinical Directors are accountable to the Course (and ultimately the education commissioners as well) for assuring the quality of placements. Therefore, trainees are always encouraged to speak to or write to the Clinical Directors directly about any concerns about placements that are not covered by the available guidance or feedback system. They are also encouraged to contact the Clinical Directors if they feel that these systems are not working effectively or responsively, or if for whatever reason, the concerns are particularly sensitive.

Complaints As with any aspect of the Course, trainees may make a formal complaint using the CCCU complaints procedure, details of which are provided in the Course Handbook. Generally, it is appropriate to use the University complaints procedure when the complaint is about the Course's management of placement concerns. Trainees are also NHS employees, and therefore they also have access to a grievance procedure through their employer (Surrey and Borders Partnership NHS Foundation Trust). Where a trainee wishes to make a formal complaint about a supervisor, then they should initiate a grievance procedure according to the policies and procedures of the host trust (i.e. the supervisor's employer). In all cases but the most serious (where immediate action and the involvement of the supervisor's employers is required, e.g. matters of service user safety and wellbeing, alleged professional misconduct), trainees should endeavor to remedy placement issues at a local level first, consult their managers for guidance and engage in informal resolution processes before making a formal complaint.

13.3 General Review Processes

13.2.1 Continuous Monitoring and Review

Opportunities are provided for BPS Faculty regional groups (for instance, the Faculty for the

Psychology of Older People) to organise workshops and meetings at Salomons (CCCU) to which supervisors in the specialty are invited. This provides a forum for supervisor and course team representatives to monitor placement issues and helps support the development of placements within individual specialties. Similarly, active involvement in the local Division of Clinical Psychology (DCP) ensures professional and NHS developments are reflected in placements.

13.2.2 Annual Review

The Joint Clinical Directors are required to report regularly to the Course Management Committee about issues relating to the establishment, monitoring and quality assurance of placements and any matters affecting placement learning. A Practice Learning Report is prepared in conjunction with the other Year Directors, the Course staff responsible for linking with particular specialisms (e.g. Older People) and Trust Representatives, and presented annually to the Course Management Committee. The Report includes a summary of the audits and actions taken, placement numbers and needs, supervisor training, and quality enhancement and development issues. Any recommendations for change are also offered, with reference to the HCPC SETs, the QAA code of practice on placement learning and the BPS Accreditation Through Partnership criteria. The reports are considered by the Course Management Committee and form part of the Annual Quality Monitoring Report to the Academic Standards Board.

13.2.3 Periodic Reviews

University Periodic Course Reviews to re-validate the doctoral course take place at least every five years. In parallel, visits are made by the BPS Accreditation Through Partnership scheme to review the Course and advise the team accordingly. A separate line of reporting directly to the HCPC is also fulfilled during the interim should there be any major Course changes. In addition, the Course is reviewed by the Health Education England as part of the monitoring of NHS educational contracts by the Department of Health (DH). The Course Director and other members of the team consider in detail the reports and associated recommendations of these bodies and, for those aspects relating to placement learning, a Clinical Director will prepare a detailed response and if necessary, a plan of action. The Course Management Committee, the Faculty Quality Management Committee, the Research Degrees Subcommittee and Faculty Board consider this response. Internally, Quality Monitoring in accordance with University Guidance is undertaken under the scrutiny of the Research Degrees Subcommittee, subject to procedures within the Graduate School.

14. APPENDICES

4.1	Placement Outline Form	**120**
4.2	Guidance for approval of placements	**123**
4.3	Trainee Placement Allocation Form	**124**
4.4	Practice Learning Support Plan	**126**
4.5	Guidelines for managers on completing Placement Allocation Forms with trainees	**129**
5.1	Practice Learning Feedback Form	**131**
5.2	Placement Audit Form	**133**
5.3	BPS Accreditation through Partnership – Additional guidance for clinical psychology training programmes: Guidelines on clinical supervision (2010)	**137**
5.4	Trainees with Dyslexia and Placements – Guidance for Supervisors	**144**
5.5	Pre-placement meeting checklist	**146**
5.6	Example of Placement Contract	**147**
5.7	Examples of Observation Week Tasks	**148**
5.8	Feedback on Observations	**152**
5.9	Guidance on video and audio recording	**154**
5.10	Consent Form for audio-video taping	**156**
5.11	GMC Guidelines on making and using visual and audio recordings	**159**
5.12	Guidance for the management of serious concerns and problems with supervision on placements	**161**
5.13	DCP Policy on Supervision	**169**
5.14	Trainee Risk assessment form CCCU & SABP	**192**
5.15	Placement Risk Assessment Process	**198**
6.8	Suggested template for Clinical Supervision Contract	**200**
7.1	BPS (2017) Core competencies	**203**
8.1	Evaluation of Clinical Competence Form	**209**
8.2	Service User Evaluation Form	**224**
8.3	Practice Learning Portfolio	**227**
8.4	Mid-Placement Visit Record Sheet	**299**
8.6	Evaluation of Clinical/Professional Competence Marking Criteria	**306**
8.7	Placement Log of Clinical Experience	**318**
8.8	PLP Individual Record of Client Contact	**319**

Canterbury Christ Church University
Salomons Institute for Applied Psychology

Placement Outline

Appendix 4.1

This information is used to aid the process of allocating trainees to suitable placements. Once allocated, this form will be made available to the trainee too.

Year Group (i.e. 1st, 2nd or 3rd year)	**Specialty** (i.e. Adult, Learning Disabilities placement etc.)
Date:	
Trust:	
Service:	

Clinical Co-ordinating Supervisor (Person responsible for the placement with whom Salomons will liaise)										
Supervisor name:										
Profession:										
Service address(es):										
Phone number(s):										
Email address(es):										
HCPC registered:	**Yes**			**No**						
Main therapy model:										
Secondary therapy model(s):										
Days worked:	**Mon**		**Tues**		**Wed**		**Thurs**		**Fri**	

Second Clinical Supervisor (if applicable)										
Supervisor name:										
Profession:										
Service address(es): (if different to Clinical Co-ordinating Supervisor)										
Phone number(s):										
Email address(es):										
HCPC registered:	**Yes**			**No**						
Main therapy model:										
Secondary therapy model(s):										
Days worked:	**Mon**		**Tues**		**Wed**		**Thurs**		**Fri**	

Description of the placement		
Service setting(s) and client group:		
Learning opportunities: Further details of the setting and the supervisors' interests or theoretical orientation(s) and any particular strengths or features of the placement		
Opportunities for developing specific competencies: Please tick those that apply	**Assessment**	
	Formulation	
	Intervention	
	Evaluation / Research	
	Neuropsychological assessment	
	Other psychometric testing / measures	
	CBT competencies (including 3rd Wave – please list under other below*)	
	Psychodynamic competencies	
	Systemic competencies	
	CAT competencies	
	EMDR competencies	
	Behavioural / Positive Behaviour Support	
	Critical / Community psychology competencies	
	Organisational / systems influence & leadership competencies	
	Work with Families, Couples or Carers	
	Group work	
	Inpatient	
	Multidisciplinary teamwork / Interagency work	
	Consultation / indirect work	
	Teaching opportunities	
	***Other therapeutic / practice model competencies** (please specify)	
Particular challenges/limitations of the placement:		
Placement dates: (availability)	**1st year Year-Long 2nd & 3rd years Oct and/or April**	
Travel to and during placement: Please tick and provide further details	**Car essential**	
	Public transport available	
	Car desirable but possible without	

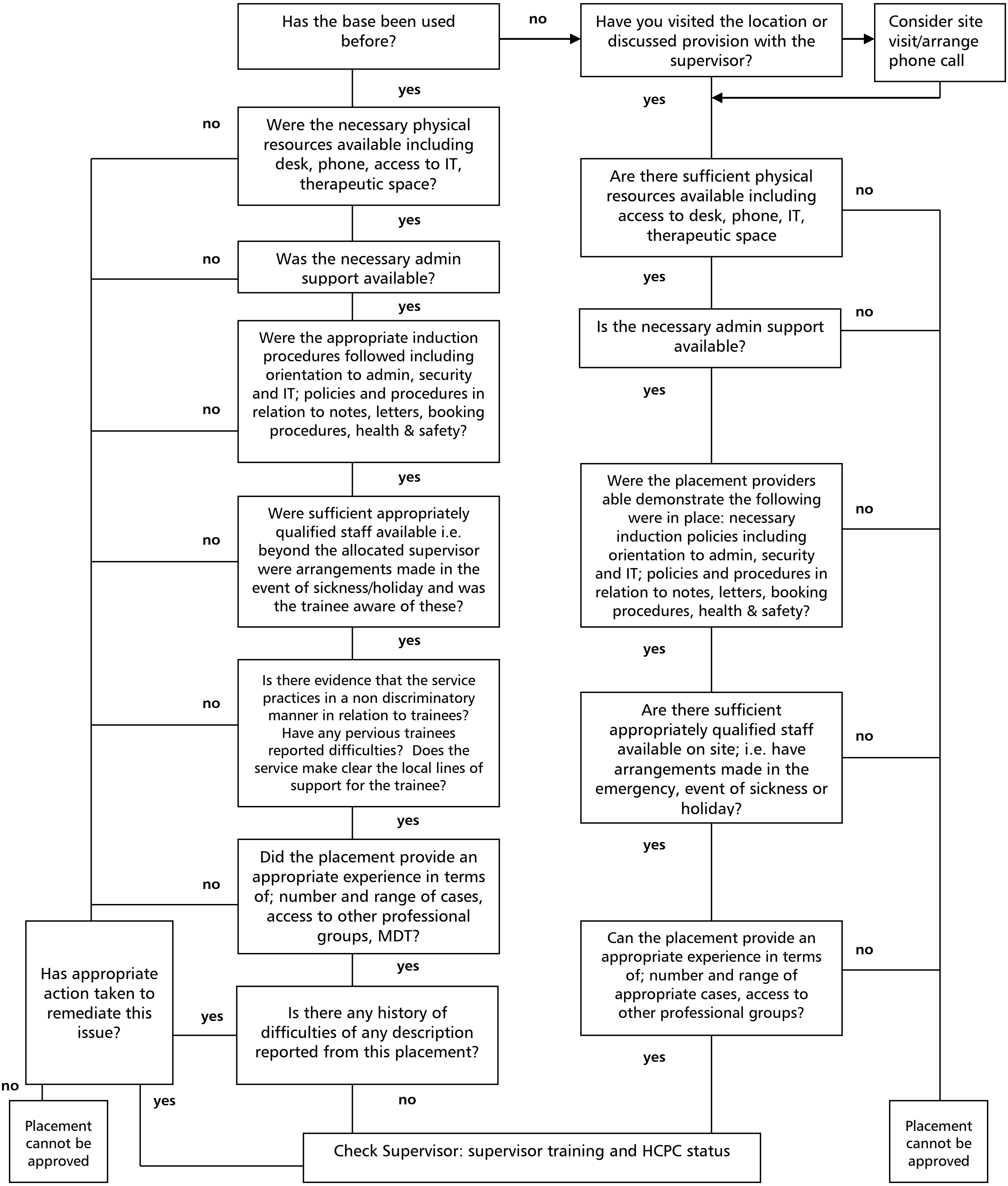
	Further information:
Remote Working Please add any information relating to the possibilities for trainees who may need to work from home occasionally, or may need to shield	
Any considerations for trainees from BAME backgrounds (e.g. wellbeing/comfort of trainee in local context & if staying overnight, service's approach to racism & understanding of possible experiences for minority ethnic trainees)	
Opportunities for involvement with service users or carers outside of service setting (e.g. visits to, or co-working with local service user groups or voluntary sector organisations)**:**	
Any other information:	

Thank you for completing this form, it provides valuable information to aid allocation of trainees to suitable placements.

Guidance for approval of placements for use by Salomons trainees

Please consider three components of placements:

- The base (physical location including policies, systems and personnel)
- Speciality (client group, appropriate cases, relevant experiences & learning opportunities)
- Supervisor



Canterbury Christ Church University

Salomons Institute for Applied Psychology

TRUST[4]

Trainee Placement Allocation Form

To be filled in by the trainee's manager in discussion and agreement with the trainee.

1st To 2nd Year Child and Families & Learning Disabilities Placements or 2nd to 3rd Year Older People & Supplementary Placements	
Date:	
Trainee:	
Manager:	

Occupational Health Referral:	**Yes**		**No**	
Practice Learning Support Plan (PLSP) in place:	**Yes**		**No**	
Double Covid Vaccination & Booster or 3rd Vaccination	**Yes**		**No**	

Previous Experience		
Please add any previous experience in Child & Families or Learning Disabilities, and specify in more detail if that will be helpful to the allocation process	**Child / Learning Disabilities**	
	Older people	

Trainee Needs	
Please specify what you feel the trainee most needs from their next placement(s) in each of these areas and then rank how important they are from 1 to 4 (1 being the most important). NB: If the trainee does not meet the BPS criteria (see below) in terms of either competency and/or experience these must be ranked highest.	
1	Engagement & Assessment, Clinical Formulation, Clinical Intervention, Evaluation (both clinical & service), Neuropsychological and Psychometric Assessment, Communication & Teaching, Professional & Ethical Practice, Reflective Practice.
2	Including clients with a range of presenting problems (including biological & psychosocial issues), with a range of severity (including challenging behaviour), from a diverse range of backgrounds, in a range of service settings (including multidisciplinary teams & inpatient/residential settings). Working in a range of modes (direct, indirect, individual, group, with families and carers) and developing competencies in CBT and at least one other model.
3	To be used at allocation by Year Team and TTCs.

	Most Important Need		[3]Addressed at allocation	
	Child and Families & Learning Disabilities Placements	**Mark with X**	**Oct**	**Apr**
Competency[1] CBT specific competencies must be met plus one other model	**Assessment**			
	Formulation			
	Intervention			
	Evaluation / Research			
	Neuropsychological assessment			
	Other psychometric testing / measures			
	CBT competencies (including 3rd Wave – please list under other below*)			
	Psychodynamic competencies			
	Systemic competencies			
	CAT competencies			
	EMDR competencies			
	Behavioural / Positive Behaviour Support			
	Critical / Community psychology competencies			
	Organisational / systems influence & leadership competencies			
	***Other -**			
Experience Needed[2]	**Work with Families, Couples or Carers**			
	Group work			
	Inpatient			
	Multidisciplinary teamwork / Interagency work			
	Consultation / indirect work			
	Teaching opportunities			
	Other -			
Interests				
Experience *Not* Needed or desired e.g. inpatient etc.				
Personal Circumstances/ Booked Leave				

Home Address / Postcode At Time Of Next Placement & Closest Train / Tube Station (please do not write '*same address as last time*')

Please return to ……………………… by ………………………..

Canterbury Christ Church University

Salomons Institute for Applied Psychology

Appendix 4.4

Practice Learning Support Plan (PLSP)

Section 1
Personal details

Trainee Name	
Programme of study	
Year	
Manager	
Date of Form Completion	
Rationale for form completion **(Disability, Occupational Health Request, Pregnancy*)** *** *If issues occur related to the pregnancy then this form to be completed in addition to standardised pregnancy risk assessment form****	

Section 2
Provision required

Effect of disability	Provision on placement for consideration	Action	Responsible person or department
Mobility	Personal Emergency Exit Plan (PEEP) Work station assessment Information on student’s own equipment. Adapted equipment Length of day, shifts, pace of work, regular breaks		
Hearing	PEEP Provision of safety equipment, or management system. Communication equipment Strategies for improving communication in meetings etc Adapted equipment		
Vision	PEEP Work station assessment Assistive technology Orientation		
Dyslexia, dyspraxia, dyscalculia	Identifying strategies to counter effects of condition. Students who bring in their laptops provided by CCCU must have them checked by the Trusts.		
Other	e.g. Medical conditions		

DISCLOSURE OF PERSONAL INFORMATION

Important

The purpose of this form is for you to give the University permission to liaise with Placement Providers about any disabilities related facilities you may need. Please sign in the space provided. If you do not sign, information will not be passed on to the department concerned, and this may prevent us from making reasonable adjustments for you. Please note that in signing this you are also agreeing for this Plan to be kept with your student record.

Organisation/Department	Reason for disclosure to them	Student's signature
Relevant staff on placement e.g. supervisors, mentors, managers.	To ensure that reasonable adjustments are delivered when you are on placement.	

Summary of information to be disseminated:	

PLEASE NOTE

It is your responsibility to inform your Manager if your condition alters if this may impact upon your experience on placement.

Read and actioned by the following members of staff within University /Practice:

Name	Organisation/Department	Signature	Date

Guidelines for managers on completing Placement Allocation Forms with trainees.

Introduction

The main purpose of the Placement Allocation Form is to provide the information needed to make a fair and appropriate match between available placements and trainees' training needs. The information provided on the form needs to be succinct and clear. In reality, only 3 or 4 considerations per trainee can be accommodated in the allocation process. In fact, adding too much information is likely to reduce the quality and effectiveness of decision making, so please distil out the essentials in the dialogue with your trainee before putting anything down on the form.

Please make full use of the meeting to construct a frame of collaboration around realistic expectations about travel, placement availability, the need for them to address main competencies and experience before interests and so on. In other words, the form should not be used as a shopping list but an opportunity to mediate the trainee's relationship with the programme and its systems!

For some years we have been saying to trainees, "You can expect to have one long journey during training". This is probably no longer helpful. "A few long journeys" would probably be a more useful expectation to cultivate.

1. In order to promote equity across trainees, only the information on the form will be used to make allocation decisions. Additional information that is not directly relevant to the training needs privileged by the form, (such as where the trainee is collecting data for their MRP, or having had a Referral recently), will not normally be attended to.

2. Lack of a car will not be taken into consideration. Trainees are expected to be able to travel to and from placement and around on placement in a timely manner as necessary (i.e. without supervisors having to circumscribe their placement to accommodate public transport constraints). Trainees are in breach of contract if they cannot travel flexibly.

3. Disabilities will be taken into consideration and reasonable adjustments made wherever possible. For a disability or health issue to be taken into account, the trainee should have preferably been through occupational health and have filled out a practice learning support plan with their manager. Please note the disability officer can also offer support to the manager when filling out the form. The practice learning support plan should accompany the placement allocation form and be available at the allocation meeting.

4. Trainees with children or other caring responsibilities will be given special consideration regarding travel but a discussion with the manager should take place. Those with dependents should discuss the impact of this when filling in the placement form (as it may not be that all of those with children need to be prioritised). In other words, please do not put it down automatically as we know that trainees without dependants can be quite systematically disadvantaged in allocations as a consequence.

5. Travel has been taken out of the list of considerations to prioritise. This is because a) travel was being listed as a top priority too often and training needs tended sometimes to get neglected, b) we always allocate to the shortest journey possible, and c) it may encourage trainees to believe

that they can travel less than they actually have to. Particular personal needs affecting travel can be entered in the Personal Circumstances box (but judiciously so).

6. Managers contributing to the allocation process should be careful not to introduce further information that may advantage their trainees compared to those whose managers are not present. There may occasionally be exceptional circumstances where additional information is appropriately and necessarily sought or offered in pursuit of the overall aim of making good and workable allocation decisions: however the principle of equity between trainees must be adhered to at all times.

7. We will try hard to respond to supervisors' preferences and service needs as part of the allocation process, in recognition of the value to them of having trainees on their placements and the importance of their supervisory work. However, if there is a conflict of interests, we will normally prioritise the trainees' needs as appropriate (e.g. if using a placement involves additional travel and a closer placement could equally meet the training needs).

Canterbury Christ Church University

Salomons Institute for Applied Psychology

PRACTICE LEARNING FEEDBACK FORM

Placement Trust ______________________________

Placement dates ______________ **to** ______________ **No. of days** ________

Placement Description ______________________________

Supervisor(s) ______________________________

Trainee ______________________________ **Year of training** **1** __ **2** __ **3** __

Please note, it is expected that this form is completed <u>after</u> discussion and completion of the ECC form.

This form will also be passed to the relevant Trust Representative.

Trainee Feedback: Placement Experience

- What features of the placement have you valued or benefited most from?

- Please specify any particular limitations, shortcomings or challenges of the placement?

- Has the level and amount of work you have undertaken on placement felt appropriate?

- Please suggest any ways that the placement might be developed or improved in the future?

- Are there any specific aspects of the placement induction, supporting materials or resources that could be enhanced?

- Please indicate which areas of competency you've had opportunities to develop on this placement:

CBT competencies		Neuropsychological assessment	
Psychodynamic competencies		Psychometric testing / outcome measures	
Systemic competencies		Teaching opportunities	
CAT/other model (specify) competencies		Consultation / indirect work	
Group work		Multidisciplin. teamwork/ Interagency liaison	
Families / carers / couples work		Organisational influence/leadership	
Other		*please specify*	

Trainee Feedback: Supervision

Structure – (e.g. issues of availability, time, boundaries, organisation, etc.)

Content – (e.g. balance of presentation/discussion, feedback, theory-practice linking etc.)

Process – (e.g. quality of guidance/support, critical thinking, personal/professional reflection etc.)

- What aspects of supervision have you valued or found most helpful?

- Appropriateness of supervision to your particular developmental and training needs.

- Please identify any specific areas in which supervision could be developed/improved in the future.

Supervisor Feedback:

- Any comments about the trainee's feedback

- Comments on quality of support, guidance and documentation provided by the course

Trainee signature ______________________ **Date** ______________

Supervisor signature ______________________ **Date** ______________

Canterbury Christ Church University

Salomons Institute for Applied Psychology

PLACEMENT AUDIT FORM

Placement Trust ____

Placement dates ________________ **to** ________________ **No. of days** __________

Placement Description ______________________________________

Supervisor(s) ____

Trainee ___________________________________ **Year of training** **1** __ **2** __ **3** __

2015 cohort: please print two copies

2016 cohorts onwards: please submit online - salomons.assessments@canterbury.ac.uk

Please note, it is expected that this form is completed after discussion and completion of the ECC form.

This form will also be passed to the relevant Trust Representative

TRAINEE SECTION: Please rate each item as: ***Y*** = *Yes*, ***N*** = *No* or ***P*** = *in Part*

A	Placement Resources	Y/N/P
1	Access to desk on placement days	
2	Access to telephone	
3	Access to secure filing/storage if required	
×4	Access to computer or laptop with internet access and a Trust user account	
5	Access to photocopier	
6	Access to test materials if required	
7	Access to adequate clinical space	
B	**Placement Induction**	**Y/N/P**
1	Pre-placement meeting/telephone call	
×2	Planned introduction to placement and provision of written materials	
×3	Guidance on service policies/procedures including health and safety	
4	Introduction to key people and their roles	
5	Orientation to available facilities, service setting and the organisation	
6	Orientation to service users and local community	
7	Completion of placement contract within first four weeks	
C	**Placement Activity**	**Y/N/P**
1	Progressive introduction to an appropriate quantity of clinical and service activity for the time available on placement	
×2	Protected learning time for trainees to reflect on practice	
×3	Practising in an environment that respects service users' rights (including confidentiality, privacy and dignity)	
4	Learning opportunities available through observing, or working alongside, skilled health care professionals other than the supervisor	
×5	Available guidance and support on placement; sensitive to equality, diversity and confidentiality issues	
6	Available support to notice, assess and manage risk appropriately, in such a way that service user safety is always understood to be paramount	
×7	Service user consent obtained when seen by a trainee; and also in relation to the trainee learning needs (for example, when service user's information is anonymously part of an academic assignment such as a case report)	

D	Supervision/Observation Arrangements	Y/N/P
1	At least one hour of scheduled individual supervision per week	
2	An additional hour of scheduled supervision either individual or group	
3	At least three hours per week total contact time with supervisor(s) (includes the above supervision, joint work, emails and discussions over the phone)	
4	Supervision times regular and consistent	
5	Opportunities to observe supervisor at work	
6	Opportunities to be observed directly or indirectly (audio/video) by supervisor	
7	Opportunities to observe or work jointly with other professionals	
8	Named alternative psychologist available as cover in the event of supervisor absence	
E	**Supervision Process**	**Y/N/P**
1	Meetings appropriately negotiated, structured and facilitated	
2	Adequate space for reflection	
3	Personal and professional development needs discussed and reviewed	
4	Issues concerning difference and power acknowledged/addressed	
5	Workload discussed and monitored	
6	Guidance on theory-practice links	
7	Advice on suitable reading	
8	Provision of timely positive feedback and support	
9	Provision of timely constructive critical feedback	
10	Process issues considered within supervision	
11	Assistance given with selection of Assessment of Clinical Skills 1 and 2 or Professional Practice Reports	
F	**Practice Evaluation and Monitoring**	**Y/N/P**
ˣ1	Placement visited by course staff member, (or placement reviewed in other location or via phone if visit not possible due to weather, illness etc.)	
2	Placement activity and Practice Learning Portfolio updated prior to placement review	
3	Outcome of mid placement visit used to inform remainder of placement	
4	ECC form discussed prior to submission at end of placement	
5	Practice learning feedback form discussed with supervisor before the end of the placement	
6	Adequate support available from programme staff during placement	

ˣCrosses against items indicate they are aggregated and reported to the education commissioners for quality assurance purposes. Content is informed by HCPC Standards of Education and Training (SET 5 Practice Placements) and Core Minimum Placement Provider Indicators (CMPPIs: Dept of Health 2010, Education Commissioning for Quality). Revised June 2017.

PLACEMENT AUDIT FORM: SUPERVISOR SECTION

The following items are based on the HCPC Standards of Education and Training (SET 5 Practice Placements) and Core Minimum Placement Provider Indicators (CMPPIs: Dept of Health 2010, Education Commissioning for Quality). The Salomons (CCCU) Programme is required to collect these data and report it in aggregate form to the education commissioners for quality assurance purposes. Please rate all items to the best of your ability. Thank you.

SUPERVISORS: please rate the following items as**:** ***Y*** = *Yes*, **N** = *No* or **P** = *in Part* as they apply to your placement

G	Supervisor Assessment of Placement Quality	Y/N/P
×1	The placement receives trainee evaluation feedback up to twice a year (via relevant sections of ECC form when a trainee completes the placement).	
×2	Trainee feedback is used to improve practice and learning (any placement development needs resulting from feedback are documented and attached).	
3	Co-ordinating supervisors collect and collate trainee feedback on their placements from the end of placement documentation. Any issues are discussed with the Trust Training Co-ordinator, or Trust placement organiser, (who informs the university as appropriate) and action plans are made to address them.	
×4	The co-ordinating supervisor has been encouraged to contribute to the training programme by, for example, participating in consultations, being invited to teach, examine or attend meetings, workshops (for example supervision workshops) at the university.	
×5	The co-ordinating supervisor prepares promptly for the placement once they receive notification that a trainee has been allocated.	
×6	The co-ordinating supervisor undertakes regular personal and professional development, enabling them to provide evidence-based teaching, assessment and practice (this can be evidenced through the supervisor's own appraisal).	
×7	The co-ordinating supervisor immediately notifies the university of any serious untoward incident, where a trainee's fitness for clinical training is called into question.	
×8	The co-ordinating supervisor ensures that the trainee receives timely and appropriate feedback on their performance and activity (as agreed between the university and placement provider).	
×9	Trainees have scheduled times with their supervisor at regular intervals to discuss their progress towards meeting their learning needs and placement contract requirements.	
×10	When applicable, the co-ordinating supervisor receives specific preparation (for example a discussion with the trainee's manager) in order to support their trainee if they have special learning needs. Reasonable adjustments are made to meet these needs.	
×11	Supervisors use a range of information to gather evidence about a trainee's skills and abilities.	
×12	Trainees are actively involved in self-assessment in the practice setting.	
13	Allowance is made within supervisors' workloads to ensure they have time to work with and assess their trainees' abilities and competence.	
×14	Supervisors are given protected time to complete assessment documentation, including evaluation forms and placement contracts as required.	
×15	The whole service contributes to each trainee's experience and promotes interprofessional learning.	

- Supervisor’s appraisal of placement learning environment and supervision

Trainee signature	______________________	**Date**	______________
Supervisor signature	______________________	**Date**	______________

***x**Crosses against items indicate they are aggregated and reported to the education commissioners for quality assurance purposes. Content is informed by HCPC Standards of Education and Training (SET 5 Practice Placements) and Core Minimum Placement Provider Indicators (CMPPIs: Dept of Health 2010, Education Commissioning for Quality). Revised June 2017.*

Appendix 5.3

ACCREDITATION THROUGH PARTNERSHIP

The British Psychological Society
Partnership & Accreditation

Additional guidance for clinical psychology training programmes: Guidelines on clinical supervision

---

Introduction

The following guidelines set out the minimum standards necessary to achieve good practice in the supervision of clinical trainees. In practice it is often helpful to adapt these guidelines and customise them to your specific programme. It is important that these guidelines are read in conjunction with the Society's standards for accredited programmes in clinical psychology, which are available at http://www.bps.org.uk/accreditationdownloads.

1. Qualifications of supervisors

1.1 Trainees must be supervised either by:

(i) A clinical psychologist who is registered with the Health Professions Council, and/or who holds Chartered Membership of the Society and full membership of the Division of Clinical Psychology, who has at least two years' post-qualification experience, and who has clinical responsibilities in the unit in which the work is carried out; *or*

(ii) Any other appropriately qualified and experienced psychologist who is registered with the Health Professions Council, and/or who holds Chartered Membership of the Society; *or*

(iii) An appropriately qualified and experienced member of another profession who is registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures.

In case of (ii) or (iii) above, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Programme Director or Clinical Tutor.

1.2 Supervision should normally be provided by a supervisor who has clinical responsibilities in the unit or service in which the work is carried out.

2. Supervisors Workshops and Meetings

2.1 Programmes must organise regular supervision workshops to train supervisors in methods of supervision; these should be designed with the needs of new as well as experienced supervisors in mind. Supervisors are expected to attend workshops on supervision. There should also be regular meetings at which supervisors have an opportunity to share information and discuss problems. Where programmes make use of team supervision, viz. where the ratio of trainee to supervisor is other than 1:1, the programme must ensure that appropriate guidance is given to supervisors and trainees on the procedures that are necessary for good team supervision. It will probably be necessary to establish supervisor workshops related specifically to team supervision.

2.2 Suggested learning objectives for introductory supervisor training are provided at www.bps.org.uk/accreditation/downloads. Programmes that have developed supervisor training that reflects these objectives are able to seek approval for their training from the Society's Learning Centre (www.bps.org.uk/learningcentre), enabling supervisors who successfully complete the training to apply for entry to the Society's Register of Applied Psychology Practice Supervisors.

2.3 It is important that supervisors keep abreast of theoretical, research and professional developments in their fields of work and participate in continuing professional development.

3. Allocation to Clinical Placements

3.1 There should be an explicit procedure for allocating trainees to clinical placements. All trainees and supervisors involved should understand the procedure and know how to influence decisions about clinical placements. The person responsible for arranging placements should give primacy to general training requirements and competency development needs but should also take account of the needs of individual trainees. Information should be provided about the experience obtainable in the various placements to help trainees and programme staff to make placement decisions.

3.2 The Programme should try to ensure effective co-working for trainees who are sharing the same placement. This is especially important where there is team supervision, with two trainees allocated to one supervisor, or when two or more trainees receive supervision from a team of supervisors, within the same placement.

4. Setting up the Placement

4.1 Both trainee(s) and supervisor(s) must have an opportunity to meet either before, or at the very beginning of the placement to discuss the range of experience, which is to be provided, and the expectations (hours, days of work, etc) of the trainee(s). The general aims of the placement should normally be agreed within the first two weeks of the placement and a clinical contract should be written. Attention must be paid in the clinical contract to the range of opportunities available in the placement, and to the needs, interests and previous experience of the trainee. Particular efforts should be made to fill major gaps in the trainee's experience, and records of the trainee's previous experience should be available for this purpose. The Programme Director or Clinical Tutor will have played a major role in the assessment of the trainee's strengths and needs and in the sequence of placements.

4.2 In cases where there is more than one supervisor involved in a trainee's placement (team supervision) a primary supervisor must be identified for each trainee who will take responsibility for the planning and co-ordination of that trainee's placement, supervision and assessment, and for liaison with Programme staff.

4.3 The supervisor must plan an induction for the trainee, arrange for cover in the event of annual or other leave and should plan casework well in advance.

4.4 Care should be taken to ensure that the trainee has access to (at least) shared office space, telephone and a desk. There must be adequate arrangements for secretarial and IT support for placement work and trainees must be given guidance on the facilities available.

4.5 Supervisors must remember that they have clinical and legal responsibilities for their trainees throughout the training period. It is good practice for supervisors to be insured, for trainees to be aware of relevant legal boundaries (e.g. re. the Data Protection Act, the Children Act). It is essential that trainees have appropriate (substantive or honorary) contracts that allow them to work in their placement.

5. Placement Content

5.1 Programmes must develop, in consultation with the Division of Clinical Psychology's Faculties and Special Interest Groups and local supervisors, guidelines on the required experience in clinical placements, recommending an appropriate amount of clinical work.

5.2 The local guidelines on placement content should be taken into account in the provision of placement experience for the trainee. The level of his/her experience and expertise and the stage of training will determine the particular balance of work for each individual trainee.

5.3 Supervisors should ensure that trainees undertake an appropriate quantity of clinical work. There are dangers in both extremes: too little work reduces the opportunity for learning and too much may reduce trainees' capacity for planning or reflecting upon the work. Supervisors should monitor the balance of time spent by the trainee on work at different levels (direct client work, indirect and organisational work). This balance will vary according to the stage of training and the type of placement. Supervisors should be alert to the dangers of time being lost at the start of the placement through suitable work not being available and should take this into account in preparing for the arrival of the trainee.

5.4 A log must be kept of the work a trainee has done in a clinical placement. The programme must ensure that the Clinical Tutor appropriately uses these records in planning future placements and by future clinical supervisors in discussing what experience they should provide.

5.5 With team supervision, the programme should give clear guidelines about the experience to be acquired so that the placement may be planned to make optimal use of others involved in providing supervision.

6. Clinical Supervision

6.1 There must be a formal, scheduled supervision meeting each week that must be of at least an hour's duration. Longer supervision will sometimes be needed, especially where team or group supervision is used. In addition, supervisors should try to make themselves available for informal discussion of matters that arise between formal supervision sessions. The total contact between the trainee(s) and supervisor(s) must be at least three hours a week, and will need to be considerably longer than this time at the beginning of training.

6.2 In cases of team or group supervision, trainees must always receive, in addition, an appropriate amount of individual supervision. Individual supervision must provide opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as on-going casework.

6.3 Adequate time for clinically relevant reading must be made available to the trainee on placement. In addition, supervisors have a crucial role in contributing to the integration of the academic and practical aspects of the Programme. They should discuss literature relevant to the clinical work in hand and suggest suitable reading to the trainee. In general they should help trainees to develop a scholarly and critical approach to their clinical work.

6.4 In addition to discussing clinical work, it is essential that the trainees and supervisors have opportunities to observe each other at work: the trainee can learn much more from this and it is essential in order for the supervisor to give the trainee accurate and constructive feedback. Placements differ in the most appropriate opportunities for such direct contact: some may use joint clinical work of some kind; others may prefer audiotape, videotape or a one-way screen. Some form of mutual observation of clinical work is regarded as essential.

7. Quality of Clinical Supervision

7.1 The quality of the supervision that is provided for the trainee will depend upon many factors. The care taken in the early stages to build up a good relationship will enhance the quality of the clinical supervision.

7.2 Supervisors should be prepared to adapt their style of supervision to the stage of the programme a trainee has reached. It is necessary to be prepared to describe basic clinical procedures in detail and to ensure that trainees have an adequate grasp of techniques they are asked to use. Detailed training in techniques should also be available to more experienced trainees if required.

7.3 Trainees and supervisors may find that they have a different orientation and interests. Where this happens tolerance should be shown on both sides. Trainees should be helped to see that they might learn much that is valuable from a supervisor whose approach they may not ultimately wish to adopt. On the other hand, supervisors should see it as one of their functions to help trainees develop their own interests in an appropriate way. Where supervisors decide they must overrule the way the trainee wishes to work, they should explain their reasons with care, rather than simply asserting that this is how things should be done.

7.4 Supervisors should be prepared to discuss seriously and sympathetically any general issues of relationships with patients or staff that arise in the programme of clinical work. They should be sensitive to any personal issues that arise for the trainees in relation to clients and be prepared to discuss these in a supportive way when they are considered to affect the trainee’s work. The range of personal issues that can be raised by clinical work is wide and includes, for example, over-involvement, dealing with anger and despair, workload and time management problems.

8. Clinical Reports and Communication

8.1 Communication with other members of clinical teams and networks involves both written and verbal reports. Verbal reporting and discussion are often more important than formal written reports in terms of their effects on clinical decisions and action. Since the relative importance of written and oral communication is likely to vary between settings, supervisors will need to identify the most important channels of communication in their placement and teach the trainee to use these channels effectively and efficiently. Training in effective communication will involve both observation of the supervisor’s behaviour, and practice by the trainee with ample opportunity for feedback.

8.2 There is a wide variation within the profession in how clinical reports are written and presented, particularly with respect to the amount of detailed information provided. Trainees need to be acquainted with a variety of report and letter writing styles. If there is agreement about minimal requirements of clarity and relevance in reports, exposure to individual differences between supervisors is more likely to be constructive than confusing. Trainees should be encouraged to write reports that are appropriate to the recipient (whether this is a professional colleague or a client), avoid jargon, distinguish clearly between fact and opinion, and provide consistent clarity of expression. Both supervisor and trainee should be aware of the potential conflict between communicating fully to professional colleagues and maintaining confidentiality.

Appendix 5.3

9. Review Meetings and Feedback

9.1 There must be a formal process during each placement whereby the Programme team monitors the clinical experience of trainees and the supervision provided, and helps to resolve any problems that may have arisen. The aims of this are:

a) to review the progress of the clinical Contract

b) to give feedback to the trainee on his/her clinical performance

c) to allow the trainee to comment on the adequacy of the placement

d) to set targets based upon the above for the remainder of the placement

e) to give feedback to the supervisor on his/her performance.

9.2 When a trainee is involved with some form of team supervision, the programme must ensure that each trainee's experience is monitored on an individual basis. Other review or feedback of meetings that may be held at the beginning and end of a placement should also allow for individual time allocation for each trainee. If possible, all team supervisors involved with any single trainee should be involved in the monitoring process (and beginning and end of placement meetings). Where it is not possible for all a trainee's supervisors to be present at a key review meeting, one designated supervisor should seek views from other team supervisors prior to the meeting, and provide feedback after the meeting.

9.3 Matters such as the physical resources available to the trainee (room space, secretarial backup, etc) and theory-practice links may also be usefully discussed at this time. Supervisors and trainees may find it helpful in the review to go through the rating forms that will be used at the end of the placement.

9.4 In general, it is expected that the programme staff member conducting the monitoring will hold discussions with the trainee and supervisor separately and then hold a joint discussion. In this way more accurate feedback about the trainee's performance and about the quality of the supervision provided may be obtained. The timing of the monitoring is important if sufficient time is to be left for improvements to be made. A plan and timetable for the review should be agreed at the start of the placement.

9.5 Mid placement qualitative feedback is essential both for the supervisor and the trainee. Supervisors should try to set aside positive or negative personal feelings about trainees when making evaluations. Feedback should be detailed and constructive and designed to help trainees develop a range of effective and appropriate skills; thus, feedback should be critical but not wholly negative.

9.6 If seriously dissatisfied about aspects of a trainee's performance, supervisors should regard themselves as under an obligation to the profession to indicate this to the programme staff.

9.7 The trainee also has a responsibility to the programme and to the profession to give feedback to the programme staff about the quality of the placement and the supervision.

9.8 At the end of the placement the supervisor must give the trainee full feedback on his/her clinical performance. The trainee must see the supervisor's written assessment. Any major points that the supervisor is concerned about should normally have been raised well beforehand, at least during the formal monitoring process, to allow the trainee time to improve. The trainee must also have ample opportunity to comment on the placement, for example, on the experience and the supervision received. The trainee's views should be recorded formally as part of the general evaluation of the placement. Feedback forms and forms for rating clinical competence should always be completed at the time of the end of placement review and returned promptly.

9.9 The points made in section 9.5 concerning the provision of balanced, constructive and detailed feedback to the trainee also apply to the end of placement review. The supervisor should, in addition, help the trainee to identify gaps in his/her experience to facilitate planning for subsequent placements. It is important for the supervisor and trainee to forward this information to the person responsible for co-ordinating placements.

10. Assessment of Clinical Competence

10.1 It is important that supervisors are familiar with the examination and continuous assessment requirements for trainees and the guidelines and regulations for these.

10.2 In cases of team supervision, all supervisors who have been involved with the trainee(s) must be familiar with the programme's assessment procedure and must give feedback on the trainee(s) clinical competence.

10.3 Supervisors must be familiar with the specific criteria for passing and failing in the assessment of clinical competence set by the programme. In addition, supervisors should be aware of appeals procedures. In cases where trainees have displayed unsatisfactory behaviour, such as regular and serious lateness for clinical appointments, professional misconduct, or failure to acquire an adequate level of clinical competence, trainees must be left in no doubt about the problem. The supervisors should discuss with the Clinical Tutor what action should be taken and it may be helpful to have a member of the programme staff present at the time of the end of placement review.

Revised September 2010

TRAINEES WITH DYSLEXIA AND PLACEMENTS – GUIDANCE FOR SUPERVISORS

There are currently around 10% of trainees on the Salomons' Programme with a diagnosis of dyslexia. (This is roughly the same proportion as is found in the general population.) Under the Disability Discrimination Act the Programme is required to make 'reasonable adjustments' to ensure that these trainees have an equal chance of successfully completing the Programme. These 'reasonable adjustments' will need to be considered on an individual basis but are likely to be ones that could be sustained once the individual is employed as a qualified psychologist. The Programme provides some tutorial support to these trainees and some funding is also available to obtain equipment that they might require to support them in completing the Programme.

Individuals will differ in the nature of the difficulties that their dyslexia presents them with. Some common difficulties include: a discrepancy between their general abilities and their language skills; poor short term memory (e.g. a difficulty holding large chunks of auditory memory long enough to process it into long-term memory); poor organisational shills; problems with reading (such as reading more slowly and difficulty with comprehension and summarising); and writing difficulties (such as poor spelling and grammar). Their written work may not fully reflect their understanding of the material. On the other hand, dyslexic trainees are likely to be better at skills in which the right hemisphere is dominant. This may be reflected in areas such as: strong conceptual abilities; an ability to see relationships and patterns; a creative ability; and good oral communication.

It is expected that if the trainee who will be on placement with you has formally disclosed their dyslexia to the Programme, then this will be raised with placement supervisors; this may be done by the trainee's Manager in their pre-placement phone-call or by the trainee themselves at an early stage in their contact with you. It will then be important to discuss with the trainee their particular difficulties and strengths and to think about how these could impact on the placement; although you may want to wait until you have got to know the trainee before exploring these issues in depth, so that you have established a relationship with the trainee before they have to talk about what may feel like a potential area of weakness. Following on from this, it will useful to plan what adjustments might be necessary to minimise the impact of any difficulties and to think about what supports might be put in place to help the trainee. It would be sensible to outline the main adjustments that you have agreed in the placement contract and to ensure that there are regular opportunities to discuss how these adjustments are working in practice. It will be important to bear in mind that some trainees may have only received their diagnosis quite recently; as a result, they may find it uncomfortable to talk about their difficulties and they may also still be working out what supports are helpful for them and which are not.

Some areas that it may be useful to consider with the trainee include:

- Will they need additional time to do the reading that is required for the placement? As the trainee may be able to read a smaller volume of material than other trainees, it would be useful if priorities for reading could be discussed with them.
- What additional supports might the trainee require in relation to writing reports, letters, etc.? (E.g. additional time to write the report; advice about how to structure the report before they start to write it; dictating notes into a digital recorder.)
- Trainees with dyslexia may find it difficult to balance managing the therapeutic tasks in a session whilst also trying to keep simultaneous notes. If so, it would be useful to help the trainee think of strategies to deal this (e.g. by using a digital recorder).
- Similarly, there may be issues for trainees in relation to supervision sessions and how they manage to attend to the content and also keep notes. It might, for example, be helpful to make a summary of the key issues jointly with trainee at the end of supervision or for the trainee to record the supervision sessions.
- Organisational skills are often affected in people with dyslexia, who often have to work hard to be organised They might, for example, find it hard to present a case without any warning and may require a few minutes to organise themselves first.
- Do trainees have access to a computer with appropriate software (such as word processing or speech recognition) that could facilitate their written work?
- Are there ways of presenting material that will enable trainees to absorb the content more easily? (If the material is written, this might be by, for example, using a minimum 12 point font size, Arial or other sans serif font, and coloured paper.) As people with dyslexia can have problems with sequential memory, they need to learn to control information through questioning; it is, therefore, important that trainees with dyslexia should feel able to ask questions to clarify information they have been given, without this being misunderstood

If you are uncertain of the best way to support the trainee, then it will be helpful to acknowledge this with them and to encourage them to take charge of their own learning needs, by thinking through the possible options for addressing any difficulties that have been identified. If you would like further advice from the Programme, please approach the trainee's manager.

Pre-Placement Meeting Checklist

This list can be used to facilitate the pre-placement meeting, ensuring coverage of key topics and promoting dialogue to align learning needs and interests, and what the placement can offer and requires. This should help to clarify the aims of the placement in preparation for drawing up the Placement Contract at the beginning of the placement.

Trainee:

- Previous experience
- Competency log – any gaps
- Perceived strengths and needs
- Interests and hopes
- Learning style
- Academic teaching relevant to placement
- Particular requests e.g. for QIPs
- Other written assessments, deadlines
- Provide supervisor with disk with evaluation forms etc on it
- First Year: Discuss induction time opportunities for completing observation week learning tasks (trainee and supervisor)

Supervisor:

- Outline of service and placement
- Any particular requirements re. attendance, travel etc.
- Meetings to attend, specific experiences available, workload expectations
- Clarify start date
- Holidays (trainee and supervisor)
- Supervision arrangements, boundaries, models – schedule first session
- Contact details (trainee and supervisor)
- Practical arrangements, local “customs”

PLACEMENT CONTRACT FORM OUTLINE

1. Trust name
2. Specialty
3. Co-ordinating Clinical Supervisor(s)
4. Clinical Supervisor(s)
5. Trainee name
6. Start/end date of placement
7. Brief description of placement and setting(s)
8. Statement that the paramount concern will always be that the trainee is enabled to raise any concerns about the safety and wellbeing of users of the service; this should be a standing item on supervision agenda.
9. Specific competencies that need to be developed by this trainee on this placement:
   1. Areas for development identified during the last placement
   2. Any competencies which were rated as *'Referral'* on the last placement that must be developed to an appropriate level on this placement
10. Main aims of the placement, including the core competencies (see ECC form) that are expected to be achieved and how these will be developed. Model-specific therapy competences should always be included
11. Specialist experience offered and how it will contribute to competency development, including specific therapy models and/or psychological testing
12. Main areas of work to be undertaken, with whom and an estimate of how much (e.g. client work, staff/team work, teaching/educational work, service user/carer/community organisation work, etc.)
13. Induction to the placement
14. Direct observation:
    i. Opportunities for the trainee to observe others (including supervisors)
    ii. Opportunities for the supervisor to directly to observe the trainee
    iii. Opportunities for detailed discussion and review of the development of model- specific competences based on observation of the trainee
15. Potential QIP area and supervision arrangements (including draft reading) if applicable
16. Supervision arrangements for selection of material, support and reading drafts of Clinical Portfolio (1st years)/ Professional Practice Report/ Supplementary Report including issues that need to be considered in obtaining informed consent
17. Supervision plan *(<u>Minimum</u> face-to-face contact: 1 scheduled hour per week plus informal contact and joint work)* and additional informal or emergency contact arrangements. Also, supervision cover if needed.
18. Supervision contract or agreement – discussion of expectations. (See suggested template on the resources webpage to guide discussion, though this is not for submission to the programme.)
19. Annual and study leave plan for this placement

    NB: Annual and study leave to be taken during the placement, needs to be negotiated by Supervisor and Trainee at the very start of placement
20. Confirmed number of placement days to be done
21. Signed and dated by the trainee and all supervisors

Examples of Observation Week Tasks

Example 1: Community Psychology / Adult Mental Health / Diversity.

Choosing a manageable geographic area served by one of the services you are working within on placement as an example, this task will to enable you to think about:

- the three questions below
- how you would identify your further learning needs
- how you might design research/inquiry strategies to meet these needs:

> ***1. Which community characteristics and living contexts in this area may be associated with a) positive mental health, b) negative mental health, and with c) access to mental health services?***
>
> ***2. How might life experiences for people living in this area be similar and different to your own, and how might this influence the way you engage and work with local people as a clinical psychologist?***
>
> ***3. If you wanted to find out more about psychological issues and social supports for people living in an area you were working in as a clinical psychologist, what knowledge-generating strategy might you use (e.g. which " informants" might you talk with, which information sources might you access, in the community and in statutory services)?***

Every one is asked to develop their learning and psychological knowledge in respect of these questions in order to contribute to discussions based on them in Teaching Session XXX. However, individuals will achieve their learning via different routes. In order to inform and develop your thinking about the questions, choose one of the three following learning inquiries to pursue (*n.b. You may need to make your choice through discussion with your supervisor in order to determine the practical feasibility of different strategies in the services you are working in)* :

a) Find out about the demographic profile of the population served by the Trust you are on placement with. What variations are there by geographic area within the Trust, and which social groups are represented as minorities and majorities? (Take one area to focus on if you wish, linked to your placement location) What are the main social and economic issues for people living in this area? Who might you ask about this information, and whose perspectives would you want to include?

(Resources: Trust information departments should have this information, also local Citizens Advice Bureaux. Census information is available on the web.)

b) Explore the demographic characteristics of referrals to one of the services you are in. Consider some of the following questions:
What patterns do you notice? Who is referred and who isn't? Who are the main referrers? What are the main referral pathways, and how might these influence who gets referred? What accounts do local clinicians give of how the social contexts in the population are reflected in referrals? Why might some groups be under/over-represented in referrals to psychological services?

(Resources: Audit or demographic information kept by service e.g. database of referrals, talking to clinicians and managers in the service and community organisations)

c) Develop some grass-roots community knowledge about what it might be like to live in a particular (small and manageable) catchment area covered by a service you will be working in. Go walk-about in it and find out if there is a local community resource directory. What do you notice? For instance:
   - Which social communities make up this geographic community?
   - How safe, clean, accessible are the resources in the area for different social groups, people of different ages and abilities?
   - Who is visible on the streets/ in public spaces at various times of day? Who isn't?
   - What is the local housing like, and where might people work?
   - Where can different people meet in informal or formal ways?
   - What is transport like and who uses what kinds?
   - What opportunities are there in the area for exercise, leisure and recreation?
   - What signs are there of spiritual or artistic life in the community?
   - What are the main community/voluntary sector organisations?
   - How accessible is information about community resources to a) clinicians and b) members of the public?
   - How did you feel (in relation to your own personal and professional identity) walking around in your patch?

(Resources: Observation skills, reflective journal, talking to clinicians and local people and organisations, NHS/ Social Services/ Community Agency resource directory of some kind)

If you want to develop your own, different learning strategy, you may do so. However, it should be placement-based, contribute to your induction and be reasonable systematic and transparent. Ideally, you should also be able to think about how the inquiry strategy you used shaped your resulting learning.

Associated teaching time for discussion of learning: AMH session.

Reading: to be provided

Example 2: Child Observation Week Task - Child Protection

Aims

To have begun a process of reflection on the issues raised in working with children who have been neglected or abused and in working within Child Protection guidelines.

To have knowledge of the local Child Protection Procedures.

Link with Academic Programme

To be integrated into problem based learning groups on child abuse and neglect starting on {DATE}.

Task Outline

1. Think about what Child Protection means to you. Write a couple of sentences.

2. What situations or scenarios come to mind when you think about:

   A. Neglect?
   B. Emotional abuse?
   C. Physical abuse?
   D. Sexual abuse?

   Write a couple of sentences about each. Think about, for example, what you might observe, be told, notice, feel, etc.

3. What would be going through your mind in these situations? What would your emotional reaction be? Write a couple of sentences about each.

4. Read the Child Protection Procedures for the Trust where you are on placement. If you have any questions discuss them with your supervisor.

5. Think about how these procedures address the scenarios you thought of in step 2 above and the issues these raised for you in step 3.

6. Think about what aspects of the Child Protection Procedures seem helpful. Also think about where concerns or worries you have are not addressed by them. Discuss it with your supervisor. Write your thoughts down.

7. Bring your knowledge of the Child Protection Procedures (from step 4) and your thoughts about them (from step 6) to the Problem Based Learning Group on Child Abuse and Neglect on {DATE}.

OBSERVATION OF TRAINEE – POSSIBLE AREAS TO CONSIDER

[This material is taken from the University of Leicester, School of Psychology, Marking Criteria for Video Submissions and is reproduced with their permission.]

1. RAPPORT

Does the trainee express non-contingent warmth (even in the light of negative responses from the client)? Is the trainee empathic? Does s/he appear genuine? Does s/he listen actively? Is s/he sensitive to difference between her/himself and the client? Is the trainee responsive to the client e.g. their emotional state, readiness to change etc?

2. EXPLORATION

Is the trainee curious? Does s/he try and find out what matters to the client? Does s/he facilitate disclosure? Does s/he facilitate emotional expression? Are the client's strengths and assets elicited? Are open questions used? Does the trainee explore the client's concerns?

3. UNDERSTANDING AND REFLECTION

Does the trainee check that the client understands? Does the trainee summarise? Does the trainee reflect back to the client? Does the trainee share her or his own thoughts (offering a psychological perspective)?

4. STRUCTURE

Generic: Is appropriate time-keeping observed? Does the trainee agree or recap upon an agenda with the client? Does the trainee provide a framework for the session? Does the trainee provide a safe environment for the client? Does the trainee demonstrate appropriate pacing of the session? *Specific:* Does the trainee clearly explain his/her role? Does the trainee discuss/explain confidentiality? Does the trainee end the session appropriately? Is time provided for client's questions and are they dealt with appropriately?

5. NON-VERBAL BEHAVIOURS

Does the trainee use appropriate eye contact? Does the trainee use appropriate posture? Does the trainee use an appropriate tone of voice? Is there an appropriate use of silence? Does the trainee demonstrate an appropriate professional demeanour (e.g. in dress, overall behaviour etc.)?

6. MAKING PSYCHOLOGICAL LINKS

Are hypotheses or interpretations being offered to the client in an appropriate and useful way? Are patterns and themes being identified which are pertinent to the client's current situation? Are links being made between the past and the present? Are links being made between the therapeutic relationship and other relationships?

7. AWARENESS AND APPROPRIATENESS OF OWN REACTIONS

Does the trainee make an appropriate expression of his/her reactions within the therapeutic relationship? Is the trainee able to manage and contain their own feelings in response to the therapeutic relationship or material presented by the client?

Guidance on video and audio recording

1) It is the responsibility of the trainee to refer to the guidelines laid down by the Trust in which a recording/s is being made, with regard to the production and use of both video and audio recordings. Trusts have devised specific protocols for the production and use of recordings for educational and/or training purposes which you are expected to access and adhere to. In particular, you should ensure that you understand specifically what is expected with regard to gaining consent from clients, as well as in the maintenance of confidentiality. Trusts vary somewhat in their interpretation of data protection laws, so be sure that you understand specifically what is required with regard to the transportation and storage of the data, as well as access to it.

2) You should use a consent form that will have been generated by your Trust and this should be held within the client's case notes. Where notes are electronic, the consent form should be scanned in.

3) In non-clinical settings, e.g. recording practice interviews with another trainee, the usual permissions and the BPS/HCPC code of conduct should be followed.

4) Some Trusts state in their protocols that the most secure device that can be used for recording audio or visual footage of clients is a Trust–owned and encrypted laptop. However, provision is made for trainees to use their own devices or those loaned by the University. If you will be producing audio-recordings primarily, it is recommended that you obtain a digital recorder specifically for the purposes of your training and that you do not use it for the production of any other material (as a confidentiality safeguard). Several suitable models are available on the Amazon website. Any digital recorder that you obtain for this purpose should have a USB port and be compatible with Windows media player. If you are using video, a limited number of camcorders are available to trainees from the admin office.

5) Check the protocol within your Trust CAREFULLY: it may be the case that you will be required to keep client audio visual recordings on the Trust network and that recordings should only be transferred to supervisors and University assessors via a Trust-owned USB safestick. You should never transmit recordings electronically (i.e. by e-mail).
6) It is important to remember that if a recording has been made from a standalone video recorder and attached camera, it may have recorded straight to the machine's hard drive. The recordings should be removed from the machine either by USB Safestick or by burning to CD/DVD and then deleted from the machine's memory.

7) From the University's viewpoint, any recording submitted for examination should be accessible until the relevant Board of Examiner's meeting has made a decision about the work. The recording should be destroyed as soon as possible thereafter.

8) Recordings should never be saved on your computer's C drive as this is not secure.

9) Should a client request a copy of a recording and it is deemed beneficial for them to listen to it, they may receive a copy. Again, be sure to follow the protocol within your Trust as to how to go about this. Some Trusts require that the client will be required to sign a declaration pledging to keep the material securely and to use it only for the purposes of enhancing the benefits of their therapy.

Canterbury Christ Church University
Salomons Institute for Applied Psychology

Appendix 5.10

Audio/Visual Recording Service User Consent Form

This form must be used in conjunction with the Trust Guidelines for Recording of Therapy Sessions and practitioners are responsible for ensuring compliance with these guidelines.

Type of recording **(please tick)**	Audio	☐	Visual	☐

To whom will the recording be shown (may be Trust practitioners or practitioners at partner institutions e.g. University)	Practitioners treating the patient ☐	Practitioners for training purposes ☐	Practitioners for assessment / supervision ☐	Practitioners for audit / research ☐

If for any other purposes please state	
How will the recording be stored?	
Date to be removed/destroyed	
Removed on (please give date and sign)	

Service User Consent (or person with parental responsibility)	I have read this form and consent to being recorded for the purpose(s) stated above. I understand that I can withdraw consent at any time and ask for recordings to be stopped or erased.	
Service User Signature and Date	**Signature:**	**Date:**

Clinician / Staff member	I confirm that to the best of my knowledge this consent has been given willingly and on an informed basis. I understand my responsibilities in relation to the recording process, storage and destruction.
Staff Name	
Staff Professional Group	

Name of person being recorded	

Date:	**Time:**	
Clinician / staff signature and date	**Signature:**	**Date:**

Source: Surrey and Borders Partnership NHS Foundation Trust

Canterbury Christ Church University
Salomons Institute for Applied Psychology

CONSENT FORM TO RECORD THERPAY SESSIONS

- I meet with (*name of psychologist*).

ADD PHOTO

- (*Name of psychologist*) wants to record what we talk about together.
- This will help (*name of psychologist*) improve his/her work.
- Also (*name of psychologist*) is doing a course. (Delete if not applicable)
- (*Name of psychologist*) works with (*name of supervisor*).
- (N*ame of psychologist*) will listen to the recordings too.
- No one else will listen to the recordings or (delete as applicable) the teachers on (*name of psychologist's course*) will listen to the recordings.
- (*Name of psychologist*) will make sure that the recordings are kept safe, so other people will not listen to them.
- (*Name of psychologist*) will destroy the recordings after our last meeting or when the course if finished.
- I can say '**NO**' to this.

Source: Surrey and Borders Partnership NHS Foundation Trust

- (*Name of psychologist*) won't mind if I say no. It won't affect my care.

- I can change my mind if I want to and (*name of psychologist*) will destroy the recordings.

My decision

It is okay for (*name of psychologist*) to record our meetings ✓ ☐

Or

I don't want (*name of psychologist*) to record our meetings ✗ ☐

My name: ___________________________________

My signature: ___________________________________

Today's date: ___________________________________

Source: Surrey and Borders Partnership NHS Foundation Trust

GENERAL MEDICAL COUNCIL'S GUIDELINES ON MAKING AND USING VISUAL AND AUDIO RECORDINGS

Excerpts from the General Medical Council's guidelines on making and using visual and audio recordings of patients (May 2002) are outlined below as they are considered useful to the production of similar material by trainee Clinical Psychologists:

1. When making recordings, you must take particular care to respect the patient's autonomy and privacy since individuals may be identifiable, to those who know them, from minor details that you may overlook. The following general principles apply to most recordings.

   A. Seek permission to make the recording and get consent for any use of disclosure (following the specific guidelines generated by your Trust).

   B. Give patients adequate information about the purpose of the recording when seeking their permission.

   C. Ensure that patients are under no pressure to give their permission for the recording to be made.

   D. Stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.

   E. Do not participate in any recording made against the patient's wishes.

   F. Ensure that the recording does not compromise patients' privacy or dignity.

   G. Do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent (i.e. make sure that the patient knows that a section of a recording will be viewed/listened to by your supervisor as well as the course examiners).

   H. Make appropriate secure arrangements for the storage of recordings (following the guidance laid down within your Trust).

2. When a mental disability or mental or physical illness prevents patients giving their permission, you must get agreement from a close relative or carer.

3. People agreeing to recordings on behalf of others must be given the same rights and information as patients acting on their own behalf.

4. Before the recording, you must ensure that patients:

   - Understand the purpose of the recording, who will be allowed to see it – including names if they are known – the circumstances in which it will be shown, whether copies will be made, and the arrangements for storage and how long the recording will be kept.

- Understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.

- Are given time to read any explanatory material and to consider the implications of giving their written permission. Forms and any explanatory material should not imply that permission is expected. They should be written in a language that is easily understood. If necessary, translations should be provided.

5. After the recording, you must ensure that:

   - Patients are asked if they want to vary or withdraw their consent to the use of the recording.

   - Recordings are used only for the purpose for which the patients have given consent.

   - Patients are given the chance, if they wish, to see the recording in the form in which it will be shown (and they may ask for a copy).

   - Recordings are given the same level of protection as medical records against improper disclosure.

   - If a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible.

Doctorate in Clinical Psychology
Salomons, Canterbury Christ Church University

GUIDANCE ON THE MANAGEMENT OF CONCERNS ABOUT CLINICAL PSYCHOLOGY PLACEMENTS

1. INTRODUCTION

This document describes how the Salomons (Canterbury Christ Church University) Doctoral Programme in Clinical Psychology will manage concerns relating to clinical supervision and placement organization. It does not specifically cover concerns about the safety of service users or professional colleagues. Similarly, trainee performance with respect to passing and failing placements is covered separately in the Assessment Handbook.

The majority of placements and the supervision provided on them are of very high quality and the Programme values the partnership with supervisors and NHS Trusts in delivering excellent training. However, it is inevitable that occasionally problems will occur on placement.

Placements on the Programme are provided by host trusts in the region. They are identified, allocated to trainees and monitored for their quality by the Trust Training Coordinators. Clinical Supervisors must be registered with the Health and Care Professions Council (HCPC) or be appropriately qualified members of professions registered with a professional or statutory body which has a code of ethics, accreditation and disciplinary procedures. The current document outlines guidance for management of concerns by the host Trust, training programmes and or trainees in relation to clinical supervision. These guidelines have been developed to support the implementation of a comprehensive framework around the provision of supervision and they complement the expectations for the supervision of trainees as outlined by *the Guidelines on Clinical Supervision (Standards for the Accreditation of Doctoral Programmes in Clinical Psychology, British Psychological Society, 2014) and Section 5 of the Standards of Education and Training (Health & Care Professions Council, 2014)*.

2. PURPOSE

There are a number of stakeholders involved in placements who may raise concerns about supervision on clinical placements, including Trust Training Coordinators (TTCs), Programme Clinical Directors, Trainee Managers and Supervisors. However, trainees are the most likely to be the first to raise concerns over the supervision they receive on their clinical placement. It is recognised that because they are evaluated on their professional performance by their clinical supervisors they may find it challenging to raise concerns over their clinical supervision particularly as many trainees may not have experience of working in the host trust or have knowledge of its procedures due to the rotational nature of clinical training. The purpose of this guidance is to outline the process of managing concerns over clinical supervision of trainees on clinical placements, and to be as transparent as possible about it.

The guidance bears in mind the importance of good relationships between the Programme and supervisors, the primacy of the safety and wellbeing of service users and the rights and obligations of trainees. It is important to state that any concerns raised about supervisors are taken in the wider context of the relationship between the trainee and the supervisor and other relevant issues. The Programme recognises and does consider the potential role of trainees in contributing to any difficulties which arise.

3. ROLES AND RESPONSIBILITIES

3.1 Trainee

- Responsible for raising his/her dissatisfaction with clinical supervision with the Clinical Supervisor providing it and to discuss ways to improve it.
- If the dissatisfaction with clinical supervision continues the trainee has a responsibility to raise it with his/her manager.

3.2 Clinical Supervisor

- Has the responsibility to discuss and address the trainee's feedback on supervision.
- The Clinical Supervisor needs to be available to discuss supervision on the placement with the Trainee Manager and to follow an agreed action plan for the placement.
- If required to, Clinical Supervisor may need to discuss concerns over the placement with the TTC and the supervisor's line manager.

3.3 Trainee Manager

- Responsible to schedule meetings with trainees and Clinical Supervisors to review the clinical supervision offered on placement.
- When the need arises, to facilitate agreed action plan for improving the clinical supervision on the placement and monitor it.
- Has the responsibility to contact the Trust Training Coordinator to inform him/her of the concerns over the placement and for any needs to support the Clinical Supervisor in his/her role.

3.4 Trust Training Co-ordinator

- Has the responsibility to keep informed about clinical placements and reported difficulties on placement.
- To support Clinical Supervisors in their role.
- To inform the relevant Professional Lead/Line Manager if there are persistent concerns over the clinical supervision on placement.
- To report to the relevant Psychology or training lead if there are cases of persistent concerns over supervision on placement and how these are being addressed.

3.5 **Professional Lead/Line Manager**

- To support Clinical Supervisors in their role.
- To address concerns over supervisory practice using relevant trust polices.

4. CONCERNS

4.1 The current guidance outlines the management of concerns with regard to:

- Deviation from good practice in supervision. This might include consistently allowing supervision session to be interrupted or curtailed, conducting supervision sessions in an unprofessional manner e.g. acting in a manner which takes advantages of status differences between trainee and supervisor.
- Failure to offer supervision e.g. leaving the trainee unsupervised with no alternative arrangement.

4.2 The current guidelines **do not** address the management of concerns relating to:

- Patients' care and safety or treatment of staff which are addressed by local w*histle blowing policy* and local service procedures.
- Trainees' performance and behaviour which are stated in the *HCPC's (2012) Guidance on conduct and ethics for students*.
- Placement failure and the actions to be taken in that situation which are documented in the *Salomons Practice Learning and Assessment Handbooks*

4.3 When considering the nature of concerns it is important to ascertain whether the concerns are:

- Specific to that particular trainee's experience of the placement; or
- Form part of a historical pattern of concerns about supervisor-competencies which have been emerging from placement previous feedback and kept by the trust's TTC; or

- Relate to the clinical competencies of the supervisor that have a broader impact beyond the placement concerns and which fall under the *HCPC guidance on How to raise and escalate a concern* and on whistleblowing and the local organisational procedure. In this case, the Trainee Manager will be required to raise the concerns with the TTC as soon as possible. They, in accordance with local polices, will liaise with the supervisor and his/her professional lead to ensure the safety of service users, trainee and staff are considered. This would be the case in the following examples:

i. Clear evidence that the quality of supervision fell significantly below the standard expected of a qualified psychologist (e.g. offering advice at clear variance with accepted professional practice, clear indications of minimal or absent knowledge of usual practice in the clinical context)

ii. Unethical professional practice (e.g. operating clearly and observably outside sphere of competence, observed unprofessional behaviour in clinical sessions)

iii. Breaches of the HCPC Standards of Conduct Performance and Ethics. Breaches of standard NHS policies and procedures (e.g. failure to follow safeguarding procedures correctly). As well as breaches of the code of ethics, conduct and performance covered by relevant professional bodies e.g. BPS Code of Ethics and Conduct.

iv. Serious doubts about the clinical competence of the supervisor (e.g. where practice is at clear variance with accepted professional practice).

5. MANAGING CONCERNS

The guidelines aim to provide a transparent outline for the management of varying levels of concerns regarding the provision of supervision on clinical placements. Although the policy outlines the management of concerns in stages there is an expectation that trainees would discuss their concerns and seek guidance on how they could be best addressed at the different stages with their manager. Therefore the process should not necessarily be viewed as linear and indeed it is recognised that it is likely that the first two stages may take place as part of the regular contacts between the trainee, their supervisor and the Trainee Manager. Therefore, when managing concerns about a placement, the starting stage chosen should be the one most relevant with the more significant concerns should start at a higher stage.
Trainees are encouraged to endeavour to resolve minor concerns through discussion with their supervisors, but also to seek support and guidance from their managers when necessary. The procedure below outlines the most likely steps towards managing placement concerns.

MINOR CONCERNS

5.1 Stage 1

In the first instance trainees and supervisors are both encouraged to discuss concerns as and when they arise, and to seek a mutually acceptable resolution without involving the TTC and the Training Programme.

5.2 Stage 2

If the first stage does not lead to a resolution of the concern, the manager should be contacted by the supervisor or the trainee as soon as possible, as it is recognised that early intervention is often more effective than waiting for difficulties to become entrenched. The manager will arrange to discuss the placement with the trainee and then separately with the supervisor usually within fourteen days of being contacted. Individual discussions should normally be followed by a meeting between all three parties. Concerns will be considered in the wider context of the relationship between the trainee and the supervisor and other relevant issues. Most issues which emerge can usually be dealt with easily by direct discussion between the manager, the supervisor and the trainee. A corrective action plan and review date should be agreed. Due to the short term nature of clinical placements (6-12 months) it is recommended that the review date should be the earliest possible date by which improvements could be expected to be implemented and monitored.

MAJOR CONCERNS

5.3 Stage 3

If the Trainee Manager concludes that:

i. The action plan was not adhered to and that the concerns were not resolved; or

ii. Recognises that there is a historical pattern of concerns about the supervisor competencies[1];

The Manager will discuss the concern with the TTC. The TTC will meet with the supervisor normally within fourteen days to devise a plan to support the supervisor to fulfil the role successfully and will closely monitor feedback on the placement.

The TTC will inform the supervisor that the supervisor will need to notify his/her professional lead about the difficulties with the placement and if this is not done by an agreed date the TTC will contact the professional lead directly. It is acknowledged that the professional lead is likely to hold a wider understanding of the contextual issues that may contribute to the concerns raised about the placement for example:

1. The difficulties in the placement could be due to competing responsibilities that the supervisor has or to the current conditions in the service. Therefore the feasibility of the placement may need to be considered.

2. The supervisor is likely to require support and supervision on their supervision from their line manager/professional lead or another colleague.

3. In some cases the concerns about the placement may constitute one part of the broader difficulties encountered by the supervisor in fulfilling his/ her role and may need to be addressed by the line manager in that context.

5.4 Stage 4

If the concerns about the placement and supervisor are not resolved, the TTC shall organise a meeting with the supervisor and his/ her line manager or professional lead to agree whether and under what conditions the placement could continue to be utilised.

---

[1] Information from trainees and tutors feedback on placement is held by the TTC

This meeting is likely to result in the development of an action plan to be addressed by the supervisor and his/her line manager/professional lead.
The TTC will notify the Clinical Director and programme staff of the decision with regard to the placement and work with them to ensure that appropriate arrangement to oversee the reminder of placement or to end the placement if its continuation with an alternative supervisor is not feasible.

5.5 Recognising complexity in power and organisational relationships

The aim of the Programme is to provide trainees with good quality placement learning experiences that are held and facilitated by a nexus of inter-relationships and communication between Programme staff, trust staff and trainees. Most of the time, these relationships are collaborative, harmonising and working well towards that outcome. The role of trainees in providing feedback and raising issues is central to the process. Providing supervisors with feedback is seen as a professional responsibility for trainees, one that involves drawing on professional competencies which they will need to draw on in multiple situations during their qualified careers.

However, the nexus of relationships is underpinned by a web of power relations, and it is important to acknowledge the challenges this could pose to trainees in particular at times. It is inherent in the relationship that trainees are being both assessed and supported by their supervisors. They are also both line managed and supported by their managers. Trainees could end up looking for jobs in services where they have had placements. In other words, there is a range of possible power considerations in the overlapping roles and relationships involved in placements, as there often is in professional life.

Whilst such considerations would not normally stand in the way of trainees raising issues with their supervisor or their manager, there could be occasional situations where the complexities of power relations or the sensitivity of the concern would make it very difficult for a trainee to do so. Therefore, trainees should note that in addition to this procedure, they can at any time contact the Clinical Director(s) of the Programme to provide feedback or discuss placement issues that may, for whatever reason, be of a particularly serious or difficult nature to talk about with those directly involved. The Clinical Director(s) are most likely to become involved in assisting the trainee to pursue an adapted pathway based on the principles underlying this guidance.
In the case of some serious concerns about supervisor competence or conduct that have a broader impact beyond the placement concerns (and which, for instance, may fall under different guidance or policy such as whistleblowing*),* the trainee would be guided to the appropriate relevant procedure and supported to use it. Such concerns would need to be dealt with by the trust employing the supervisor and probably the HCPC. Exceptionally, the Clinical Director(s) may have to act on information given, with or without the consent of the trainee, in the interests of service user care and safety.

6. OTHER CONSIDERATIONS

The Programme staff are not the supervisor's employer or line manager and their duty of care to service users is discharged once the Programme's concerns have been brought to the attention of the supervisor's employer via the supervisor's line manager or TTC. Programme staff do, however, have a remaining duty to trainees to ensure that they make appropriate arrangements to end the placement if its continuation is not feasible, or to oversee the remainder of the placement following the serious concerns meeting if the outcome is for the trainee to remain within that service.

None of the above steps will be taken on the basis of trivial or unsubstantiated complaints. It is in the interest of the Programme and trainees as well as supervisors that this is so. There should be sufficient checks and balances built into applying this guidance to ensure that only serious and substantiated complaints are addressed as major concerns as outlined in 5.3 and 5.4. If an accusation by a trainee is deemed to be malicious, this will be conveyed to the trainee's line manager, who will need to consider invoking the appropriate disciplinary procedures for the trainee.

7. CONCLUSIONS

The Programme recognises that supervisors often work in services in which significant demands are placed upon their time and where such pressure may in some circumstances affect the quality of supervision offered. The Programme is keen to engage constructively with supervisors in conversations about such issues, respond flexibly and commensurately with the concern, and to provide support in a number of different ways to help them to continue to supervise trainees and to uphold NHS values. The aim of this guidance is to ensure that minor concerns are dealt with constructively, and that where serious concerns about supervisory competence or conduct are raised these are responded to in a clear, safe and transparent way. The Programme hopes that this policy does not raise anxiety - it is not intended to alarm but to inform.

8. REFERENCES

- HCPC (2014) The Standards of Education and Training.
- HCPC (2012) Guidance on conduct and ethics for students
- HCPC (2012) How to raise a concern
- BPD (2009) Code of Ethics and Conduct, British Psychological Society
- BPS (2014) Guidelines on Clinical Supervision, Standards for the Accreditation of Doctoral Programmes in Clinical Psychology

Acknowlegements:

This guidance has built on and been adapted from the work of others, for use by the Doctorate in Clinical Psychology Programme at Salomons, CCCU.

Thanks and acknowledgements are due to:

1. *Dr. Idit Albert and South London and Maudsley NHS Trust*
2. *Nan Holmes and regional clinical psychology representative members of the PsychD Board of Studies at Surrey University whose document was developed from work done by the North London Doctoral Courses in Clinical Psychology at UCL, UEL and Royal Holloway and by Lancaster, Liverpool and Manchester Universities Doctorate Programmes in Clinical Psychology.*

Revised by Louise Goodbody, October 2015

Appendix 5.13

The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

DCP Policy on Supervision

January 2014

This document was written on behalf of the Division of Clinical Psychology Professional Standards Unity by:

Dr Catherine Dooley	Director, Division of Clinical Psychology Professional Standards Unit
Thomas Peyton–Lander	DCP Publications Assistant

Acknowledgements

The Division of Clinical Psychology Professional Standards Unit wishes to thank the following trusts:

- Camden and Islington NHS Foundation Trust, Camden Primary Care Trust and Islington Primary Care Trust for allowing us to use their 'Responsibilities of Psychology and Psychological Therapy Managers in Multi-professionally Managed Services' in Appendix E.
- South West London & St George's Mental Health Trust for allowing us to use their examples of 'Supervision Contracts' in Appendix A.

We would also like to thank the following people who commented on earlier drafts. The comments made were extremely helpful and many have been incorporated into this policy document.

Tina Ball	Clinical Director, (Learning Disabilities), Sheffield Health & Social Care Trust
Dr Helen Beinart	Chartered Clinical Psychologist
Dr Laura Golding	Academic Director, DClinPsychol Programme, University of Liverpool
Jane Street	Consultant Clinical Psychologist, Associate Director for Psychology & Psychotherapies, Wandsworth and Clinical Lead, Wandsworth Psychological Therapies and Wellbeing Service (IAPT)

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

Contents

Page

DCP Equality and diversity statement 2
Introduction 3
1. Aim of this document 4
1.1 Purpose and function of supervision 4
2 Standards and recommendations for good practise 5
3 Types of supervision 6
3.1 Operational/line management supervision 6
3.2 Professional supervision 6
3.3 Clinical supervision 7
3.4. Alternative approaches to the provision of supervision 9
3.5. Informed consent from clients in relation to supervision 9
4 Complex issues that might arise in supervision 9
4.1 Aspects of the supervisory relationship 9
4.2 Sociocultural aspects to consider in supervision 10
4.3 Diversity impact assessment in relation to supervision 11
5 Quality, aspects of effective supervision 12
5.1 Expertise in the provision of effective supervision 12
5.2 Training and CPD for supervisors 12
5.3 Problems in accessing supervision 12
5.4 Monitoring and audit 12
6 Conclusion 13
References
Appendix A – Two examples of supervision contracts 15
Appendix B – Recording of supervision sessions 17
Appendix C – Psychology and psychological therapies: Responsibilities of psychology and psychological therapy managers in multiprofessional managed services 18
Appendix D – RAPPS learning outcomes 20

DCP Equality and Diversity Statement

The British Psychological Society's *Code of Ethics and Conduct* (2009) is based on the four ethical principles of respect, competence, responsibility and integrity. This code is the basis for the Division of Clinical Psychology's work and is the foundation for the Division's diversity statement.

The Health and Care Professions Council (HCPC) as the regulatory body for the profession set out their statements in relation to equality and diversity in the *HCPC Equality and Diversity Scheme* (2007).

The Division of Clinical Psychology expects members to deliver services fairly in response to individual needs, and to behave with respect and decency to all. Members of the DCP do not discriminate based on a person's age; ability or disability; family circumstance; gender; political opinion; race, nationality, ethnic or national origin; religion or belief; sexual orientation; socio-economic background; or other distinctions. Such forms of discrimination represent a waste of human resources and a denial of opportunity.

The DCP recognises that discrimination, harassment and bullying does occur and expects members to challenge inappropriate behaviour and discriminatory practice either directly, or through working within cultures and systems to establish changes to practice.

Supervision is a critical element of clinical practice since it links scientific research to the realities of clinical work, and is the means by which theory becomes linked to practice (e.g. Fleming & Steen, 2012; Scaife 2001; Bernard & Goodyear, 1998).

Introduction

Supervision is one strand of clinical governance for professions within health services, alongside continuing professional development (CPD) and life-long learning to ensure safe and accountable practice and high quality clinical and professional services.

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance the Care Quality Commission's *Essential Standards of Quality and Safety* (2010) and the Health and Care Professions Council's Standards of Practice 2c.2 (HCPC, 2011).

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill.'

Supervision within clinical psychology can be defined as 'the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of junior colleagues'. (Milne, 2007)

This document updates and replaces previous guidance from the DCP on this area, namely *Policy Guidelines on Supervision in the Practice of Clinical Psychology* (2003) and *Continued Supervision* (2006). Reference should also be made to the BPS *Code of Ethics and Conduct* (2009), the BPS *Generic Professional Practice Guidelines* (2008), *DCP Continuing Professional Development Guidelines* (2010) and *DCP Guidelines on Activity for Clinical Psychologists* (2012). The BPS's *Register for Supervisors* (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision and these would be recommended as good practise for those offering supervision. (See Appendix D for RAPPS learning outcomes.)

This document confines itself primarily to the supervision needs of qualified clinical psychologists; supervision of trainee clinical psychologists is determined by additional guidance for clinical psychology training programmes: *Guidelines on Clinical Supervision* (BPS 2010). Supervising of assistant psychologists is addressed within the *Guidance on the Employment of Assistant Psychologists* (DCP, in preparation).

These standards apply to all members of the DCP and provide a good practice benchmark for all clinical psychologists, although it is recognised that there may be different approaches within different organisations. Individuals in independent practice, either as sole practitioners or within an organised service, will require robust supervision arrangements that meet these standards and the underlying principles that underpin them.

1. Aim of this document

The aim of this policy is to:

- Describe managerial, professional and clinical supervision.
- Set out standards for best practise in supervision for and by clinical psychologists
- Outline responsibilities for the line/operational manager, supervisor and supervisee within this process. In particular, to demonstrate that the supervisee has a proactive role to bring concerns and issues to supervision and engage openly and honestly with the process.
- Reference how supervision, CPD and appraisal work together to provide a system for clinical governance and staff development.
- Provide guidance on the delivery, development and audit of supervision – such as contracts, recording, monitoring and audit.

1.1 Purpose and function of supervision

The primary purpose of supervision is to ensure the safety and quality of care and treatment for service users.

Supervision also supports professional development, developing and embedding new skills and ensuring adherence to good practice both in clinical and professional areas.

Where clinical psychologists work with more complex/transdiagnostic clients there is a particular role for supervision to support them to develop and refine (and re-refine) formulation and intervention plans.

Effective supervision also has a role in providing support for the individual and maintaining morale. This can be of particular value when psychologists are working in highly complex and sensitive areas – such as trauma or child sexual abuse – where the need to establish sufficient time to take issues to a safe and confidential place away from the normal work setting may need to be factored into the job plan.

At a time of ongoing change within services, the supervisory function has a particular role to allow the individual practitioner to reflect on the personal impact of their work and manage concerns in order to assist them in maintaining their level and standard of functioning.

Several models of supervision (see Beinhart, 2012 for a review), identify supervision tasks and functions such as: education; support; quality assurance/monitoring; conceptualisation/formulation and consultation. These occur in the broader service/team context and models such as Hawkins and Shohet (2012) and Holloway (1995) stress the importance of the broader context. Current theory and research also emphasis the centrality of the supervisory relationship to effective supervision, e.g. Beinart (2012) and Watkins (2013).

2. Standards and recommendations for good practise

1. All clinical psychologists, at all stages of their career and in all work contexts, will engage in regular planned supervision of their work.
2. All aspects of a clinical psychologist's work including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.
3. The amount and frequency is dependent on context, experience and work demands:
   - 3.1 An absolute minimum will be one hour per month, one to one supervision with a psychologist, for all staff, however part time.
   - 3.2 It is recommended that a full time newly qualified clinical psychologist will have weekly clinical supervision for a minimum of one hour.
   - 3.3 It is recommended that a full time mid career clinical psychologist will have clinical supervision for a minimum of one hour per fortnight.
   - 3.4 It is recommended that a senior psychologist would have clinical supervision for a minimum of one hour per month.
4. It is recommended that a supervision contract (see Appendix A for examples), agreed and signed by supervisor and supervisee be established, and reviewed regularly, at least annually. The annual review will identify the amount of supervision required and incorporate supervision time in relation to the demands of the work and may be reflected in a work plan (DCP, 2012).
5. All clinical supervisors will be appropriately trained for the role.
6. All supervision will be documented and records kept (see Appendix B)
7. The individual has a responsibility to identify the need for and to seek access to supervision within their work situation.
8. Supervisors apply supervision models and best evidence to their supervisory practice and attend carefully to their supervisor relationships.
9. Supervisors demonstrate ethical practice and are respectful of diversity in all its forms.

3. Types of supervision

It is important conceptually to separate out:

- Line management supervision
- Professional supervision
- Clinical supervision.

In practise, in some services these three areas will each be dealt with within different supervisory arrangements, with an individual meeting with their team manager (a non-psychologist) on perhaps a monthly basis, meeting with their professional supervisor monthly and with clinical supervisor on a weekly basis.

However, at times two or even all three may be combined within one supervisory relationship. In these situations it may be particularly important to ensure that all aspects are appropriately addressed. There are examples of matrices illustrating how and where the different elements may be met (Appendix C).

It should be noted that at times a particular issue will be and should be addressed in all three areas; one example would be a clinical issue concerning safeguarding of a vulnerable adult which may need to be discussed with the line manager (to support formal reporting), within professional supervision in terms of how the individual managed the situation and within clinical supervision to refine the clinical intervention.

3.1 Operational/line management supervision

Line management structures are determined by the employing organisation and line managers are responsible for developing systems for the managerial supervision of staff within their service. Line management supervision has a focus on appraisal and monitoring of performance, and is specifically concerned with operational issues and quality of service. This complies with clinical governance requirements, and addresses the need for accountability. Line management supervision ensures that staff perform the tasks they are paid to perform as part of the services that the organisation is commissioned to deliver. A key aim is to ensure that there is consistency between the individual's work and the objectives of the service.

3.2 Professional supervision

Professional supervision is a distinct function but may be combined with other roles. It has the overall focus on the individual as a professional within a professional role and its key function is to ensure that professional practice standards, ethics and codes of conduct are met.

Such supervision will address issues such as

- team working and relationships;
- progress against personal development plan (PDP) goals and organisational objectives from the appraisal;
- CPD needs and priorities;
- use of broader competencies, in particular leadership skills (DCP, 2010);

- professional and ethical issues and concerns; and
- longer term career development.

This offers a confidential (in so far as there are no concerns regarding fitness to practice and/or competence) reflective space for clinical psychologists to think and talk about their work, and their responses to the work.

Supervisors will need to possess solid understanding and expertise in key areas of professional competence for clinical psychologists, and have had appropriate preparation for their role of supervisor of qualified professional staff members. In most situations this would be provided by a psychologist in a more senior position; however, for senior psychologists peer supervision could be acceptable although this should be monitored within the appraisal system and access to a more senior psychologist should be available, even if external and in some circumstances warranting funding.

The frequency and duration of professional supervision will be of a standard that allows all aspects of work to be discussed, and enables the development of a beneficial supervisory relationship. This will be negotiated with, and agreed by all involved parties: supervisee, supervisor and line manager. A minimum standard is one professional supervisory session per month.

The focus, content, and process of supervision will be negotiated between supervisee and supervisor. The focus and content of supervisory discussions will shift and vary from individual to individual, over different work contexts, and over time.

Professional supervision may incorporate clinical supervision wholly or partly depending on the individual's need and/or the organisational context. Ideally the two would be kept separate or have clearly defined times as in practise one can easily be neglected in favour of the other.

3.3 Clinical supervision

Clinical supervision has the specific purpose to maintain, update and develop clinical skills in assessment, formulation and interventions. This may address clinical work from various orientations – complex cases, based on diagnoses/conditions, interventions or model specific.

Regular clinical supervision within the model of care that the clinician uses is a prerequisite for clinical practice. Such supervision also requires integration of clinical material with theoretical perspectives. There is a particular focus on the need to ensure that the work is evidence based and relates to most recent research and theoretical literature, as well as guidance from National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and other formal guidance.

The function is to ensure safe and effective practice within a respectful and trusting relationship. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

Clinical supervision will allow reflective space to review on-going clinical work where the individual practitioner can step back and critique this with a view to addressing biases or errors within work and learning new skills, fresh ideas, new perspectives dealing with 'stuckness', dealing with the personal aspect of this. In particular it would allow the exploration of challenging attitudes and mind sets or particular mental frameworks.

This would also offer a 'safe space' to allow recognition of the personal impact of the work both generally and particularly at times with individual cases.

Traditionally the emphasis has been on the provision of reflective space but increasingly the formative and normative component is becoming stronger as demonstrated by clear guidance from NICE, SIGN and local protocols; in addition to the focus on payment by results (PBR) and the requirements for more immediate information on clinical activity. There is also the statutory aspect to the work, e.g. where a psychologist is working with a case where there is child sexual abuse or financial abuse of a vulnerable adult and safeguarding issues. The supervisor may need to give a clear message and direction and this will be recorded formally. The boundaries of confidentiality and informed consent should be negotiated within the supervision contract.

In some areas of work, clinical supervision will be highly structured and model specific, such as within IAPT services. At times there may be supervision focusing on specific areas, such as development disorders/neuropsychology, trauma.

Where the clinician is working to develop clinical skills (and/or qualification) within a particular modality, such as cognitive, interpersonal, psycho-dynamic or systemic therapy, there may be externally determined standards required for accreditation for both the supervisor and supervisee. In this case there will be an expectation to prioritise time for such supervision (including possible travel), CPD opportunities or even to pay for external supervision.

Supervision is normally hierarchical with a more experienced supervisor providing supervision to a less experienced supervisee. However, clinical supervision is normally competency based so it is possible that a more 'junior' staff member could provide clinical supervision to a more 'senior' member of staff. This may provide particular challenges to the supervisory relationship which need to be carefully negotiated and managed. With an increasingly wider range of clinical areas of work, and the need to be more self directed, individual practitioners are more likely to seek this collaborative, co-creative model. Regular supervision may be supplemented with ad hoc sessions (for instance where there is a recognised expert, e.g. in trauma, to whom colleagues are utilised for specific cases). Increasingly, no one supervisor can meet all clinical supervision needs. Consultation is considered to be the term for ad hoc or one off use of supervision.

The status of any advice from the supervisor will vary given the level of qualification and autonomy of the practitioner – for newly qualified clinical psychologists or supervisees undertaking initial training in a new clinical areas, the supervisee might be advised to follow the advice of their supervisor. Once qualified, generally the psychologist is autonomous and decides whether to take advice; they would then be accountable as an individual for that judgement.

3.4. Alternative approaches to the provision of supervision

Supervision, especially clinical supervision, is normally considered to be provided one-to-one and face-to-face. However, there are many examples of alternative types of provision. Clinical supervision could be group based, with an identified lead, or peer based, with all members sharing expertise. It can be conducted by telephone (such as is common within mindfulness CBT); Skype or other instant messaging solutions as well as email. Some models (e.g. systemic) use reflective teams or live supervision, where the supervisor is in the room with the clinician and client. Good practice would indicate the use of recorded or observed material within supervision at times.

These approaches all have benefits, even if primarily pragmatic, but there would also be disadvantages and a situation where a psychologist did not receive face-to-face and one-to-one supervision with reasonable frequency would not be considered acceptable practise.

3.5. Informed consent from clients in relation to supervision

Clinical psychologists will inform clients and supervisees of their own supervisory arrangements. Clients undertaking a course of formal psychological therapy will be informed of the fact that all therapists use clinical supervision as part of their work. Clinical psychologists will attempt to gain a general and informed consent from clients and supervisees for those occasions where potentially identifiable case or supervisory material needs to be part of supervisory discussions.

4. Complex issues that might arise in supervision

4.1 Aspects of the supervisory relationship

There can be a number of issues that arise in supervision that require careful management. The prime concern for all practitioners should be patient safety and well-being; this will also include concern about the wider governance of the service and the provision of safe and effective care, as well as professional ethics.

Some examples are:

- concerns about confidentiality, breaches of information governance;
- reporting of safeguarding issues;
- whistle blowing;
- personal issues – for instance, managing carer responsibilities;
- concerns about own fitness to practise;
- concerns about others fitness to practise;
- addressing capability issues within one's position, for instance being asked to take on work that is outside current skill range;
- ethical dilemmas within the local team/service; and
- managing boundary violations or dual relationships.

These issues could arise within different areas of supervision and may require different courses of action. Most organisations have policies and procedures in relation to these areas, and the human resources department may be able to assist; in some areas the Health and Care Professions Council (HCPC) might need to be involved.

It needs to be stressed that supervision should not be viewed as 'personal therapy' for the supervisee; it could be easy for boundaries to be affected. In such situations it may be valuable for the supervisor to take this to their own professional supervision to ensure that they provide the right balance, for instance where a staff member brings an issue such as their own substance misuse to supervision.

Supervisory space needs to be a safe space for the individual but there can be times when organisational changes threaten this. Increasingly, as work roles change, there may be boundary issues that affect the supervisory relationship, such as for instance in a reorganisation where two psychologists were originally peers but now one is in a more senior position than the other. A supportive and contained relationship between supervisor and supervisee are cited as factors promoting satisfaction with supervision. In order to achieve these goals a supervisor and supervisee should have an explicit agreement about the circumstances under which issues discussed in supervision will be discussed with a third party. This should be reflected in the supervision contract, e.g. under 'boundaries' and should include reference to third party discussion where:

- concerns about the supervisee's work with service users are not being resolved through supervision;
- concerns about the supervisee's well-being are not being resolved through supervision;
- there appears to be a breach of the HCPC's *Standards of Proficiency*, BPS *Code of Conduct, Ethical Principles and Guidelines*, the DCP's *Professional Practice Guidelines* or the DCP's *Core Purpose and Philosophy of the Profession* on the part of the supervisee or supervisor; and
- behaviour on the part of the supervisor or supervisee where disciplinary proceedings might apply.

4.2 Sociocultural aspects to consider in supervision

The relationship between the supervisor and supervisee must be built on mutual trust and respect to ensure safe and effective practice. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

It is therefore important to recognise that people who have grown up in sexist, homophobic, racist or other discriminatory cultures may have problems building a trustful relationship between themselves and a supervisor or supervisee who comes from a very different cultural background. In such instances the reallocation of the supervisor or supervisee without prejudice may be the only possible solution to ensure a good outcome.

4.3 Diversity impact assessment in relation to supervision

Category	Impact	Solution
1. Age	Differences in experience, values, knowledge and understanding.	Can be worked through in an open, accepting and trustful setting.
2. Disability (including long-term physical health problems)	Access, travel, time commitment, impact of sensory impairment.	Deal with practical issues, including reducing travel and ensuring accessible facilities. Ensure aids and adaptations are provided.
3. Religion/ 4. Culture	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
5. Pregnancy and maternity	Possible gaps in continuity, maternity leave, childcare.	Need to ensure standards are met, especially around continuity of supervision.
6. Marriage and civil partnerships	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
7. Sexual orientation and 8 Gender re-assignment	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor supervisee without prejudice.
9. Gender	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.

5. Quality, aspects of effective supervision

5.1 Expertise in the provision of effective supervision

The Society's Register for Supervisors (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision at an introductory level and is recommended as good practise for those offering supervision. These are attached in Appendix F.

5.2 Training and CPD for supervisors

The supervisor will ensure that they have attended core supervision skills training and undertake further regular training relating to supervision over the course of their career. There are introductory and advanced training available from most of the training courses for placement supervisors. The BPS and many training courses provide training that is BPS approved and confers eligibility for the Register for Applied Psychology Practitioner Supervisors.

5.3 Problems in accessing supervision

There may be some settings where it is difficult to access suitable supervision to meet these standards, where, for instance, a psychologist is the only psychologist working in an organisation, for example, the sole clinical psychologist within an district general hospital or in an independent or third sector provider. In these situations, the individual and their manager will need to ensure they meet the standards of the HCPC and BPS and use this document to ensure the supervision needs are met. It would be advised to liaise with local DCP branch chairs for professional advice.

5.4 Monitoring and audit

All services employing clinical psychologists will ensure that effective supervision is provided and received. This can be monitored in a variety of ways, including formal audit and via annual appraisals.

The outcomes of supervision will be systematically reviewed and evaluated on a regular basis (at least annually). A minimum audit would be to ensure that psychologists all have this at the minimum frequency and more detailed analysis of qualitative aspects, such as the content and purpose. An ideal would be annual monitoring of the quality of supervision via a survey of supervisees associated with annual appraisal.

6. Conclusion

This document updates the guidance from the DCP for members and builds on that provided by earlier documents.

It sets clear standards in terms of supervision in relation to grades, quality aspects of supervision and for the supervisors in providing supervision.

It has become clear during the process of writing this document that supervision within clinical psychology is very much an area in development in terms of:

- the emergent literature on theoretical aspects of supervision;
- the work on a competency framework for supervisors; and
- the currents plans to take forward the STARR system to accredit supervisors.

It is hoped that the guidance within this document will be relevant over a reasonable timescale; it had been written, where appropriate, quite broadly to ensure that the increasingly diverse work contexts within the delivery of psychological services are addressed within it.

References

Beinart, H. & Clohessy, S. (2009). Clinical supervision. In H. Beinart, Kennedy, P. & S. Llewelyn (Eds.), *Clinical psychology in practice*. Oxford: Wiley-Blackwell.

Beinart, H. (2012). Models of supervision and the supervisory relationship. Fleming, I. & Steen, L. (2012). *Supervision and clinical psychology: Theory, practice and perspectives* (2nd edn). Hove: Routledge.

Bernard, J.M. & Goodyear, R.K. (1998). *Fundamentals of clinical supervision* (2nd edn). London: Allyn & Bacon.

British Psychological Society (2008). *Generic professional practice guidelines*. Leicester: Author.

British Psychological Society (2009). *Code of ethics and conduct*. Leicester: Author.

Care Quality Commission (2010). *Essential standards of quality and safety*. London: Author.

Department of Health (1993). *A vision for the future. Report of the Chief Nursing Officer*. London: DoH.

Division of Clinical Psychology (2010). *Continuing professional development guidelines*. Leicester: British Psychological Society.

Division of Clinical Psychology (2010). *Clinical psychology leadership development framework*. Leicester: British Psychological Society.

Division of Clinical Psychology (2012). *Guidelines on activity for clinical psychologists.* Leicester: British Psychological Society.

Fleming, I. & Steen, L. (2012). *Supervision and clinical psychology: Theory, practice and perspectives* (2nd edn). Hove: Routledge.

Hawkins, P. & Shohet, R. (2012). *Supervision in the helping professions* (4th edn). Milton Keynes: Open University Press.

Health and Care Professions Council (2007). *Equality and diversity scheme*. London: Author.

Health and Care Professions Council (2011). *Continued professional development and your registration*. London: Author.

Health and Care Professions Council (2012). *Standards of proficiency – practitioner psychologists.* London: Author.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications Inc.

Milne, D. (2007). An empirical definition of clinical supervision. British *Journal of Clinical Psychology, 46*, pp.437–447.

Partnership and Accreditation Team (2010). *Additional guidance for clinical psychology training programmes: Guidelines on clinical supervision*. Leicester: British Psychological Society.

Scaife, J. (2001). *Supervision in the mental health professions*. New York: Brunner-Routledge.

Watkins, C.E. Jnr. (2013). The contemporary practice of effective psychoanalytic supervision. *American Psychological Association, 30*(2), pp.300–328.

Appendix A. Two examples of supervision contracts

SAMPLE CONTRACT FOR INDIVIDUAL AND GROUP CLINICAL SUPERVISION OF PSYCHOLOGICAL THERAPY

For use by all qualified practitioners within ……….

Name of Supervisee (s): ....

Name of Supervisor: ....

Work Base: ....

Place of Supervision: ....

The supervision contract is a commitment by the supervisor and the supervisee to enable the supervisee, as a qualified practitioner of psychological therapy, to discuss in confidence issues relating to their clinical work with clients/patients, to ensure safe practice and to enable the development and maintenance of clinical therapeutic skills.

1) Supervision will take place on a …… weekly basis for ……. hours.
2) Supervision will usually be provided individually unless otherwise agreed and reviewed at least annually.
3) The supervisor has the responsibility of ensuring that a private venue (as free from interruption as possible) is available and booked for each session.
4) Sessions cancelled unavoidably due to annual leave, sick leave, etc, should be re-booked as soon as convenient to both parties.
5) Notes will be taken by the supervisor and a copy given to the supervisee.
6) Subjects discussed will be treated as confidential as set out by the Trust's guidelines on supervision.
7) The supervisee has the responsibility to highlight in supervision concerns, pressures and information they feel the supervisor should be aware of.
8) The supervisor has responsibility to use supervision to provide structure, support and exploration to maintain, enhance and/or develop the supervisee's clinical skills.
9) ……………… is the qualified clinician who will act as third party, in a consultative role, if difficulties and conflicts arise between supervisor and supervisee.
10) When requested the supervisor will provide feedback for the supervisee's appraisal.

Date agreed: .... Review date: ....

Signed:

Supervisor: .... Supervisee: ....

PROFESSIONAL SUPERVISION CONTRACT

Supervisor: .... Supervisee: ....

Date contract agreed: .... Contract to be reviewed: ....
(Minimum annually)

Frequency of supervision: Monthly Duration of each session: 1–1.5 hours

Focus:

The professional supervisor ensures that the individual clinician is working within appropriate professional boundaries, and is adhering to appropriate professional standards, in line with the objectives of the service and the Trust. They also contribute to appraisals, identification of training needs and reviewing of objectives in the personal development plan.

The primary focus of professional supervision will therefore be on the development and maintenance of professional and clinical skills appropriate to the role of the supervisee.

Clinical caseload/workload will be reviewed routinely to monitor the types of clinical work undertaken, the caseload mix, waiting times and the development of clinical expertise.

Appraisal objectives will be routinely reviewed.

CPD activities will be reviewed and objectives discussed/recorded.

The supervisee will take responsibility for highlighting areas of need for further support in relation to specific aspects of clinical work, professional roles or managerial tasks.

Issues discussed and agreed outcomes will be recorded and agreed by both parties for each supervision session. The notes will be emailed to the supervisee who will then be able to comment or amend if necessary

Boundaries:

Regular supervision will be scheduled by agreement at the frequency specified with a commitment to good time keeping and avoidance of interruption.

Where issues of personal well-being are of concern to either party and appear to fall outside of the supervisory relationship, a third party (within the department) may be consulted with the permission of the supervisee/supervisor. We have identified XX.

The content of supervision and associated written records are confidential unless there are concerns raised about competence or risk.

Material from supervision/related records, specific to either party, is only to be discussed outside of supervision with the agreement of the supervisee and/or supervisor except where it is necessary to consult with a third party in the event of concerns regarding clinical or professional misconduct on the part of either the supervisor or supervisee.

Signed:

Supervisor: .... Supervisee: ....

Date: ....

Appendix B: Recording of supervision sessions

Good practise would indicate that the recording of supervision sessions should include:

a. Copies of all supervisory contracts and updates to the contract.
b. The date and duration of each session.
c. A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.
d. A written record should be made of all regular reviews, including outcomes, of supervision. This would normally be the responsibility of the supervisor to ensure that a record is kept.
e. In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement within the relevant case file or as part of the clinical record; this is the responsibility of the supervisee. It would be good practise to record within the clinical case record, in particular any clinical decisions. The supervisee will record in the clinical record any risk issues and how they are addressed.

Appendix C: Psychology and Psychological Therapies: Responsibilities of psychology and psychological therapy managers in multiprofessional managed services

1. This document sets out the responsibilities of psychology professional management in multi-professionally managed services and teams. The majority of NHS services are multi-professional and managed through general service managers and/or clinical directors. Professional management supplements service management, with responsibility for managing and advising on profession specific areas where general managers may not have expertise. This paper clarifies the respective responsibilities of service and professional managers where these may be unclear.

2. Service management involves all aspects of managing the service/team. It includes:
   - Strategic direction for the service
   - Operational policies
   - Clinical governance of the service
   - Workload allocation
   - Supervision of staff in relation to their work in the service.

3. Professional management involves ensuring the professional standards and continuously improving the professional quality of work of professional staff. It includes:
   - Appointment of professionally competent and skilled staff
   - Profession specific elements of clinical governance – professional standards assurance and quality improvement
   - Profession specific clinical supervision
   - Continuing professional development.

4. Responsibility for hiring, appraisal and disciplinary matters can rest with either service or professional management. Line management is the term often used for this 'hiring and firing' responsibility. Sometimes there is a degree of vagueness as to which of service or professional manager has the line responsibility or it may be stated that this responsibility is shared.

5. As there can be different understandings as to what is the responsibility of service management and what of professional management, it can be useful to set out and agree the specific responsibilities of each. The Appendix is a suggested matrix of the respective responsibilities of service/team managers and psychology/psychological therapy professional managers in relation to psychologists and psychological therapists working in a multi-professional team. In this example, the psychology professional manager takes the line management responsibilities.

6. Job descriptions should include that the post holder is responsible to both service manager and professional manager. The precise form of wording will vary depending on the balance of responsibilities. In the example in the Appendix where the psychology/psychological therapy manager undertakes line management responsibilities for a psychologist who is working in two different teams, the job description should set out the relationship with regard to line management arrangements for both teams.

	Service/team manager	Psychology/psychological therapy manager
Recruitment	Contributes to writing and agreeing job description, recruitment procedures and selection of candidates.	Leads on recruitment, ensuring team/service manager(s) agree job description and procedures for selection of candidates.
Induction	Lead for induction is by agreement between service/team manager(s) and psychology manager, with the other contributing. Where psychologist is to work full-time in a team, the service/team manager will usually be responsible for induction; where the psychologist will work in more than one team, the psychology manager will usually be responsible.	
Work allocation	Responsible for allocation of work within the team/service.	Advises service/team manager(s) on parameters of appropriate kind of work/roles for psychologist in the team.
Standards, quality monitoring and clinical governance	Responsible for monitoring and ensuring work of the psychologist is within the policies and standards of the team/service.	Responsible for standards, quality monitoring and clinical governance of specialist psychology work in the team, within overall clinical governance arrangements of the team.
Appraisal/ IPR	Where a psychologist is full-time in a team/service, the service/team manager and psychology manager jointly carry out the annual IPR/ appraisal. Where the psychologist works in more than one team/service, the psychology manager leads on the annual appraisal/IPR and ensures the relevant team/service managers contribute and agree IPR objectives.	
Training and CPD	Contributes to setting CPD goals as part of the IPR process and scheduling and facilitation of CPD.	Responsible for agreeing annual CPD plan and facilitating psychologist in undertaking agreed CPD, with involvement of team/service manager(s) in setting CPD goals and scheduling of CPD.
Annual leave/ absence monitoring	Lead responsibility for agreeing annual leave and ensuring absence reporting and monitoring is by agreement between service/team manager and psychology manager, with the other contributing. Where psychologist works full-time in a team, the service/team manager will usually be responsible for leave arrangements; where the psychologist works in more than one team, the psychology manager will usually be responsible.	
Disciplinary	Ensures matters that might require formal disciplinary procedures are brought to the attention of the psychology manager. Liaises with psychology manager in taking forward disciplinary procedures where these relate to the performance of the psychologist in the team/service.	Responsible for any needed disciplinary procedures, with involvement of service/team manager(s) as needed.

While in principle, these respective responsibilities can be detailed in the job description of the post, in most cases a summary of line management and reporting arrangements for both teams should be sufficient.

Appendix D: RAPPS learning outcomes

Understanding and application

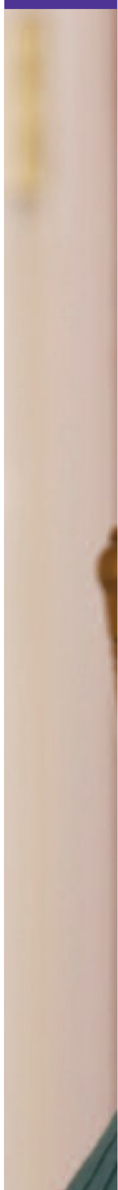
1. Have knowledge of the context (including professional, ethical and legal) within which supervision is provided and an understanding of the inherent responsibility.
2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, including protecting time), confidentiality, accountability.
3. Have knowledge of developmental models of learning which may have an impact on supervision.
4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.
5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.
6. Have skills and experience in developing and maintaining a supervisory alliance.
7. Have knowledge of the structure of supervised professional experience including assessment procedures at different levels of qualification up to Chartered status level, and the changing expectations regarding the supervisor's role.
8. Have skills and experience in contracting and negotiating with supervisees.
9. Have an understanding of the transferability of professional skills into supervision and the similarities and differences.
10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating supervisees.
11. Have skills and experience in the art of constructive criticism, on-going positive feedback and critical feedback where necessary.
12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).
13. Have skills and experience of using a range of supervisory approaches and methods.
14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.
15. Have an understanding of the issues around difference and diversity in supervision.
16. Have an awareness of the on-going development of supervisory skills and the need for further reflection/supervision training.
17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

Printed and published by the British Psychological Society.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Telephone 0116 254 9568 Facsimile 0116 247 0787
E-mail mail@bps.org.uk Website www.bps.org.uk

Incorporated by Royal Charter Registered Charity No 229642

INF224/01.2014



Joint Surrey & Borders Partnership Trust (SABP) & CCCU Salomons Institute

Risk Assessment Tool for Staff during the COVID-19 Pandemic – 'Working Together To Save Lives'

Please read guidance notes at the end before completing this form. N.B. Please use this Joint SABP/Salomons form if possible as it covers issues of particular relevance to trainees. However, a local host placement Trust form may be used instead If more suitable, provided it covers all the same main areas.

General Information			
Staff Member's (trainee's) Name(s):		**Job Title:**	Trainee Clinical Psychologist
1. Manager at Salomons **2. Placement coordinating supervisor**		**Managers' job title** **Supervisor's job title**	
Placement Location / Ward / Area:		**Working hours:**	
Date of Assessment:		**Review date:**	
Individuals underlying health condition category / other factors	Please tick appropriate box: ✓	**Current Post / Placement Involves**	Please tick appropriate box: ✓

	Notified as on 12 week Shielding (very high risk group)			Directly caring for Covid-19 patients (tested as positive) and undertakes Aerosol generating procedures (AGPs)	
	Age (> 65yrs) Please tick if age is over 50 for BAME Staff			Directly caring for Covid-19 patients (tested as positive) – not undertaking AGPs	
	Diabetes			Directly caring for patients not tested / unknown Covid-19 status but within 2 meters of patient – within any setting	
	Chronic Lung Disease			Providing a service to colleagues but not directly in the care setting (e.g. training, giving/receiving supervision))	
	Chronic Heart Disease			All placement activity will be conducted remotely i.e. with none of the above contacts	
	Cancer				

	Pregnancy please tick if over 28 weeks, under 28 weeks if pre-existing risks present			Are there any other Covid-19 related risks the trainee could be exposed to on this placement? Please describe.
	Immunosuppression			
	Impact of carers stress or concerns about family			
	Pre-existing Disability that impacts on Respiratory morbidity			
	Do you have caring responsibilities for a Covid-vulnerable other			
	BAME background			
	Gender (please tick if Male BAME above 50)			

What are you already doing?		
Interventions	**Current Position**	**Additional action to reduce risk**
Can *this* work be done at home?		
Could *alternative* work be undertaken at home or elsewhere in the Trust (redeployment)? e.*g review of serious incident,*		
Can face to face interactions be limited?		
Have arrangements been made for remote working? e.g. IT facilities for audio and video consultation.		
PPE (the appropriate PPE for the clinical setting) including FIT testing		
Access to swab testing and prioritising at risk groups and their family members		
Has the individual had any sickness in the past linked to their health condition?		
Has the individual had a Vitamin D test showing deficiency?		
What arrangements are you going to put in place to ensure regular contact / wellbeing?		
Other considerations:		

Assessment		
Please tick appropriate box:	✓	Monitoring / further action:
Actions agreed as detailed above reduce the risks to the colleague		Local manager to review and monitor.
Actions agreed as detailed above do not fully reduce the risks to the colleague / some concerns remain.		Contact the SABP HR Team for further advice and support

Additional notes
Please add any additional notes as appropriate / following discussion with SABP HR Team:

Individual's (trainee's) signature (can be electronic signature or reference to email confirmation)		**Date signed**	
Print Name			
Salomons line Manager's signature **Print Salomons manager name** **Coordinating supervisor's signature (can be electronic signature or reference to email confirmation)**		**Line Managers job title**	
Print Name			

HRBP Workforce Mobilisation signature (can be electronic signature or reference to email confirmation) All completed forms will be sent to a centralised email address - Covidstaffingrequest@sabp.nhs.uk		**HRBP Workforce Mobilisation Name**	

<u>Guidance Notes</u>

1. The tool is intended to facilitate a structured one to one conversation with the staff member to seek a pragmatic and safe working arrangement.
2. It can be used in conjunction with but does not replace Occupational Health Assessments of pre-existing disabilities.
3. The risk factors are based on emerging data on deaths, further information is also available on this article: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

   Pregnancy related risks from https://www.rcog.org.uk/

   At Risk_patient

4. Please also refer to the Government's advice on shielding patients letter_CEV1c_ FINAL
5. **<u>Suggested Approach to Interpreting Risk Factors</u>**

Number of Risk Factors	**Proposed Action**
Singular Risk Factor	Consider Home Working
Multiple factors (>/=2) or have a very high risk single risk factor	Strong Emphasis on Home Working

Acknowledgements: Thanks to Lincolnshire Partnership NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust and Somerset Partnership NHS Foundation Trust for sharing their version of the risk assessment tool with us.

Salomons Institute for Applied Psychology
Doctorate in Clinical Psychology

Process for Trainee Risk Assessment on Placement

1. Trainee completes personal health risk assessment (SABP or host Trust, to include additional question re any caring responsibilities for a Covid-vulnerable other)

NB**. Please use joint SABP/Salomons form (as opposed to the one on the SABP website) if possible as this version has been tailored to cover additional issues of particular relevance to trainees on placements.**

2. Pre-placement call between trainee and coordinating placement supervisor: as part of this, the trainee discusses the contextual risks particular to this placement, completing the sections of the SABP or Trust assessment form that indicate any contact with COVID known/unknown clients, whether whole placement will be remote & whether there are any other Covid-related risks

3. Trainee sends copies of fully completed form covering both person and exposure to environmental risks to Salomons Administrator (Gaynor McCracken), Salomons Manager, SABP Risk Assessment E-mail (Covidstaffingrequest@sabp.nhs.uk) and coordinating placement supervisor.

4. Admin keep central copy. Salomons manager screens form.

5. If no particular identified risk, no further action.

Salomons Institute for Applied Psychology
Doctorate in Clinical Psychology

Process for Trainee Risk Assessment on Placement

6. If risk to self or others for whom responsible is identified on form, Salomons manager arranges discussion with trainee.

↓

7. Consequently, Salomons manager may: 1. activate an OH referral 2. Decide with trainee that additional risk mitigation measures needing to be put in place and discussed with supervisor 3. Decide with trainee that risk is adequately managed by agreed arrangements.

↓

8. Salomons manager discusses outcome of trainee's risk assessment with coordinating supervisor during pre-placement or follow up call to address any supervisor concerns and to consider any further risk mitigation procedures needed.

↓

9. If further risk mitigation is agreed, relevant information is added by Salomons manager to trainee's Risk Assessment form, with updated copies being sent to admin, SABP, coordinating supervisor and trainee.

Suggested Template for Clinical Supervision Contract

The following template includes some guidance on areas worth attending to together. Detailed suggestions of general expectations between trainee and supervisor are given at the end, though these are intended to guide rather than be prescriptive. The clinical supervisory relationship has multiple purposes including education, support, management and assessment. Through navigating these roles, it is expected that communication by all will be respectful, constructive and as open as is possible within the boundaries of protecting personal privacy as appropriate.

The contract should include additions and adaptations to suit the specific needs and preferences of the individual trainee and supervisor*. NB. The written content below is less important than the conversation so lots of written detail is not necessary*.

Placement details

Trainee name:	Year of training:
Placement:	Placement dates:
Co-ordinating supervisor:	
Co-supervisor (if applicable):	
Salomons manager:	

Practical arrangements for supervision:

Frequency and duration:
Day and time:
Cover arrangements:
Best way to make ad hoc contact if needed:

Supervision process:

How will content be agreed?
How will feedback be shared (in both directions)?
How/what should we prepare for supervision?
How can we attend meaningfully to 'race', culture, and other aspects of social identity in the placement setting, supervision dyad and in the clinical work?
How will we know if supervision isn't working well for either of us, and how will we resolve this?

Thanks to Anna Ruddle for original content which has been adapted for this form.
Some content also informed by Research in Practice PSDP – Resources and tools for practice supervisors.

Expectations

What is expected of the trainee?
What is expected of the supervisor?

Expectations of the trainee that could usefully be discussed

- To make supervisor(s) aware of learning and competency development needs, styles and preferences.
- Carry out the advice or instructions given in supervision and feedback where this was not possible.
- Pro-actively inform supervisor/s of actions carried out and barriers to this (e.g. insufficient time; unsure of what to do; external obstacles).
- Keep all supervisors informed of whereabouts including attendance at meetings, any changes to normal working week. Start by seeking permission/advice on which meetings to attend and how to use time best over placement. The trainee can negotiate changes as long as supervisor/s are kept informed.
- Use local procedures (e.g. update Outlook calendar) to keep supervisor/s updated on whereabouts and activity.
- Discuss openly in supervision the rationale for decisions/actions, reflections on supervisors' feedback, what they have learnt and how they have put this into practice.
- Plan study and A/L suitably far in advance so as not to adversely impact on clinical work or his/her ability to fulfil all placement competences, and to give supervisor/s sufficient notice to plan their supervisory duties.
- Plan time sufficiently to fulfil the multiple demands of placement (and training) and seek support if struggling with time management, especially planning of work-based assignments such as the QIP or PPR. Complete work in a timely manner and seek clarification on expected timescales if unclear.
- Reflect openly on personal circumstances/history/context where it may impact on practice including clinical work, supervisory relationship and any other competences. This will include their career experience to date and previous experience of clinical supervision and/or being managed. (Include any relevant personal circumstances/experience if applicable.)
- To be open with their supervisor/s and/or manager if they are struggling with any aspect of placement, in order for them to be supported as early as possible.

Expectations of the supervisor that could usefully be discussed

- To provide supervision regularly and reliably in a planned and appropriate way e.g. without interruptions, at agreed times.

- To be clear with the trainee from the outset about individual supervision style preferences and expectations.
- To take on multiple roles of assessor, educator and mentor/supporter and reflect openly on the inherent challenges of this for them and the supervisory relationship.
- To provide regular, constructive and accurate feedback on progress, based on own or others' direct experience of the trainee.
- To be open to receiving feedback from the trainee about their experience of the placement, work setting or supervision.
- To be clear on the nature of advice given e.g. when suggestions are just points of learning and when they are non-negotiable e.g. due to Trust policy or concern over competence.
- To offer the trainee a supportive and confidential space to reflect on their personal-professional development, including discussion of any relevant personal factors.
- To support the mutual development of cultural humility and intercultural competencies by creating a space where assumptions, values, similarities, and difference can be explored.
- To liaise regularly and share relevant, negotiated information with the trainee's Salomons manager and with their co-supervisor if applicable, to ensure their support and assessment is clear and well-coordinated.
- Supervisor/s to use their own supervision to discuss their supervision as needed, in order to develop their own practice and enhance the service they are offering.
- Beyond these regular contacts, supervisor/s to discuss with the trainee any plans to discuss them or their needs with any other professional.
- Allow the trainee to express specific preferences for work to be undertaken on placement and accommodate these where the service constraints allow.
- To give the trainee adequate notice of any planned A/L or absence from work (e.g. for training/meetings) and make appropriate plans for cover.
- To share own experiences including rationale for actions, where this may be helpful for the trainee's learning e.g. to model open reflection.
- Where difficulties arise in the supervision process, to discuss openly the emotional experience of this, if this feels helpful for understanding the difficulties and moving forward.
- To work closely with Salomons manager to ensure the trainee is well supported, including adjustments for any relevant personal circumstances.
- Where there are concerns that the trainee is not fulfilling their training requirements, these are to be discussed at the earliest opportunity with the trainee and their Salomons manager, and a three-way meeting scheduled as necessary.

Trainee name:	______________________	Date:	______________________
Trainee signature:	______________________		
Co-ordinating supervisor name:	______________________	Co-supervisor name:	______________________
Signature:	______________________	Signature:	______________________
Date:	______________________	Date:	______________________

THE CORE COMPETENCIES: BPS (2017)

https://www.bps.org.uk/sites/beta.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%20(2017).pdf

Please note: these competencies are developed and assessed across academic, research and practice learning aspects of the doctoral training programme, and not just on placements. However, placement supervisors are encouraged to read through the nine core competencies as they may provide useful guidance when considering assessment of their trainee's attainments on placement.

2.1.3 NINE core competencies are defined as follows:

1. **Generalisable meta-competencies**

    a. Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.

    b. Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations.

    c. Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.

    d. Being familiar with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision-making without being formulaic in application.

    e. Complementing evidence-based practice with an ethos of practicebased evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

    f. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

    g. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.

    h. Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and nonspecialist), in order to influence practice, facilitate problem solving and decision making.

    i. Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity, and working as a reflective practitioner within ethical and professional practice frameworks.

2. **Psychological assessment**

a. Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.

b. Ability to choose, use and interpret a broad range of assessment methods appropriate: • to the client and service delivery system in which the assessment takes place; and • to the type of intervention which is likely to be required.

c. Assessment procedures in which competence is demonstrated will include: • performance based psychometric measures (e.g. of cognition and development); • self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours); • systematic interviewing procedures; • other structured methods of assessment (e.g. observation, or gathering information from others); and • assessment of social context and organisations.

d. Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.

e. Conducting appropriate risk assessment and using this to guide practice.

3. **Psychological formulation**

a. Using assessment to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors.

b. Constructing formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.

c. Constructing formulations utilising theoretical frameworks with an integrative, multimodel, perspective as appropriate and adapted to circumstance and context.

d. Developing a formulation through a shared understanding of its personal meaning with the client(s) and / or team in a way which helps the client better understand their experience.

e. Capacity to develop a formulation collaboratively with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

f. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

g. Ensuring that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

h. Using formulations to guide appropriate interventions if appropriate.

i. Reflecting on and revising formulations in the light of ongoing feedback and intervention.

j. Leading on the implementation of formulation in services and utilising formulation to enhance teamwork, multi-professional communication and psychological mindedness in services.

4. **Psychological intervention**

a. On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with: • individuals • couples, families or groups • services / organisations

b. Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

c. Ability to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological interventions, of which one must be cognitive-behaviour therapy. Model-specific therapeutic skills must be evidenced against a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.

d. In addition, however, the ability to utilise multi-model interventions, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.

e. Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and wellbeing.

f. Conducting interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals.

g. Having an awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.

h. Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives.

i. Implementing interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

j. Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to clients and carers.

5. Evaluation

a. Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).

b. Devising innovate evaluative procedures where appropriate.

c. Capacity to utilise supervision effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.

d. Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.

e. Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.

f. Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

6. Research

a. Being a critical and effective consumer, interpreter and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

b. Conceptualising, designing and conducting independent, original and translational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and merit publication including: identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis (both quantitative and qualitative), reporting outcomes and identifying appropriate pathways for dissemination.

c. Understanding the need and value of undertaking translational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.

d. The capacity to conduct service evaluation, small N, pilot and feasibility studies and other research which is consistent with the values of both evidence-based practice and practice-based evidence. e. Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups etc.) and within the ethical and governance frameworks of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

7. Personal and professional skills and values

a. Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.

b. Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.

c. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices.

d. Understanding the impact of one's own value base upon clinical practice.

e. Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.

f. Capacity to adapt to, and comply with, the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

g. Managing own personal learning needs and developing strategies for meeting these. Using supervision to reflect on practice, and making appropriate use of feedback received.

h. Developing strategies to handle the emotional and physical impact of practice and seeking appropriate support when necessary, with good awareness of boundary issues.

i. Developing resilience but also the capacity to recognise when own fitness to practice is compromised and take steps to manage this risk as appropriate.

j. Working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

8. Communication and teaching

a. Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

b. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

c. Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

d. Understanding of the supervision process for both supervisee and supervisor roles.

e. Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

f. Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof.

g. Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

9. Organisational and systemic influence and leadership

a. Awareness of the legislative and national planning contexts for service delivery and clinical practice.

b. Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as inpatient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.

c. Providing supervision at an appropriate level within own sphere of competence.

d. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and crossprofessional teams. Bringing psychological influence to bear in the service delivery of others.

e. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.

f. Working with users and carers to facilitate their involvement in service planning and delivery.

g. Understanding of change processes in service delivery systems

h. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.

i. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with ‘whistleblowing’ policies and issues.

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology

EVALUATION OF CLINICAL/PROFESSIONAL COMPETENCE FORM (ECC)

Trainee's name: ____

Coordinating supervisor's name(s): ____

Additional supervisor's name(s): ____

Description of the placement: ____

Dates of the placement: ____

Number of days on placement: ____________

What can be counted as a placement day:

If trainees are required or obtain permission to attend course meetings or conferences on placement days they can normally still be counted as placement days. Study and annual leave do not count as placement days.

In the case of sickness the first three days of a period of sick leave on a maximum of two occasions in a six month placement can be counted as placement days. For the longer first year placement, the first three days of a period of sick leave may be counted on a maximum of three occasions. Emergency leave days (e.g. for caring responsibilities) may also be counted as placement days in this way as well but must be included with any sick days so that together the maximum limits of the allowance outlined above are not exceeded. The number of such days included in the total should be indicated for monitoring purposes.

EXPERIENCE GAINED ON PLACEMENT

Please record here any special features of the placement, contextual issues or unusual experiences gained which it may be important to consider when reading this form.

SECTION A: RECORD OF DIRECT OBSERVATION OF TRAINEE'S WORK

It is essential that trainees be directly observed by their supervisor(s) [and receive feedback on such observation] on EACH placement during training in order for their clinical competence to be accurately assessed. Observation can be done in a variety of ways, including: joint work; observation using audio or video; transcripts or process notes, etc.

Trainees should receive a minimum 25 observations over 3 years of which a minimum of 10 in Year 1; 10 in Year 2; and 5 in Year 3. Please record all observations of trainees in work on placement below.

	Number of Assessment Sessions Observed	***Number of Intervention Sessions Observed***
Direct Observation of Trainee's Work (sitting in or using one-way screen)		
Sessions undertaken jointly by Supervisor and Trainee		
Observation using audio or video recording		
Transcripts / Detailed Process Notes		

Observation of model specific competencies:

Model(s) used on this placement (may be single model work or part of broader psychological approach or adapted to service user group)	***Competencies observed and rated?*** ***Yes/ No***	***Feedback given and discussed in supervision?*** ***Yes / No***

Please comment on the trainee's openness to direct observation and review of their work through the use of observation. Please comment on the use made of such observation and what was learned as a result. *Please also summarise any key competencies which the trainee has had opportunities to develop in any specific therapeutic model/s with reference to competence frameworks where these are available*: https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

SECTION B: RATINGS OF THE TRAINEE'S COMPETENCE AND SKILLS

For each of area of competence, please rate their level of competence for their stage in training as Pass, Referral or Fail, using the Clinical Competence Marking Criteria as guidance. Qualitative feedback and comments are optional provided the competence has been rated as a Pass.

1 Working relationships

Please rate the trainee's ability to facilitate and maintain safe working alliances with service users, carers, groups and staff and to manage challenging situations in those relationships. .

Please give overall rating for ***working relationships****: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

2 Psychological Assessment

Please rate the trainee's ability to design and conduct, or to select, administer and interpret assessments (including risk assessment). These may include standardised neuropsychological and psychometric tests as well as idiosyncratic assessments.

*Please give an overall rating for **assessment**: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

3 Psychological formulation

Please rate the trainee's ability to develop and use formulations, to prepare an action plan, and to reformulate in the light of further information.

*Please give an overall rating for **formulation**: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

4 Psychological interventions

Please rate the trainee's ability to make theory-practice links and adapt interventions within differing theoretical models to individual needs.

*Please give an overall rating for **interventions**: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

5 Evaluation and quality improvement work

Please rate the trainee's ability to evaluate their own clinical practice, to conduct appropriate research and use departmental evaluation and auditing procedures, to be critically appraise research literature relevant to their clinical work, and use research skills appropriately in their work.

*Please give an overall rating for **evaluation and quality improvement**: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

6 Communication and Teaching

Please rate the trainee's ability to design communications (written and oral, formal and informal) that are appropriate to the audience, carry them out in a manner that is both timely and accessible, and to monitor their effectiveness.

Please give an overall rating for ***communication and teaching****: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

7 Organisational and systems influence and leadership

Please rate the trainee's knowledge of the organisational setting, ability to work collaboratively with other professionals and colleagues, and contribution to influencing psychological thinking in services and about developments, for instance, through co-working, provision of supervision and consultation, initiating, co-ordinating or leading on a development.

Please give an overall rating for ***organisational/systems influence and leadership work****: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

8 Personal and professional skills and values

Please rate the trainee's professional attitude and behaviour, including their awareness of power and socio-political issues, risk, and their ability to work within the HCPC Code of Conduct and Guidance on Conduct and Ethics for Students, underpinned by NHS values.

Please give an overall rating for ***personal/professional skills and values****: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

9 Reflective practice

Please rate the trainee's ability to demonstrate an active and continuous commitment to developing their self-knowledge and interpersonal awareness as it relates to their practice.

Please give an overall rating for ***reflective practice****: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

10 Use of supervision

Please rate the trainee's ability to prepare effectively, engage in and respond to the supervision process.

*Please give an overall rating for **use of supervision**: (Please circle)*	***N/A***	***Pass***	***Referral***	***Fail***
Comments on particular strengths or developmental needs (optional if rated Pass):				

SECTION C – EVALUATION BY USERS

Service user evaluation: (Appendix 1)

Please comment on the process of selecting and obtaining feedback from a client. Comment on the content of the feedback and how the trainee responded to this.

SECTION D: SUPERVISOR'S OVERALL RECOMMENDATION

Please give your overall rating for the trainee's clinical competence on this placement.

Trainees who have passed all competencies (including those with developmental needs) or have received a referral on ONE competency should be rated "Pass".

Trainees who have been given a referral on TWO areas of competence should be rated "Referral". (N.B. Competencies referred on the previous placement can only be rated as pass or fail.)

Trainees who have either been rated referral on THREE or more areas of competence or fail on at least one area of competence should be rated "Fail". (N.B. Competencies failed on the previous placement, or any competencies on a repeat placement, can only be rated as pass or fail.)

Supervisor's overall recommendation: please circle appropriate rating

Pass	***Referral***	***Fail***

	(not an option for final placement)	

Supervisor's Signature:	
Date:	

SECTION E: TRAINEE COMMENTS

Please comment on your view of your learning on placement and the feedback given on this form by your supervisor. Please note, it is expected that this section of the form is completed after discussion and completion of ECC form up to this point, including the supervisor's signature.

Trainee's Signature:	
Supervisor's Signature:	

SECTION F: INFORMATION FOR NEXT SUPERVISOR
(not to be completed on final placement)

Trainee: ………………………… Placement: ………………………………………..

In discussion with the trainee, please complete the following summary of the trainee's development on your placement for their next supervisor.

Areas of most significant development:

Most challenging aspects of work on this placement:

Most important areas to continue working on and significant gaps in experience:

If any competencies have been rated as Referral or Fail, *please specify below so that the next supervisor knows that these can only receive a "pass" or "fail" on their placement. Details can be provided in the boxes above.*

1.
2.
3.

Appendix to ECC Form: Further information about competencies, professional standards and regulation to help in assessment of trainee competencies

The competency headings that we use in the ECC form are based on the core competencies specified in the BPS *Accreditation Through Partnership* documentation (2015). Programmes must demonstrate they support and assess the development of these competencies. In addition, programmes must prepare trainees to achieve the HCPC Standards of Proficiency (SoPs) required for registration as a Clinical Psychologist. Each of these Standards of Proficiency can be mapped onto one or more of the BPS competency headings. They provide further detail about what the competencies are expected to include in practice. We have therefore provided a list of some of the relevant SOPs below. When rating your trainee on a specific competency, you may find it helpful to refer the examples that describe the elements of that competence.

Below we have listed the core competencies, and followed each one with examples of the relevant HCPC (2015) Standards of Proficiency (and their reference numbers) that trainees need to meet under supervision.

1. Therapeutic relationships

Example SoPs:

6	Be able to practise in a non-discriminatory manner
7.1	Understand the importance of and be able to maintain confidentiality, & be aware of limits of the concept of confidentiality
2.6	Understand the importance of and be able to obtain informed consent
9.5-9.6	Understand the dynamic present in relationships between service user and practitioners, be able to initiate, develop and end a service user-practitioner relationship
9.1	Be able to work, where appropriate, in partnership with service users, other professionals, support staff and others

2. Psychological assessment

Example SoPs:

14.15	Be able to choose and use a broad range of psychological assessment methods, appropriate to the service user, environment and type of intervention likely to be required
14.17	Be able to use formal assessment procedures and other structured methods of assessment
14.34	Be able to assess social context and organisational characteristics
14.20	Be able to critically evaluate risks and their implications
BPS	Be able to undertake neuropsychological and cognitive testing as appropriate

3. Psychological formulation

Example SoPs:

14.19	To be able to analyse and critically evaluate information collected
14.5	To be able to formulate specific and appropriate management plans including the setting of timescales
14.7	Be able to use psychological formulations to plan appropriate interventions that take the service user's perspective into account
13	Understand the key concepts of the knowledge base relevant to their profession, e.g.: • 13.9 Understand theories and evidence concerning psychological development and psychological difficulties across the lifespan and their assessment and remediation • 13.11 Understand more than one evidence-based model of formal psychological therapy

4. Psychological intervention

Example SoPs:

14	Be able to draw on the appropriate knowledge and skills in order to inform practice, e.g.: • 14.10 Be able to make informed judgements on complex issues in the absence of complete information • 14.1 Be able to apply psychology across a variety of different contexts using a range of evidence-based and theoretical models, frameworks, and psychological paradigms
14.3	Be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely and skilfully, e.g.: • 14.38 Be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the service user • 14.2 Be able to adapt practice as needed to take account of new developments or changing contexts

5. Evaluation and quality improvement

Example SoPs

14.22 Be able to use research, reasoning and problem solving skills to determine appropriate actions, e.g.

14.24 recognise the value of research to the critical evaluation of practice

12 Be able to assure the quality of their practice, e.g.

- 12.6 be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user
- 12.8 recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes
- 12.1 be able to engage in evidence-based and evidence-informed practice, evaluate practice systematically and participate in audit procedures

6. Communication and teaching

Example SoPs

8.1 Be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to colleagues, service users, colleagues and others e.g.

- 8.5 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as culture, age, ethnicity, gender, religious beliefs and socio-economic status
- 8.7 be able to select the appropriate means for communicating feedback to service users
- 8.8 be able to provide psychological opinion and advice in formal settings, as appropriate

9.8 Be able to plan, design and deliver teaching and training which takes into account the needs and goals of participants

8.11 Be able to summarise and present complex ideas in an appropriate form

7. Organisational and systems influence and leadership

Example SoPs

9.7	Be able to contribute effectively to work undertaken as part of a multidisciplinary team (including
9.2	understanding the need to build and sustain professional relationships as both an independent practitioner and collaboratively as part of a team)
13.6	Understand the role of the clinical psychologist across a range of settings and services
8.14	Be able to use formulations to assist multi-professional communication and understanding
13.8	Understand application of consultation models to service-delivery and practice including the role of leadership and group processes
11.4	Understand models of supervision and their contribution to practice
14.40	Be able to promote awareness of the actual and potential contribution of psychological services
14.41	Be able to evaluate and respond to organisational and service delivery changes, Including the provision of consultation
12.8	Recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and quality improvement programmes

8. Personal and professional skills and values

Example SoPs

2	Be able to practise within the legal and ethical boundaries of their profession
2.7	Be able to exercise a professional duty of care
3	Be able to maintain fitness to practise e.g. 3.4, manage the physical, psychological and emotional impact of their practice,
4	Be able to practise as an autonomous professional, exercising their own professional judgement
14.6	Be able to manage resources to meet timescales and agreed project objectives
1	Understand the need to practise safely and effectively within their scope of practice
10	Be able to maintain records appropriately
NHS	Practise in accordance with NHS constitution and values

9. Reflective practice

Example SoPs

11.3	Be able to reflect critically on their practice and consider alternative ways of working
11.1	Understand the value of reflection on practice and the need to record the outcome of such reflection
5.1	Understand the impact of differences such as gender, sexuality, ethnicity, culture, religion and age on wellbeing and behaviour
14.11	Be able to work effectively whilst holding alternative competing explanations in mind
3.3	Understand both the need to keep skills and knowledge up to date and the importance of career-long learning
3.4	Be able to manage the physical, psychological and emotional impact of their practice
12.2	Be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care

10. Use of supervision

Example SoPs

4.6	Understand the importance of participation in training, supervision and mentoring
12.8	Recognise the need to monitor and evaluate the quality of practice
11.4	Understand models of supervision and their contribution to practice
11.3	Be able to reflect critically on their practice and consider alternative ways of working

A note about model specific competencies, the ECC Form and Practice Learning Portfolio

The HCPC does not focus on proficiencies for model-specific competencies, but says that clinical psychologists must:

- 14.37 Understand therapeutic techniques and processes as applied when working with a range of individuals in distress
- 14.39 Be able to implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy, including the use of cognitive behavioural therapy

There is no specific summative rating of individual model-specific competencies on the ECC Form. However, the trainee's development of them is likely to contribute to the supervisor's ratings of the core competencies (e.g. Assessment, Intervention).

However, observation and discussion of model-specific competencies is expected through supervision, and formative comment on the trainee's progress in this area should be documented in section A of the ECC form. Such discussion may not only inform the supervisor's summative rating of core competencies as suggested above, but also inform the trainee's completion of the model-specific competency development log in their Practice Learning Portfolio, kept cumulatively over the course of their training. The supervisor for each placement should sign and date this log at the end of the placement, subsequent to and based on observation and discussion of the trainee's model-specific competencies during the placement.

The Practice Learning Portfolio provides condensed model-specific competency frameworks, anchored in established frameworks. The regulatory professional therapy organisations have developed their own competence frameworks. For CBT, Systemic and Psychodynamic frameworks, see the well-established CORE competence frameworks found at:
https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks
For links to condensed guidance on the following model competencies: CBT, Systemic, Psychodynamic, CAT, Community and Critical Psychology, and Leadership.
https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

ECC FORM - APPENDIX 1: SERVICE USER EVALUATION FORM

Name of Trainee Clinical Psychologist: ***Date:***

Please tell us about your experience of working with me, your trainee clinical psychologist. Please be honest as it helps me to learn whilst I am training.

There are no right or wrong answers.

If you have any questions or would like help with filling out the form, please tell me.

Please circle the number or response that applies to you for each question.

1. When you arrived for your appointments how long were you usually kept waiting?

Not kept waiting | Up to 5 to 10 minutes | Over 10 minutes

2. **How welcoming was your trainee psychologist?**

Very Welcoming ... Not Very Welcoming

1 2 3 4 5

3. **How well did your trainee psychologist explain confidentiality?**

Very Well ... Not very well

1 2 3 4 5

4. **How useful was the information your trainee psychologist gave you?**

Very useful ... Not useful

1 2 3 4 5

5. **How respectfully were you treated by your trainee clinical psychologist?**

Very respectfully *Not respectfully*

1 2 3 4 5
| | | | |

6. **How well did your trainee psychologist listen to you?**

Very well *Not well*

1 2 3 4 5
| | | | |

7. **How well did your trainee psychologist understand your problems?**

Very well *Not well*

1 2 3 4 5
| | | | |

8. **Have the meetings with your trainee clinical psychologist) helped you?**

Helped a lot *Did not help*

1 2 3 4 5
| | | | |

9. **From your meetings, what has been most helpful?**

10. **What has been least helpful?**

11. **Please add anything else you would like to say.**

12. **Would you recommend your trainee psychologist to a friend or relative if they needed to see someone about difficulties they were having?**

No Maybe Yes

Thank you for filling out this form. Your feedback will be used to help your trainee clinical psychologist's learning during their training.

Salomons Institute for Applied Psychology

DOCTORATE IN CLINICAL PSYCHOLOGY

TRAINEE PRACTICE LEARNING PORTFOLIO

Trainee: ....

Year commenced training: ……………………..

Manager: ……………………………………………

CONTENTS

Note to anyone editing these pages

- *To update the contents list if page numbers change, put the cursor on the contents table and press F9. Select 'update page numbers only'.*
- *To follow a link on the contents lists, control and click on the selected item.*

Practice Learning Portfolio: A1 – Placement log of clinical experiences . **Error! Bookmark not defined.**

Practice Learning Portfolio: A2 – Cumulative summary of clinical experiences 14

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences..... 16

Practice Learning Portfolio: A4 - Cumulative summary of indirect & strategic organisational influence experiences 26

Section B: Clinical psychology competencies development 28

Practice Portfolio: Cumulative Log of Developing CBT Competencies 31

Practice Portfolio: Cumulative Log of Developing Psychodynamic Competencies 39

Practice Portfolio: Cumulative Log of Developing Systemic Competencies 48

Practice Portfolio: Cumulative Log of Developing Critical and Community Psychology Competencies 57

Practice Portfolio: Cumulative Log of Developing Leadership Competencies..................................... 64

Section C: Cumulative Summary of Development of Psychological Testing Competencies................ 69

Section A stage summaries to be completed by the trainee and signed by both trainee and supervisor. Cumulative summaries to be completed and signed by trainee.

Section B competency logs to be completed by the trainee and agreed with supervisor. Both to sign.

Section C to be completed by the trainee and agreed with supervisor. Both to sign.

Section A: Logs of clinical and indirect/strategic organisational influence experiences.

There are four types of logs covering two areas of professional practice learning experience. All four should be completed or updated for each placement:

A1 Placement log of clinical experiences
All clinical contacts and clinical activity should be recorded in this log. It is likely to document clinical assessments and interventions, involving face-to-face work with service users, their carers and families.
However, indirect work and time spent liaising or consulting with others about a person should also be noted.
Please record only clinical contacts where you are the principal or joint lead.

A2 Cumulative summary of clinical experiences
As for A1 above but summarizing the clinical activity information for all placements to date.

A3 Placement log of indirect & strategic organisational influence experiences
This log should be used to record all other types of professional activity such as teaching, training, presentations, research activity, inter-professional liaison, multidisciplinary work, supervision, consultancy, service development, service user involvement work, leadership experiences etc.

A4 Cumulative summary of indirect & strategic organisational influence experiences
As for A3 above but summarizing professional practice experiences for all placements to date.

Individual placement clinical experiences and indirect/strategic influence experiences logs should be signed off by the placement supervisor.

Cumulative summaries should be used by trainees and their managers to plan future learning opportunities on subsequent placements, for instance at Training Reviews and when meeting to determine training needs for the next placement.

Practice Learning Portfolio: A1 – Placement log of clinical experiences

Trainee.. **Placement type ……………………………………….**

For Stage of training: **1**

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex

Female		Male		Non-Binary	

Age

< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)

White		**Mixed/Multiple ethnic groups**		**Asian/Asian British**	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	

Black/African/Caribbean/ Black British		**Other ethnic group**	
African		Arab	
Caribbean		Other	
Black/African/Caribbean Other			

Social Class

1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion

Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area

Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration

< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity

Mild		Moderate		Severe	

Challenging Behaviour	
Yes	

Life Events					
Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities					
Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role					
Observation		Independent Work		Joint Work	

Activity					
Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work			
Individual		Family	
Couple		Group	

Type of Work					
Direct		Indirect - Carers		Indirect - Staff	

Contact Time (D = Direct, C = Consultation/Liaison)					
< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods					
Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models					
Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting			
Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Supervisor:	Date:

Practice Learning Portfolio: A1 – Placement log of clinical experiences

Trainee.. **Placement type ……………………………………….**

For Stage of training: **2a**

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex

Female		Male		Non-Binary	

Age

< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)

White		Mixed/Multiple ethnic groups		Asian/Asian British	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	

Black/African/Caribbean/ Black British		Other ethnic group	
African		Arab	
Caribbean		Other	
Black/African/Caribbean Other			

Social Class

1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion

Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area

Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration

< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity

Mild		Moderate		Severe	

Challenging Behaviour	
Yes	

Life Events					
Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities					
Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role					
Observation		Independent Work		Joint Work	

Activity					
Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work			
Individual		Family	
Couple		Group	

Type of Work					
Direct		Indirect - Carers		Indirect - Staff	

Contact Time (D = Direct, C = Consultation/Liaison)					
< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods					
Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models					
Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting			
Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Supervisor:	Date:

Practice Learning Portfolio: A1 – Placement log of clinical experiences

Trainee.. Placement type ……………………………………….

For Stage of training: **2b**

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex					
Female		Male		Non-Binary	

Age					
< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)					
White		**Mixed/Multiple ethnic groups**		**Asian/Asian British**	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	
Black/African/Caribbean/ Black British		**Other ethnic group**			
African		Arab			
Caribbean		Other			
Black/African/Caribbean Other					

Social Class					
1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion					
Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area			
Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration			
< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity					
Mild		Moderate		Severe	

Challenging Behaviour	
Yes	

Life Events					
Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities					
Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role					
Observation		Independent Work		Joint Work	

Activity					
Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work			
Individual		Family	
Couple		Group	

Type of Work					
Direct		Indirect - Carers		Indirect - Staff	

Contact Time (D = Direct, C = Consultation/Liaison)					
< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods					
Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models					
Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting			
Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Supervisor:	Date:

Practice Learning Portfolio: A1 – Placement log of clinical experiences

Trainee.. **Placement type ……………………………………….**

For Stage of training: **3a**

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex

Female		Male		Non-Binary	

Age

< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)

White		Mixed/Multiple ethnic groups		Asian/Asian British	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	

Black/African/Caribbean/ Black British		Other ethnic group	
African		Arab	
Caribbean		Other	
Black/African/Caribbean Other			

Social Class

1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion

Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area

Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration

< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity

Mild		Moderate		Severe	

Challenging Behaviour	
Yes	

Life Events					
Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities					
Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role					
Observation		Independent Work		Joint Work	

Activity					
Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work			
Individual		Family	
Couple		Group	

Type of Work					
Direct		Indirect - Carers		Indirect - Staff	

Contact Time (D = Direct, C = Consultation/Liaison)					
< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods					
Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models					
Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting			
Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Supervisor:	Date:

Practice Learning Portfolio: A1 – Placement log of clinical experiences

Trainee.. **Placement type ……………………………………….**

For Stage of training: **3b**

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex

Female		Male		Non-Binary	

Age

< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)

White		Mixed/Multiple ethnic groups		Asian/Asian British	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	

Black/African/Caribbean/ Black British		Other ethnic group	
African		Arab	
Caribbean		Other	
Black/African/Caribbean Other			

Social Class

1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion

Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area

Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration

< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity

Mild		Moderate		Severe	

Challenging Behaviour	
Yes	

Life Events

Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities

Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role

Observation		Independent Work		Joint Work	

Activity

Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work

Individual		Family	
Couple		Group	

Type of Work

Direct		Indirect - Carers		Indirect - Staff	

Contact Time **(D = Direct, C = Consultation/Liaison)**

< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods

Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models

Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting

Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Supervisor:	Date:

Practice Learning Portfolio: A2 – Cumulative summary of clinical experiences

Trainee.. **Placement type ……………………………………….**

At end of stage of training:

2a	2b	3a	3b

SERVICE USER DEMOGRAPHICS

Total Clients	

Sex					
Female		Male		Non-Binary	

Age					
< 5		25 - 34		65 - 75	
5 - 11		35 - 44		75 +	
12 - 18		45 - 54			
19 - 24		55 - 64			

Ethnicity (ONS 2011)

White		Mixed/Multiple ethnic groups		Asian/Asian British	
White British (Eng/Welsh/Scot/NI)		White and Black Caribbean		Indian	
White Irish		White and Black African		Pakistani	
White Gypsy or Irish Traveller		White and Asian		Bangladeshi	
White Other		Other Mixed/Multiple ethnicity		Chinese	
				Asian Other	

Black/African/Caribbean/ Black British		Other ethnic group	
African		Arab	
Caribbean		Other	
Black/African/Caribbean Other			

Social Class					
1.1 – Employers, senior managers		3 – Intermediate		6 – Semi-routine	
1.2 – Higher professionals		4 – Small employers		7 – Routine	
2– Intermediate professionals		5 – Low supervisory		8 – Long term unemployed	

Religion					
Christian		Jewish		Other	
Buddhist		Muslim		Not Applicable	
Hindu		Sikh			

CLINICAL DATA

Problem Area			
Biological/Health		Emotional/Behavioural	
Cognitive Function		Social/Interpersonal	

Problem Duration			
< 1 year		< 10 years	
< 5 years		> 10 years	

Problem Severity					
Mild		Moderate		Severe	

Challenging Behaviour

Yes	

Life Events					
Bereavement/Loss		Abuse		Other	
Health		Trauma			

Disabilities					
Communication		Mobility		Other	
Learning		Sensory			

ACTIVITY DATA

Role					
Observation		Independent Work		Joint Work	

Activity					
Assessment Only		Assessment & Intervention		Intervention Only	

Mode of Work			
Individual		Family	
Couple		Group	

Type of Work					
Direct		Indirect - Carers		Indirect - Staff	

Contact Time (D = Direct, C = Consultation/Liaison)					
< 2 hours		< 10 hours		< 25 hours	
< 5 hours		< 15 hours		25 + hours	

Assessment Methods					
Interview		Self-Report Tools		Neuropsychology Tests	
Observations		Standardised Tests			

Models					
Behavioural		Systemic		Community/critical	
Cognitive Behavioural (CBT)		Cognitive analytic (CAT)		Other (specify)	
Psychodynamic		Integrative			

Service Setting			
Primary Care		In-Patient/Residential	
Secondary		Other e.g. third sector (specify)	

Confirmed and signed by:

Trainee:	Date:

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences

Trainee...

For Stage of training: **1**

Complete total number of occasions have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing supervision	

Leadership & Organisational Influence see http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *DURING* THIS STAGE:	

Quality/Service Improvement Activities on this placement *(briefly describe)*

Organisational initiatives and interventions on this placement *(briefly describe)*

Public education/community engagement presentation done? YES / NO *(e.g. careers talk to school, talk on mental health, community workshop. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Supervisor: .... *Date:* ....

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences

Trainee...

For Stage of training: **2a**

Complete total number of occasions have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing supervision	

Leadership & Organisational Influence see http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *DURING* THIS STAGE:	

Quality/Service Improvement Activities on this placement *(briefly describe)*

Organisational initiatives and interventions on this placement *(briefly describe)*

Public education/community engagement presentation done? YES / NO *(e.g. careers talk to school, talk on mental health, community workshop. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Supervisor: .... *Date:* ....

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences

Trainee...

For Stage of training: **2b**

Complete total number of occasions have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing Supervision	

Leadership & Organisational Influence see http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *DURING* THIS STAGE:	

Quality/Service Improvement Activities on this placement *(briefly describe)*

Organisational initiatives and interventions on this placement *(briefly describe)*

Public education/community engagement presentation done? YES / NO *(e.g. careers talk to school, talk on mental health, community workshop. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Supervisor: .... *Date:* ....

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences

Trainee...

For Stage of training: **3a**

Complete total number of occasions have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing Supervision	

Leadership & Organisational Influence see http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *DURING* THIS STAGE:	

Quality/Service Improvement Activities on this placement *(briefly describe)*

Organisational initiatives and interventions on this placement *(briefly describe)*

Public education/community engagement presentation done? YES / NO *(e.g. careers talk to school, talk on mental health, community workshop. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Supervisor: .... *Date:* ....

Practice Learning Portfolio: A3 - Log of indirect & strategic organisational influence experiences

Trainee...

For Stage of training: **3b**

Complete total number of occasions have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing Supervision	

Leadership & Organisational Influence **see** http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *DURING* THIS STAGE:	

Quality/Service Improvement Activities on this placement *(briefly describe)*

Organisational initiatives and interventions on this placement *(briefly describe)*

Public education/community engagement presentation done? YES / NO *(e.g. careers talk to school, talk on mental health, community workshop. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Supervisor: .... *Date:* ....

Practice Learning Portfolio: A4 - Cumulative summary of indirect & strategic organisational influence experiences

Trainee..

At end of stage of training:

2a	2b	3a	3b

Complete total number of occasions you have had experience under each category:

Meetings Attended	
Professional	
Specialty	
Service planning/review	
Multidisciplinary team allocation	
Multidisciplinary team other	
Team building/awayday	
Staff support	
Other	
Liaison Work or Contact	
Service user groups/forums	
Voluntary groups/services	
Social services/housing	
Education/schools	
Police/prison/probation	
Other professions/agencies	
Teaching & Consultation	
Clinical/journal presentation	
Small-group teaching < 15	
Large-group teaching > 15	
Inter-professional consultancy	
Team/service consultancy	
Providing Supervision	

Leadership & Organisational Influence see http://www.bps.org.uk/system/files/Public%20files/DCP/cat-710.pdf	
Interagency/community liaison, networking, capacity building	
Lead on psychological issue in teams, e.g. formulation, testing	
Promote/facilitate staff reflective practice & other psychological skills	
Assist with public relations/ marketing activities	
Contribute to service development processes/local policy or procedures	
Chair meeting, coordinate working party/collaborative project/training	
Model/educate re. role of psychology & its contribution to services	
Shadow/engage with service leads/managers, commissioners	
Offer constructive evidence-based critique/evaluation of models/services	
Facilitate service user/carer involvement/coproduction	
Training Events Attended, Shared Learning	
Trust policies, procedures, briefings	
Health & safety	
Multidisciplinary seminar/workshop	
Multidisciplinary conference	
Professional seminar/tutorial/SIG	

TOTAL NUMBER OF DAYS ON PLACEMENT *FOR ALL STAGES*:	

Quality/Service Improvement Activities to date *(list briefly)*

Organisational initiatives and interventions to date *(list briefly)*

Public education/community engagement presentation done yet? YES / NO *(e.g. careers talk to school. Briefly describe)*

Confirmed and signed by:

Trainee: .... *Date:* ....

Section B: Clinical psychology competencies development

1. The Salomons Programme is committed to the development of model-specific competencies as part of the broader range of clinical psychology practice competencies.

This section of the Practice Portfolio is a way of tracking the accumulation of therapy-specific and other professional practice skills across placements during training. It will provide the trainee with a record to:

a) monitor development and training needs to assist placement planning and reviews of progress
b) document skills when seeking employment
c) provide evidence should the trainee wish to seek therapy-specific accreditation in the future.

2. The following pages provide competency frameworks for trainees to record their development in relation to:
   - common models of therapy (CBT, Psychodynamic, Systemic, Cognitive Analytic Therapy, Positive Behavioural Support)
   - broader areas of professional practice (Critical Community Psychology, Leadership and Organisational Influence).

The frameworks provided are anchored in CORE or BPS frameworks if available, or adapted from frameworks produced by therapy accreditation bodies.

3. Trainees are required to log development of model-specific therapy skills in CBT and at least one other therapy model during training. They are also required to provide examples of their developing competencies from their placement practice. In addition, competencies developed in whichever models the trainee encounters in a significant way on placements should also be reflected in the record. In addition, trainees should record their development of leadership, organizational and community skills through the Leadership and Critical Community Psychology frameworks.

4. Trainees are responsible for completing the framework logs. However this should be done in conjunction with supervisors who have observed trainees' practice in dedicated development discussions. Only the competency framework(s) relevant to the particular placement experience should be completed for each placement. For instance, if the placement has not included any systemic work, there should be no entry into the Systemic framework for that placement.

5. Integrated and adapted therapy practice It is not expected that all or even most

skills associated with a model will be covered on a single placement. Nor is it expected that all trainees will always work to a strict model with service users. The aim is to provide a record of key areas of competency development that reflects the diversity of practice in clinical psychology across the lifespan. Therefore, trainees may do significant amounts of work informed by more than one therapeutic model and adapted for particular client groups or individual services users. Consideration of model-specific skills used within such work should be included in the records.

6. If no competency framework is provided here for the specific therapy used by the trainee on placement, supervisors and trainees should draw upon the literature to identify a recognized competency framework or list of skills which can be reproduced and used instead.

Resources (for information only)
Both trainees and supervisors may find their discussions are assisted by looking at the detailed frameworks accessible through the following links:

CBT https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/cognitive-and-behavioural-therapy
CTS-R http://www.getselfhelp.co.uk/trainees.htm

Psychodynamic https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychoanalytic-Psychodynamic-Therapy

Systemic https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Systemic_Therapy
Systemic Family Practice-Systemic Skills Rating Scale (SFP-SSRS) –
https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

Positive Behavioural Support Framework (PBS)
http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf

CAT – Competence in Cognitive Analytic Therapy - https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

Community psychology http://www.scra27.org/what-we-do/practice/18-competencies-community-psychology-practice/

Leadership
https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Faculties/Leadership/Clinical%20Psychology%20Leadership%20Development%20Framework%20-%20BPS%20%282010%29.pdf

Some additional model specific frameworks are available here: https://www.canterbury.ac.uk/science-engineering-and-social-sciences/salomons-institute-for-applied-psychology/programmes/doctorate-in-clinical-psychology/resources.aspx

Salomons Institute for Applied Psychology

Doctorate in Clinical Psychology
Practice Portfolio: Cumulative Log of Developing CBT Competencies

Trainee name: ……………………………………………………………………

For the trainee: It is your responsibility to hold this record and refer to it during the course of your various placements, as a tool to assist discussions in supervision about your development of specific CBT competencies. Add to this log on each placement that offers experience in CBT. Our definition of CBT includes second and third wave therapies and group work as well as standard individual therapy.

When reviewing the placement with your supervisor, decide together whether 'emerging', 'establishing' or 'consolidating' best describes your competency in each of the six areas *on that particular placement,* i.e. with that particular client group. Since each placement and client group is different, ratings on later placements may be either more or less advanced than earlier ones. Your work may not have involved all competency areas (for instance, if working integratively or adaptively), in which case, leave those competency areas blank for that placement.

To indicate your stage of competency development, please insert the code below for the placement (made up of stage of training and specialism) under the *Emerging, Establishing* or *Consolidating* column for each of the six competency areas that is relevant to that placement.

1A   2a CH or LD   2b CH or LD   3a OA or S   3b OA or S

Then, you are required to give some examples in the text boxes provided, referencing the type of placement each time by using the above codes. Note any adaptations made in respect of the setting/client group.

For the supervisor: You may find it helpful to refer to this form (perhaps in addition to standard tools you may use already such as the CTS-R) when giving the trainee feedback following observations and audio-recorded sessions. The ratings are intended to support a conversation rather than indicate a "pass or fail" though they may help to inform your overall ratings on the ECC form. Competency areas should be left blank if not observed/not applicable.

These competencies have been informed by the UCL CORE CBT competence framework

NB. Please note that trainees are required to give examples of the competencies they are developing.

Area of Competence	Emerging	Establishing	Consolidating
1. **Structuring sessions e.g.** • Agenda setting • Keeping to a structure in sessions • Pacing and use of time			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
2. **Assessment e.g.** • Ability to conduct a focused CBT assessment • Ability to elicit relevant developmental history			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
3. **Formulation e.g.** • Disorder specific formulations • Use of developmental information • Trans diagnostic formulations • Communicating formulations • Drawing on and integrating a range of theoretical ideas (a meta-competency) • Choosing the most relevant model (a meta-competency)			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
***4.* Specific techniques e.g.** • Guided discovery • Cognitive interventions (cognitive change diaries, continua, responsibility charts, evaluating alternatives, examining pros/cons, imagery restructuring, reliving and re-scripting) • Behavioural interventions (behavioural activation, activity diaries, behavioural experiments, role play, graded exposure, ERP, graded task assignments, modelling, applied relaxation, controlled breathing etc.) • Adapting interventions to the client (a meta-competency) • Selecting most appropriate interventions (a meta-competency) • Timing of interventions (a meta-competency)			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
5. Therapeutic relationship e.g. • Fostering therapeutic alliance • Collaboration • Ability to manage the emotional content of sessions – to elevate expression of emotion where relevant, or to manage heightened emotions • Ability to grasp the subtleties of the client's perspective • Capacity to manage obstacles to therapy, e.g. alliance rupture and repair • Awareness of own reactions and beliefs about self as a therapist			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
6. Using CBT to inform indirect work e.g. • Leadership • Consultation • Communication • Teaching • Supervision			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Record agreed by*:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

**signatures required for each placement where this form has been added to*

Canterbury Christ Church University

Salomons Institute for Applied Psychology

Doctorate in Clinical Psychology
Practice Portfolio: Cumulative Log of Developing Psychodynamic Competencies

Trainee name ………………………………………………………………….

For the trainee: It is your responsibility to hold this record and refer to it during the course of your various placements, as a tool to assist discussions in supervision about your development of psychodynamic competencies. Add to this log on each placement that offers experience in psychodynamic work. Not all trainees will have direct experience of 'pure' psychodynamic working, so it is expected that these competencies will develop and be noticed in a variety of settings.

When reviewing the placement with your supervisor, decide together whether 'emerging', 'establishing' or 'consolidating' best describes your competency in each of the thirteen areas *on that particular placement,* i.e. with that particular client group. Since each placement and client group is different, ratings on later placements may be either more or less advanced than earlier ones. Your work may not have involved all competency areas (for instance, if working integratively or adaptively), in which case, leave those competency areas blank for that placement.

To indicate your stage of competency development, please insert the code below for the placement (made up of stage of training and specialism) under the Emerging, Establishing or Consolidating column for each of the 13 competency areas that is relevant to that placement.

1A 2a CH or LD 2b CH or LD 3a OA or S 3b OA or S

Then, you are required to give some examples in the text boxes provided, referencing the type of placement each time by using the above codes. Note any adaptations made in respect of the setting/client group.

For the supervisor: You may find it helpful to refer to this form when giving feedback following observations or more generally. The ratings are intended to support a reflective conversation rather than indicate a "pass or fail", though they may help to inform your overall ratings on the ECC form. Competency areas should be left blank if not observed/not applicable.

These competencies have been developed with reference to:

UCL CORE Psychodynamic competence framework (https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychoanalytic-Psychodynamic-Therapy).

BPS Standards for the accreditation of Doctoral programmes in Clinical Psychology, Section B: Therapy competencies, 2, Psychodynamic therapy (October 2014)

Ten psychodynamic competencies of general relevance to clinical psychology training. Leicester Doctoral Clinical Psychology programme. Kurtz,A; Schroder,T & O'Reilly, M. (2015)

A. CORE PSYCHODYNAMIC COMPETENCIES

Area of Competence	Emerging	Establishing	Consolidating
A1. Knowledge of the basic underlying principles and rationale of psychodynamic approaches.			

Examples of how this competency was demonstrated:

Placement code (e.g. 2aLD):
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
A2. Ability to understand the importance of establishing an effective therapeutic relationship, involving both empathic and non-judgemental understanding and acceptance, as well as constructive challenge.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
A3. Ability to establish and maintain an appropriate therapeutic frame, to include the provision of emotional containment and management of boundaries around the therapeutic task.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
A4. Ability to undertake assessment and formulation: a) incorporating a **developmental** perspective, making use of information regarding formative events in building an understanding of the client, and appreciation of the impact of early experience on the way the client presents in the here-and-now. b) incorporating a **dynamic** perspective drawing on an understanding and awareness of unconscious conflict and the role of the mechanisms of defence in protecting against psychic pain. c) incorporating a **relational** perspective – understanding how past and present significant attachment relationships can come to be re-enacted within the therapeutic relationship.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
A5. Ability to understand and maintain an appropriate psychodynamic attitude and focus towards clinical work: a) including an ability to facilitate the exploration of unconscious dynamics influencing relationships. b) including an ability to work with the client's internal and external reality, linking these as necessary. c) including an awareness of and ability to work with unconscious communication/motivation in client and self. d) including an ability to be mindful of and work within the distinct phases of therapy, with due regard to the importance of engagement and termination.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
A6. Ability to engage with and make use of supervision provided from a psychodynamic perspective acknowledging the central role of personal exploration and reflection within this.			
Examples of how this competency was demonstrated: Placement code Example/s:			

B. SPECIFIC PSYCHODYNAMIC TECHNIQUES:

Area of Competence	Emerging	Establishing	Consolidating
B1. Ability to identify and work with the transference and counter-transference, noticing one's own and the client's emotional reactions in the clinical setting, and making use of this awareness to develop and enhance the psychological understanding of the client.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
B2. Ability to understand the role of interpretation in furthering the therapeutic process and learning its effective use in deepening rapport and the emotional understanding of the client.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
B3. Ability to recognise and work with defences.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
B4. Ability to recognise and work with processes of therapeutic impasse and rupture, and the ability to generate a psychological formulation to make sense of this and inform therapeutic action aimed at repair.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

C. APPLICATION OF PSYCHODYNAMIC PRINCIPLES TO BROADER CONTEXTS:

Area of Competence	Emerging	Establishing	Consolidating
C1. Ability to adapt methods to understand and work with different populations such as with children, adolescents and people with learning disabilities etc. (please specify in box below)			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
C2. Ability to adapt methods to understand and work with other contexts, such as with groups, teams and professional systems (please specify in box below)			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
C3. Ability to make use of psychodynamically informed process reflection when working within other psychological models.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Record agreed by*:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:

Trainee Signature:	Supervisor Signature:

**signatures required for each placement where this form has been added to*

Salomons Institute for Applied Psychology

Doctorate in Clinical Psychology
Practice Portfolio: Cumulative Log of Developing Systemic Competencies

Trainee name ………………………………………………………….

For the trainee: It is your responsibility to hold this record and refer to it during the course of your various placements, as a tool to assist discussions in supervision about your development of systemic competencies. Add to this log on each placement that offers experience in systemic work. Not all trainees will have direct experience of working with families using with an observing team, so that it is expected that these competencies will develop and be noticed in a variety of settings including in individual work, team work, being part of a reflecting team and taking part in pre and post therapy conversations.

When reviewing the placement with your supervisor, decide together whether 'emerging', 'establishing' or 'consolidating' best describes your competency in each of the six areas *on that particular placement,* i.e. with that particular client group. Since each placement and client group is different, ratings on later placements may be either more or less advanced than earlier ones. Your work may not have involved all competency areas (for instance, if working integratively or adaptively), in which case, leave those competency areas blank for that placement.

To indicate your stage of competency development, please insert the code below for the placement (made up of stage of training and specialism) under the Emerging, Establishing or Consolidating column for each of the six competency areas that is relevant to that placement.

1A 2a CH or LD 2b CH or LD 3a OA or S 3b OA or S

Then, you are required to give some examples in the text boxes provided, referencing the type of placement each time by using the above codes. Note any adaptations made in respect of the setting/client group.

For the supervisor: You may find it helpful to refer to this form when giving feedback following observations and audio-recorded sessions, or more generally. The ratings are intended to support a reflective conversation rather than indicate a "pass or fail" though they may help to inform your overall ratings on the ECC form. Competency areas should be left blank if not observed/not applicable.

These competencies have been informed by:

the UCL CORE systemic competence framework

Systemic Family Practice Systemic Competency Scale, developed by Judith Lask in 2013 and revised in February 2016

Area of Competence	Emerging	Establishing	Consolidating
1. **Convening and managing a session collaboratively e.g.** • Engages all family/ clients (including young children by use of toys etc.) and includes everyone in decisions about goals and the development of the work. • Incorporates the family/ clients understanding into the developing map/formulation • Acknowledges and uses the expertise of the family/clients in thinking about the problem. • Uses own expertise to help the family/clients, but does not get stuck in an expert position. • Uses tentative language that allows for a co-construction of ideas. • Retains a curious position. • Uses the above competencies in non-family systems e.g. staff teams			

Examples of how this competency was demonstrated:

Placement code (e.g. 2aLD):
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
2. Use of questioning/ assessment e.g. • Demonstrates a good use of circular and other question - used both for information gathering and intervention. • Demonstrates an ability to ask questions that address differences and that are culturally sensitive. • Asks questions adapted to fit in with needs of clients/ family members, purpose and context of the work. • Questioning takes into account different members' viewpoints. • Assessment includes historical and transgenerational factors; developmental stages and family life cycle; issues around gender, culture, power, class and spiritual beliefs; strengths, resources and attempted solutions. • Demonstrates an ability to construct a genogram with families/clients to clarify patterns of relationship and current influences on the system. • Uses the above competencies in non-family systems e.g. staff teams			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
3. Conceptual map/ formulation/hypothesis e.g. • Shows understanding of different systemic theories and principles, and uses them in an understanding of psychological problems, resilience and change. • Appropriately uses hypotheses to widen thinking around all aspects of the referral (including professional systems) and is able to develop and change these hypotheses as new information emerges. • Uses the formulation/hypotheses to create a road map and to create coherence in and between sessions. • Demonstrates an ability to conceptualise the interactions and relationships between systemic factors picked up in the assessment (e.g. historical and transgenerational factors.) • Is able to help the family/client develop a systemic and relational understanding of their issues. • Demonstrates an ability to incorporate family resiliencies across generations and considers cultural resiliencies. • Uses the above competencies in non-family systems e.g. staff teams			

Examples of how this competency was demonstrated:

Placement code (e.g. 2aLD):
Example/s:

Area of Competence	Emerging	Establishing	Consolidating
4. Enabling change e.g. • Understands and applies systemic approaches that enable change e.g. externalising, reframing, role play, sculpting. • Uses feedback to provide a response to content and process that is helpful to families/clients – e.g. through re-framing, unique outcomes, exceptions, scaffolding, and solution focussed questions. • Intervenes using process: working with the family on patterns of interaction e/g through communication work, active questioning, enactment, role play. • Demonstrates an ability to work with a systemic team and/or co-therapists in an effective way. • Explores and manages emotions. • Uses a variety of communication means (including written communication) as a vehicle for creating change and encouraging engagement. • Uses the above competencies in non-family systems e.g. staff teams			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
5. Therapeutic relationship and reflexivity • Demonstrates an ability to manage families/clients' different emotions in the room: • Shows awareness of own values, 'prejudices', thoughts and beliefs and an ability to use these on behalf of the client/s. • Shows an understanding and ability to manage and work with endings from a systemic perspective (e.g. being curious about endings in different cultures) • Uses the above competencies in non-family systems e.g. staff teams. • Knows the limits of their own knowledge/ lenses and seeks appropriate help to expand their understanding particularly when working cross-culturally.			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
6. Uses a systemic approach model in indirect or group work, e.g. in • Group work • Leadership • Consultation • Communication • Teaching • Supervision			

Examples of how this competency was demonstrated:

Placement code (e.g. 2aLD):
Example/s:

Record agreed by*:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:

Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

**signatures required for each placement where this form has been added to*

Cumulative log of developing Positive Behavioural Support competencies to be inserted here

Canterbury Christ Church University

Salomons Institute for Applied Psychology

Doctorate in Clinical Psychology
Practice Portfolio: Cumulative Log of Developing Critical and Community Psychology Competencies

Trainee name ……………………………………………………………

For the trainee: It is your responsibility to hold this record and refer to it during the course of your various placements, as a tool to assist supervisory discussions about your development of critical and community psychology leadership competencies. Add to this log on each placement that offers relevant experiences. Remember that they may not come badged as relevant to critical or community psychology, so it may be helpful to think with your supervisor about which experiences might be relevant on any particular placement.

When reviewing the placement with your supervisor, decide together whether 'emerging', 'establishing' or 'consolidating' best describes your competency in each of the four areas *on that particular placement,* i.e. in that particular setting. Since each setting is different, ratings on later placements may be either more or less advanced than earlier ones. Your work may not have involved all competency areas, in which case leave those competency areas blank for that placement.

To indicate your stage of competency development, please insert the code below for the placement (made up of stage of training and specialism) under the Emerging, Establishing or Consolidating column for each of the four competency areas that is relevant to that placement.

1A 2a CH or LD 2b CH or LD 3a OA or S 3b OA or S

Then, you are required to give some examples in the text boxes provided, referencing the type of placement each time by using the above codes. Note any adaptations made in respect of the setting/client group.

For the supervisor: You may find it helpful to refer to this form when giving the trainee feedback. The ratings are intended to support a reflective conversation rather than indicate a "pass or fail" though they may help to inform your overall ratings on the ECC form. Competency areas should be left blank if not observed/not applicable.

These competencies have been informed by the Society for Community Research and Action's *Competencies for Community Psychology Practice* and by Prilleltensky & Nelson's (2002) *Doing Psychology Critically: Making a Difference in Diverse Settings* (Table 5.2).

Area of Competence	Emerging	Establishing	Consolidating
1. Application of Community and Critical Psychology Principles to Achieve Second Order Change • *Multiple Perspectives*: The ability to articulate and apply multiple perspectives and levels of analysis (e.g. individual, group/organisation, community, society). • *Empowerment:* The ability to articulate and apply a collective empowerment perspective, and to support members of marginalised communities. The ability to design and implement interventions where the process as well as the outcome has the potential to be transformational e.g. promoting increased agency, mutuality, respect and wellbeing. • *Cultural Competence*: The ability to value, integrate, and bridge multiple worldviews, cultures, and identities. • *Anti-discriminatory practice*: The ability to oppose discrimination and facilitate supportive, egalitarian relationships and inclusive practices. • *Deconstruction and consciousness raising*: The ability to analyse situations and language in order to understand the operations of ideology and power (e.g. whose interests are being served and how). Ability to help others to develop and apply critical awareness and reflexivity. • *Values-based practice:* Understanding and enacting values of self-determination, care, compassion, respect for diversity, participation and collaboration, accountability and social justice. Promoting wellbeing through addressing values, power relations, and the distribution and accessibility of resources in interventions. • *Reflective Practice*: The ability to identify and address ethical issues in one's own practice and to recognise how one's own values, assumptions, and life experiences influence one's work. To develop and maintain professional networks for ethical consultation and support.			

Examples of how this competency was demonstrated:
Placement code (e.g. 2aLD): Example/s:

Area of Competence	Emerging	Establishing	Consolidating
2. Community Level Interventions e.g**.** • *Community Partnership:* The ability to work in partnership with community stakeholders to plan, develop, implement and manage projects. • *Prevention and Health Promotion*: The ability to articulate and implement a prevention perspective, and to implement prevention and health promotion interventions. • *Group facilitation:* The ability to facilitate productive group and inter-group processes even in the presence of power differentials or conflict, supporting participatory decision-making and co-production. • *Resource Development*: The ability to identify and integrate use of human and material resources. • *Consultation & Organisational Development*: The ability to facilitate processes that can increase an organisation's capacity to attain its goals.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
3. Working for community and social change, e.g. • *Community Organising and Community Advocacy*: The ability to work collaboratively with community members to improve conditions affecting their community, e.g. through practicing advocacy and 'accompaniment'. • *Policy Analysis, Development and Advocacy*: Knowledge of public policy and ability to analyse its psychosocial effects, contribute to its development and challenge it where necessary. To build communication and working alliances with policymakers. • *Community Education, Knowledge Exchange, and Building Public Awareness*: The ability to communicate with diverse audiences through effective writing, use of social media and public speaking in ways that inspire, encourage change and promote critical thinking about knowledge and its sources, and about social justice.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competence	Emerging	Establishing	Consolidating
4. **Community Research** e.g. *Participatory Community Research*: The ability to work with community partners to plan and conduct high quality, contextually appropriate research, and to communicate the findings in diverse ways. The ability to use methods of inquiry that change power relations e.g. collaborative methods that build agency, mutuality, respect and wellbeing. *Programme Evaluation*: The ability collaboratively to evaluate community initiatives in order to make improvements and report to stakeholders. *Scholar Activism*: The ability to share the results of scholarship in the pursuit of community wellbeing and social justice.			

Examples of how this competency was demonstrated:

Placement code:
Example/s:

Record agreed by*:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

**signatures required for each placement where this form has been added to*

Salomons Institute for Applied Psychology

Doctorate in Clinical Psychology
Practice Portfolio: Cumulative Log of Developing Leadership Competencies

Trainee name ……………………………………………………………….

For the trainee: It is your responsibility to hold this record and refer to it during the course of your various placements, as a tool to assist supervisory discussions about your development of specific leadership competencies. Add to this log on each placement that offers the relevant experiences.

When reviewing the placement with your supervisor, decide together whether 'emerging', 'establishing' or 'consolidating' best describes your competency in each of the three areas *on that particular placement,* i.e. in that particular setting. Since each placement and client group is different, ratings on later placements may be either more or less advanced than earlier ones. Your work may not have involved all competency areas, in which case leave those competency areas blank for that placement.

To indicate your stage of competency development, please insert the code below for the placement (made up of stage of training and specialism) under the Emerging, Establishing or Consolidating column for each of the six competency areas that is relevant to that placement.

1A 2a CH or LD 2b CH or LD 3a OA or S 3b OA or S

Then, you are required to give some examples in the text boxes provided, referencing the type of placement each time by using the above codes. Note any adaptations made in respect of the setting/client group.

For the supervisor: You may find it helpful to refer to this form when giving the trainee feedback. The ratings are intended to support a reflective conversation rather than indicate a "pass or fail" though they may help to inform your overall ratings on the ECC form. Competency areas should be left blank if not observed/not applicable.

These competencies have been adapted from the DCP's *Clinical Psychology Leadership Development Framework (*trainee and newly qualified levels*).*

Area of Competency	Emerging	Establishing	Consolidating
1. Clinical Leadership Competencies e.g. • Broad knowledge of psychological models to inform own and team's formulation and interventions. • Psychological perspective on multifarious health and mental health presentations • Emotional Intelligence/resilience • Self-reflection/helping others self reflect. • Reflection and awareness of systemic issues operating within teams/able to lead team dynamics discussions. • An understanding of the emotional impact of change (including resistance). • Encourage team reflection on current/innovative practice • Able to lead on comprehensive psychological assessment, including risk • Ability to develop and operationalise clinical and service outcome evaluations			
Examples of how this competency was demonstrated: Placement code (e.g. 2aLD): Example/s:			

Area of Competency	Emerging	Establishing	Consolidating
2. Professional Competencies e.g. • Understanding of diversity, values, ethics and integrity. • Application of different psychological models to supervision and consultation with other professionals. • Training other professionals in the application of psychological models. • Conflict management skills. • Ability to participate in and oversee research projects			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Area of Competency	Emerging	Establishing	Consolidating
3. Strategic Competencies e.g. • Critiquing the literature and guidelines regarding therapeutic interventions used in service. • Ability to use evidence, data collection, outcomes and audit to constructively critique current service practice. Clinical • Able to construct and share service development plans. • Influence organisational policies and procedures.			
Examples of how this competency was demonstrated: Placement code: Example/s:			

Record agreed by*:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:
Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

Placement Code:	Date:
Trainee Signature:	Supervisor Signature:

**signatures required for each placement where this form has been added to*

Section C: Cumulative Summary of Development of Psychological Testing Competencies

All performance and paper and pencil psychometric assessments should be logged in the following cumulative table, across all placements. Tests should only be logged where the trainee has utilised the test as principal / joint lead in a case (not observation only). Successive supervisors should validate the form with their signatures.

Cumulative Record of Development of Psychological Testing Competencies.

Trainee name ………………………………………………………….

<u>For the trainee</u>: It is your responsibility to complete and hold this record and refer to it during the course of your placement, as a tool to assist supervisory discussions about your development of competences in standardised testing. All performance and pencil/paper psychometric tests should be logged in the following table. Tests should only be logged where the trainees has utilised the test as principle/joint lead.
Please record Stage of Training according to the following: ***1*** ***2a CH or LD*** *(specify)* ***2b CH or LD*** ***3a OA or S*** ***3b OA or S***
<u>For the supervisor</u>: You may find it helpful to refer to this form when giving the trainee feedback following observations or audio-recorded sessions. The ratings are intended to support a conversation rather than indicate a "pass or fail" though they may help to inform your overall ratings on the ECC.

Stage of Training	Test Used	Age of Client	Clinical Use (reason for testing - outcome measure, treatment planning, eligibility)	Administration			Interpretation		
				Emerg-ing	Establish-ing	Consol-idating	Emerg-ing	Establish-ing	Consol-idating

Stage of Training	Test Used	Age of Client	Clinical Use (reason for testing - outcome measure, treatment planning, eligibility)	Administration			Interpretation		
				Emerg-ing	Establish-ing	Consol-idating	Emerg-ing	Establish-ing	Consol-idating

Psychological Testing Competencies Record agreed and signed by: Placement 1

Trainee ………………………………………….. Date ………………… Supervisor ………………………………… Date …………………

Placement 2a Child / LD

Trainee ………………………………………….. Date …………………

Supervisor …………………………………… Date …………………

Placement 2b Child / LD

Trainee ………………………………………….. Date …………………

Supervisor …………………………………… Date …………………

Placement 3a OA / Supplementary

Trainee ………………………………………….. Date …………………

Supervisor …………………………………… Date …………………

Placement 3b OA / Supplementary

Trainee ……………………………………….. Date …………………

Supervisor …………………………………………………… Date …………………

Salomons Institute for Applied Psychology

PLACEMENT VISIT RECORD

PLACEMENT DETAILS

Trainee: ______________________________

Co-ordinating Supervisor: ______________________________

Location: ______________________________

Placement Stage:

1a	☐	**2a**	☐	**3a**	☐
1b	☐	**2b**	☐	**3b**	☐

PLACEMENT VISIT

Supervisor(s) present: ______________________________

____

Manager: ______________________________

Date: ______________________________

MEETING WITH THE TRAINEE

Key points arising from the conversation with the trainee about their experience on placement and their clinical development should be noted below.

Some areas that could be explored include:

Any general or ongoing issues concerning their current progress and experience with the training programme.

Their clinical work (e.g. outline their current caseload; give a more detailed description of their formulation in one case, or of a recent session; other work they are doing on placement in addition to client work; things they are getting good experience of; things they would benefit from experience of). Include attention to the development of model-specific competences, and competences in psychometric testing and any neuropsychological assessment.

Supervision (e.g. how does the supervision on this placement work, in term of process and content; what are its strengths; what could be improved)

The team/organization (e.g. issues working with other professionals in the team, how they understood and managed those; issues that are affecting the team/organisation as a whole and how they understand and engage with those)

Their overall development (e.g. what have they noticed as their own strengths on this placement; what have they noticed that they struggle with; what have they learnt; what do they think they need to work on in the next stage).

KEY POINTS

CHECKLIST

Areas to check have been covered (depending on trainee cohort – some may be left blank):

- [ ] Placement contract
- [ ] Induction / observation week arrangements
- [ ] Supervision arrangements
- [ ] Placement structure / timetable
- [ ] Observation [by trainee of others]
- [ ] Observation [by Supervisor(s) of trainee]
- [ ] Ongoing development of model specific competences
- [ ] Competences in psychometric and neuropsychological assessment
- [ ] How is clinical reading/writing time being taken
- [ ] Practice learning log records
- [ ] PPR: QIP or Supplementary Report
- [ ] PPR: Direct Work or Clinical Skills Portfolio
- [ ] Any placement equality or diversity issues for trainee

MEETING WITH SUPERVISOR(S)

Key points from the conversation with the supervisor/s about the trainee's practice and development should be noted below.

Some areas that could be explored are:

- The trainee's clinical practice (e.g. their strengths and needs in terms of the core clinical competencies including model-specific competences and testing; their ethical practice; their ability to work with diversity issues)
- The trainee's use of supervision (e.g. their preparation; the process and content of supervision; their response to feedback; their capacity to reflect)
- Observation [by trainee of others], and
- Observation [by Supervisor(s) of trainee]
- The trainee's integration into the team/organization (e.g. issues in their work with other team members and how they have managed these; issues within the team/organization and how they have engaged with these)
- The trainee's overall development (e.g. areas in which the trainee is particularly strong or has particular needs; areas of development on the placement so far; areas for future development; areas to focus on for the next stage)
- Any areas of concern

KEY POINTS

AGREED ACTION POINTS FROM THE JOINT MEETING

THIS PAGE CAN BE COPIED FOR THE TRAINEE AND SUPERVISOR IF REQUESTED

Blank page,
do not type here.

MANAGER'S FEEDBACK TO TRUST TRAINING CO-ORDINATOR

Manager: ____________________ **Date:** __________

Trainee: ____________________ **Year (1st etc.):** __________

Supervisor: ____________________ **Trust:** __________

Information or Action: ____________________

Trainee's contact with Clinical Psychologist(s):

Feedback:

PLEASE EMAIL TO THE RELEVANT TRUST TRAINING CO-ORDINATOR, COPYING IN THE PLACEMENTS ADMINISTRATOR.

THANK YOU

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

EVALUATION OF CLINICAL/PROFESSIONAL COMPETENCE

Contents

1. Learning Outcomes
2. Marking Criteria and Guidance for Supervisors
3. Procedures and Outcomes

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.
- 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 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.

MARKING CRITERIA AND GUIDANCE FOR SUPERVISORS

Marking Criteria

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

Pass
Referral[1]
Fail

Please provide assessment of the trainee's ability, as observed on your placement, in each of the ten competencies on the Evaluation of Clinical/Professional Competence (ECC) form by providing a rating of pass, referral or fail for each competency, and for the overall placement. These comments will help inform the recommendation that is made to the Board of Examiners.

Qualitative assessment comments are required if a competency is referred or failed, but they are optional if competencies are assessed as passed.

Marking Standards for the Grades

Pass. The trainee's clinical competence is of an acceptable or above standard **for their stage in training** and **with appropriate support and guidance from supervision**. They are able to facilitate and maintain a therapeutic alliance with clients, carers, groups and promote positive working relationships with staff. They can select, administer and interpret psychometric and idiosyncratic assessments, including risk assessments. They can develop and use formulations to prepare an action plan and can reformulate in the light of further information. They can make

[1] A grade of referral cannot be given for the final placement as this is the final assessment of competencies and all must have been met by this stage.

theory-practice links, can draw on therapy model-specific competencies and adapt interventions within differing theoretical models to individual needs. They can conduct appropriate research and use evaluation and auditing procedures to contribute to service developments. They can design communications (written and oral, formal and informal) that are appropriate to the audience, carry them out in a manner that is both timely and accessible, and monitor their effectiveness. They have an understanding of the organisational setting and work collaboratively with other professionals and colleagues, taking initiative to develop the psychological understanding and practices of others. They demonstrate a range of professional attitudes and behaviour, including an awareness of power and socio-political issues, and the need to practice within the HCPC Code of Conduct and Guidance on Conduct and Ethics for Students and enact NHS values. They exhibit an active and continuous commitment to developing self-knowledge and self-awareness in relation to their work with others, and they prepare effectively for, engage in and demonstrate learning from the supervision process. With support and guidance from supervision they meet the guidance of the HCPC Standards of Proficiency. They may have some developmental needs but these are not of significant concern.

Referral. The trainee's clinical competence has failed to reach an acceptable standard for their stage in training despite support and guidance from supervision. They may not have not developed helpful therapeutic or other working relationships, or been able to conduct appropriate assessments. They may have struggled to formulate and reformulate or to make theory practice links in interventions, or to adapt them to individual needs. They may not have conducted required research appropriately. Communications may not have been appropriate to the audience, and the trainee may not have worked well with other professionals and colleagues. You may have had some concerns regarding the trainee's professional attitude, behaviour or values, and their understanding of the organisational context and the responsibilities of their role. The trainee may not have demonstrated sufficient self/relational awareness or may not have engaged adequately in the supervision process. NB This overall placement grade cannot be awarded to a final placement as all competencies must have been met by the end of the course. A final placement with one competency rated as referral, with an overall placement outcome of Pass, would require section F to be completed for the trainee to pass to their new employer. If more than one competency would have been awarded a referral had it been an earlier placement in the course, they must be awarded a fail on this last ECC form and hence the placement given an overall fail mark. All or a proportion of the placement must then be repeated, again without the option of a referral grade. If it is failed again the candidate will have met the criteria for course fail.

Fail. The trainee's clinical competence is below an acceptable standard for their stage in training despite support and guidance from supervision. This applies to direct work with service users and to work within the organisation. **Either** the trainee's conduct has been of significant concern and may have placed service users at risk or been highly unprofessional or unethical and has not improved despite guidance. The supervisor may feel that the trainee's behaviour means that they are not suitable to practice as a clinical psychologist. **Or** the trainee's competence has not improved from a rating of referral on a previous placement.

Guidance

1. The coordinating supervisor should complete the ECC form in consultation with any other supervisors on the placement at the end of each placement (in July of the final placement). Exact deadlines will be provided to the trainee at the beginning of the academic year. These are submission deadlines for the trainee and failure to meet them could result them not passing the placement at that time.

2. In addition, a formative ECC form should be submitted in March/April of the first year to aid the early identification of any areas of difficulty.

3. The following table provides guidance under each competency to be rated on the ECC form to assist supervisors in evaluating the trainee's clinical competence. This is generic guidance, which should be seen as providing examples rather than exhaustive, and due consideration must also be given to the trainee's stage in training when rating their competence. Support and guidance for coordinating supervisors in making the assessment is available from Trust Training Co-ordinators (TTCs) and Course staff. In cases of potential placement failure, it is recommended that coordinating supervisors consult with their TTC and/or another senior colleague in addition to discussing the problems with the trainee's manager at the earliest opportunity.

	PASS	REFERRAL	FAIL
Working Relationships	The trainee demonstrated that they were able to form and facilitate a therapeutic alliance with clients and carers, demonstrating empathy and a respectful attitude. They also showed respect, understanding and a collaborative approach to work with colleagues. They demonstrated understanding issues of power and of oppressive practice. They exhibited skills in maintaining rapport and working with challenges within therapeutic/collegiate relationships. They have shown an awareness of boundary and termination issues.	The trainee often failed to adequately engage clients in psychological work. They demonstrated a significant lack of understanding of the psychological experience of others. They were often didactic in therapeutic style. They demonstrated a lack of awareness of boundary issues. They failed to demonstrate an understanding of the impact of termination issues in therapy. They often had poor therapeutic relationships with clients, families and carers, and did not actively build constructive relationships with colleagues.	Over the course of the placement, the trainee has consistently demonstrated an inability to engage with clients/families/ carers that indicates a major problem in recognising, acknowledging, understanding, and/or being aware of the emotional or psychological state of others. **Or** they have had an inappropriate contact/relationship with a client or family/carer. **Or** they were consistently unable to demonstrate an awareness of the importance of boundary and termination issues. **Or** they consistently failed to show awareness of issues of power to an extent that they have engaged in oppressive practice.

	PASS	REFERRAL	FAIL
Psychological Assessment	The trainee demonstrated that they were able to conduct appropriate interviews, including taking a detailed history and incorporating observation skills. They demonstrated good use of interpersonal skills to encourage active participation of service users in the assessment process. They were able to plan an assessment in the context of wider information relevant to the problem, and select appropriate assessment procedures. They were able to administer and interpret psychometric, formal and idiosyncratic assessment measures. They were able to conduct an appropriate risk assessment.	The trainee has not developed skills of guiding an assessment interview such that relevant information was missing and/or there was a lack of awareness of what important information is required for assessment and/or they were unable to distinguish between relevant and irrelevant information. They often demonstrated a lack of awareness of supporting service users through the assessment process. They struggled to select, administer and interpret assessments despite supervisor guidance. They often failed to notice issues of risk and its importance in assessment.	The trainee has shown a significant lack of development in fundamental assessment such that relevant information was not obtained and procedures were not followed. They repeatedly failed to support service users through the assessment process, undermining them when gathering information. They were unable to adequately select, administer and interpret assessments, despite supervisor guidance. They failed to understand the importance of inclusion of psychometric assessment and its value. They did not demonstrate an awareness of the importance of risk.
Psychological Formulation	The trainee demonstrated that they could hypothesise and use theory and assessment evidence to develop a formulation, and use this to develop a coherent action plan and recommendations for others. They were able to reformulate problems and situations in light of further information. They were able to incorporate individual systems, lifespan and socio-political contexts in formulations. They were able to use psychological formulations with clients to facilitate their understanding of their experience.	The trainee repeatedly struggled to use theory to understand clients' presentations and to develop an action plan based on this. They repeatedly struggled to integrate new information into the client's formulation. They demonstrated a lack of awareness of individual systems and wider socio-political contexts when formulating. They repeatedly struggled to feed back coherent formulations to clients and/or showed a lack of awareness of the importance of formulation in helping clients to gain an understanding of their experience.	The trainee was unable to synthesise information to develop formulations to inform interventions. Theoretical knowledge and theory practice links were absent and the socio-political context was not considered. The original formulation was upheld despite contradictory evidence. They consistently demonstrated a lack of awareness of the need for formulation feedback to clients.

	PASS	REFERRAL	FAIL
Psychological Interventions	The trainee demonstrated that they have knowledge of the empirical basis of interventions, including knowledge and critical appraisal of relevant literature. They were able to competently carry out the procedures in the action plan. They could draw on and apply model-specific competencies in their work. They made theory – practice links and adapted their approach or techniques to the individual needs of clients and carers. They utilised and interpreted appropriate measures and critically assessed the outcome of their work.	The trainee repeatedly struggled to maintain theory-practice links or use model-specific approaches adequately during interventions, including carrying out procedures from the action plan when it was not clinically indicated. They often demonstrated limited knowledge of the empirical and theoretical basis to interventions in their attempts to apply techniques. They demonstrated poor utilisation of measures and/or the use of inappropriate measures.	The trainee was unable to adapt intervention models to individual needs either in terms of the action plan, or how it was used flexibly session to session. They were unable to demonstrate knowledge of the empirical and theoretical basis to interventions. They were not able to adequately assess when further intervention was inappropriate.
Evaluation and quality improvement work	The trainee demonstrated competence to use research and evaluation skills in clinically related or service activity. They were able to plan and organise data collection. They provided coherent feedback to the service and understood their contribution to change and service development processes.	The trainee demonstrated a lack of awareness of department evaluation and auditing procedures They struggled to use research skills to meet service needs. They were disorganised in planning and data collection. They provided incoherent feedback.	The trainee refused to adhere to departmental auditing procedures without explanation. The trainee's own interests dominated over service needs. Data collection was haphazard or not completed The trainee failed to feedback to service despite ample opportunity to do so.

	PASS	REFERRAL	FAIL
Communication and Teaching	The trainee demonstrated good ability to write timely letters and reports of the work undertaken. Reports were clear, comprehensive and concise, expressed the aims of the intervention clearly and demonstrated adequate and careful outcome assessment. They were able to provide coherent oral reports of work undertaken. They demonstrated awareness of their role in engaging the public and colleagues about psychological perspectives, showing good ability to plan and prepare appropriately for both formal and informal teaching (e.g. consider the aims and needs of participants, methods available to support learning and facilitate cooperative engagement). They used appropriate language, were responsive to participants and adapted content accordingly. They monitored the effectiveness of their communication and utilized structured feedback mechanisms, as well as self appraisal.	The trainee's letters and written reports were frequently poorly structured, imprecise, poorly formulated or late. Oral reports were often muddled, confused and incoherent. The trainee demonstrated a high degree of reluctance to take on teaching/training role despite encouragement. The trainee demonstrated consistently poor planning for and appreciation of informal/formal teaching and education. The trainee demonstrated a lack of awareness of the effectiveness of their communication in terms of their engagement, and failed to provide the information required for the audience.	The trainee's oral and written communication either consistently failed to communicate the nature of their assessment, formulation and intervention, or was absent or incomplete despite opportunity and support from the supervisor. The trainee consistently failed to consider the needs of audience or goals of communication in relation to informal/formal teaching resulting in ineffective or inappropriate communication despite guidance. The trainee consistently failed in planning and preparation either due to disorganisation or lack of awareness.

	PASS	REFERRAL	FAIL
Organisational and systems influence and leadership	The trainee demonstrated their ability to work collaboratively with others Including using a consultancy model, supervision or mentoring. They worked with multidisciplinary teams (e.g. meetings, case conferences) to contribute to the development of psychological thinking. They demonstrated an understanding of the organization of the professional setting in which the placement was based and the development of processes involved in the service delivery systems. They demonstrated an understanding of the interface with other services and agencies, relevant legislation and national planning, and the salient issues for clients and their families/carers (including professional practice guidelines). They demonstrated their ability to work with service users and carers to facilitate their involvement in service planning and delivery.	The trainee demonstrated a poor understanding of the contributions of other professionals. They often struggled to manage differences of professional opinion. The trainee frequently needed prompting to seek the opinion or involvement of other professionals or to contribute a psychological perspective themselves. They demonstrated a lack of awareness of the relevance of the organisational context, the psychologist's role in service development and influence in systems.	The trainee demonstrated an inability to consider or value the contribution of other professionals. They were unable to recognise, tolerate or accept differences in opinion. The trainee was unable to recognise when to seek an opinion from/involve other staff. The trainee devalued, dismissed and/or denigrated the experience of partners/ families/carers. The trainee did not appreciate the need to understand/make sense of the organisational context (philosophy, channels and routes of communication, roles and functions).

	PASS	REFERRAL	FAIL
Personal and professional skills and values	The trainee demonstrated professional attitudes (reliable and responsible, open to learn, exhibiting an ethical framework for all aspects of the work). They managed an appropriate case and workload (took responsibility for this and was prepared to negotiate; were able to prioritise; demonstrated a developing ability to take on and plan work after general discussion; recognised when further consultation was necessary; and requested assistance when in difficulty). They recognized and understood inherent power imbalances and how these may be minimized. They worked effectively with difference and diversity in individuals' lives. They demonstrated an awareness of professionals' codes of conduct (including the HCPC code of conduct and guidance on conduct and ethics for students), of NHS values and of local policies and procedures.	The trainee frequently demonstrated an unprofessional attitude (e.g. often late, unreliable and not always open to learning without reasonable explanation, at times has an unconscientious approach). They often demonstrated an inability to recognise when task is beyond their capacity and did not seek support appropriately. They demonstrated reason for concern regarding their ethical framework. The trainee demonstrated a lack of awareness of codes of conduct and local procedures.	The trainee portrayed a reluctance and resistance to developing knowledge and skills. The trainee continued to demonstrate a prejudicial attitude towards a client group, or area of clinical work, or group of colleagues despite supervisor intervention. The trainee was unreliable, irresponsible, and lacked a conscientious approach. The trainee gave little or no importance to confidentiality or obtaining informed consent. The trainee demonstrated an inability to prioritise or manage an appropriate caseload. Despite support, they were unable to recognise when a task was beyond their capacity.
Reflective Practice	The trainee demonstrated a range of personal development strategies. They showed an awareness of power imbalances and how these impact on others' lives and effect the work, and of how their own personal history influences their work.	The trainee frequently demonstrated a lack of self awareness in relation to the importance of personal development strategies and/or issues of power imbalance. There was either a lack of understanding of the relevance or an avoidance of thinking about issues for themselves and service users. Or they frequently struggled to distinguish the clients' needs and their own.	The trainee demonstrated a significant of lack of insight into the impact of themselves on others, power issues and/or their own vulnerabilities. They had poor personal development strategies and/or lacked awareness of the importance of the importance of their own fitness to practice. The trainee consistently failed to distinguish between own personal history from that of the client(s).

	PASS	REFERRAL	FAIL
Use of supervision	The trainee demonstrated their ability to understand the roles of both supervisor and supervisee in the supervision process. They prepared for supervision and engaged in the supervisory process. This included asking for access to knowledge and learning, giving and receiving feedback and constructive criticism, and willingness to join in a shared debate, in supervision where there is an emphasis placed on mutual value and respect. They utilised supervision to discuss support issues and needs (including the knowledge and awareness of the boundaries between supervision and personal therapy).	The trainee was often late for supervision and continued this practice even when it was raised. They were consistently poorly prepared for supervision. They regularly demonstrated reluctance to discuss clinical work or be observed. They demonstrated an inability to think outside one theoretical model and were often defensive. They were unable to reflect on how their personal attitude was directing consideration of the clinical work. They experienced significant difficulty in receiving feedback and were often defensive.	The trainee persistently failed to attend supervision sessions. They were unwilling to discuss clinical work or allow direct or indirect observation. They demonstrated extreme defensiveness or rigid adherence to one theoretical model. They seemed unable to consider that personal attitudes were directing consideration of clinical work. They behaved in an inappropriate or unprofessional way towards the supervisor (see the HCPC guidance on conduct an ethics for students).

4. The overall evaluation of clinical and professional competence the trainee has demonstrated on placement is made to the course by the coordinating supervisor(s) and allows for three choices:
   a. A "Pass" indicates that the trainee has reached a satisfactory level of competence as appropriate to his/her current stage of training. Trainees who have been rated "Pass" on every area of competence, or rated "Referral" on no more than one competency in section B should be given a "Pass" on the overall evaluation.
   b. A "Referral" indicates that there are more concerns than would be expected at this stage of training about the trainee's clinical competence, and that these concerns need to be improved upon in future placements for the trainee to be deemed clinically competent. Trainees who have been given a rating of "referral" on two of the competencies in section B should be given a "referral" on the overall evaluation. Please see note above with regard to the exception of the final placement.
   c. A "Fail" indicates that the trainee is having a serious and significant amount of difficulty in developing the competencies appropriate to this stage of training. Trainees who have been given a rating of "referral" on three or more competencies in section B, or a "fail" on any one competency, should be given a "fail" on the overall evaluation.

5. Following completion for the form, the trainee should have the opportunity to read it and add their comments on what the supervisor has written. The coordinating supervisor and trainee should then meet to discuss the form and

write the feedback that is to be passed to the supervisor on the next placement together.

6. After receiving and discussing the ECC form, the trainee also completes a practice learning feedback form, the placement resource audit and the Practice Learning Portfolio which logs the work undertaken on placement and records the trainee's model-specific competency development. All these documents are read and signed electronically by the coordinating supervisor.

7. The trainee will then submit the ECC form and the rest of their practice learning documentation electronically to the training course. The trainee's line manager will read the ECC form, the Practice Learning Portfolio and the trainee's feedback forms and, on the basis of this and their knowledge of the trainee and the placement, decide whether they concur with the supervisor's recommendation. If they do not agree the manager and coordinating supervisor should meet to produce a resolved recommended grade. If they are unable to resolve a grade then the information will be passed to a third assessor, normally a Course Director.

8. The recommended grade will be presented at the Board of Examiners. In the event of a disagreement between the line manager and the coordinating supervisor, the third assessor's recommended grade and the relevant information will be presented in order for the Board to make a final decision about clinical competence.

9. Trainees will be informed of the results of their evaluation of clinical competence following the meeting of the Board of Examiners.

10. In the event of a trainee receiving a referral on one or more competencies in their Evaluation of Clinical Competence form, they will be required to demonstrate significant improvement in those competencies on the next placement. This will mean that previously referred competencies can only receive a fail or pass grade on the next placement. Overall referral of an Evaluation of Clinical Competence constitutes referral of one assessment.

11. In the event of a trainee receiving an overall fail of their Evaluation of Clinical Competence, this will constitute failure of one assessment. The trainee's line manager will recommend a course of remedial action which may involve a repeat of the full placement (i.e. the placement days will be deemed not to have counted to the overall number required), or additional placement days to address particular aspects of competence (partial placement), or specific opportunities to develop particular competencies on the next placement. The next assessment of these competencies can only award a pass or a fail.

Ref: Assessment Handbook/Clinical Competence/2018 revised October 2021

Practice Learning Portfolio:

Part A1 – Placement Log of Clinical Experiences

Trainee...

Stage of training:

1	2a	2b	3a	3b

Client No: .... *(number consecutively and keep own reference list)*

Sex:		F M non-binary
Age:	<5	5-11 12-18 19-24 25-34 35-44 45-54 55-64 65-74 75+
Ethnicity:		w british – w irish - w other - white/caribbean - white/african-white/asian - white/other – indian – pakistani – bangladeshi – asian other – caribbean – african - black other – chinese - other
Class:		1.1 1.2 2 3 4 5 6 7 8
Religion:		Christian Buddhist Hindu Jewish Muslim Sikh Other N/a

Problem area*:	biol/health cog function emotional/behavioural social/interpersonal
Problem duration:	<1 year <5 years <10 years >10 years
Problem severity:	mild moderate severe
Challenging beh:	no yes
Life events*:	bereavement/loss health abuse trauma other (specify)
Disabilities*:	communication learning mobility sensory other

Role*:	observation independent work joint work
Activity:	assessment only assessment & intervention intervention only
Mode of work*:	individual couple family group
Main type of work*:	direct indirect-carer indirect-staff
Total direct contact time:	<2 hours <5 hours <10 hours <15 hours <25 hours 25+ hours
Total liaison/consultation time:	<2 hours <5 hours <10 hours <15 hours <25 hours 25+ hours
Assess method*:	interview observations self-report tools standardised tests neuropsychological tests
Model applied*:	Behavioural CBT Psychodynamic Systemic Community/Critical Integrative CAT Other (specify)
Service setting*:	primary care secondary in-patient/residential Other eg 3rd sector (specify)

***** *Tick each category that applies*

Practice Learning Portfolio:

Part A1 – Individual Record of Client Contact

Trainee...

Stage of training:

1	2a	2b	3a	3b

Client No: .... *(number consecutively and keep own reference list)*

Sex: F M non-binary
Age: <5 5-11 12-18 19-24 25-34 35-44 45-54 55-64 65-74 75+
Ethnicity: **White:** White British (Eng/Welsh/Scot/NI) - White Irish - White Gypsy or Irish Traveller - Other White (describe)
Mixed/Multiple ethnic groups: White and Black Caribbean - White and Black African - White and Asian - Other (describe)
Asian/Asian British: Indian – Pakistani – Bangladeshi – Chinese - Other Asian (describe)
Black/ African/Caribbean/Black British: African – Caribbean - Other Black/African/Caribbean (describe)
Other ethnic group: Arab - Other (describe)
Class: 1.1 1.2 2 3 4 5 6 7 8
Religion: Christian Buddhist Hindu Jewish Muslim Sikh Other N/a

Problem area*: biol/health cog function emotional/behavioural social/interpersonal
Problem duration: <1 year <5 years <10 years >10 years
Problem severity: mild moderate severe
Challenging beh: no yes
Life events*: bereavement/loss health abuse trauma other (specify)
Disabilities*: communication learning mobility sensory other

Role*: observation independent work joint work
Activity: assessment only assessment & intervention intervention only
Mode of work*: individual couple family group
Main type of work*: direct indirect-carer indirect-staff
Total direct contact time: <2 hours <5 hours <10 hours <15 hours <25 hours 25+ hours
Total liaison/consultation time: <2 hours <5 hours <10 hours <15 hours <25 hours 25+ hours
Assess method*: interview observations self-report tools standardised tests neuropsychological tests
Model applied*: Behavioural CBT Psychodynamic Systemic Community/Critical Integrative CAT Other (specify)
Service setting*: primary care secondary in-patient/residential Other eg 3rd sector (specify)

***** *Tick each category that applies* This record should not be stroed electronically