Department of Psychology

Doctorate in Clinical Psychology

(2016– 2017)

Programme

Handbook

This handbook and the regulations therein relate to 2016-2017 only

and will be updated on an annual basis. Details may vary, usually after staff/student consultation.

This handbook is available in alternative formats if required[1].

[1] This handbook should be read in conjunction with other programme documentation, including the separate Research Handbook and the programme and unit specifications/regulations, which can be found in the appendices. If in doubt regarding what applies, trainees should discuss with their Cohort Tutor or the Course Directors. Clinical placement supervisors will be provided with a version focussing on their role. Online versions of the handbooks including updates can be found on Moodle at http://moodle.bath.ac.uk

1 Introduction and general information

The Northern area South West Region clinical psychology doctoral training Programme, based at the University of Bath started in October 2011. As a relatively new Programme it has been and continues to be developed to reflect recent advances and developments not only in Clinical Psychology, but also in adult learning strategies and supervision. The current annual intake is 14 students.

This handbook is meant to supplement the programme specification, unit descriptors, programme regulations and other University of Bath documentation, which is included in full in Appendices A-P. Trainees are expected to meet standards set by the programme in clinical, research and academic areas, which include a range of specific assessments in these areas. These assessments are set out in appendix D. There is a separate Research Handbook which provides more detailed guidance for aspects of the research that is conducted as a key part of the programme, which is classed as a Postgraduate Research Degree.

The primary aim of the Programme is to select and train highly competent Practitioner Clinical Psychologists who will not only meet the manpower needs of the profession (and therefore the needs of health and social care providers in the region and elsewhere) but who will also embark on a career which will further the aims of the profession. Like all clinical psychology training Programmes, the programme is designed to enable trainees to apply the methods and findings of the science of psychology to both clinical work and clinical research, consistent with the British Psychological Society Professional Practice Guidelines (1995). The training Programme also recognises that the application of such methods requires more difficult to define clinical skills which can be applied across a wide range of settings. The Programme therefore emphasises the practice of professional clinical psychology as involving a skilful blend of *clinical science* and *clinical art*. The core values, ethos and philosophy of the Programme are outlined below in section 3 of this handbook.

1.1 Professional recognition

Health and Care Professions Council

This programme has been approved by the Health and Care Professions Council, the statutory regulator for Practitioner Psychologists in the UK, as an education provider for Clinical Psychology. It is a legal requirement that anyone who wishes to practise using a title protected by the Health Professions Order 2001 (e.g., Clinical Psychologist) is on the HCPC Register. For more information, please see the HPC website at: www.hcpc-uk.org. Those completing the programme are eligible to apply for registration with the HCPC as a clinical psychologist; once registered they are able to described themselves as "Practitioner Clinical Psychologist".

British Psychological Society

The programme is also accredited by the British Psychological Society. The Society is the professional body responsible for developing and supporting the discipline of psychology and disseminating psychological knowledge to the public and policy makers. It is the key professional body for psychology

and psychologists. Successful completion of the programme confers eligibility to apply for Chartered Membership of the Society and full membership of the Division of Clinical Psychology.

British Association for Behavioural and Cognitive Therapies

Level 2 accreditation for BABCP registration has been approved. This means that upon completion of the programme and application to the BABCP graduates will be able to describe themselves as BABCP Accredited Practitioners.

Other accreditations

The programme emphasises empirically grounded approaches to the understanding and management of psychological difficulties and related issues, which means that in practice the majority of the knowledge, understanding and skills gained in the course of training will be Cognitive-behavioural, as will the research components. The second treatment modality taught by the programme is Systemic (Family) Therapy.

The Association of Family Therapy (AFT) has recently approved the foundation level programme for accreditation. This applies to the cohorts admitted in 2014 and at least 5 years beyond, at which point reaccreditation will be sought. AFT Intermediate Level approval is being sought for the 2015 cohorts onwards; the accreditation exercise will take place in late 2016 and, if obtained, will apply to the same cohorts as foundation accreditation, which is a prerequisite for the intermediate level.

The Clinical Psychology Doctoral Training Programme works in close partnership with NHS trusts in the South West region, including close links with the clinical services in Mental Health, Acute Hospital Trusts and social enterprises, which provide excellent training placements. We do not currently work with private health care providers.

This handbook includes details of matters specific to the Clinical Psychology Training Programme, and is intended to supplement the information on a range of matters both from the University of Bath and the NHS Trust responsible for the employment of trainees, Taunton and Somerset NHS Foundation Trust.

1.2 University of Bath

1.2.1 Changes in your circumstances/registration status/accessing University email

Note that only registered students may use the University's facilities, such as email and the Library. You will be asked to register online at the start of your programme of study and then to re-register at the start of every academic year thereafter until you have completed your programme. It is a requirement of University regulations that you register when asked to do so.

University Email Account

The University will often communicate to you a range of important matters including registration, unit-enrolment, assessment, and degree ceremonies, via your University email account. So that you do not

miss out on (and as a consequence fail to act on) important information, it is a University regulation (Regulation 1.3) that you access your University email account regularly, even if you are out on placement or study abroad. **You therefore have a responsibility to ensure that your University email account can receive incoming mail and that you read your email regularly.**

NHS Email Account

During your first placement you must set up an NHS.net email address, as Trusts may restrict access to external websites and email for security reasons.

You can set this up yourself but you must be on a NHS PC at the time. This website has info about getting set up with an email account:

http://systems.hscic.gov.uk/nhsmail

After you have done this you should contact the Taunton NHS IT helpdesk (01823 287728) to get a password and get the account activated. If you have worked for the NHS previously you would need to let the IT helpdesk know that you should be down as a "leaver" from whichever Trust you worked for and need now to be set up as a "joiner" with Taunton NHS.

If the Trust your placement is with has offered to organise this for you, please let them do that. Otherwise, please set up the NHS.net email for yourself. Once you have the email address you should let the admin team have it so that we are able to contact you whilst you are on placement.

You can collect your **post** from the trays located in the trainee base. Any mail addressed to you care of the University or the Department, internal mail, and messages from members of staff will be placed there, and you can also leave messages there for other students. There is also a tray for you to leave post for the admin office.

Personal circumstances

You must ensure that the University holds your correct, up-to-date, personal and academic details within SAMIS. If you change your address – either your semester-time or home address – please ensure that you update your details online at http://www.bath.ac.uk/registration-on-line/.

In addition, it is extremely important that the Programme team have your contact details, including home address and home and mobile numbers and details of next of kin, as the programme also administers key aspects of your NHS employment contract.

If you change your name, you will need to complete form CC1 (*Notification of Change of Student's Personal Circumstances)* and provide valid proof of the change. Please speak to your Department or Faculty/School administration, or Student Services in the Roper Centre, for a copy of the form and advice.

You should also contact Alan Taylor at Taunton and Somerset NHS Trust (alan.taylor@tst.nhs.uk) to inform him of changes of name or address.

1.2.2 Academic circumstances

If you are considering suspending your studies, transferring from one programme to another, or withdrawing from your programme, please discuss your situation with the Director of Studies, Paul Salkovskis. He will be able to advise you on an appropriate course of action.

2 Contact details

Programme Address:

University of Bath Department of Psychology
Clinical Psychology Unit and Research Centre
10 West Level 3
University of Bath
Claverton Down
Bath BA2 7AY

Telephone no: 01225 385506
General email: bathcp-admin@bath.ac.uk

Trainee Base: 10 West, 3.41
Telephone no: 01225 383603

The Clinical Psychology Programme team is part of the Psychology Department, which is based in Building 10 West on the first three floors.

Head of Department: Professor Gregory Maio
Department of Psychology, 10 West,
University of Bath
Bath BA2 7AY

If you need to contact any member of staff or student, you can check for their details by using the **person finder facility** at http://www.bath.ac.uk/contact/

Programme team

Programme Director and Research Director	Professor Paul Salkovskis
Clinical Director/Deputy Programme Director	Dr Ailsa Russell
Academic Director	Dr Catherine Hamilton-Giachritsis
Clinical/Admissions Tutor	Ms Lorna Hogg
Clinical Tutors	Dr Catherine Butler
	Dr Jo Daniels
	Dr Cara Davis
	Dr Cathy Randle-Phillips
	Dr James Gregory
	Dr Emma Griffith

	Dr Maria Loades Dr Elizabeth Marks Ms Josie Millar Dr Megan Wilkinson-Tough
Head of Department and Chair of Board of Examiners	Professor Gregory Maio
Programme Manager	Rachel Nee
Programme Administrators	Ewan Soubutts Julia Warburton
Clinical Psychology Administrator	Catherine Woodman
Graduate School Manager, Faculty of Humanities & Social Sciences	John Brice

3 Programme Context and Background

The Doctorate in Clinical Psychology (DClinPsy) is a full time Postgraduate Research Degree, in the Department of Psychology; the Psychology Department is currently headed by Professor Gregory Maio. As a trainee you are registered as a full time postgraduate research student of the University. Throughout your training you are also a full-time employee of the National Health Service, for employment purposes your employer is Taunton and Somerset NHS Foundation Trust.

On placement, teaching, research and study days you are expected to adhere to standards set by the Health and Care Professions Council (HCPC) Guidance on conduct and ethics for students (http://www.hcpc-uk.org/publications/brochures/index.asp?id=219) and the professional standards laid down by the British Psychological Society (BPS): http://www.bps.org.uk/what-we-do/ethics-standards/ethics-standards. Please refer to these documents or consult the Programme team if uncertain as to how these standards apply.

Most of the academic teaching and clinical supervision is carried out either by the core Programme team, staff from the University Department of Psychology or by clinical psychologists working in the local NHS Trusts. Teaching sessions are held in 10W unless otherwise notified.

3.1 Programme Philosophy, Structure and Content

The Programme aims to train clinical psychologists to high levels of competence in the academic, clinical and research domains. Graduates will not only possess the range of expected competencies as clinical psychologists but also meta-competencies, meaning that they will be trained to be capable of extending their competencies into areas not directly dealt with by their training or where existing knowledge does not provide any specific indications of how to apply psychological principles to a particular clinical domain.

Trainees will learn to become highly capable “scientist practitioners”. The Programme ethos emphasises the importance of a clear understanding of how psychological theory can be applied to clinical problems by attention to the empirical grounding for processes, strategies and techniques in the work of clinical psychologists. An explicit feature of this approach is the recognition that competent practitioners are able learn and develop a skilful blend of the scientific basis of clinical psychology (“clinical science”) with reflective practice and personally adapted approaches (“clinical art”). This type

of development requires close co-ordination between Programme teaching staff and placement supervisors.

Learning, teaching and training is “research led”. Given the present state of the field, this means that in terms of psychological treatment training, the main therapeutic approaches used will emphasise the full range of evidence based and empirically grounded approaches to understanding and treatment of clinical problems. This in practice will mean behavioural, cognitive and cognitive behavioural approaches together with empirically grounded interpersonal and systemic approaches.

The training provided by the Programme thus draws upon the full range of empirically grounded psychological theory, not only in psychopathology but also in other areas of psychology such as social and developmental psychology in order to allow consideration of context and lifespan development. The emphasis in assessment and therapy will be person-centred in the broad sense mostly within the framework provided by Cognitive-behavioural and behavioural theory and the related assessment and therapeutic approaches. The Programme also has major strengths in Clinical Health Psychology and it is expected that some students will develop this specialisation throughout their training whilst gaining core competencies across other specialties. Subject to special considerations (see Section 16.4 below), Clinical Health Psychology will be defined as an additional core placement in addition to the more usual BPS recommended placements, *viz:* Working Age Adults, CAMHS, Older Adults and Learning Disabilities. A range of other specialisations can also be developed, based on trainee career aspirations and NHS manpower requirements, availability of appropriate expertise and supervisory capacity. Such specialisation can begin relatively early in the Programme. Assuming sufficient development of core professional competencies and expertise, specialisation will be emphasised should the trainee wish during the third year of the Programme through elective placements.

The third year will in general emphasise the development of higher level competencies and meta-competencies, including supervisory, management and leadership abilities, with a progressive shift from first to third year from supervision towards mentoring and peer supervision and supervising others.

The Programme emphasises the integration of University based theoretical and skills training with clinical practice by using a range of research led teaching and learning strategies including lecturing, workshop based training, problem based-learning, small group sessions and so on, matching the topics to be taught to the methods of teaching. Some academic work will also be carried out as part of clinical placements, with integrated clinical/academic teaching being delivered by supervisors.

The clinical/research/academic integration will be enhanced by teaching which will be conducted both by Programme staff (all of whom will be clinically and research active) and clinical psychologists from across the region and beyond. From the beginning of the Programme, some teaching days will take place in NHS settings elsewhere in the region as ‘away-days’ hosted in a variety of sites. These sessions will also be an opportunity for trainees to familiarise themselves with the range of NHS and social care services across the region.

The programme will ensure that trainees develop professional roles characterised by being collegial, incorporating an understanding of the roles and approaches of professional colleagues in order to

enable good working relationships to promote the psychological well-being of people accessing our services.

An awareness of the needs of people who access our services, and the needs of their family / friends, is integral to the course. This will be discussed with you during Induction Week and in various other activities during the course. An awareness of the needs of the wider community is also emphasised in the programme. The programme training and placements are based on an understanding of the importance of equality, diversity and empowerment.

The Programme regards trainees as adult learners and will match the requirements of local, regional and national organisations for competent qualified professionals with those of a learner-led model of teaching, training, and learning. Such an enterprise requires attention and responsiveness to feedback both from the trainees and from placements and regional representatives. An important part of this is the substantial representation of both trainees and regional stakeholders, particularly supervisors, on the committees which direct Programme functions.

The Programme seeks to help trainees develop enthusiasm for learning, development and research in the field. Questioning and in depth investigation will be encouraged; trainees will be helped to develop personal areas of interest in terms of clinical, academic and research focus over the entire period of their training in ways which are intended to allow and equip them to continue to develop professionally, clinically, academically and in research once they have qualified.

4 Administrative Structure of the Programme

The programme's academic staff are all active in clinical and clinical-research domains. Although staff have specific responsibilities as outlined below, these responsibilities will frequently be delegated to other staff, with the oversight remaining with the responsible person.

The Programme is led by a ***Programme Director***, Professor Paul Salkovskis, who is also the Programme Research Director. The Programme Director has overall responsibility for the running of the Programme. Within the context of the University of Bath, this role is also defined as Director of Studies for the Programme.

The ***Research Director*** (also Professor Salkovskis) is responsible, together with the lead Research Tutor (Dr James Gregory), for implementing the research components of the training Programme. This includes not only the main research project but other components of the research portfolio.

The ***Academic Director*** (Dr Catherine Hamilton-Giachritsis) is responsible, together with the other clinical academic tutors for the academic components of the programme including the curriculum and all teaching. She is also Disability Lead; any longer-term health issues should in the first instance be discussed with her.

The ***Clinical Director*** (Dr Ailsa Russell), together with other clinical tutors is responsible for all aspects of the clinical placement component of the Programme and key aspects of the clinical component of training both in University and on placements. She is also the Deputy Course Director.

The ***Programme Manager*** (Rachel Nee) leads the Programme administrative team, which draws upon both Departmental and Faculty resources. The Programme Manager is supported by the *Programme Administrators* (Ewan Soubutts, Julia Warburton and Catherine Woodman) who have a range of responsibilities regarding programme administrative matters.

There are twelve Clinical/Academic/Research Tutors, who have overlapping but somewhat distinct roles. Almost all clinical tutors are, in addition to being academic Programme staff, active in NHS clinics and research.

There are three ***Cohort Tutors***, each of whom is responsible for a particular trainee cohort for the first six months of their training period. The cohort tutor provides a point of support and advocacy for the allocated cohort of trainees as they begin their training programme. Cohort tutor for the 2016 cohort is Lorna Hogg.

The ***Lead Research Tutor*** (Dr James Gregory) manages aspects of the research components of the programme working closely with the Research Director, research team and research supervisors. This tutor has an important role in ensuring liaison with clinical services, clinical supervisors in placements where research will be conducted and research supervisors based outside the University.

The ***Admissions Tutor*** (Ms Lorna Hogg) is responsible for overseeing the admissions and selection process liaising with the Programme team and regional leads and supervisors.

The ***Trainee Support Coordinator*** (Cathy Randle-Phillips) is responsible for organising the personal support tutor system which is based in the region, with personal support tutors being drawn from the range of supervisors in the region. This tutor will also have oversight of other aspects of student/trainee support, including the "buddy" system.

Programme post holders are usually University employees with honorary NHS contracts.

4.1 Programme Administration Committees

Committee Structure and Membership:

The programme has a number of committees. Each cohort nominates representatives for key programme committees.

For an up-to-date membership list for each committee, please see the 'General information for Trainees' page on Moodle.

Clinical Psychology Programme Committee

Is responsible for the oversight of the development and delivery of the Doctorate in Clinical Psychology programme. This Committee will consider any recommendations or proposals brought by other committees of the programme and will ensure effective liaison between the programme, the department of Psychology and regional stakeholders. Its membership includes Senior Departmental and Programme Staff, Regional/Trust Staff, People with personal experience and Trainees.

Admissions Committee

This committee has oversight of the admissions process for the Programme including the description of the Programme in the Clearing House materials and website. It will define the way in which applicants move through the application and selection process. It will be responsible for recommending to the programme committee shortlisting and selection criteria. It will recommend the structure of interviews and other selection procedures. It will also recommend the way in which places are offered and how these offers are subsequently managed.

Curriculum and Research Committee

This committee will operate in two ways. Initially, it is responsible for recommending to the programme committee the structure and content of academic teaching across the three years of the programme. To do this the committee will identify the overall structure and then further delegate particular time periods to limited life sub-groups, for example, specialist teaching in CAMHS, learning disability, health psychology and so on. The committee will match the detailed teaching to learning objectives in order to ensure the appropriate levels of quality. Where necessary it may recommend adjustments in the learning objectives, which must then pass to the Programme committee who can recommend changes to the appropriate University Committees. The committee will keep the teaching under review on an annual cycle based on trainee feedback and expert opinion regarding whether the teaching reflects both best practice and best evidence.

This committee will also oversee the research component of the Programme including all of unit seven (research) and the research components of other units including both academic and placement units. The committee will recommend to the programme committee procedures and guidelines for research assessments including case studies carried out on placement. The committee will also be responsible for ensuring appropriate supervisory arrangements are in place linking both regional and university supervision. The committee will make recommendations regarding the suitability of specific projects; for some of these it may delegate to a sub-committee(s).

Clinical Practice and Placement Committee

This committee will oversee the development and implementation of guidelines for trainees on placement by making recommendations to the Programme Committee. It will also be responsible for the development and oversight of a placement allocation system based on the trainee needs assessment. The committee will review the suitability of placements and receive and act upon placement feedback both by and about trainees and supervisors. The committee will make other recommendations to the programme committee regarding placements, placement documentation

and the implementation of Programme processes on placement. This committee will make recommendations regarding the suitability of both placements and supervisors for the clinical Programme, taking into account BPS and HCPC requirements. It makes recommendations in conjunction with the North of Region Supervisor's Committee. (The North of Region Supervisor's Committee is not a formal programme committee but a valuable forum for the programme to engage with our regional supervisors and is hosted at the University of Bath.)

Programme Processes Working Group

This group will be responsible for ensuring the smooth running and management of all aspects of the Programme. It will recommend any major changes to the Programme committee. Feedback from programme staff, trainees and regional supervisors will be sought at regular intervals in order to modify processes where appropriate.

Staff-Student Liaison Committee

Staff/ student liaison committee is the main official channel of communication between staff and students. Student representatives are elected annually through online elections run through the Students' Union. The SSLC provides an annual report on issues arising from its meetings to the University Learning, Teaching and Quality Committee.

Programme Executive Group

The purpose of this group is to implement decisions made by the Programme Committee and all other committees as required. It is composed of all programme staff.

People with Personal Experience Advisory Group

The role and purpose of this committee is to advise on and promote the involvement of people with personal experience of the conditions that Clinical Psychologists treat, across all areas of the Bath Doctorate in Clinical Psychology.

5 Programme Processes

5.1 Practical details regarding timings and time management across units

The programme is full-time. There is no part-time option. Appendix C shows the timings of units.

As part of Unit C1 trainees will make an initial placement visit on 11 October. The remainder of your time during October will be spent in teaching, with some private study time. From week 5 of the programme you will spend three days a week in teaching (Wednesday to Friday) and two days in placement. From week 9, this will move to two days per week on teaching at the university (Thursdays and Fridays), with the remaining balance of time spent on placement. From that point forward, practice placements will typically be three days a week with two days a week for teaching, study and research, although there may be minor variations in this pattern from time to time to accommodate particular events.

In order to meet the requirements of relatively longer treatments in some specialties, some “tapering in” and “tapering out” of clinical placements may be arranged between the trainee’s university tutor and the placement supervisor. “Split” placements, where the trainee is doing more than one placement at the same time (e.g. 1 placement day per week in CAMHS, two days per week LD) are possible and may be helpful, provided the practicalities are arranged in advance with all concerned. However, these will not be the norm, and will require careful planning to ensure the quality of placement and trainee experience, and require approval from the Programme team, with the clinical practice and placement committee being notified.

The taught elements of the programme comprise a mixture of lectures, small groups, seminars, tutorials, problem based learning (PBL) and workshops with some on-line learning and self-directed study also incorporated as appropriate. Topics will include those cutting across specialties as well as the main clinical areas trainees are required to work in including:- adult mental health, psychology and psychiatry of childhood and adolescence, neuropsychology, intellectual disability, psychology of older adults, health psychology and behavioural medicine. The Programme continually seeks to innovate in terms of teaching and learning and continues to develop new and better ways of helping trainees develop their knowledge and understanding and learn clinical, academic, research and transferable skills.

The Programme will organise debates on clinically relevant topics, with wider participation from the region and the university and, where appropriate, from others including external supervisors. However, the first debate undertaken by each cohort will usually be restricted by invitation by agreement with that cohort. The debates are intended to be both intrinsically interesting and an exercise in team working and strategic thinking. A small group of trainees will be convened for each debate, joined by an expert from the Programme or from the region who meets with them briefly. An explicit part of the role of the expert is to evaluate team working abilities of the trainees; these observations will be fed back to the trainees, and will form part of the University assessment.

The debate itself will not be evaluated as part of the Programme. Each debate will be led by at least one trainee proposer and respondent. Trainees will if appropriate be paired with qualified/expert seconders for the purpose of the debate; this seconder can include people with personal experience, other professionals and so on from time to time. Debate topics will be assignments which trainees are expected to prepare for in a team context. See section 6.11 for further information about debates.

Some year group teaching days will be held in regional centres away from the University. These will be regular teaching/workshop/skills training sessions. The days will be planned to allow the teaching sessions to be delivered by clinicians local to the site visited; where appropriate, these will be combined with the opportunity to visit specific facilities in the location concerned, and the opportunity to meet with staff in the local department. Given the geographical extent of the region, these days will allow the development of closer links across the region.

5.2 Placement configuration and start and finish times

Placements C1 (Working Age Adults) and C2 (Older Adults/Later Life) are fixed and sufficient experience must be gained to enable progression to Year 2.

Placement 3 will be CAMHS/LD (combined or separate).

Placement 4 will be CAMHS/LD (depending on placement 4).

Placement C5 will be Clinical Health Psychology unless otherwise agreed; it can be elective as C6 below.

The final placement (C6) is elective and may, with the approval of the Practice and Placements Committee, be combined with a preceding placement to make a full 12 months placement.

It may be possible, on the basis of an individual's Personal development plan and training needs assessment to configure the placements beyond placement 3 with some degree of flexibility. However, such an arrangement would be considered on an individual basis and require sufficient justification and may not always be feasible even if desirable.

Research skills are an important part of training, with unit R1 (research training) beginning in October of the first year, then, on completion, moving to R2 (full research) for the remainder of the programme. A requirement for award of the Doctorate in Clinical Psychology is completion of a portfolio of written material, mostly in the format consistent with publication or submission suitable material. The research portfolio consists of a literature review, main research project, a service related/improvement project and a connecting narrative. It is supplemented by the case study portfolio, comprising of five case studies being taken from clinical placement, *at least two of which* must be conducted and presented as Single Case Experimental Designs, four have to be CBT cases and have CTS-R assessment to be BABCP compatible. The research portfolio should normally have been submitted by mid-May in the 3rd or final year of training.

5.3 Supervision

Clinical experience and supervision are provided in accordance with the requirements of the British Psychology Society (BPS) and the programme is accredited by the BPS. We follow the BPS recommendation that trainees should complete clinical placements in 4 core areas; mental health of working age adults, child and adolescent psychology, intellectual disability and mental health of older adults/later life. At the same time, this structure is used as a basis for acquiring clinical and other competencies, the assessment of which forms a major part of the placement (C) units.

In addition, it is intended that supervision (taken as a whole over the period of the entire Programme) will meet the requirements of the British Association for Behavioural and Cognitive Psychotherapy (BABCP) for a Level 2 Cognitive-Behavioural Therapy training, and will, through the same route, be compliant with training and skills requirements of Increasing Access to Psychological Therapies (IAPT) services, so that graduates will be able to work in such services without additional training. The programme is accredited at Level 2 by the BABCP. To ensure trainees satisfy the minimum requirement for BABCP accredited supervision over the course of the training, additional specialist supervision will be provided by regional supervisors (who are BABCP accredited) in the final year of training. This will consist of monthly, locality based supervision groups which will take place during placement time and will be monitored by the BABCP accredited programme staff.

Further supervision requirements may be introduced in line with pending Association of Family Therapy Intermediate Level Accreditation requirements.

5.4 Attendance

Attendance at all teaching and placements is mandatory and attendance will be monitored through registers or other appropriate means. If for good reasons you anticipate being unavoidably absent from either training days or placements, you should report your absence and the reasons for it beforehand to the programme admin team and your clinical tutor, not later than the day of absence. Usually you should seek approval for such absence from your clinical tutor. The programme will make appropriate arrangements to allow you to catch up with missed material, such as the use of the University's "Panopto" recording system. For this reason, ample notice must be given for any planned absences. Where absence is from clinical placement, you must let your supervisor and the admin team know and, where possible, ensure that they are able to deal with clinical commitments at the placement. All absences must be communicated by phone (01225 385506) and by email (bathcp-admin@bath.ac.uk)

In most instances, absence from Programme elements would be required to be made up at a later date. It may be possible in some instances to record training sessions for a trainee who is ill or otherwise unavoidably absent, especially if prior notice is given. However, it may sometimes be the case that the trainee will be required to participate in a further training session in order to make up for missed elements, possibly in subsequent years.

Please note that the Programme team is required to notify the central Student Records and Examinations Office on a quarterly basis of all trainee absence and leave. The Compliance Team will update your student record on SAMIS. In the case of sickness absence, they will only be notified that this occurred, and will not be given any further information about the nature of the absence. However, as all students are also NHS employees, NHS HR sickness procedures as set out below must be strictly adhered to.

For further information on University attendance policies please see the 'General Information for Trainees' page on Moodle.

5.5 Handouts and other materials

Programme materials including handouts, PowerPoint presentations, and, where appropriate recommended reading will be placed on Moodle so that they can be readily accessed. (http://moodle.bath.ac.uk/)

5.6 Moodle

Moodle is the Virtual Learning Environment (VLE) used at the University of Bath. It is used by academic departments to support learning and teaching at programme and unit level. It provides a platform for the delivery of resources and online activities, and can also support student interaction and collaboration.

Programme materials including handouts, PowerPoint presentations, and, where appropriate, recommended reading will be placed on Moodle so that they can be readily accessed. (http://moodle.bath.ac.uk/). The programme timetable contains links to the relevant teaching pages on Moodle.

A list of the Moodle pages relating to the programme/year will appear at the side of the page under 'My courses'.

In addition to pages with teaching, research and placement information there is a General Information for Trainees page which contains

- Handbooks
- Timetables
- Deadlines
- Details of loan arrangements for test materials
- NHS HR information; expenses, leave policies and procedures etc.
- Staff-Student Liaison Committee
- Other related information

Other general pages, not specific to the programme, include information on the' Academic Integrity Initiative', 'Research Integrity Training and Test' and 'Psychology Ethics' and we require trainees to be familiar with these. Indeed, completion of the Academic Integrity and Research Integrity online courses and tests are compulsory and must be completed by all trainees within their first few weeks of the course.

If 'Psychology Ethics' is not listed in 'My Courses' , go to 'All courses', select 'Psychology' from the 'Faculty of Humanities & Social Sciences' and then select 'Psychology Ethics'.

Interactive features of Moodle include the Discussion Forum and areas for submitting documents and assignments. Programme staff monitor these forums and will respond to specific queries.

Support for Moodle can be found at: http://moodle.bath.ac.uk/faq/category/43/student-support.html

All assessed pieces of work should be submitted via Moodle. In turn, your marks and scoresheets (including comments) will also be uploaded to Moodle for you to access.

5.7 Use of Laptops in Teaching Sessions

We recognise that many trainees will wish to use laptops in teaching sessions to aid their learning in taking notes during teaching sessions, however we need to be mindful that this does not detract from the learning experience of the group. Following consultation with programme staff and other trainees and feedback from teachers, we have agreed a programme policy that laptops are permitted to be used in teaching sessions but that trainees should always check with the teacher before the start of the each session that they are happy for laptops to be used. Trainees need to be mindful that they use their laptops appropriately during teaching sessions and that they should not be responding to emails, etc, during teaching sessions.

6 Assessment Systems and Examinations

6.1 Personal Planning and Training Needs Assessment (PPTNA)

Trainees are assessed in a variety of ways throughout the programme, as described later in this handbook (appendices B&D; see also appendix C for phasing of components). Central to the development of the training component is the Personal Planning and Training Needs Assessment (PPTNA), which is intended to function as a cumulative progression and development tool rather than being evaluative, although it is linked into the clinical evaluation component (specifically, the end of placement review). The clinical/placement Unit evaluations are formatted in a similar way to the PPTNA, but the PPTNA is meant to be formative only, meaning that it is not the subject of formal assessment other than in terms of the final reflective report which is an assessment linked to the professional development unit, P1; see section 6.10 on the Professional portfolio below.

6.2 Examinable components: Academic and Professional Performance Evaluations

Full details of assessment regulations and the specific assessments linked to Units can be found in the Programme Regulations (appendix B; these regulations form part of the university documentation set out in appendices A-P of this handbook). These should be referred to for full details of all university matters, where necessary in consultation with the programme team. All non-trivial modifications will be discussed at SSLC prior to Submission for University approval, allowing student input at that point.

In summary, the examinable components comprise: three academic units assessed by exams and examinable case reports, six clinical practice units assessed by placement reviews supplemented by case reports (a minimum of five), practical ratings (particularly the CTS-R or its variants and equivalents) from recorded clinical work and two research units. The first research unit is assessed by written submissions which for all, except the critical review of a qualitative paper, will be supplemented by a presentation, assessed by at least two team members. The second, longer research unit will be assessed by a written portfolio consisting the Main Research Project, Service Improvement Project and Literature Review; this will be examined alongside the Professional Portfolio (which is the assessment for the Professional practice unit, which runs for the full three years) in a final *viva-voce* examination, supplemented the five clinical practice case studies. The Professional portfolio is submitted in mid-May in year 3 of the programme at the same time as the research portfolio.

All specified assessments (including the first year examinations, case studies, clinical placements, research project, literature review, service-related project and service review/consultancy) must be passed. Only two attempts are permitted for assessments, with the specific exception of the two main research proposals, where a third submission is allowed (Main research project and Service Improvement Project).

At the University of Bath, the examination pass mark is 40%, and marking schemes are calibrated accordingly.

Failing any component twice will result in a failure of the entire Unit, with the exception of R1 as specified above and the Portfolios, where the *viva voce* examiners' recommendations determine the outcome.

Failure of any two clinical placements represents a failure in terms of the Doctorate in Clinical Psychology and will result in removal from the Programme.

Students who pass all components other than the clinical placements can be considered for a Master of Philosophy degree from the University of Bath.

These and other assessment issues are dealt with definitively in the Programme Regulations, which can be found in appendix B.

6.3 Written Examinations

Written examinations are held in April of the first year, consisting of two 2-hour papers:

- Paper I Empirically Grounded Psychopathology (3 Questions)
- Paper II Assessment and Treatment in Clinical Psychology (1 assessment and 2 treatment questions)

Both papers must be passed. In the event of either or both papers being failed, resits will be scheduled for the end of July in the same year. At least one question in each paper will have Cognitive-behavioural therapy, Behaviour therapy or Cognitive therapy as its focus and it will be indicated on the paper that these must be answered. Failure to answer at least one of these questions per paper will automatically result in failure of the entire examination.

These examinations assess relevant knowledge and critical thinking skills based on the learning outcomes from the teaching programme, and on clinical placement experience, pertinent to your stage of training. Paper 1 of this exam relates to lectures, workshops, and other academic components of the programme in your first year; paper 2 of this exam has a clinical focus, and relates to both the taught and clinical placement elements of your first year. Progression to the second year of the programme is dependent on passing these exams, with one resit being allowed if necessary.

6.3.1 Examination and marking procedure

The examinations are set and marked in accordance with University of Bath's regulations, with the proviso that the requirement is simply to pass. This means that specific marks will not be awarded and communicated beyond the overall result (pass/fail). Each paper must be passed, and compensation of marks within each paper is implemented as necessary.

http://www.bath.ac.uk/regulations/ and the QA Code of Practice
http://www.bath.ac.uk/quality/cop/statements.html, in particular QA16:
http://www.bath.ac.uk/quality/documents/QA16.pdf

The purpose of the examination is to ensure trainees are properly trained in terms of declarative knowledge of the first academic unit and for quality assurance by the University. The Examinations test the ability to deal with, summarise and prioritise information, to express ideas and knowledge with clarity, to use a coherent structure, to link and cross-reference relevant material from different areas, to make the reader understand innovative or creative ideas and the ability to cope with anxiety/stress and perform under pressure.

6.4 Problem Based Learning sessions

The Problem Based Learning (PBL) sessions run throughout the first year and form part of the assessment of Unit A1 (core competencies) and Unit P1 (professional practice and development). They are usually timetabled for half a day. For these sessions the cohort will be divided into groups and one trainee will lead / co-ordinate each group. Each group will collaboratively produce a brief presentation to present to the whole group and members of the programme team. The trainee leading the group and one other group member will deliver the presentation at the end of the session. The presentation is expected to demonstrate theory-practice links and the synthesis of knowledge from a variety of sources including placement observations. These sessions are an opportunity to further develop independent learning skills. Both the presenters and group work will be assessed in accordance with the learning objectives of the A1 Core Competencies academic unit. Feedback will be given by a member of the course team who will be present at the oral presentation. An opportunity to present twice will be provided if necessary.

6.5 Case Studies

Five case studies need to be submitted as assessments for the clinical units and as demonstration of links between academic training and clinical practice, including theory practice links, for the Academic Unit A2. As a demonstration of the ability to apply and derive research from working with individual cases, they are also provided to supplement the research portfolio at viva, although they are not examined at that point, the requirement being that they must have already been marked and passed. Two of these five should take the form of single case experimental designs (SCED), although we encourage students to use SCED for as many as possible, with the intensive investigation and understanding of the single case being a core competence for the programme. Four of the five case-studies need to be oriented within a cognitive-behavioural framework and have been closely supervised. In the event that the minimum requirements for CBT or SCED are not met in the five case reports, a sixth will be required for the final placement in order to meet these requirements.

Trainees have the option of submitting systemic case studies if they wish to pursue Systemic qualification at Foundation and/or Intermediate level. For Foundation qualification, this will involve writing a 1,500 word appendix to their first case study, explaining how they would have re-worked the case systemically. This can thus be hypothetical as trainees will not be expected to have completed systemic clinical work for Foundation level. For Intermediate qualification, 60 hours of systemic clinical work is required and trainees can either submit one 3,000 case report of this work that will apply for both the Doctorate and Intermediate qualification, or write a 1,500 appendix of actual systemic work completed on the case they have written up in a different modality for the Doctorate. More details of the requirements for the systemic case reports in located in the Systemic Handbook (section 4.3 for

Foundation and 4.5 for Intermediate) and submission is via the Systemic Moodle pages. For the qualification to be achieved, these requirements must be met.

All case studies must be written up in the format specified and case studies from C2, C3 and C4 must demonstrate clear academic knowledge of the clinical domain which forms the focus of that placement, as these case reports form an assessment of Academic Unit A2. The case reports will be marked for this requirement.

There should be a direct assessment of clinical competence linked to the case study. Ideally this will be the Cognitive-Therapy Scale (Revised; CTS-R), its variants or equivalents (a similar structured rating). In some placements an equivalent structured assessment may be used, with the pass rate being set at an equivalent level.

6.6 Service Improvement Project (see section 14.8 and research handbook)

The basic aim of these projects is to ensure that all trainees are involved in the process of identifying, developing and conducting health service related research and audit. This piece of work should be no longer than 5,000 words, and will usually be shorter (although no less than 3,000 words).

6.7 Main Research Project and Critical Review of the Literature

(see section 14.9 and research handbook)

1. Main Research Paper

A full-length report of the practical work that you have done as a piece of research. This report should be written as a paper for submission to a specified journal. Therefore, it should 'stand-alone' from the literature review and should have its own, much briefer and narrower, summary of the pertinent literature. As with the review paper, for ease of reading, tables and figures should be integrated into the text and referencing should follow APA guidelines. Recommended length: 3,000-5,000 words. The word limit for the target journal should be observed wherever possible; if this is problematic, then the student should discuss with the Programme Director/Research Director at the earliest possible point.

2. Critical review of the Literature

Trainees will have the option of presenting either a meta-analysis of empirical research papers on a specific topic, or a systematic/narrative review of research. Recommended length: 4,000-7,000 words. This report should be written as a paper for submission to a specified journal relevant to Clinical Psychological research and/or practice.

6.8 Placement Assessments

Your clinical and professional skills and knowledge are assessed by your placement supervisor and this assessment will be reviewed by your programme clinical tutor, who is a member of the programme

team assigned during the first few days of the Programme. The programme clinical tutor will usually be involved in all of your placement reviews, co-ordinating with the cohort tutor. However, overall responsibility for these decisions lies with the Clinical Director, Dr Ailsa Russell.

Placement assessment comprises:

- Clinical Supervisor ratings of clinical skills and competencies at Mid and End of Placement, with less than 2 of the mandatory competencies rated as 'needs attention' in order to pass. Failure is ordinarily indicated at the latest at the mid-placement point, and will be considered where ≥2 of the mandatory skills and competencies for that placement are rated as needs attention or there are serious concerns about performance on the placement. This will be discussed with the tutor and a remediation plan developed in collaboration with the trainee and supervisor to address the concerns. Should the concerns persist, and ratings not improve by the end of placement, failure may be recommended by the clinical supervisor and referred to the programme team.

- The relevant sections (i.e. placements 3, 4 and 5) of the clinical logs can also be submitted for the Systemic Intermediate qualification.

- Two direct assessments of clinical competence via standardised tools as set out on the schedule for the assessments of clinical competence: (https://moodle.bath.ac.uk/mod/resource/view.php?id=548523). A pass requires the case to be evaluated above a specified threshold. The threshold required for the CTS-R is ordinarily 50% (total score of 36 with a minimum of 2 on each item). For placements C1 and C2 in the first year of training, the threshold set for the CTS-R is 40% (total score of 29 with a minimum of 2 on each item). A comparable successful pass on the specified equivalents is required according to the relevant unit.

- The Intermediate course requires trainees to submit a Systemic Family Practice - Session Rating Scale (SFP-SRS) during placement 3, 4 or 5 and pass this at 50%. This can count as one of the alternatives to the CTS-R trainees can submit for the Doctorate in parallel. More information can be found in the Systemic Intermediate Handbook (section 4.4)

- Ability assessment as specified for the clinical speciality e.g. for C3 the Wechsler Intelligence Scales for Children-IV and an interpretation of information about educational attainment in light of findings regarding academic ability.

- A pass on the case study for each C unit. The exception is unit C6 which does not ordinarily require case report submission but will require 1 direct assessment of clinical competence and ratings of skills and competences at mid and end of placement commensurate with the pass threshold.

- Details of the documentation to be uploaded to Moodle at the end of each placement can be found on the Placements Moodle page

- The systemic Foundation and Intermediate courses require trainees to complete a reflexive log of their systemic learning (either on the course or on placement) handed in at the end of the year. This is not marked but completion is a requirement for course qualification. More information can be found in the Systemic Handbooks (section 4.2)

- The Intermediate systemic course also requires students to speak to a ten minute clip of them conducting systemic therapy within their reflexive small group. These groups take place on Intermediate systemic teaching days and more information can be found in the Systemic Intermediate Handbook (section 4.3)

6.9 Research Portfolio; see Research handbook for full details

Doctoral level research skills, service related research skills and clinical skills related to the overall teaching and clinical programme are assessed via submission of a research portfolio in the third year; some aspects of this will have already been assessed. The presentation of the research portfolio must demonstrate a clear understanding of appropriate research methodology, address psychological processes analytically and contain an acceptable amount of original work by the candidate. The specific reports should be of a standard which could be regarded as worthy of publication and trainees are encouraged to submit for consideration for publication at any time (i.e. there is no requirement to wait for completion of the programme in order to submit). All parts must be in a form which, if not already published, are written to a standard and in a style judged suitable for publication in an appropriate journal, which should be specified. Note that in the event of a component already being published at the time of *viva voce* examination, modification can still be required for the award of the doctorate.

The focus of either or both of the service improvement project and the main research project should include a major element of cognitive, behavioural or cognitive behavioural approaches.

The Research Portfolio should be soft bound and handed to the Programme Administration Office Manager by mid-**May of the third year.** The research portfolio is examined orally (with the main specialist emphasis being on the empirical paper and literature review) in June of the 3rd year by two examiners (one of whom will be external to the University), who may require changes to be made before the portfolio is passed. Trainees are advised not to make arrangements to go on leave immediately after the viva so that they can make any required changes and have these approved in time to be considered at the relevant Exam Board. See programme regulations in appendix B for further details.

The Research Portfolio should include at least the following sections:

1) Title Page

2) Contents listings

3) Critical Review of the Literature: A review of the literature pertinent to some aspect of your practical work. It can be related to your main research project, but theoretically should tackle a different aspect to that which will be covered in the introduction of this paper. It should be written as a paper for submission to a specified journal. However, for ease of reading, tables and figures should be integrated into the text and referencing should follow APA guidelines (although English spelling is preferred for all submissions). It is suggested that you consider the format and scope of existing review articles (e.g., Clinical Psychology Review; Psychological Bulletin) when writing such a paper, and you may also wish to consult previous portfolios. Recommended length: 4,000-7,000 words.

4) Service Improvement Project (SIP): A report of a piece of work that you have done collaboratively within a service to analyse some aspect of it, and to thereby make recommendations or changes to the service (i.e., improvement). The project should demonstrate that you have consulted with stakeholders and analysed the issues involved, and that you have tackled the issues or problems under investigation in a systematic way. SIPs can encompass both research work (the development of new knowledge and practice) and audit work (the assessment of practice to influence the activity of a service and identify when further research is required). The essential features of the projects are that they are driven by a clear research or evaluation question; that they arise from actual clinical or service issues and that they are relevant to clinical and health services. Therefore, the projects must report on a piece of work that has been commissioned by or agreed with an NHS or social care organisation. This report should be written as a paper for submission to a specified journal. Recommended length: 3,000-5,000 words.

5) Research Paper: A full-length report of the practical work that you have done as a piece of research. This report should be written as a paper for submission to a specified journal. Therefore, theoretically although it can be related, it should 'stand alone' from the literature review, and should have its own, much briefer and narrower, summary of the pertinent literature. As with the review paper, for ease of reading tables and figures should be integrated into the text and referencing should follow APA guidelines. Recommended length: 3,000-5,000 words.

6) Narrative Overview. A brief section describing the areas covered in the Literature Review and Research Paper/s. This section should also provide a detailed factual narrative of the process of research, including an account of the student's and others' contribution to all stages of the development and realisation of the research studies. Other issues which should be described here include service user consultation and the process of obtaining ethical approval and Research and Development clearance. As with other aspects of reflective review, the trainee is expected to incorporate ideas concerning their personal reactions, what these might mean about them and the context in which the work was conducted and so on. In addition, the trainee is expected to conclude this section by identifying how they might continue to be actively involved in research, its application and dissemination, considering both benefits and barriers. Recommended length: 1,000-2,000 words.

7) Executive Summary/Dissemination document for the research project: This provides an overview of the review and empirical paper or the empirical paper alone in a manner suitable for dissemination to stakeholder in the research (e.g. NHS Research and Development departments or staff of other disciplines). It should therefore be relatively free of jargon. Recommended length: 500 – 1,000 words.

8) Acknowledgements. Including any substantial assistance received during the course of the research.

9) Research appendices. The appendices should include information which is supportive in nature and are presented separately from the main text to prevent impeding the progress of the reader. We recommend that you are 'over-inclusive' in this section, and provide any information that you think will inform the examiners or will allow them to gain a wider context to the work that you have undertaken. They should also be used to provide further clarification. The following materials should be included in the appendices:

- Relevant "Instructions to Authors" for nominated journals.
- Measures used where appropriate.
- Additional data.
- Information relevant to ethical review and conduct.

The research portfolio is usually examined orally in July of the 3rd year by two external examiners, who may insist changes are made before the portfolio is passed. Trainees are advised not to make arrangements to go on leave immediately after the viva so that they can make any required changes and have these approved.

Reference copies of previous cohorts' Research and Professional portfolios are available for trainees to borrow from the Programme admin team.

6.10 Professional portfolio

The professional portfolio comprises the examinable components of Unit P1, the professional development unit which is spread over the entire three year programme. It concerns the development of trainees' professional identities and skills beyond core competencies, academic and research skills. It enables trainees to place their evolving identities and skills as clinical psychologists in the context of their personal experience and broader social and cultural influences. It ensures that trainees' reflective learning and practice is properly integrated with their professional development as scientist practitioners, applied scientists, therapists and reflective practitioners.

The unit will also ensure that trainees are aware of the need for their professional practice to meet the HCPC's standards of conduct, performance and ethics, and the importance of the HCPC standards of proficiency for their post-qualification practice.

It also aims to help the trainee to understand the importance of management in the provision of mental health services, and how individual leadership roles and styles can be developed.

Trainees' understanding of and ability to develop and implement supervision and mentoring skills will be emphasised. The unit also enables trainees to develop expertise in service review and learn consultancy skills.

Unit P1 incorporates a range of teaching approaches including lectures and workshops in the academic curriculum, self-directed learning sessions, reflective sessions, and an eight week Mindfulness programme. It also covers reflection on clinical practice with clinical supervisors, research skills with research supervisors, and regular discussion, including annual appraisals, with clinical tutors. The PPTNA is central to unit P1 and this is reflected in one of the key examinable components, although the PPTNA is not itself evaluated in order to retain its integrity as a self-assessment instrument.

The Professional portfolio comprises four elements of written coursework: a service review specification which is incorporated into the consultancy/ service review itself, reflective narrative of professional development and final reflective report of the PPTNA, all of which are summative assessments and must be passed. P1 also includes a teamwork assessment linked to the debates (see section 6.11), which is formative only, and is not included in the portfolio.

The portfolio must be submitted alongside the research portfolio during May of the third year. Although the main emphasis of the oral exam is on the research portfolio, examiners may also explore aspects of the professional portfolio, which will be assessed in any case by the examiners.

A more detailed description of each of the four components of the Professional portfolio is as follows:

1. **Consultancy/Service review specification** (maximum of 1,000 words)

This should make the case for the consultancy/ service review described below. It should be comparable to the main research proposal. It should specify the commissioner and details of the piece of work being commissioned including the likely or actual scope; provide relevant contextual and background information such as local service issues, relevant literature and local and national guidelines, policy documents and legislation. It will be reviewed by the student's clinical tutor prior to proceeding with the consultancy itself getting under way. Although this is a formative assessment, usually marked by your clinical tutor, the specification is incorporated in the full consultancy and will be subject to examination at *viva voce*.

2. **Consultancy/Service review** (maximum of 4,000 words to include specification)

Trainees are required to conduct a service review/consultancy during their second or third year. This may be a review of an aspect of a service or an entire service; unlike the SIP, it is primarily organisation rather than service-user facing. Most commonly it will be on behalf of an NHS service, but could be commissioned by another area (e.g. third sector, prison, residential service). The report of the review or consultancy will include a consultancy agreement/contract, final report, a commissioner's response and a reflective statement; these will all be included in the thesis. Consultancy can be conducted in the context of an NHS service, a social enterprise or a relevant charitable organisation. Other possibilities may be allowed at the discretion of the Director of Studies.

3. **Reflective narrative** (2,000 words)

For this task, trainees will write a reflective narrative of their professional development as a clinical psychologist. It should consider the totality of their academic, research and clinical experience on the

Programme. As with other reflective review processes, the trainee is expected to incorporate ideas concerning their personal reactions to the experience of training and the tasks undertaken, and what these reactions might mean for them in terms of their personal and professional development. Trainees should draw on insights gained through the reflective components of the Programme, including clinical supervision and both regular meetings and annual appraisals with their clinical tutor. The trainee is expected to conclude this section by considering future aspirations consistent with lifelong learning, both in terms of clinical and research interests.

4. **Final Training Needs Assessment** (1,000 words)

The trainee will be required to submit a final reflective report based on the PPTNA. It will be a narrative of the process spanning the full three years of the Programme and the outcome of undertaking the PPTNA as part of their training experience and in relation to meeting their needs.

Formative assessments for unit P1 include:

- Assessment of group work skills through Debates,
- Consultancy/service review specification
- Annual review/Appraisal, including Personal Development Plan,
- Years 1+2 Training Needs Assessment.

6.11 Debates

Debates are included in the programme structure as a way to assess teamwork in a group project. There will be two debates held each year in years one and two. The first debate will usually be attended only by programme staff members and guests invited by the trainees, this restriction being in place is to permit practice the process of debating in a "safe" environment. The second debate will be open, with external placement supervisors or teachers invited to attend, and others allowed as appropriate. There will be two subsequent debates in the second year and a debate-like event in the third year, format to be agreed with the cohort.

Members of the debate team

Trainees will be separated into two teams as specified by programme staff. Each team will decide on the individuals they want to propose and second the motion. Each team will be allocated a member of programme staff to act as mentor.

The Motion

Every debate has a motion; this is the issue for discussion. A good motion has clear arguments in favour of it and against it. The motions used will be issues around mental health; psychological services and input; topical issues in the field etc. Each team is allocated whether they will propose or oppose the motion. You must not contradict the other team on your side, but you are competing against them: you are trying to persuade the audience of your side of the motion. You should therefore not discuss with the other team on your side what you are going to say or help them in any way.

Basic rules and advice about structure

- Speeches are **seven minutes** in length for the first speakers on the opposition and proposition.
- Speeches are **four minutes** in length for the second speakers on the opposition and proposition side

- The debate will be opened to the floor for **twenty minutes**
- Summary speeches should be **four minutes** in length.
- Speeches should have a clear Internal Structure. It is often best to begin by attacking the arguments of previous speakers from the other side (especially the one just before you) and then to make you own points. Try to separate your arguments into two, three or four areas. Signpost your arguments clearly (e.g. "this is my first point", "now to move onto my second points", "lastly, looking at my third point" etc.): this makes it much easier for the audience and the judges to follow your speech.
- Work as a team, ensuring that your arguments are consistent and complementary.

The roles of the team members

1. Opening Proposition Team:
First speaker -

- Define the motion
- Outline the case you and your partner will put forward and explain which speaker will deal with which arguments
- Develop your own arguments, which should be separated into two or three main points
- Finish by summarising your main points

Second speaker -

- Re-cap the team line
- Rebut the response made by the first opposition speaker to your partner's speech
- Rebut the first opposition speaker's main arguments
- Develop your own arguments – separated into two or three main points
- Finish with a summary of the whole team case

2. Opening Opposition Team:
First speaker -

- Respond to the definition if it is unfair or makes no link to the motion. You can re-define (offer an alternative interpretation of the motion), but this can be risky and should only be done when the definition is not debatable (usually better to complain a little – "well this is a silly definition but we're going to debate it and beat you on it anyway" approach)
- Rebut the first proposition speech
- Outline the case which you and your partner will put forward and explain which speakers will deal with which arguments
- Offer additional arguments (roughly 2) about why the policy is a bad idea, or develop a counter case (i.e. an alternative proposal). This decision is largely based on the circumstances of the debate.

Second speaker –

- Rebut the speech of the second proposition speaker
- Offer some more arguments to support your partner's approach to the motion
- Summarise the case for your team, including your own and your partner's arguments

3. Closing Proposition Team

- The last speech of a debate is known as a Summary Speech. In it you should step back and look at the debate as a whole and explain why on all the areas you have argued your side has won.

You should try and go through the debate according to the main points of contention explaining why on each of the main issues that have been debated have been won by your side.

4. Closing Opposition Team

- Like the closing proposition, the last opposition speaker must devote their whole speech to a summing up and should not introduce new material.

The floor

After the two teams have spoken, the debate is thrown open to the floor. Members of the audience can ask questions, raise points of information, make comments and arguments of their own. Members of the teams will not be able to respond to these points and questions at the time, but may answer any of these points in their closing summary speeches. Following the 20 minutes allocated to the floor, the first speakers will provide their summary speeches.

Voting

The chairperson will take a vote by a show of hands at the beginning of the debate for all those in favour of the motion, against the motion and undecided. This vote will be repeated at the end of the debate. The chairperson will then decide whether the motion is carried or not.

6.12 End of programme conference

At the end of the programme, in conjunction with the programme research team trainees will be expected to organise and participate in a two day conference with each trainee presenting on a specialist topic which will usually be linked to one of their elective placements. The content of this presentation will be agreed with their clinical tutor at the mid-placement review for placement five. The presentation will be assessed by an agreed member of the programme team (not their clinical tutor). This usually takes place in the first week of September of year three. At least two invited speakers also present as exemplars of Clinical Psychology research. Trainee preference for who those should be will operate.

6.13 Marking of Research Proposals

Details of marking of the R1 assessments are set out next.

Critical Appraisal of a Qualitative paper

The Critical Appraisal submission is pass/fail only, although often some formative feedback may be offered by the staff member marking it.

Submission deadlines

Deadlines for submission will be published on Moodle at the start of each academic year.

Under exceptional circumstances, an extension to the date by which work must be handed in can be negotiated. This should be requested in advance by discussion with the trainee's clinical Tutor. The usual grounds for an extension would be illness or major life-events. Extensions may also be granted if trainees are waiting for follow-up data, or if they are waiting for the supervisors to review and feedback their draft of the report. A form which requests an extension should be completed with either your

clinical tutor or internal research supervisor (whichever is most appropriate) and then returned to the Programme Administrator.

Submission procedure
Work is submitted via Moodle (unit title to be confirmed and cohort to be informed). As described in the Case study guidelines, each report should have a front sheet which states:

- the title of the report
- the word count
- the date

Note that it is University policy to scan all submitted work using the Plagiarism detection software, Turnitin (see section 17 on Academic Misconduct for details,)

Marking
Marking of Main Research Project and Service Improvement project proposals will take place at timetabled meetings at which the trainee will be required to verbally present their proposal, having usually submitted their written proposal no less than two weeks prior the presentation day. In the event that this deadline cannot be met, an extension can be sought for the written submission of the proposal (by no more than one week). Alternatively the trainee can, provided they have good reason to do so and provide adequate notice, request a postponement of one (and only one) presentation and evaluation. Three days are timetabled for this eventuality. In the event that a trainee wishes to have a proposal approved ahead of scheduled presentation sessions and can give good reasons for doing so then, subject to formal approval by the Director of Studies supported by both University and Field Research Supervisors, they can apply for early presentation. Please note that although every effort will be made to accommodate reasonable requests of this type, approval cannot be assumed.

Details of the format and marking presentations are given in the Research Handbook, but usually the university supervisor will be present and the field supervisor encouraged to attend.

Marking Categories
There are three possible marking categories:

- Pass, including pass with minor suggestions/corrections; approval of any changes will be by the University Supervisor.
- Pass conditional on major design Modifications/Corrections to be approved by the University Supervisor and notified to the programme research team (no more than 3 weeks)
- Fail, requiring a new Proposal which will be considered *de novo* where possible at the next timetabled session

The criteria for assignment to these categories are as follows:

Pass
The piece of work meets the requirements of the particular assignment as it stands. This does not necessarily mean that it is perfect: sometimes the assessors may make suggestions for improvement. However, these would be intended as learning points, and there is no obligation for the trainee to make changes to the report.

Pass conditional on more major design Modifications/Corrections
This category is used when one or more important aspects of the proposal are inadequate or require modification. Examples would include design flaws (e.g. in control conditions), failure to specify

theoretical underpinnings, major measurement problems or failure to discuss important strands of literature which are directly relevant to the research proposal.

Fail
This category is used when the piece of work has such significant failings that revision is not an option. Specific problems could include work which raises major and likely insoluble ethical problems, a clearly inappropriate clinical approach to the case, or a highly confused or incoherent proposal. A new piece of work, will need to be submitted and considered *de novo*.

For the conditional pass, a statement that clearly indicates how the proposal has been revised to meet the concerns of the markers should be prepared in collaboration with the university supervisor. This should provide a clear account of all changes which have been made, referring to the points raised in the marker sheet, and ensuring that all these points are addressed

6.14 References and use of EndNote

Early in the first term, trainees will be introduced to Bibliographic Software (EndNote), so that a reference library can be built up and kept in searchable form. All written assessments which include bibliographic references must use Endnote. Failure to do so may result in the assessment not being considered. Ensuring that all references consulted during the development and writing up of the portfolios are entered on this system will save you a great deal of time towards the final stages of writing up your portfolios.

7 Professional registration accreditation

This section details the standards and requirements for professional registration and qualification as a clinical psychologist with the relevant professional bodies and organisations. In addition to setting out the standards and requirements, this section outlines the processes by which these standards can be demonstrated and evidenced throughout the duration of training, and how this maps on to the specific assessments and appraisals systems currently in place for the University of Bath clinical psychology doctoral training programme.

7.1 Health and Care Professions Council

The University of Bath Clinical Psychology doctoral training programme has been approved by the Health and Care Professions Council (HCPC), the statutory regulator for Practitioner Psychologists in the UK, as an education provider for Clinical Psychology. It is a legal requirement that anyone who wishes to practise using a title protected by the Health Professions Order 2001 (e.g. Clinical Psychologist) is on the HCPC Register. For more information, please see the HCPC website at: www.hcpc-uk.org. Those completing this programme are eligible to apply for registration with the HCPC as a clinical psychologist.

7.1.1 Requirements for registration with the HCPC

As the University of Bath Clinical Psychology doctoral training programme has been approved by the HCPC, trainees who complete the course and pass all required assessments will meet the requirements to apply for registration as a practitioner psychologist with the Health and Care Professions Council.

There are two core requirements for registration with the HCPC: competency in the 'standards of proficiency' and observation of the HCPC 'standards of conduct, performance and ethics'.

7.1.1.1 Standards of proficiency:

The standards of proficiency are standards to ensure for safe and effective practice for entry to the HCPC Register. The primary purpose of the standards is to describe the knowledge, understanding and skills necessary to register as practitioner psychologist with the HCPC. They include both generic elements and profession-specific elements which are relevant to clinical psychologists only. The generic standards explain the key obligations that are expected of the health professional, in this case the qualifying clinical psychologist.

The full 'Standards of Proficiency' for practitioner psychologists can be found at http://www.hcpc-uk.org. To summarise, they are divided into the following sections and sub-sections:

1) Expectations of a health professional
    a. Professional autonomy and accountability
    b. Professional relationships
2) The skills required for application of practice:
    a. Identification and assessment of health and social care needs
    b. Formulation and delivery of plans and strategies for meeting health and social care needs
    c. Critical evaluation of the impact of, or response to, the registrant's actions
3) Knowledge, understanding and skills

7.1.1.2 Standards of conduct, performance and ethics:

Please refer to section 8 for information relating to standards of conduct, performance and ethics pertaining to all professional bodies.

7.2 Accreditation with the British Psychological Society

The programme is also accredited by the British Psychological Society (BPS). The BPS is the professional body responsible for developing and supporting the discipline of psychology and disseminating psychological knowledge to the public and policy makers. It is the key professional body for psychology and psychologists.

7.2.1 Requirements for accreditation

As the University of Bath Doctorate in Clinical Psychology has been accredited by British Psychological Society, successful completion of the programme confers eligibility to apply for Chartered Membership of the Society.

In line with BPS requirements, trainees must have successfully completed the programme of academic study, supervised clinical practice and research which will enable them to demonstrate the key learning outcomes. The key learning outcomes will be demonstrated with a range of clients, service settings and modes of work throughout the course of training.

7.2.1.1 Required learning outcomes

- Knowledge and understanding of psychological theory and evidence, encompassing specialist client group knowledge across the profession of Clinical Psychology and the knowledge required to underpin clinical and research practice.

- A professional and ethical value base, including that set out in the British Psychological Society's Code of Conduct, the Division of Clinical Psychology (DCP) statement of the Core Purpose and Philosophy of the Profession, and the DCP Professional Practice Guidelines.

- Clinical and research skills that demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.

- Professional competence relating to personal and professional development and awareness of the clinical, professional and social context within which the work is undertaken.

7.2.1.2 Core competencies

The BPS also set out 'core competencies' which are broad, high-level summaries of the required objectives that demonstrate competence in clinical psychology and clinical settings. On completion of the course trainees will be expected to be competent in all of the core competencies and meta-competencies:

The core competencies are divided into seven sections, as follows:

- Transferable skills
- Psychological assessment
- Psychological formulation
- Psychological intervention
- Evaluation
- Research
- Personal and professional skills
- Communication and teaching service delivery

For a more detailed breakdown of the core competencies please see http://www.bps.org.uk. Please refer to the BPS Division of Clinical Psychology website for further guidance on specialty specific competencies (http://dcp.bps.org.uk/).

7.3 Meeting the requirements for registration with the HCPC and BPS

To demonstrate evidence of satisfactorily meeting the HCPC standards of proficiency and the BPS learning outcomes and core competencies, trainees will be required to complete a range of assessments throughout the course of training.

Trainees are expected to attain an average overall rating of 'established' on the Personal Planning and Training Needs Assessment (PPTNA), where there is opportunity to do so. Trainees are required to attain 'established' ratings within the 'core skills' section and categories which relate to formatively

evaluated categories in the supervisor feedback form (see below). The PPTNA encompasses all relevant competencies and standards of proficiency relevant to the HCPC and BPS

The PPTNA is used as a cumulative progression and development tool and will be reviewed to ensure adequate progression of knowledge and skill development throughout the course of training. Whilst the PPTNA is designed to be formative only and not the subject of formal assessment, the PPTNA forms part of the final reflective report which is an assessment linked to the professional development unit, P1.

In the event that a problem in meeting the criteria of the PPTNA is identified, the person undertaking the review (i.e., usually the trainee's clinical tutor) should agree with the trainee what measures are required to ensure full compliance with the standards, referring the plan for review by the Programme Executive.

Formal assessment of the clinically relevant competencies and standards of proficiency will take place at the mid-point and end of each clinical placement. Trainees will be required to achieve an overall rating of 'satisfactory' on the supervisor rating placement feedback form, with mandatory passes on placement specific competencies. The placement feedback form encompasses all relevant competencies and standards of proficiency relevant to the HPC and BPS. A rating of 'needs attention' in two or more categories, or one mandatory category confers placement failure. Failure in two placements constitutes programme failure. Trainees are also required to pass a case study on each placement as part of the clinical module. Please refer to course handbook for further details.

The BPS core competency 'research' is assessed through R1 and R2 units. All trainees are required to pass all R1 and R2 assessments. An exception, for Research unit R1 is that it is possible to resubmit twice for the assessments of proposal components.

See the research handbook for more information on the specific requirements for components of the R1 and R2 unit.

7.4 Accreditation with the British Association of Behavioural and Cognitive Psychotherapy

This programme has been approved by the British Association of Behavioural Cognitive Psychotherapies (BABCP) as Level 2 Cognitive Behavioural Therapy training, and will be compliant with training and skills requirements of Increasing Access to Psychological Therapies (IAPT) services.

7.4.1 Requirements for accreditation

Successful completion of the programme confers Level 2 Cognitive Behavioural Therapy training, which includes the training, skills and experience required to fulfil BABCP's Minimum Training Standards. Trainees will also be expected to observe and compliance with the BABCP standards of ethics and conduct. Please see www.babcp.com for a detailed breakdown of the minimum training standards and standards of ethics and conduct.

7.4.2 Meeting the requirements for accreditation

This table summarises the relevant minimum training standards for level 2 accreditation and is divided into teaching and clinical practice dimensions. The evidence column indicates supporting evidence of how each of these minimum training standards are met during training.

Table 1: BABCP minimum training standards

BABCP Criteria	Minimum training standard for level 2 accreditation	Evidence
Teaching and training		
3.1	Attendance requirement	Compulsory attendance recorded by the course
3.2	200 hours CBT based teaching	Time-tabled teaching.
3.3	Teaching consisting of 50% skills based and 50% taught theory	
3.4	250 hours CBT based self-directed learning	
Clinical practice and supervision		
3.5	200 hours number of hours' face to face contact with CBT clients	Clinical log book Case studies
3.6	Minimum of 40 hours clinical supervision by a BABCP accredited or accreditable practitioner	
3.7	Record of supervision including: • Hours in individual supervision • Hours in group supervision • Size of group • Number of hours per supervision session • Frequency of supervision.	
3.8	Minimum of eight completed CBT cases that will have been treated for a minimum of five sessions	
3.10	Minimum five hours' of clinical supervision received on each of the above training cases	
3.11	Minimum three of eight training cases meeting the criteria for 'closely supervised' , which may include: • Audio/visual recording • In depth close supervision • CTS-r or specialty equivalent The opportunity to conduct out of the office 'in vivo' work with clients.	
3.12	Minimum of three different types of problem of the eight training cases	
3.13	Opportunity to observe experienced CBT clinicians in practice.	Structured observation forms, clinical log

3.14	Pass all submission requirements for the CBT components of the course (40%) for written components	Portfolio, clinical log
3.15	Four formal CBT case studies written up (2000-4000 words)	Portfolio: case studies
3.16	Four or more passes on formal rating/assessment of clinical work, e.g. CTS-R or other assessment measure	Clinical log

Progression will be reviewed at placement visits and annual appraisal by the trainee's clinical tutor. The trainee is expected to take responsibility for keeping an up to date log of relevant clinical experiences and activities to demonstrate evidence of meeting the BABCP criteria.

In addition to the summary sheet used to record BABCP relevant activities, trainees are required to complete a specialist CBT group supervision contract at the commencement of their final year of training (this can be found with the supervision dates on the A3 teaching page on Moodle). This summary sheet should be submitted to the Programme Manager at the end of Year 3.

A key review point is at the point of progression from Year 2 to Year 3. Your clinical tutor, at the annual meeting, will identify any outstanding requirements that must be met in the final year and make arrangements accordingly.

7.5 Standards of conduct, performance and ethics – BPS, HCPC and BABCP

The standards of conduct, performance and ethics is central to achieving registration and accreditation with all core professional bodies, and should be considered a fundamental overarching theme of professional development.

All trainees must observe the 'standards of conduct, performance and ethics' as outlined by the Health and Care Professions Council (http://www.hcpc-uk.org); the 'code of ethics and conduct' as outlined by the British Psychological Society (http://www.bps.org.uk) and the British Association of Behavioural and Cognitive Psychotherapy 'standards of ethics and conduct' (http://www.babcp.com).

The broad standards and principles of these codes of ethics and conduct are shared by the HCPC, BPS and BABCP professional bodies, as outlined here:

1. You must act in the best interests of service users.
2. You must respect the confidentiality of service users.
3. You must keep high standards of personal conduct.
4. You must provide (to us and any other relevant regulators) any important information about your conduct and competence.
5. You must keep your professional knowledge and skills up to date.
6. You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.
7. You must communicate properly and effectively service users and other practitioners.
8. You must effectively supervise tasks that you have asked other people to carry out.
9. You must get informed consent to give treatment (except in an emergency).
10. You must keep accurate records.

11. You must deal fairly and safely with the risks of infection.
12. You must limit your work or stop practising if your performance or judgement is affected by your health.
13. You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.
14. You must make sure that any advertising you do is accurate.

In addition to these shared principles the BABCP outline an additional standard that trainees must 'maintain high standards of CBT assessment and practice'.

Please see http://www.babcp.com/Files/About/conduct--ethics.pdf

As part of the observation and compliance with the codes of conduct, trainees are also expected to be able to demonstrate and maintain fitness to practice. Please refer to section 8 of the handbook on fitness to practice.

Please also refer to the BPS Division of Clinical Psychology website for further professional practice guidelines (http://dcp.bps.org.uk/).

7.5.1 Social networking

Social networking has become commonplace in a range of forms, from Facebook, Instagram, Twitter through to the more professionally oriented LinkedIn. There are a number of implications of these developments from the point of view of clinical psychology, which are well set out in the British Psychological Society Supplementary professional and ethical guidance, which can be found here:

http://www.bps.org.uk/what-we-do/ethics-standards/supplementary-guidance-use-social-media/supplementary-guidance-use-socia

Trainees on the programme are required to adhere closely to these guidelines. If you are experiencing problems in this area, you should always consult a member of the programme team and, if appropriate your clinical supervisor (if for example a client is seeking to insist on contact through social media).

Key points include

You should:

- Remember that social networking sites are public and permanent. Once you have posted something online, it remains traceable even if you later delete it.
- Keep your professional and personal life as separate as possible. This may be best achieved by having separate accounts, for example Facebook could be used for personal use and LinkedIn or Twitter used for professional purposes.
- If 'friends' requests are received from clients and service users, decline the request via more formal means of communication.
- Be minded that whether you identify yourself as a psychologist or not on your profile, you should act responsibly at all times and uphold the reputation of the profession.
- Protect your privacy. Consider the kinds of information that you want to be available about yourself and to whom. Ensure that you regularly check your privacy settings. We suggest

highest levels of privacy should be used in your settings, so that you are not identifiable directly by searching.

- Be aware that social networking sites may update their services and privacy settings can be reset to a default that deletes your personalised settings.
- Remember that images posted online by family (for example, your children) or friends, may be accessible as they may not set privacy settings as tightly as you do.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other members on such social networking sites to any relevant parties (such as the employer, the Health and Care Professional Council and the Society).

You should not:

- Establish inappropriate relationships with clients and service users online.
- Discuss work-related issues online in any non-secure medium.
- Publish pictures of clients or service users online, where they are classified as clinical records.
- Discuss or otherwise identify client or related information in any type of online posting, even anonymously;
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity

If you have any concerns, please discuss in the first instance with your clinical tutor

7.5.2 Electronic communication and electronic records

The increased acceptance of email as a primary form of communication has significant implications for the transmission of clinical information. Please ensure the following:

- Only use secure NHS internal and external (e.g. nhs.net) work email addresses if you are going to use email to communicate patient information.
- Never send patient information to non-NHS email addresses such as @yahoo.com or @gmail.com, no matter who the recipient is, for instance a clinical supervisor.
- Be extremely careful about emailing information about clients; password protect attachments wherever possible and ensure compliance with NHS Trust rules.

A further issue is that of the electronic patient record. It is crucial that only records where one is clinically involved are searched for and accessed.

For further information pertaining to these issues please consult with the BPS Generic Professional Practice Guidelines and the Guidelines on the use of Electronic Health Records:

http://www.bps.org.uk/sites/default/files/documents/generic_professional_practice_guidelines.pdf

http://www.bps.org.uk/sites/default/files/documents/electronic_health_records_final.pdf

7.5.2.1 Work, including voluntary, outside your employment

In the event that you intend to undertake any voluntary or paid work outside your NHS contract involving your expertise as a psychologist or therapist, you must first discuss with your clinical tutor and the Programme Director if appropriate. Failure to do so may be regarded as a fitness to practise issue and will be dealt with using that procedure.

7.5.3 Meeting professional requirements

Evidence of observing the standards of conduct, performance and ethics are assessed throughout all clinical, academic and research activity. This is particularly pertinent to the professional development unit (P1) which assesses personal and professional development.

Formative assessments of professional practice include the supervisor completed placement feedback form (see previous section) and self-directed learning sessions which trainees are required to pass and the first submission of the Consultancy/Service Review Specification.

Trainees will also be required to complete and maintain a professional practice log throughout training which will be reviewed at placement visits and annual appraisal.

8 Employment Issues

Trainees are both students of the University of Bath and employees of the Taunton and Somerset NHS Foundation Trust. Regardless of prior experience and salary, all trainees without exception are appointed at the first point of Agenda for Change Scales Band 6 for a fixed term of three years, with two annual increments being offered specifically on the basis of satisfactory progression. On this basis, Trainees are line-managed by the Programme Director, who is responsible for all line management matters but will, as appropriate, delegate this responsibility to other Programme staff on the basis of the trainee's clinical tutor.

The Programme Director is responsible for ensuring that all trainees are appraised annually (see section 8.1 for further information).

8.1 Appraisal System

On admission to the Programme, each trainee is allocated an Appraiser who will usually be their clinical tutor. This appraiser will continue until the end of training (unless there are unforeseen circumstances) to give continuity to appraisals.

The role of the appraiser is to ensure that the trainee is progressing in their development of key skills and competencies at a level which reflects their stage of training. The appraiser will work with the trainee on their Personal Development Plan as incorporated into the PPTNA at the commencement of training, and at the end of each year of training, during the annual appraisal meeting (see appendix 12 for the appraisal form and guidelines).

Prior to the appraisal meeting, the appraisee should review and update their PPTNA to consider the development of their clinical competencies and personal and professional development (see section

17 and 17.1). They may wish to consult their placement ratings, clinical and professional practice logs to assist with this.

Following review of the PPTNA and in light of their own career aspirations/interests, the trainee will be invited to complete the Personal Development Plan (PDP) section of the PPTNA, outlining their objectives and plan for the forthcoming year (Section 3 of the PPTNA).

The trainee should also use the appraisal meeting to consider their progress in terms of course assignments and academic work using their individual Gantt chart.

As well as offering an opportunity to evaluate development against health service requirements, the appraisal meeting is also an opportunity to consider progression towards clinical psychologist status. Your appraiser will discuss this with you, and is available to guide you should you feel you are missing essential aspects of development or if you are struggling to keep up with the demands of the programme.

At the end of the 3rd year of training, the final appraisal will help you to consider your scope and range of experience in line with prospects of employment and also encourages you to consider your ongoing professional development once you have graduated.

8.2 Mandatory Training

As employees of Taunton and Somerset NHS foundation trust, trainees are required to undergo mandatory training in Information Governance, Equality & Diversity, Major Incidents, Fire, Safeguarding Children, Safeguarding Vulnerable Adults, Counter Fraud, Conflict Resolution, Waste Management, Risk, Moving & Handling. Training which is considered necessary and specific to particular placements will be on a per placement basis. Taunton and Somerset have agreed that if appropriate and agreed with the Programme, mandatory training can be gained in placements and, in some instances, through the University of Bath. Note, however that it is the trainees' responsibility to arrange and attend sessions or engage in e-learning. Attendance at mandatory training sessions is checked yearly at trainee appraisal. Failure to keep abreast of required training could lead to disciplinary action. It is the trainees' responsibility to keep a record of all your attendance.

8.3 Holidays

The NHS leave year runs from 1st April – 31st March. Holiday entitlement is 27 working days plus Bank Holidays.

Details of fixed and flexible dates of leave will be provided at the beginning of each academic year and can be found on the General Information for Trainees page on Moodle. In general there will be two weeks' fixed holiday at Christmas (including bank holidays) and one week in the spring, both periods linked to National holidays.

Trainees can take up to 2 weeks (10 working days) additional holiday during the second placement of the year. These ten working days can be taken either:

- As a block between July to September (e.g. a fortnight or two separate single weeks) note however that the third year research conference takes place in early September;

- A mixture of a shorter block of leave between July – September combined with some single days.
- Third-year trainees should be aware that they may have revisions to make to their research portfolio following vivas in early July. Corrections will need to be submitted by the final week in August and trainees should be mindful of this when planning leave and in order to be presented at the final Board of Examiners meeting in September.

Please note the following:

- Annual leave should never be taken on days when academic teaching or training is scheduled.
- Timing of flexible leave should be agreed beforehand with the relevant placement clinical supervisor and clinical tutor.
- The Programme Administrator should be informed by email once leave has been approved by the trainee's clinical tutor through inclusion of the admin team in the original request.
- Exceptionally, other holiday arrangements might be possible. This would have to be discussed with your clinical tutor.
- It is not possible to carry leave over into the next leave year under any circumstances. Any outstanding leave at the end of the programme cannot be carried on into NHS positions.

There are a number of University of Bath closure days throughout the year. Trainees are not entitled to these days as leave, so if a closure day falls on what would normally be a teaching day, trainees will be notified of alternative arrangements i.e. study day.

8.4 Special Leave

Other reasons for leave will be considered on a case by case basis. You should discuss with your Cohort Tutor in the first instance. Compassionate leave is an option in exceptional circumstances; in the first place all such issues should be raised as early as practicable with your clinical tutor. For further information about special leave please refer to the detailed policy on Moodle.

8.5 Reimbursement of Expenses

Trainees may claim expenses for travel and subsistence in accordance with the policies set out by Taunton and Somerset NHS Trust. The most recent version of the policy can be found on the General Information for Trainees page of Moodle.

8.6 Conduct, ethics and Fitness to practise

The HCPC booklet, *Guidance on Conduct and Ethics for Students* can be found as an appendix to this handbook (appendix 27). All students must follow the specific guidance points (pages 9-12) on conduct and ethics, and failure to do so would trigger a Fitness to practise review.

8.7 Fitness to Practise Regulations

The University of Bath has a particular responsibility in respect of students who are following a programme of study leading to a professional qualification such as the Doctorate in Clinical Psychology. In addition to conferring the appropriate academic qualification, the University must be satisfied that

the student would be a safe and suitable entrant to the given profession, and thus would be fit for registration with the HCPC as a clinical psychologist and fit to practise. The University policy can be found here: http://www.bath.ac.uk/regulations/Appendix2.pdf.

This gives full details on all aspects of assessment of Fitness to Practise from the University's point of view. In brief, there are two possible routes of referral to the Fitness to Practise Committee: either Misconduct or *Other matters justifying referral* (where a student demonstrates behaviour and/or health issues which do not constitute misconduct under the terms of the University's Misconduct Regulations but raise issues of fitness for registration and practise). The latter is likely to relate to a trainee's breach of the Health and Care Professions Council (HCPC) *Guidance on conduct and ethics for students*.

8.8 Disclosure and Barring Service (DBS) checks (NHS)

University of Bath Clinical Psychology Doctoral Programme Policy regarding applicants with criminal convictions, cautions or other criminal records.

Annual declaration:

In the course of the trainee's annual appraisal, their clinical tutor will ask whether there are any recent convictions, cautions or police warnings, or any such possibly pending. This will be recorded on the appraisal form. If any are declared, the programme will investigate as described below and take appropriate action.

Event reporting:

Trainees are required to notify their clinical tutor, the Programme Director or the Deputy Programme Director within 48 hours in the event of any recent convictions, cautions or police warnings, or any such possibly pending. Full details must be provided in writing. Failure to do so may be regarded in and of itself as a fitness to practice issue. The Programme Director and clinical tutor (or nominated deputies if required) will evaluate the reported event and conduct further inquiries as they regard appropriate including discussion with the trainee. Within 5 working days of such a declaration, the student will then meet with the Programme Director to be informed of the likely course of action, which most usually would involve a fitness to practise investigation as set out in University policy. The Programme Director can, where the matter involved is serious, immediately suspend placement work pending the outcome of the investigation.

Whistle-blowing

In the event that you have serious concerns about the conduct of colleagues, both on the programme or external to it including your supervisors, as health service staff and professionals you have an obligation to draw this to the attention of someone in a position either to act or to advise you on actions you may need to take. This could be your placement supervisor, your clinical or cohort tutor or one of the Programme Directors. Informal confidential discussion would in the first instance be appropriate, although if serious criminal activity or service user safety issues are involved the extent of confidentiality will necessarily be limited.

9 Support Systems & Student Representation

Each year, the previous first-year trainees become "buddies" for new starters. The new and continuing trainees will be emailed the contact details of their buddy before the beginning of the academic year and will be encouraged to make contact. The Trainee Support Co-ordinator (Cathy Randle-Phillips) will have responsibility for working with trainees to implement this system.

Although typically trainees find undertaking the programme enjoyable and interesting, we also recognise that challenges and personal stress may arise as a result of training and/or life events that occur during the course of training. Learning to balance these and take appropriate care of your physical and mental well-being is an important part of becoming a clinical psychologist. There are a number of systems in place to help you with this important work during the course of your training. It is expected that you will take an active and responsible approach to your personal and professional development, mainly through the Personal Planning and Training needs assessment and appraisal system.

You will be allocated a personal support tutor with whom you should endeavour to meet/make contact with around 3 times in the first year in order to establish a relationship and subsequently *at least once each year* throughout training in addition to meetings arranged in response to specific needs. The main function of the meetings with your personal support tutor is pastoral rather than academic support and the content will remain confidential unless extreme circumstances require breach of this. Your personal support tutor will not be involved in your evaluation or appraisal during your training, although they may, on your behalf and with your permission, discuss aspects of your training and experience with Programme staff or others as relevant. Individual personal support tutors will be based in SW regional Clinical Psychology Departments, and will have undertaken training in this role. See appendix 25 for more detailed information about the personal support tutor scheme.

9.1 The Library

The Library is open 24 hours a day and provides print and electronic materials and information services to support study and research across the University. It houses over 520 networked workstations, wireless networking and laptop docking points and provides areas for both quiet individual study and group work. The Library's copy and print service includes black and white and colour photocopying, laser printing and scanning. Charges are kept as low as possible.

Information specialists, known as Subject Librarians (see the Department's Library resources page), are responsible for services to individual Departments and Schools. They provide individual help to students and staff, as well as teaching information skills. All new students receive library introduction sessions during the induction period.

Further information
For information on all library services and resources, please see http://www.bath.ac.uk/library/ This Department's Library resources page is: http://www.bath.ac.uk/library/subjects/psychology/index.html
The Department of Psychology librarian is Mr Justin Hodds (J.Hodds@bath.ac.uk)

9.2 Computing Facilities and IT Skills

You will have been issued with a unique username and password to register online. This forms your email address (username@bath.ac.uk) and once registered, you can use one of the thousand or so Computing Services student access workstations anywhere on campus. These enable you to use email, the internet, file storage, Office programs such as word processing and often give access to the more complex software used on your programme. The machines print to laser-printers in the library for which there is a charge per page.

With your username and password you can also register your own laptop, smart phone or similar for connection to the campus wireless network (which covers communal areas, the Library, cafes and similar) or to around 150 student docking ports.

Support is available from the IT Service Desk on level 2 of the Library or online at http://go.bath.ac.uk/computing-services. Tutorials and FAQs are provided in the self-help section.

If you have a disability or learning difficulty, Computing Services can support you with your computing needs. An Assistive Technologist is available to provide advice and support. Additional resources available include a purpose-built room, specialist software, and computer hardware, including laptops for loan.

The IT shop in the Library stocks popular products such as academic software, DVDs, network cables and headsets. You can order many further IT products through the shop. Prices are often lower than in high street shops.

Further information
Computing Services: http://go.bath.ac.uk/computing-services E-learning: www.bath.ac.uk/e-learning/ Information for new users: http://go.bath.ac.uk/newusers Information for users with a disability or learning difficulty: http://go.bath.ac.uk/assistive-technologies IT shop: http://go.bath.ac.uk/ITshop

9.3 Academic study skills support and development

To succeed in your studies, you will need to develop subject-specific knowledge, enhance your existing skills and also develop new ones for academic study. Effective development of these skills will help you to become an independent learner and attain the very best results from your academic study here. Many of these skills are transferable to the workplace so will also benefit you in your future career and beyond.

You will receive, and have access to, academic and wider skills support and development in a number of different ways. These include:

- Subject-specific academic study skills support as part of your academic programme

- Academic skills classes available to all students at all levels
- Online self-study resources
- One-to-one tutorials to support you in your studies
- One-to-one writing tutorials through the Writing Centre
- Courses to enhance English language proficiency for non-native speakers
- Self-access language learning to develop your language skills
- Academic integrity (how to avoid plagiarism)
- Mathematics and statistics support through Mathematics Resources Centre (MASH)
- Information and referencing skills through the Library
- Information technology skills through Computing Services
  Employability skills, including CV writing and interview techniques, through the Careers Service.

- ***Further information***
- You can find out more about the support we offer to help you study effectively and make the most of your time here by visiting: http://www.bath.ac.uk/students/support/academic/index.html
- Writing Centre: http://www.bath.ac.uk/asc/writing-centre/
- Self Access Language Centre: http://www.bath.ac.uk/salc/
- Mathematics Resources Centre: http://www.bath.ac.uk/study/mash/
- Library: http://www.bath.ac.uk/library/
- Computing Services: http://www.bath.ac.uk/bucs/
- Careers: http://www.bath.ac.uk/students/careers/

9.4 English Language Centre

The English Language Centre (ELC) offers a range of English courses during term time to support undergraduates and postgraduates in their studies and to improve their English. The ELC's in-sessional programme includes classes that will help students with academic writing, giving presentations and taking part in seminars, as well as Cambridge examination classes. While most of its units are for non-native speakers of English, it also offers an academic writing unit for students whose first language is English. The ELC also runs full-time courses to prepare students for their studies at Bath. These preparation courses include a full social programme, with trips to places of interest, and evening and weekend activities.

Further information
English Language Centre http://www.bath.ac.uk/elc
Self Access Language Centre (SALC) (www.bath.ac.uk/salc) provides students with a variety of material to study English and other languages.

9.5 Building on your skills using Personal Development Planning

Personal Development Planning (PDP) is a process of recording and reflecting on your skills and experience which will help you to plan for your personal, educational, and career development. The

University provides information and tools to guide you through the process. However, mostly this function within the clinical doctorate will be dealt with through the PPTNA process, which incorporates a personal development plan and is reviewed at the commencement of the course and at annual appraisal.

Further Information
http://www.bath.ac.uk/learningandteaching/enhance-learning-experiences/personal-development-planning.html

9.6 Recognition for extra-curricular activities: The Bath Award

PDP is an important element of The Bath Award. The Bath Award recognises and accredits the skills and achievements of students engaged in all types of extra-curricular activities. It operates alongside your degree programme and aims to capture the extra-curricular achievements at university that you will find valuable in your future life and career.

Further information
www.bathstudent.com/bathaward/

9.7 Careers Service

The University Careers Service can support you through the career planning process. In addition to providing support with developing your employability, and guidance on how to make informed career decisions, Careers Advisers will provide help with writing your CV, practising aptitude tests, and improving your interview skills.

Further information
The **Careers Advisory Service** (www.bath.ac.uk/careers/) is open throughout the year from 9.15am to 4.30pm, with lunch time closure from 1-2pm in vacations.
www.bath.ac.uk/careers/ includes the ***Myfuture*** vacancies portal

Note that in the third year of training the Programme will have sessions on career development. Personal support tutors and programme tutors will also be arranging to meet with trainees for such advice, and other Programme and regional staff can be contacted as required.

9.8 Health

The **University Medical Centre** is conveniently situated in Quarry House on the main University Campus. The practice is part of Bath and North East Somerset Primary Care Trust and provides a range of NHS services to all patients within the practice area. The medical centre building offers level access. More information may be found at www.umcbath.co.uk

If you have health concerns which may affect your ability to carry out or complete your studies, and you would like to discuss this, please contact your cohort tutor or disability lead (Catherine Hamilton-Giachritsis) who will be able to advise you on relevant sources of support.

9.9 Student Support

Most students find there are occasions when it can help to talk to someone about a personal problem or issue. In many cases, your personal support tutor, Director of Studies (Paul Salkovskis), cohort tutor or clinical tutor will be able to help. However, there is also a range of specialist University support services that you may be referred to, or can approach directly. Your two main contact points are the Student Services Centre in 4W and the Advice and Representation Centre in the Students' Union.

The Roper Student Services Centre

Student Services can provide advice and support on a range of issues including disability, funding, counselling and well-being, and visa queries. Individual appointments and "drop-in" sessions are available.

Student Services can also provide letters confirming student status for a variety of purposes, which can be requested by logging onto Registration on–line (http://www.bath.ac.uk/registration-on-line/).

The Students' Union Advice and Representation Centre deals with academic and welfare issues; these range from representation at academic reviews and appeals to housing and welfare issues. It also provides information for students, including those wanting to submit individual mitigating circumstances, change their course or experiencing problems with their course.

The Students' Union Advice and Representation Centre is open Monday to Friday 09:00 to 17:00 in term time (From 10:00 on Fridays) and 10:00 to 16:00 during vacations; tel: 01225 386906; email at suadvice@bath.ac.uk.

For the full range of services see http://www.bathstudent.com/advice/

Further information and contacts

A guide to the wide variety of support and information available to students can be found at http://www.bath.ac.uk/student and the Students' Union website http://www.bathstudent.com. This includes essential information on medical services and security and other facilities such as the Chaplaincy.

9.10 Dealing with a problem involving the Programme

Trainees will be working closely with their cohort tutor, and are encouraged to discuss difficulties with that person if possible. If the trainee feels unable to do so, then they can arrange to meet informally with senior programme staff and/or their personal support tutor. Trainees will be able to discuss issues confidentially unless the issue involves serious illegality or risk to self or others. Such cases will be dealt with in line with University guidance.

9.11 Dealing with a problem involving the University

We want to ensure that, if you have a problem concerning the University, it is resolved as quickly as possible. As described above, there are student representatives on all formal decision-making committees – at programme, departmental, and university level. Student representatives help to anticipate problems and, when problems occur, to deal with them promptly. As a result we can often resolve problems *before* they get to the stage where a formal complaint might be necessary.

9.12 Complaints

If you do need to make a complaint, there are procedures in place to deal with it, outlined in the Student Complaints Procedure (below).These procedures are designed to ensure that your complaint will be dealt with in good faith and that you will not be penalised for complaining. When we receive a complaint, we will first seek to deal with it through informal discussion. If this fails to resolve the issue at hand, you can raise the complaint formally.

In addition, there are procedures for requesting a review of progression or award classification decisions, or of the level of attainment.

Further information:
Student Complaints Procedure: http://www.bath.ac.uk/regulations/Appendix1.pdf

9.13 Bullying, harassment and victimisation

We believe that all our students and employees are entitled to be treated with dignity and respect and to be free from unlawful discrimination, victimisation, bullying, or any form of harassment. This is set out in the University's policy, Dignity and Respect for Students and Staff of the University of Bath: Policy and Procedure for Dealing with Complaints (below). This policy and procedure applies to all staff, students and third parties (e.g. contractors to the University).

Further information:
http://www.bath.ac.uk/equalities/policiesandpractices/dignityandrespectpolicy.pdf

9.14 Mediation

If you are involved in a disagreement or dispute, you can seek help from the University's Mediation Service. This service is impartial, non-judgemental, and confidential. Requests for mediation support should in the first instance be made either to the Mediation Service Manager, or the Students' Union Advice and Community Manager.

Further information and contacts
Mediation Service: www.bath.ac.uk/universitysecretary/equalities/policies/mediation.html

Mediation Service Manager: Marlene Bertrand (01225 383098); M.Bertrand@bath.ac.uk or Students' Union Advice and Representation Centre coordinator: Carol Lacey C.Lacey@bath.ac.uk; (01225 385863)

9.15 Programme Support

Besides these supports, we also currently have a reciprocal arrangement with a neighbouring Programme, whereby any trainee may confidentially arrange to seek help should s/he have any

problems s/he does not wish to discuss through any of the above avenues. Details of this arrangement will be discussed during the first week of training.

9.16 Advice for students with disabilities, long-term illness and specific learning difficulties

If you have a disability, specific learning difficulty (such as dyslexia), we strongly advise you to disclose this. This will enable us to assess your needs and make arrangements to support you.

Please speak to the Disability Service team, your clinical tutor or Director of Studies, as soon as possible – preferably before your course begins. Any personal information you give when disclosing your disability will be treated in confidence and made available *only* to relevant members of staff and only *with your permission*.

Please recognise that if you don't disclose your disability – or if you withhold permission to forward information to the relevant members of staff – you may make it difficult for the University to provide suitable support to help you achieve your academic targets. Disclosure will not disadvantage you in any way.

The Disability Service provides advice, guidance, information and support for a range of needs including:

- Autism Spectrum Disorders/Asperger's Syndrome;
- dyslexia and other specific learning difficulties;
- mental health;
- mobility impairments;
- sensory impairments;
- unseen disabilities like Epilepsy/HIV/AIDS/Chronic Fatigue

Disability advisers can advise students about support available and putting support into practice. A screening process is available if you feel you may have a specific learning difficulty / dyslexia. Disability Advisers are responsible for making applications for alternative arrangements for exams and assessments. Therefore, if you think that, because of a disability, you need alternative exam arrangements (such as extra time or the use of a computer) discuss this with a Disability Adviser without delay.

Further information: *http://www.bath.ac.uk/groups/disability-service/*

9.17 Maternity, paternity and adoption

The University of Bath believes that being or becoming pregnant, terminating a pregnancy or having a very young child should not, in itself, be a barrier to applying for, starting, or succeeding in, or completing a programme of study. The University is committed to being as flexible as possible in supporting students in these circumstances to ensure they have access to their programme of study.

You are not under any obligation to inform if you become pregnant, have a child, or decide to terminate a pregnancy while are a Bath student. However, staff will not be able to take a flexible

approach to an individual's programme of study or offer specific support, unless informed of the situation.

The position as an NHS employee is slightly different; all trainees are NHS employees. If a trainee becomes pregnant during the course of the programme they must (in their capacity as an NHS employee), notify the Taunton NHS (either directly or through their line manager), at least 15 weeks before the date of confinement, so that maternity arrangements can be made.

In any event, trainees who become pregnant during the programme would be well advised to inform Taunton NHS at the earliest opportunity, not least because Taunton NHS will then arrange for a risk assessment to be carried out at the clinical practice placement. The clinical tutor responsible for the trainee will oversee this process. Taunton NHS will also provide trainees with written maternity/paternity information.

You can seek advice, guidance and support via your Programme Directors, Personal Tutor and the University's Student Services.

Information and guidance around the maternity leave policy should be sought from the employing Trust's HR department (contact Alan Taylor: Alan.Taylor@tst.nhs.uk).

Further information:

Student Services: http://www.bath.ac.uk/studentservices/policy/maternityindex

9.18 Health and Safety

The University's Health and Safety Policy is available at www.bath.ac.uk/internal/safety/safetypolicy.htm and is also displayed throughout the campus. Staff within the Safety, Health and Environment Unit (WH3.26) monitor the health and safety management of the University and advise on health and safety issues.

Trainees on placement should make themselves aware of the H&S policies of the NHS trust they are placed with and adhere to those policies.

Further guidance on personal safety can be found in appendix 18. During the first term, there will be teaching on risk assessment and management and other clinical safety matters.

Further information

E-mail safety@lists.bath.ac.uk

9.19 Data Protection

The University's Data Protection Policy and Guidelines on Data Protection may be accessed via the data protection website - http://www.bath.ac.uk/internal/data-protection/

If appropriate include reference to the guidance notes for students and academics undertaking research (http://www.bath.ac.uk/data-protection/guidance/academic-research/index.html).

9.20 Equality and Diversity

Everyone at the University of Bath has a responsibility for promoting equality and fostering good relations between all members of the community, students and staff, and also for eliminating unlawful discrimination, harassment and victimisation against anyone for reasons of age, disability, gender, pregnancy and maternity, race (means colour, nationality (including citizenship) ethnic or national origins), religion or belief, sexual orientation, transgender status. The new equality duty also covers marriage and civil partnership with regards to eliminating discrimination in employment. Follow this web link to an important document which explains the practices in the University: http://www.bath.ac.uk/equalities/policiesandpractices/EqualityObjectives.pdf

Also available is an access guide which outlines the disabled access features and route plans at the University of Bath http://www.disabledgo.com/organisations/university-of-bath/main-2

Further information:
http://www.bath.ac.uk/equalities/ or email equalsdiv@bath.ac.uk .

Placements

Whilst on placement, trainees are entitled to the same protection with regard to equality and diversity, bullying and harassment, as employees in the service concerned. In the event of problems in these areas, this would normally be discussed with the supervisor/s for that placement, the Clinical Tutor/Director or your personal support tutor. Alternatively, depending on circumstances, it may in certain instances be appropriate to use the Programme complaints procedure outlined below.

9.21 Feeding back your views to the Programme and the University

You can get actively involved in determining how your educational and student experiences are organised by becoming active in the Students' Union. The Programme will discuss other ways you can be involved soon after enrolment.

The Clinical Programme and the University are committed to reviewing and improving its practice. The Staff / Student Liaison Committee is an important component of this commitment; it meets four times a year, more if required.

The University requires every department to have a formal system so that all students can comment routinely, in confidence, on the teaching they have received. Such comments help us to check that:

- you have a clear idea of the aims and requirements of each unit you study;
- our teaching is effective and stimulating;
- the advice and feedback we provide on your work is helpful;
- our resources are adequate.

The main means by which we seek your feedback is through questionnaires/rating scales. This is requested after each workshop in order to inform the ongoing development and teaching of the course. Time is allocated at the end of each teaching day for this to be completed (online) and this is seen as part of a trainee's engagement with the course. Please complete each questionnaire fully,

thoughtfully, and candidly. Be mindful that feedback from teaching sessions will be forwarded to the presenters of those sessions. In particular, please tell us, not only your opinion on the unit you have studied, but also the *reasons* behind your opinion. Collecting this information will be the joint responsibility of the Programme Academic Director, Academic Tutor and the Programme Administrator.

Summaries of the feedback and the actions taken will be included in Director of Studies' (Programme Director) Annual Monitoring Reports. Each report is presented to the Faculty Learning, Teaching and Quality Committee, which will make sure that the actions taken are adequate, appropriate, and properly implemented.

9.22 Student Representatives

As a student of the University you are automatically a member of the Students' Union (although you have a right to opt out - see section below on Student Union Membership). Officers of the Students' Union represent students' interests on University decision-making bodies.

In addition, numerous elected student representatives play important roles on various Departmental, Faculty/School and University committees. All student representatives are elected through Students' Union online elections.

There are many opportunities for elected student representatives, and the programme welcomes participation on its committees (see section 4 to identify areas where student representation is sought). The Department has a member of staff who can advise on the opportunities and the responsibilities involved. For this department, this is currently Paul Salkovskis. If you are elected by fellow students to serve on departmental, faculty or University committees you will be expected to represent the views of your fellow students and provide feedback following meetings. Mostly this will be done through the Programme SSLC (see above).

Departmental level: Each Department has at least one Departmental SSLC. These comprise six or more elected student members, known as Academic Reps and an equal or smaller number of staff members. Academic Reps are elected at the beginning of every year through online elections. Their role involves collecting the views of the students on their programme, attending SSLCs where they represent these views to their Department.

Each SSLC produces an Annual Overview Report briefly outlining their work and highlighting good practice, the key themes explored and the actions that have been taken as a result. The Students' Union reviews all these reports and prepares a summary report for the University highlighting issues which need to be addressed by the institution as a whole.

There is also provision for student membership of the Department Learning, Teaching and Quality Committee: normally one undergraduate and one postgraduate taught representative.

Academic Reps attend the Academic Council, as well as Faculty / School Forums, of the Students' Union. These meet, alternatively, every three weeks during semester time in order to:

- keep Students' Union Officers and fellow Academic Reps informed of academic developments throughout the University
- discuss common problems and interests affecting Departments
- gather student opinions and views to be used by the University and the Students' Union
- update Academic Reps on key issues.

Do feel free to approach your student Academic Reps at any time to inform them of good practice or areas for enhancement in your units and programme. This is normally the person who represents your year or degree scheme on the Departmental SSLC.

Faculty/School level: : Four student representatives (two undergraduates, ~~and~~ one postgraduate taught and one postgraduate research) are elected as Faculty Reps to sit on a number of Faculty/School level committees such as the Faculty/School Board of Studies, Learning and Teaching Quality Committees, and Research Students Committees. The Board makes most decisions in relation to teaching and research and reports to Senate. The Faculty/School Learning, Teaching and Quality Committee considers all matters relating to taught programmes across the Departments within the Faculty and makes recommendations to the Faculty/School Board of Studies. Faculty Reps are also members of the Students' Union Academic Exec Committee.

University level University committees with student representation include the Council/Senate/Students' Union, the University Learning, Teaching and Quality Committee, University Research Students' Committee; the Programmes and Partnership Approval Committee and Senate. Elections to many of these posts take place at the start of the academic year.

If you are interested in representing student views at Faculty/School or University level, please contact the Students' Union: email: academicreps@bath.ac.uk. The Students' Union runs a full training programme for student representatives including an online course in Moodle and additional sessions through the Skills-training programme.

If you need to raise a concern, remember there are various routes open to you. You can discuss issues directly with a member of staff, your clinical tutor or cohort tutor, your personal support tutor, or the Director of Studies (Programme Director). Individual problems are often more readily resolved in this way. The Students' Union Advice and Representation Centre, described below, also provides students with information and confidential advice.

Further information

Better@Bath: http://go.bath.ac.uk/betteratbath

Your SSLC: See General Information for Trainees page on Moodle

Students' Union Academic Representation: http://www.bathstudent.com/education/

Contact details of Academic Reps: http://www.bathstudent.com/education/mydepartment/

Election of Academic Reps-http://www.bathstudent.com/elections/

Outline election procedures are included in QA48 Student Engagement with Quality Assurance and Enhancement, Annex A: Staff/Student Liaison Committees at http://www.bath.ac.uk/quality/documents/QA48_Annex_A.pdf

Students' Union Skills Training programme: http://www.bathstudent.com/skills-training/

Postgraduate representation

All postgraduate students of the University (on taught and research programmes) are automatically members of the Students' Union and its Postgraduate Association. The Postgraduate Association is dedicated to representing the interests and views of all postgraduate students. For further information, please visit www.bathstudent.com/PGA .

Further information

www.bathstudent.com/arc/ provides information on student representation and contact details of academic representatives.

9.23 Students' Union Membership

All students registered with the University are automatically given membership of the Students' Union however you have the right not to be a member. For further information on opting out of this membership, please go to the Code of Practice for the Students' Union: http://www.bath.ac.uk/university-secretary/guidance-policies/codeofpracticebusu.html

10 Academic components of the Programme required for progression

10.1 Academic requirements of the 1st year

During the first four weeks of the first year, the Academic and training schedule takes place on all five days of each week, the exception being a placement observation day. During weeks five to eight teaching takes place on Wednesday, Thursday and Friday with Monday and Tuesday as placement days. From then onwards, Thursday and Friday are the academic days, until the end of June/early July. See appendix 23 for a summary of placement and academic days over the three years of the programme, including arrangements over the summer periods.

Lectures, workshops, seminars and tutorials will be scheduled for these times. Trainees are expected to prepare appropriately where required. This will include undertaking specified reading prior to some of the teaching sessions.

Some days of training will be scheduled in locations across the region (usually full days at a time). These days may include site visits to particular facilities (such as general hospital units, forensic mental health units and so on, as appropriate). As with other academic days, attendance is mandatory and will be monitored.

Trainees will be provided with the relevant programme timetable no later than the first day of each part of the teaching year, i.e. October, January and April. This provides a clear outline of each day's timetabled teaching and location. However, some adjustments to the timetable may be necessary and trainees will be informed about changes as far in advance as possible. Each year teaching typically ends towards the end of June, when the emphasis in University days shifts to research work and supervision.

Before formally proceeding to the second year of the programme, all trainees must have satisfied the examiners of their proficiency as follows:-

Written examinations - both of which must be passed in order to progress to the second year. In the event of failure, the examination (or examinations) must be re-taken at an arranged date in July. In addition, both placements must be passed, including the case studies.

10.2 Academic requirements of the 2nd year

In the 2nd year, Thursdays and Fridays are dedicated to timetabled teaching with occasional days in other regional locations. This teaching is timetabled from the end of September until the end of June.

Trainees are expected to prepare appropriately where requested. The case reports for units C2, C3 and C4 involve assessment of academic knowledge of developmental problems.

10.3 Academic requirements of the 3rd year

In the 3rd year, the main block of teaching takes place on Thursday from the last week of September until the end of June, with a number of occasional days taking place over the summer. Trainees are expected to prepare appropriately where requested.

In the 3rd year, there will usually be one day a week of dedicated research time from October to June. In July and August there will be two days a week of study time.

In May in the 3rd year of training, the research and professional portfolios should be submitted for examination. See Research handbook for details.

11 Timeline

In order to help students understand the requirements of the programme assessments and their associated deadlines, a timeline has been devised. It is recommended that you familiarise yourself with this Gantt chart which is available on Moodle at http://moodle.bath.ac.uk/

These timings shown may be provisional. Students will be required to have identified a personal timeline, graphically illustrated using Microsoft Project or similar planning tools in January of the first year, to be updated in review with their cohort tutor annually in June/July. There will be teaching on this task in the first year.

12 Additional guidance on major components required by the Programme

For more detail on the research components of the programme, please refer to the Clinical Psychology Programme Research Handbook.

12.1 Clinical Placements

See section 16 below.

12.2 Case study Guidelines/General information about case studies

12.3 Aims

The work clinical psychologists undertake is underpinned by their ability to apply models and theories in a reflective and individualised way. Clinical work can be viewed as a process. Firstly, evidence based assessment leads to the development of hypotheses about the problem and/or psychological formulation. This then leads to (a) further assessment to refine the formulation or confirm the hypotheses or (b) to the introduction of interventions based on the formulation. Monitoring the intervention as it unfolds provides feedback about how well the formulation fits the clinical picture. Openness to the feedback provided by monitoring combined with the clinical psychologist's capacity to reflect on their own practice in supervision is central to best clinical practice and the development of clinical competence.

Case studies provide the opportunity for clinical psychologists in training to develop and demonstrate clinical competence. As such they are a key part of placement assessment and an indicator to the programme of an individual trainee's capacity to function well as a clinical psychologist.

In summary, case studies provide evidence of:

- Developing clinical competence across a range of different types of work and setting, in the context of a range of theoretical perspectives

- Ability to integrate academic and theoretical ideas with clinical experience
- Ability to reflect on the way in which clinical, professional and ethical issues interact and impact on work.

12.4 Schedule of submission

A total of 5 case studies must be completed during the course of training, one case study for each of the first 5 placements (Units C1-C5).

A case study must be submitted at the end of each placement with the other placement assessments.

An extension of ordinarily no longer than 2 weeks can be sought from your clinical tutor if there are valid reasons for a delayed submission e.g. awaiting final outcome measure.

The 5 case studies should be submitted as part of the main research portfolio.

12.5 Breadth of content

The case studies submitted should aim to show work with a range of clinical problems, clients, contexts and interventions.

The case study should reflect work carried out on the clinical placement for which it forms part of the assessment. In relation to the core clinical placements (Working Age Adult, Older Adults, Child and Adolescent Mental Health and Learning Disability), the case study provides further illustration of the specific clinical competencies gained on that placement.

The case study for units C2-C4 also act as the assessment for unit A2 (Developmental applications of clinical psychology). To this end, the case study for C2, C3 and C4 must demonstrate:

- An understanding of the importance of lifespan/developmental context, based on research evidence, and how this links to clinical practice
- An understanding of developmental issues in the context of clinical assessment, formulation and/or intervention
- An understanding of clinical neuropsychology issues where relevant

Four of the 5 case studies should describe assessment and / or intervention within a cognitive behavioural framework. This is important for subsequent accreditation with the British Association of Behavioural and Cognitive Psychotherapy (BABCP). The BABCP requirements are for submission of information about a minimum of 8 cases, all of which must be of at least 5 sessions duration, and 4 of which must be case studies. Interventions based on cognitive or behavioural principles are acceptable and these can include mindfulness based interventions, behaviour modification, dialectical behaviour therapy etc.

Two of the 5 case studies should meet criteria for a single-case experimental case design. The criteria for single case experimental case design are clearly outlined on the case study marking sheet, and the information is supplemented in these guidance notes and specific teaching on this topic.

It is always a good idea to plan the case study at the early stages of a placement with your clinical supervisor. This can facilitate the planning for outcome monitoring and clinical assessment. It is also a good idea to discuss the suitability of a piece of clinical work as a potential case study with your clinical tutor before starting to write the report. We would encourage trainees to speak to both their clinical supervisor and their personal tutor as soon as possible to start identifying suitable cases.

12.6 Choosing a case

In principle, any piece of clinical work can be a suitable subject for a case study. However a case study is not simply a description of a piece of clinical work. The clinical material contained in a case study should serve to illustrate a theory-practice link i.e. considering the clinical case in its theoretical context, what can the literature tell us about this case and how can this case inform the literature.

The clinician who supervised your work on the case must agree that it constitutes an acceptable subject.

The definition of a "case" can include a ward, a service, a group etc; that is, a case means an *instance.*

Where a case study is descriptive, it could be an assessment case (including a neuropsychological assessment) or a treatment case, or one involving both aspects of psychological practice.

The retrospective reporting of a clinical case is not advisable. Although this may sometimes be feasible, it is generally best to plan and carry out your study on a pre-selected case.

If psychological intervention forms the basis of the case study, it is important to include follow-up data, as far as possible.

Understandably, trainees often imagine that the course is looking for reports of "successful" cases. The course is actually assessing your ability to make links between theory and practice, to reflect on the work and to show appreciation of any issues raised by the clinical material. Whether the case has a "good" outcome is much less relevant than the ability to demonstrate a thoughtful and sensitive approach to practice. Although it is always nice to read about successful outcomes, the report is not a test of a trainee's ability to make things better.

A trainee does not need be restricted to work that has been completed; unfinished work can be just as interesting and useful. However, this should be balanced carefully: it may not be sensible to submit a case study based on a very limited amount of clinical contact, and for BABCP accreditation you need 4 CBT case-studies based upon a minimum of 5 sessions.

It is strongly recommended that before writing begins, trainees talk to their course tutor about the cases they have in mind.

12.7 Reporting joint work

The trainee may submit a case study on work that they have undertaken jointly, for example with their supervisor, but the write-up should always make clear which aspects of the work was the individual trainee's responsibility. The write-up must all be the trainee's own work. If two trainees are on placement together, a report could be submitted on work that was done together (e.g. running a group, or teaching to a team, etc.), but this is only appropriate if each report focuses on a separate, defined piece of the work and cross-references the existence of other report.

12.8 Client consent

The client's consent to the use of material for a case study should be obtained when this is possible (See Case Study Consent Form Appendix (a) and Supervisor Confirmation of Consent Form (Appendix b) – both available on Moodle).

There are some cases where informed consent may be very difficult to obtain. In this way, being obliged to seek consent could restrict the choice of case and reduce the educational opportunities offered by case studies. At this stage the course is reluctant to make a general rule about this, and discussion with supervisors on this issue will be important. If an individual does not have capacity to give informed consent, it is usually acceptable to approach the clinical team/consultant and gain assent in this way. If the case is a child, then the parent(s) need to be approached.

Informed consent means letting the client know:

- that the client does not have to give consent, and that withholding consent will not adversely affect their treatment
- that the trainee will be writing up their case for educational purposes
- that the client's details will be disguised in order to preserve confidentiality
- that the case study will be seen only by the trainee's clinical supervisor, and by members of course staff and external examiners for the purposes of marking, all of whom are clinical psychologists
- that the case study will be bound into the trainee's thesis, but will not be accessible to the general public
- that the client can request to see a copy of the study (using the same procedures as for access to any medical record).
- That the case study may be submitted for consideration for publication in a relevant practice journal

If the client does ask to see the case study, the trainee might need to give some thought about how this is best done (for example, taking them through the report, giving the client a chance to ask questions regarding its accuracy and to discuss their responses to it).

13 Supervision and Support for writing the Case Study

13.1 Involving the clinical supervisor

It is essential that plans for a case study are developed in collaboration with the clinical placement supervisor. They are best placed to advise on the trainee's caseload, suitability of cases and also the clinical area/population forming the focus of the case study. However, the case study is very much the trainee's own work, and not all of the clinical supervisor's suggestions may be possible or meet the parameters required for an individual trainee at a particular stage in training.

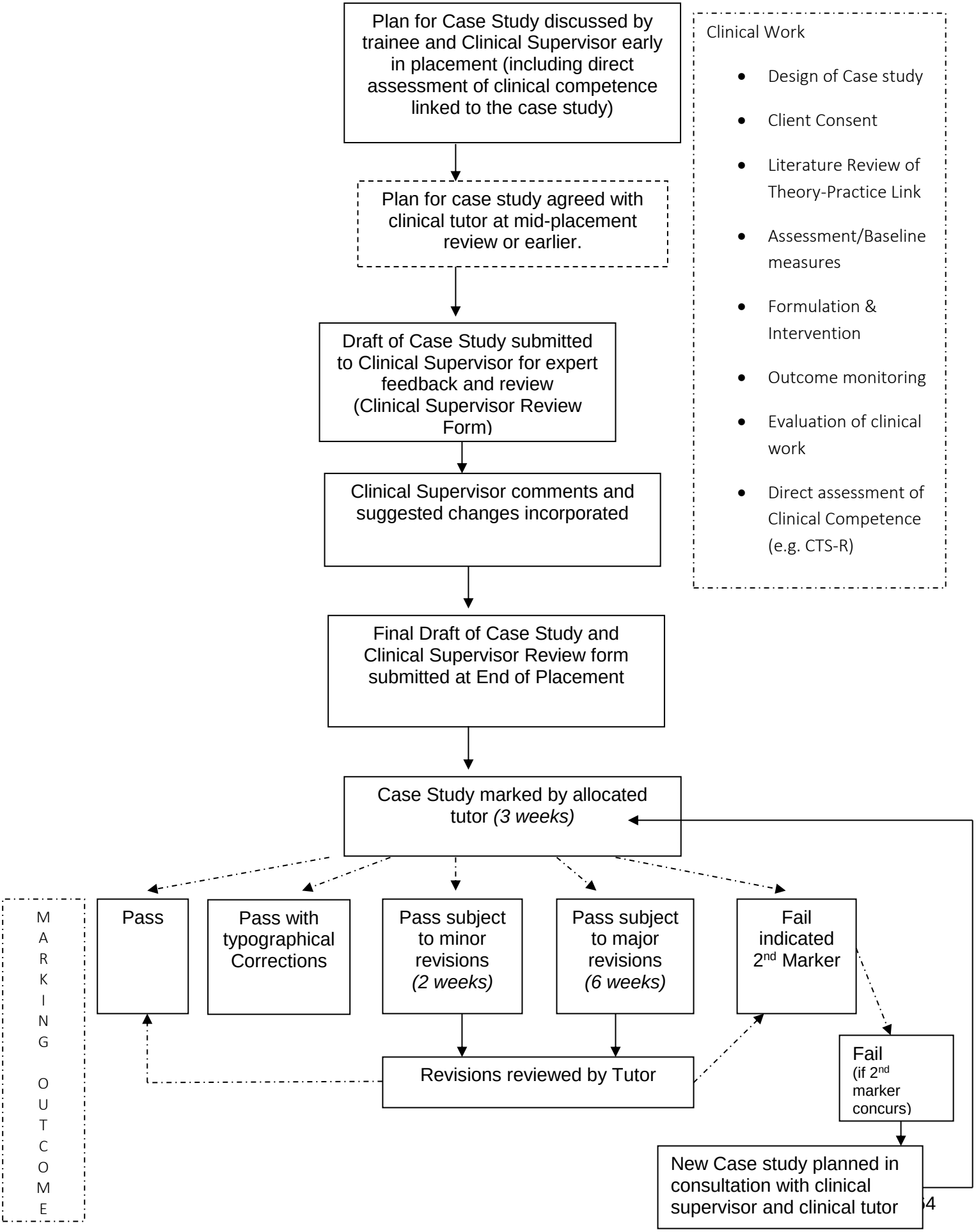
The clinical supervisor needs to provide the trainee with feedback and recommendations which can be incorporated prior to submission. This should be done using the supervisor case study review form. This feedback form should be submitted with the case study. This is to gather expert clinical opinion about the case study and also improve the trainee's chances of a successful submission.

13.2 Involving the clinical tutor

Trainees are encouraged to discuss their case study plans with their clinical tutor before they start writing. This is particularly relevant during the early stages of training. Tutors can help think about which case seems most appropriate for a case study, and which format is best suited to the write-up.

In the first placement (C1), trainees can ask their clinical tutor for feedback on the first draft of their case study – although the timing of this needs to be negotiated with the clinical tutor to allow time for feedback and revision. In subsequent placements, clinical tutors will not look at a draft of the report.

Case Study Flowchart



Guidelines for the format of Case Studies

13.3 Basic formatting

Reports should be:

- Typed
- Double-spaced
- Stapled
- Each page must be numbered

The cover sheet should give the following information:

- Title of Case study
- Clinical Placement and supervisor
- Date of submission (e.g. Case Report 1, January 2012)
- The word count (see below)
- A formal statement regarding confidentiality, as follows: “all names, ages, family structure etc. used in the report have been changed in order to preserve confidentiality”.
- A statement indicating whether or not client consent was sought/obtained for the study. There is a client consent form available on Moodle (see appendix (a)).
- The Journal at which the case report is aimed

13.4 Length of reports

The maximum word count for case reports is 4,000 words. This excludes references and appendices (but should include the abstract). This is an absolute limit, which cannot be exceeded. Additional information can be included in the appendices if needed.

13.5 Quality of writing, grammar and spelling

Case studies are submitted as part of the thesis. As doctoral level reports they should be clear, with few spelling or grammatical errors, or errors introduced as a result of word-processing. Up to a point, content is the main focus. However, trainees will be required to revise submissions that contain a large number of grammatical or spelling errors.

13.6 Preserving copies of case studies for binding into the portfolio

The case studies will be marked at each submission point – i.e. at the end of each placement. On the basis of feedback some reports may need to be revised. The final version of 5 case studies will be bound together, and will form part of the portfolio to be submitted in the final year of training. Trainees are responsible for keeping copies of their case studies in such a way that they can be submitted at the end of training. For this reason it is critical that each trainee retains a secure electronic copy of the final version of the case study.

13.7 Maintaining confidentiality

Reports will only be read by programme tutors and external examiners, the trainee's supervisor and potentially other trainees, journal reviewers and journal readers. It is essential that anyone reading the case report should be unable to work out the identity of the trainee's client. Achieving this requires some care, since it is surprisingly easy to include details that inadvertently breach confidentiality.

- Do not use real names – these must be changed, and a statement indicating that this has been done should be included on the cover sheet.
- Rather than inventing names, referring to Mr A., or Ms B. can be sensible; it makes it clear that these are not real names, and avoids the risk of reverting to the client's real name if a pseudonym was used. However, if there are a lot of people in the report, invented names become a necessity (there is a limit to how many Mr S's, E's and T's the reader can keep track of), but trainee's should make sure they proof read carefully and check that the same pseudonym is used throughout.
- Make sure that there is no information which could inadvertently identify the location of the service. For example, if the service has a particular name ("The Retreat", "The Pathways Project"), this will identify the location where the client is being treated.
- If letters or reports are included in the appendix, care should be taken to remove all addresses, Trust logos and references to the trainee's name, the name of the patient or anyone involved in their care, and any professional involved in the case. A high level of attention should be given to this, because it can be surprisingly easy to overlook names in the body of a letter.
- Only necessary items of demographic and clinical information should be included, and appropriate steps should be taken to disguise some of it. However, this should be done in a way that doesn't distort relevant issues. For example: 'a professional in her forties' is much better than 'the client was aged 43 and worked as a solicitor in a medium-sized law firm'; or he lives on a deprived inner-city housing estate' is better than 'he lives on a deprived inner-London housing estate', which in turn is better than 'he lives in a tower block on a deprived housing estate in Dalston'.
- Some details of the history (for example size of family, ages and sex of family members, occupation, timing of problem onset, specific details of the problem) may provide identifying information to somebody reading the work. This risk increases if the case includes a lot of specific and slightly unusual details which, taken together, could hint at a client's identity.

The more details given, the more confidentiality is at risk. Equally, withholding information to preserve confidentiality can deprive the reader of crucial clinical information. There is a balance to be struck, and it is worth giving careful thought to this issue. In rare cases describing the case properly would inevitably reveal the client's identity; if so it will be unsuitable for writing up as a report.

Framework

Case studies must demonstrate the understanding and application of psychological skills and knowledge to clinical problems. As well as providing an overview of the relevant literature at the

beginning, throughout the report, clear links must be made between the theoretical framework and the particular situation and intervention described. This will involve referencing the psychological literature where appropriate. Case studies should include relevant information in the appendix, such as summary tables of assessment scores. However, **case materials must not be included in the report** (e.g. consent forms, completed measures, referral letters).

Case studies should include most of the following elements or sections, which should be clearly defined, although it is not necessary to follow the order given below or to use the same sub-headings. For example an assessment case report or report of a group/ward intervention would clearly differ in style and structure from a more straightforward individual intervention report.

i. ***Abstract.*** – This will briefly summarize the case study, the aims of the case study, heuristic value, methods, findings and conclusion.

ii. ***A critical overview of the literature relevant to the case study*** - This will outline the theoretical context and evidence base within which your case conceptualisation is situated. For example, if your case relates to anxiety management with a person with a learning disability, you may wish to provide an overview of models of anxiety as applied to this client group along with the evidence base for different interventions. Your presentation of the case can then refer to this research context.

iii. ***An introduction to the case or problem situation*** **-** This will probably include some information about the referral or the initial stimulus for intervention, if no formal referral was received. It will also usually include the client's initial presentation of the problems to the psychologist.

iv. ***A detailed assessment of the problem situation*** – This should be based on the trainee's own (or joint) investigations. The case conceptualisation should give a clear description and justification of the approach taken for data gathering, as well as a clear summary of the results obtained.

v. ***Referral and assessment*** **-** The referral information and client's initial presentation of the problems provide the basis for the initial hypotheses about the case that are then able to be tested out through the assessment. At the initial stages of assessment it is likely that there may be alternate or competing hypotheses or explanations to account for the problem situation. The assessment section should show the most likely explanations, together with an account of how these hypotheses will be tested. Reporting the results of the assessment may include details gathered in the initial interview(s), with the client or significant others, concerning such factors as home background, social, sexual, educational and occupational histories, client beliefs or attitudes, and history of the presenting problem(s). It may also include reports of any standardised tests, or additional behavioural, cognitive or self-report forms of

assessment. If risk issues are particularly pertinent to the case formulation or theory-practice links, then please describe the approach taken to, and the outcome of, risk assessment. If risk factors are not relevant to the approach taken, then risk assessment should still be mentioned (if preferred it can be included in the appendix).

vi. ***A psychological formulation of the problem*** **-** The formulation is at the centre of the case conceptualisation report and should make sense of the data that has been gathered in terms of psychological principles, and clearly point to an intervention plan or therapeutic recommendations. The formulation should focus on formulating the presenting problem rather than the case i.e. individual's life. Within the formulation, it may be useful to distinguish between aetiological factors and maintaining factors. It may be useful to illustrate the formulation schematically. The formulation should clearly link the case material to a key area of psychological knowledge and cite appropriate key references for that area. All reports should include a text-based formulation. Diagrams should only be used to illustrate material that has already been alluded to in the text (for example to show the relationship between various elements in the presentation). They should not be used as a substitute for a full written account of the formulation. If a diagram is used it should be labelled as a figure, and referred to as such in the text, or it can be placed in the appendix.

vii. ***An account of the intervention itself and design*** **-** This should give a brief description of the intervention itself, which should follow on from the original formulation. The justification for the choice of the intervention e.g. NICE guidance or other evidence should be summarised. You should give an account of the intervention process including and any issues arising out of this, any problems encountered, and any outcome measures taken. The planning of the study should involve a clear decision about the design to be used, and you should state what your design is. Sometimes it may be necessary to justify the selection of a particular design in preference to others.

viii. ***Assessment Measures***: Well-defined measures of the variables in question are **essential**. If you are using (as sometimes one has to) your own ad hoc / idiosyncratic measures, these must be clearly described and justified. Sometimes you may be able to collect your own normative data, for use with such measures, without too much effort. The use of statistics is encouraged, but it is recognised that this may not be possible in all cases and consultation with a statistician at an early stage will be useful. Wherever such data is available, there should be an indication of the clinical implications of any test results. For example, stating that a client has a BDI of 32 does not convey very much. Reference to normative data would show that this indicates a fairly high level of depressive symptoms. On this basis the score would be reported as: "The client scored 32 on the BDI, which would indicate a high level of depressive symptomatology". Another example might be: "The client's score of 23 on the Recognition Memory Test places them at the 10th percentile". If test results from previous recorded assessments are available, it will be helpful to contrast these with

the trainee's results, and indicate the implications both of stability and of change. The choice of measures should be justified in terms of psychometric properties, use with this clinical population etc.

ix. ***Discussion –*** This should include a brief summary or interpretation of the results of the case study and any conclusions that can be drawn from the findings. The process of change almost inevitably brings forth additional information. This may substantiate the original formulation or require a revision of the formulation, and a change in tactics. With the benefit of hindsight, it may be possible to see how things could have been done differently, or how therapeutic benefits could have been maximised. It is not essential to present successful cases, but it would be a matter of concern if psychologists were presenting unsuccessful cases from which nothing had been learned. If follow up information has subsequently become available, it can be briefly included in this section. There must be a return to the theoretical issues raised in the introduction and considered central to this case, the theory-practice links can be reviewed in the light of the information illustrated by the present case study.

x. ***Reflective Section –*** There must be a 'reflective section' in all case reports. This is intended to be a brief section and essentially is your opportunity to comment on your experience of carrying out the work reported and your learning experiences from it. This section could include: what you might have done differently, in retrospect,; Whether a different model or formulation would have been more appropriate; why the client improved rapidly, or did not improve; whether it would have been useful to have involved family members; and, in the case of reporting a group, whether it would have been better if it was an open group or a closed group. Some comments on your own reaction to the client may also be useful – such as whether your first reaction to the client affected your intervention in any way; and how it changed over time. Equally comments on the way the client reacted to you may be relevant. Try to include a few sentences on what you learned from the experience.

xi. ***References***

xii. ***Appendices***

13.8 Writing up cases focused on Assessment rather than Intervention

It may be that the assessment of a case is the important aspect in respect of illustrating a theoretical or conceptual point. In such cases, it is acceptable to submit a case-report of the assessment process, provided it follows the same guidelines for a case report as described above. Examples of case-studies focused on assessment might include extended assessment and formulation in a CBT framework, a behavioural assessment or a neuropsychological assessment.

In case-reports where the focus is on assessment, the following points must be included:

- Explicit reference to *what point the case-report illustrates.*
- Sufficient review of the literature in the area.
- Attention paid to the background of the presenting problem, including previous assessment where relevant.
- Clear outline of the rationale underpinning the choice of assessment paradigm e.g. neuropsychological assessment, and how this contributes to a formulation of the problem.
- Assessment methods that are clearly outlined
- Findings that are reported and discussed
- Test scores, questionnaire item scores, behavioural observation data etc. should be contained in the appendices to the report and summaries/conclusions referred to in the main body.
- Clear explanation about how the findings / scores are interpreted, and reference to any normative data being used.
- A formulation section that draws together the findings from the assessment and returns to the theoretical issues raised in the introductory section.
- Although intervention may not have been embarked on or included in the write-up, the main body of the report should include a section outlining recommendations (which may include specific treatment recommendations), following the conclusions of the assessment.

13.9 Single Case Experimental Design (SCED) in case reports

The clinical psychology programme has a minimum requirement that at least two of the five submitted case reports should use SCED at an appropriate level for Clinical Psychology. We consider that, where possible, all cases seen should be regarded as systematic investigations of the single case; taking this approach will of course make it easier to identify some for submission as case reports.

The principle underpinning SCED is to design the case study to address a hypothesis such as "*It is hypothesized that the symptoms of depression will reduce as a result of cognitive therapy in a person with learning disabilities"* or to demonstrate a serendipitous but important observation with broader implications. The case study will then be designed to include repeated measures in a way which makes it possible to draw inferences about the impact of the intervention as opposed to the passage of time or regression to the mean. Most commonly, this is in the form of AB design, where a baseline (A) is used to establish the pattern of data over time, particularly its stability in terms of level and trend, followed by an intervention phase (B) where the data following the clear beginning of an intervention is monitored/sampled in a similar way and time intervals/frequency relative to the baseline allowing inferences regarding the likelihood of changes in either trend or level (or both). Typically this would mean a bare minimum of three baseline measures and an absolute minimum of three points immediately post-intervention (usually more) measured over comparable periods and with comparable frequency/time intervals (although intervention will usually be longer). Additional measures at follow up might also be reported in some cases. The aim is to repeat measures in a way which allows a judgment to be made regarding a likely causal link between the intervention and any change detected with moderate degree of confidence. This means that simply measuring baseline points then points towards the end of treatment would NOT be sufficient. Regular monitoring, session

by session, is recommended where possible. In some instances, much higher rates of measurement over shorter periods may be used, including over a single observation period.

The basic single case experimental design can be supplemented in various ways to strengthen inferences and decrease threats to validity. The baseline can take account of historical factors and third party reports and previous measures done some considerable time before. A primary measure should be designated a priori but additional measures can be taken either as part of a multiple baseline within subjects or using standardized measures to supplement semi-idiographic measures (e.g. simple rating daily of "how hopeless I feel about completing my single case designs for the programme" 0-100, 100 being completely hopeless, 0 being not hopeless at all, supplemented by PHQ-9 measures at the beginning and end of each placement).

Other more complex designs could of course be used, such as alternating treatments; this would be one of the few SC designs where a baseline is not an absolute requirement (although even then it is desirable).

Occasionally, assessment paradigms can take the form of SCED. For example, a hypothesis about the possible functions of a behaviour may be formed e.g. 'It is hypothesized that this behavior occurs more frequently when there are low levels of stimulation in the environment'. This hypothesis can be tested out as part of a case study by observing the behaviour across a 'natural baseline' and then a set of clearly defined conditions where levels of environmental stimulation are manipulated. Repeated measurement of the behaviour across these analogue conditions thus allows the hypothesis to be tested.

Justification of the design used (in terms of the questions being considered) should be offered as part of the written report, together with some discussion of threats to validity inherent in the design.

13.10 General comments about the structure and content of reports

The comments below are general observations.

It is important to think carefully about structure and content before writing is undertaken. There is a discipline to writing clearly and concisely, including details that are important for the reader, and leaving out irrelevant detail. Two fundamental questions to ask are:

"*What facts does the reader need to know about in order to understand the case, and what's the best order for reporting them?"*

"Which issues are critical, and which issues are interesting, but not strictly relevant?" This question about the focus of the report is particularly important given the word limit.

Consider what aspects of the history and what relevant background information the reader needs. Try to be concise, but include enough detail so that the reader is supplied with all the basic facts they need at an early stage.

All information in a clinical report should be evidence based. For example, an observation that Mr X seemed 'distracted' during the assessment should be qualified with a description of the behavioural features which led the therapist/assessor to this conclusion e.g. he looked out the window frequently in response to passers-by necessitating the examiner to remind him of the task at hand.

Consideration should be given to the source of the evidence. For example it may be more accurate to state that 'Mr X reported physical abuse during childhood by his father' rather than 'Mr X was physically abused during childhood by his father'. These two statements have different status and meanings.

If the client's view of the problem is not consonant with the trainee's, it is important to make this clear. For example the trainee might write 'Mr X's understanding of his problems differed from that of the mental health team'.

It is important that the report and your formulation show coherence in relation to the model being used. Discussion of the intervention should try to show how the formulation and the intervention link together in a 'dynamic' manner. This requires selection of relevant and illustrative clinical material, limiting the writing to include only those details which show developing understanding of the case.

The concluding discussion depends on the type of report the trainee has written, but will usually include some reflection on the work that was done. This reflection can include consideration of wider issues raised by the case and its impact on the trainee, as well as an appropriately critical appraisal. In this context 'appropriate' means that criticism should not be invented for the sake of it. If the approach taken worked really well, there's no need for a critique. On the other hand, there is little in clinical psychology that is completely cut and dried, so it's often sensible to include suggestions about other ways in which the case could have been approached or managed. However, these should be realistic and feasible alternatives that could have been offered within the constraints of the trainee's experience and the service they are working in.

14 Additional Help

You may wish to see some examples of good single case studies that have been published. The best sources of these are the following journals:

- *Behaviour Research and Therapy*
- *Behaviour Therapy*
- *Cognitive & Behavioural Psychotherapy*
- *Journal of Applied Behaviour Analysis*
- *Journal of Behaviour Therapy and Experimental Psychiatry*
- *Clinical Case Studies*

Current issues and past volumes of these are available in the library.

Some other useful references include:

- Yule, W and Hemsley D. (1977) *Single case methodology in medical psychology*. Pergamon,
- Hersen, M. Barlow, D.H. (1976) *Single Case Experimental Designs: Strategies for Studying Behavior Change.* New York: Pergamon,. 72
- Edgington, E.S. Statistics and single-case analysis, in M. Hersen, , R. Eisler & P.M. Miller (Eds.) *Progress in Behaviour Modification,* Vol. 16, New York: Academic Press.
- D.F..Peck. Small N experimental designs in clinical research. In F.N. WATTS (Ed.) (1985) New Developments in Clinical Psychology**.** Chichester: Wiley.

Case Study marking

14.1 Submission deadlines

The deadline for submission of each case study is the end of placement unless otherwise communicated by the programme team.

14.2 Requesting an extension

Under exceptional circumstances, an extension to the date by which work must be handed in can be negotiated. This should be requested in advance by discussion with the trainee's Course Tutor. The usual grounds for an extension would be illness or major life-events. Extensions may also be granted if trainees are waiting for follow-up data, or if they are waiting for the supervisors to review and feedback their draft of the report.

14.3 Submission procedure

Work is submitted via your cohort submission point in Moodle (e.g., Cohort 2016 submissions) for the relevant clinical unit.

14.4 Procedure for marking reports

Each report is marked by a tutor from the team within three weeks of submission. Generally, the marker will not be the trainee's individual clinical tutor. Feedback provided by the clinical supervisor will be taken into account when marking the report.

The criteria against which the case study are marked are clearly outlined on the supervisor and tutor review sheets.

14.5 Marking categories

There are 5 possible marking categories:

- Pass
- Pass with typographical corrections - to be completed within 2 weeks
- Pass subject to minor revisions - to be completed within 2 weeks
- Pass subject to major revision - to be completed within 6 weeks
- Fail

14.5.1 Pass

The report meets the requirements of the particular assignment as it stands. This does not necessarily mean that it is perfect and sometimes the markers may make suggestions for improvement. However, these would be intended as learning points, and there is no obligation for the trainee to make changes to the report.

14.5.2 Pass with typographical corrections

This category is used when a report nearly meets requirements, but contains some specific minor problems that can be corrected quickly (such as incorrect format for references, grammatical, spelling or typographical errors, missing references or a detail which reveals the client's identity). These should be completed within 2 weeks and do not ordinarily need to be reviewed by the marker unless they specifically request. However, the amendments should be completed for inclusion in the final portfolio submission.

14.5.3 Pass subject to minor revisions

This category is used when a report is generally in line with requirements but some changes to content are needed to satisfy the marking criteria. This might include some restructuring of a section, insertion of additional information in at least 1 section, or reconsideration of some aspect of the assessment and/or formulation. The changes although significant should not be substantial in the sense that they alter the overall conceptualisation of the case. These should be completed within 2 weeks and submitted for review by the marker.

14.5.4 Pass subject to major revisions

This category is used when one or more aspects of a report are inadequate or require modification that significantly alters a central aspect of the case study. Examples might include deficiencies in formulation, the absence of significant clinical details, failure to discuss important literature which is directly relevant to the case, or where the work undertaken is not reported sufficiently clearly. This category may also be used when very substantial revisions are required in the conceptualisation and/or write-up of the report. Normally the trainee needs to rethink the case in several ways and redraft most of the report including clinical presentation, formulation and critical appraisal. These should be completed within 6 weeks and submitted for review by the marker.

14.5.5 Fail

This category is used when the report has such significant failings that revision is not an option. This would be the case where the clinical work being described does not meet the usual professional standards in essential ways or the report falls significantly below the academic standards expected of doctoral level work. Specific problems could include work which raises major ethical problems, a clearly inappropriate clinical approach to the case, or a highly confused or incoherent report.

If a fail grade is indicated, the case study is reviewed by a 2nd marker. If agreement is reached between the 2 markers that a fail grade is appropriate then where possible feedback will be provided in person to the student as well as grading the assignment on Moodle.

A new report, based on a different case, will need to be submitted.

14.6 Feedback on the report

Feedback will be returned to the trainees normally 3 weeks after submission. This will show the final marking category, with feedback and revisions required to attain a pass grade if relevant.

Trainees can expect to receive reasonably detailed feedback from the markers, indicating both the strengths and the limitations of their reports. Markers will try to be clear about the changes they require. If the trainee is unclear about any aspect of the feedback they can approach the marker named on the final mark sheet for clarification. It is the trainee's responsibility to decide how the specified changes can be made (for example, deciding which parts of the report to edit in order to accommodate additional issues raised by markers). If the trainee requires further supervision or assistance in making the revisions requested, they should approach their clinical tutor.

14.7 Procedures for resubmission

14.7.1 Minor revisions – (2 weeks resubmission deadline) and Major revisions – (6 weeks resubmission deadline)

The trainee will need to submit (via Moodle – amended case study submission point) a single document that includes:

1. A statement that clearly states how the report has been revised to meet the concerns of the marker. This should provide a clear account of all changes which have been made, referring to the points raised in the marker sheet, and ensuring that all these points are addressed.

2. A copy of the revised report, showing changes from the original in "track-changes" (so that the examiner can see where changes from the original have been made).

The programme tutor who had previously marked the report will then mark the resubmission. If it is judged to reach passing standard, no other marker will be involved. If there are still problems with the work, a second internal marker will also assess it. The trainee will receive a revised mark sheet showing the mark and giving any relevant feedback.

Once the marker(s) have agreed the final version of the report the trainee should 'accept' the changes as agreed. It must also be ensured that it is the amended report which is included in the bound submission of the case reports in the final year.

14.7.2 Fail

A new report, based on a different case, will need to be submitted. Guidance from the clinical supervisor and clinical tutor will be required.

PLEASE NOTE; THE FOLLOWING SECTIONS ON RESEARCH ARE SHORTER VERSIONS OF THE DEFINITIVE GUIDANCE GIVEN IN THE RESEARCH HANDBOOK.

14.8 Service Improvement Project

14.8.1 The aim of the project:

The basic aim of these projects is to ensure that all trainees are introduced to the process of conducting some health service related research and audit within a general "Quality Improvement" framework. Examiners will expect the study to demonstrate how the trainee has analysed the issues involved, and how they have tackled the problems in a systematic way linked to service provision.

Clearly the range of potential topics is very wide. Clinical supervisors who regularly work in clinical settings will often have many ideas for potential projects that they would like to see conducted in their own services. Ideas for any project will have to be approved by them, as they are in the best position to then help trainees carry out the projects within their service. It is a good idea to approach your placement supervisor and enquire about any potential projects.

14.8.2 Ethical Approval/ Audit approval

In the first instance, trainees should consult the NHS National Patient Safety Agency booklet *Defining Research: NRES guidance to help you decide if your project requires review by a Research Ethics Committee*. If still unclear, trainees should seek specific guidance from the research tutor or programme director about whether the project constitutes a clinical audit (and therefore requires approval by the Audit committee in the Trust where the work is to be conducted) rather than a research study. If defined as a research study, a full Research ethics application must be made through the IRAS system. Note however, that if it is defined in this way, the trainee and their supervisor may wish to reconsider the scope of the project. In either case, approval must also be sought from the Clinical Governance Committee for the clinical area of the NHS Trust that the project is being carried out in. The clinician supervising the project who works in this area should guide you as to the mechanisms for this.

14.8.3 Structure of the Write-up of the Service Improvement Project

The exact structure of each project will vary, so it is difficult to be prescriptive as to how each should be written up. It may help if trainees try and work around the following guidelines:-

1. Introduction: including the aims of the research, essentially what you set out to investigate, and why it was important for the service to examine this issue and a brief literature review: What existing service related research literature can you draw on? How might these studies be linked to your own? Your literature review should be brief and focused.

2. Methods: What methods did you use to conduct the service related research project? How was the scoping for the project carried out? Who were the participants (if any), what measures did you select? What can you say about the reliability and validity of the measures/data used?

3. Findings: What were the main findings of your service related project? This need not necessarily involve exhaustive statistical analysis, but should be presented in such a way that

multidisciplinary colleagues could understand your findings. Wherever feasible, description of a presentation to the service should be included, together with an account of their reactions.

4. Discussion/Implication of the Study: What are the main implications of your study for health service practice? Are these accepted by the service concerned, and how has their practice been affected by the results? Is there further work to be done on the issue investigated, and if so, how could you conduct such a study?

14.8.4 Practical Aspects

A copy of your report should be submitted typed and double spaced. Reports should be no more than 5,000 words. Longer reports are not acceptable.

References should not be too numerous, and should be set out in a format used by a mainstream journal.

14.9 Main Research Project

14.9.1 Guidelines for the research project

The research project is intended to provide trainees with experience of carrying out clinically relevant research of a type that is feasible for clinicians working as scientist-practitioners or applied clinical scientists. Consequently, the range of acceptable topics and designs is broad. Given the time-scale of the project, it is possible to conduct quite complex work, including treatment outcome studies and tests of psychological theories/formulations.

It is recommended that trainees consider the scope of material presented in clinically oriented journals (including, but not confined to, Clinical Psychology Review, British Journal of Clinical Psychology, Behavioural and Cognitive Psychotherapy, Journal of Abnormal Psychology, Journal of Mental Health) when deciding the area to be covered in their project proposal. Trainees should also review previous cohorts' portfolios.

For the main research section of their portfolio, trainees should produce a report in the form of a journal publication which indicates that they have the capacity to become part of the discourse of the discipline in their chosen area of work. They should demonstrate a clear, scholarly and analytic understanding of the current clinical and academic literature in their chosen area. The portfolio should show an aptitude for research, with evidence that they have exercised powers of observation and the ability to collate the results of their research, synthesising with existing research. They should demonstrate the ability to present research findings and their context concisely and with clarity. The research report should also demonstrate the trainees understanding of the psychological processes, clinical and/or service issues involved in their research area. Actual submission to a journal prior to examination may be an advantage, although it should be noted that acceptance for publication does not in any way guarantee acceptance at examination.

14.9.2 Choosing a topic and supervisor

Two supervisors are required for the main research project: a main supervisor and a second supervisor. The first supervisor must be a member of academic staff at the University of Bath whose contract extends at least as far as the end of the submission time for the main project. The first supervisor would be expected to have some experience of having supervised DClinPsy trainees previously as main or second supervisor. The second supervisor should be someone with expertise in the proposed area, and often they will also have access to the patients needed for the research. The second supervisor would usually have experience supervising research projects as well. There will be unexpected instances when the second supervisor will have to step in as the main supervisor, and a further supervisor should also be involved if this is the case. The Course Director or one of the Research Tutors should be able to advise you if this should arise.

In consultation with their supervisors, trainees will choose a topic in any area of clinical psychology. In December of each year, there will be a research fair where possible projects will be outlined verbally and written, with students having the opportunity to discuss options in a preliminary way. In addition, the range of supervisors and projects in the University and in the Region will be available in the Programme Research Handbook. In addition, trainees may develop their own proposal *de novo*, or in the course of discussions with supervisors or trainers on the Programme.

Although the first supervisor is always a member of academic staff, this is an administrative issue, and it may be that the "lion's share" of supervision may be carried out by a regional supervisor outside the University. However, the University based supervisor has the final say in the unlikely event of disagreement.

The supervisory relationship is discussed in more detail in the research handbook. A research contract, indicating roles and responsibilities, should be discussed and signed by both supervisors and student at the time of submission of the research proposal.

14.9.3 Research Proposal

After the research fair, students are expected to meet regularly with their clinical tutor to discuss interests and options. Once the projects are identified, supervision of both SIP and Main Research Project proposals will be by University project supervisor and field supervisor as appropriate. The final summative assessment will be scheduled for two days in the first year timetable. Each student presents at a scheduled time on that day either their SIP or MRP following previous (at least two weeks before) submission of a written version. In the oral presentation session, a review panel of at least two of the research team will assess the project and provide feedback. In addition to the presenting student, the University and field supervisor/s are invited to attend. Presentation should be no more than10 minutes with up to 20 minutes discussion. Supervisors should only respond if requested by the review panel. Feedback will be given on the day. Fail requires re-examination, otherwise oversight of required modifications are the responsibility of the university supervisor and clinical tutor as appropriate. (Other staff can choose to attend.

If a case is made and agreed by the research team, individual SIPs can be brought forward timewise to take advantage of placement based opportunities.

Submission of proposals

Deadlines will be published on Moodle regarding submission dates. Once submitted, each research proposal will be reviewed and marked by members of the Research team. Comments will be fedback to the trainee and supervisors.

The research proposal should be three to five typed A4 pages. It is essentially a summary of the introduction, hypotheses and methods of your study. In brief, there should be an introductory section providing a summary of the salient issues in the literature and how they lead you to formulate your hypotheses and study. Write the aims and/or hypotheses out clearly. Summarise the methodology in the usual way, i.e., design, methods and measures, participants, procedure. A power analysis will be essential. End with a statement of how you intend to analyse the data when you have gathered it.

In some instances, your supervisor will be able to provide expert and/or specialist statistical advice. Such advice is also available from Dr Ian Walker in the Department of Psychology (i.walker@bath.ac.uk), who will also be involved in statistics teaching on the Programme. Note that he will also be involved in reviewing the statistical component of the research project.

Structure of Research Proposals
(Approx. 3-5 pages)

Title Names of 1st and 2nd Supervisor

Brief outline of aims and objectives (1 paragraph)

Literature review (approx. 2 pages)

Hypotheses

Method and Design. Pay particular attention to feasibility of obtaining required participants. Carry out power analyses to estimate numbers needed. Justify measures to be employed. Consider whether any piloting of these is necessary (e.g. reliability studies). Outline timescale for data collection.

Analyses to be carried out.

Costs and budget : A separate page setting out details of costs must accompany the proposal. Typical costs include payment for participants, questionnaires, travel, equipment, etc.

References: During the first term, trainees will be introduced to Bibliographic Software (EndNote), so that references can be kept in searchable form. Ensuring that all references consulted during the

development and writing up of the portfolio are entered on this system will save you a great deal of time towards the final stages of writing up your portfolio. References should be presented in APA 6 format.

14.9.4 People with personal experience participation

All students should seek to involve people with personal experience in their research, if possible from the very beginning. People with personal experience representatives are involved in the Research committee, but students are encouraged to develop their own links. People with personal experience participation in research will form part of the November/December research days, and students will be able to discuss this issue with the Programme team as part of the research project development process.

14.9.5 Ethical Approval

Ethical permission needs to be sought as soon as possible once the research proposal has been vetted and amendments agreed. Ethical approval must be given for the project **before** any work is carried out. Application and approval can be a lengthy process and trainees are advised to embark upon this as soon as possible. Ethical applications for samples recruited via NHS sites are made online through the Integrated Research Application System (IRAS). If that route is followed, it is important to apply to notify the Dept of Psychology ethical committee once approval is obtained to ensure that the University of Bath is aware. There is more information about this process in the research handbook.

14.9.6 Write Up

Make sure to allow sufficient time for finalising the portfolio. You can start writing up while you are still collecting data; the method section for example will form part of the ethics approval, and can be modified once approved ahead of completion. Aim to complete the first complete draft no later than 1st March of Year 3 so that your supervisor can comment on it and revisions can be made. Earlier will always be better!

As the core of the research project write up is meant to take the form of a submission for publication, your supervisors will try to identify an exemplary publication broadly in the area of your work and in the target journal you agree. As the Programme is still relatively new, there are no examples of previous students' theses available for reference purposes at this time.

14.9.6.1 Binding and Submission

Two soft bound copies of all written research components (bound together as a portfolio) and two soft bound copies of your case studies (bound separately) are to be handed to the Programme Administration Office by mid-May. For binding purposes a 1½"/2" left-hand margin should be used and 1½ line spacing.

After viva, two hard bound corrected copies of the research portfolio and two clean, soft-bound copies of the case study and professional portfolios are to be handed to the Programme Administration Office.

Please see full submission details at http://www.bath.ac.uk/student-records/pgresources/docs/Thesis%20Specification.pdf

14.9.7 Planning

As part of their proposal, students will be required to produce a Gantt chart of their research project. The Gantt chart is a helpful planning tool, and will be introduced with examples of how it can be used in your first term teaching block.

Be alert to potential projects. Ideas will come from your reading, clinical experiences, other work going on in the University, your own prior interests and experiences. It is quite acceptable to choose a project that dovetails with, or is a discrete part of larger scale research going on in the university, or in placements. Discuss your ideas with staff members or potential supervisors early on in your decision-making process.

While making your decision, bear in mind: manageable scope of project, accessibility of participants, availability of materials, equipment, ethical considerations.
Once you have decided on your topic and supervisor, you should work with your supervisor and the Programme team to crystallize your ideas into a project that is circumscribed and that you feel you can live with for the next year. To ensure that your project is feasible and manageable, bear in mind:

Availability of participants: Avoid choosing a topic which requires a highly selected rare population; check that you have the permission of necessary authorities or people, e.g. consultants, school authorities, G.Ps. etc. to contact potential participants. RECRUITMENT IS ALMOST ALWAYS THE BIGGEST PRACTICAL ISSUE.

Check for possible overlapping demand for similar groups of participants with someone who has an overview of the situation. See a research tutor(s) to ensure that you are not approaching the same group as other researchers. The research supervisor should be alert to other projects in the area.

Randomised controlled trials are almost never feasible for DClinPsy projects; they are not forbidden but are likely to be scrutinised very carefully for feasibility. Such research is usually carried out by well-funded large teams.

Limited access to resources: Try to use available equipment or materials as special apparatus may take far too long to acquire or build (even if you can afford it). Remember that the development of valid and reliable instruments such as interview schedules, questionnaires, computer programmes is a lengthy process. Be cautious about embarking on such ventures for the DClinPsy.

14.10 Reflective Practice

Reflective practice is a key part of professional development as a clinical psychologist. It provides an opportunity for trainees to reflect on training and the impact of clinical work. The Programme regards reflective practice to be an integral part of training, starting with the first term where reflection on the observation occurring on placement and how this links to both the teaching during that period and the trainees personal reactions to both aspects will form part of the University training block.

There will be two specific reflective sessions in the first block; the first of these will focus on the experience of becoming a new trainee on a Clinical Psychology Doctorate Programme and will be scheduled about half-way through the first term. The session will be divided into two components; firstly trainees and Programme staff will meet separately, then in the second section staff and trainees will form a single group. A second session structured in a similar way will be held during the final week of the term. However trainees will also be asked to consider the form and content of future reflective practice sessions over the remainder of the year. This process will be repeated at the end of the first and second years. As far as possible the Programme team will seek to accommodate trainees' wishes in this respect.

There has been much debate about the role of personal therapy in the context of clinical training. Although the Programme recognises that there are circumstances where personal therapy will be appropriate for trainees, this would be only in circumstances where such therapy was appropriate as a result of a trainee experiencing more serious problems in the course of their training. However the Programme also recognises the value of first-hand experience of self-focused therapeutic work. Trainees will therefore be offered mindfulness based cognitive therapy group sessions as part of their training from the first year. The advantage of this approach is that it does not assume that participants are currently experiencing any specific problems and it is recommended that health professionals experience an eight-week mindfulness programme themselves before delivering this intervention to others. There will be the opportunity to reflect on how mindfulness-based approaches can be used to help one's therapeutic work in general.

The training logbooks will be adapted to include a reflective component. It is also expected that there be a reflective component to placement supervisory sessions. *Note that this component will be developed in the course of the work of the practice and placement committee in the coming year.*

14.11 Consultancy / Service Review

Trainees are required to conduct a service review/consultancy during their second or third year. This may be a review of an aspect of a service or an entire service. Most commonly it will be on behalf of an NHS service, but could be in another area (e.g. third sector, prison, residential homes). The report of the review or consultancy will include a consultancy agreement/contract, report of 3,000 – 4,000 words, a commissioner's response and a reflective statement; these will all be included in the portfolio.

Joint working is possible if approved by the unit convenor and the Programme Director. Both the service review specification and the service review report can be prepared and submitted jointly, but

for the purposes of the submissions to the University, a clear statement should be included about the division of responsibility.

15 Guidelines for DClinPsy Research Supervision

This issue is also dealt with in the Clinical Psychology Programme Research Handbook.

16 Rules regarding assessment, examination processes and examination of the research portfolio and 3rd year vivas

The specific rules regarding the programme can be found in the Programme Regulations (see appendix B); as specified there, these regulations in turn need to be taken in the context of University of Bath Regulations. This section of the handbook is meant to place these regulations in context, containing much of the same material.

In order to be awarded the Doctorate in Clinical Psychology, trainees must successfully complete all assessments in all units of the programme. All units are thus compulsory as are all assessments, which have a pass mark of 40% in line with University Regulations. The schedule of units and their assessment components is shown in appendix D. It is not possible to use passes in one unit for another which has been failed.

Failure in an assessment component of a unit (mark<40% or a designated failure) results in failure of the entire unit. Following initial failure of an assessment, a student is normally permitted one further attempt to retake that component of the unit. An exception, for Research unit R1 is that it is possible to resubmit twice for the assessments of proposal components.

With the exception of the clinical placement assessment, resubmission within a unit is normally only the specific component(s) which have been failed. In the unlikely event of failure of an assessment, resubmission must usually take place within 28 days of official notification of failure, to facilitate continuation on the normal study schedule. A second failure of the same unit will result in withdrawal from the Programme. A student will be given the opportunity to retrieve failed units, to a maximum of two units in any single study year, and no more than three units across the whole Programme.

One component of the assessment of clinical units is the Clinical Placement Review for which students will receive a mid-placement report as described elsewhere in this handbook.

If a Clinical Placement Review is not passed and the possibility of failure had been noted and communicated at mid-placement, then the clinical unit must be repeated immediately with a new clinical supervisor. If a Clinical Placement Review is not passed at the end of placement, **but this was not identified at the mid-placement review** and communicated in writing, a fail will not be recorded, but the placement will be extended, with the same clinical supervisor, by the period corresponding to the time between that placement's mid-placement review and the end of placement. If the student then fails following this extension, then a failure of the unit is registered and an immediate repeat of that unit is required with a new clinical supervisor.

In the Clinical Placement Review, the student will be judged on their clinical performance as assessed at the mid and end of placement reviews with the supervisor and programme staff member, taking into account the overall placement ratings and the competencies ratings (rated on the basis of the regular supervision sessions throughout the placement including review of video and/or audio recordings) and the placement specific single case study. Part of the assessment concerns an overall fitness to practise evaluation. Forms for these assessments are included in appendix 4, although these may be updated year on year to reflect the requirements of professional and regulatory bodies and other developments. The mandatory categories vary slightly with clinical speciality.
Concurrent study of other non-clinical units will not be affected by extension or repeats of clinical units but all subsequent clinical units will be deferred. Consequently the student's registration on the programme will be extended to allow for completion of all clinical units.

Late submission of coursework, extension to assignment submission deadlines and mitigating circumstances

If there are valid circumstances preventing you from meeting a deadline, you may apply for an extension from your clinical tutor using the form available on Moodle. This will then be considered by the programme executive. An extension will then be subject to approval by the Programme Director (Director of Studies) who may delegate this responsibility to other programme staff members including your tutor. You must specify the reason for the request and should be normally sought at least one month in advance of the deadline. You may be asked to produce supporting evidence. If an extension request is approved, normally it will not usually be for more than four weeks, except in the case of the C (placement) units, in which instance the timing to be agreed by the programme executive and monitored by the Clinical Director. Students should raise the possibility of an extension being required with their cohort tutor as early as possible.

Individual Mitigating Circumstances

Individual Mitigating Circumstances (IMCs) are the conditions which temporarily prevent you from undertaking assessment or significantly impair your performance in assessment. As such, the measure of their severity is not about impact on you, but the impact on your affected assessment.

Full information and guidance on Individual Mitigating Circumstances and Assessment is available at http://www.bath.http://www.bath.ac.uk/registry/imc/imc-students.html. It is strongly advised that you become familiar with the available guidance so that you understand the process and timescales should such circumstances arise.

Definitions of IMCs can be found in "What are Individual Mitigating Circumstances" (http://www.bath.ac.uk/registry/imc/documents/what-are-imcs.pdf). You should make yourself familiar with these definitions, in addition to any IMC guidance offered by your Department, and support and guidance offered through the Student Disability Advice Team (http://www.bath.ac.uk/disabilityadvice/) or the Students' Union Advice and Representation Centre (http://www.bathstudent.com/advice/).

The Programme Manager will be able to advise you on how to submit an IMC claim, and your Programme Director can help you to understand the potential implications of your IMC claim on your overall progress and/or award, in light of your academic achievement to date and the assessment regulations for your programme.

Should you wish any IMCs to be taken into account by the Board of Examiners for Programmes when considering your progression or award classification, notify your Director of Studies no more than three days after the affected assessment by completing the IMC report http://www.bath.ac.uk/registry/imc/documents/imc. You will also need to submit evidence of how your circumstances affected the relevant assessment(s), for example, a medical certificate in the case of illness or injury.

If you know of a potential IMC that may affect your assessment before you begin an assessment period, it is important that you notify your Director of Studies/Programme Leader in advance. Note that if you do intend to submit a formal IMC claim for the affected assessment(s), you will still need to complete the form and follow procedures.

Progression decisions

Decisions relating to the progression of students from Units, or Year of study, to the next, are considered by the Board of Examiners for Programmes (BEP). Examination processes are conducted within the framework of the University of Bath Regulations for Postgraduate Research Degrees, overseen by the Examination and Assessment Committee of the Programme, which forms the basis of the Board of Examiners for Programmes. The Examination board is formally chaired by the Head of Department, Prof Gregory Maio, and will include external examiners who will be appointed to follow each year group (i.e. each for a term of three years).

Cohort 2014	Dr Rachel Handley	University of Exeter
Cohort 2015	Dr Louise Waddington	University of Cardiff
Cohort 2016	TBC	

Examiners will invariably be HCPC registered Practitioner Clinical Psychologists. For the *viva voce* examination in year 3, the three external examiners will be joined, as required by the topics chosen by students for their research work, by specialist examiners who will also usually be HCPC registered Practitioner Clinical Psychologists. At any time, at least one of the three External Examiners will have registration at least at practitioner level with the BABCP. Examiners for the research components of the programme and for the viva voce examination in year three are appointed on an individual basis for each student; to ensure appropriate expertise amongst examiners, it may be required that an additional external examiner for a specific research topic is appointed. Students will be notified of the examiners for the viva voce examination no less than three months from the examination itself.

It is inappropriate for students to make direct contact with External Examiners, in particular regarding their individual performance in assessments. The sections of this Handbook on "Procedures for Academic Reviews (Appeals) " and "Dealing with a Problem Involving the University/Complaints" explain what to do if you are dissatisfied in this respect and are considering a formal or informal

complaint or appeal. The section on "Student Representation" sets out how students can engage formally with the quality management process through which institutions consider and respond to External Examiners' comments and suggestions.

You can read the latest External Examiner's report for your programme at www.bath.ac.uk/quality/externalinput/external-examiners-reports.bho/index.html

The Programme Board of Examiners will meet at the end of Years 1 and 2 to determine whether trainees have successfully completed the requirements for progression to the next year of the programme.

The Programme Board of Examiners will meet in September of Year 3 to review the research and professional portfolios and results of the *viva voce* examinations for the third year cohort. On the basis of the research and professional portfolios, performance at the *viva voce* examination, and other assessments carried out up until that time, the Examination Board may recommend, subject to satisfactory completion of the remaining assessments the following:

Award of degree

As specified in the programme regulations, the degree of Doctor of Clinical Psychology shall be awarded to a candidate who has fully completed the required programme of study, including all units. In addition, the student must have also presented work as prescribed for the programme including a research portfolio which satisfies the Board of Examiners as

(a) making an original and significant contribution to knowledge

(b) giving evidence of originality of mind and critical judgement in a particular subject

(c) containing material worthy of peer-reviewed publication

(d) being satisfactory in its literary and /or technical presentation and structure with a full bibliography and references

(e) demonstrating an understanding of the context of the research as appropriate for the subjects of the papers in their scientific, professional and social contexts,

Part of that process requires the student to pass a viva voce examination conducted by the examiners on the broader aspects of the field of research in addition to the subjects in the portfolio.

On the basis of the research portfolio, performance at the *viva voce* examination, and all previous unit assessments the Board of Examiners for Programmes may recommend:

(i) That on successful completion of the remaining units (normally C6 and P1) by the subsequent meeting, the student be awarded the Degree of Doctor of Clinical Psychology; or

(ii) As (i) above, but subject also to minor corrections to the portfolio being executed to the satisfaction of the Board of Examiners for Programmes; or

(iii) That the student be required to attend a second *viva voce* examination normally within six months of the decision; or

(iv) That the student be given the opportunity of submitting a revised portfolio for examination normally within 12 months of the decision. The Programme Board of Examiners, considering the recommendations of the examiners of the *viva voce,* shall determine whether a second *viva voce* examination is necessary; or

(v) That the student fail and not be awarded the Degree of Doctor of Clinical Psychology.

At this point, the Board of Examiners for Programmes will comply with the professional and statuary body requirements, and deadlines, by submitting an indicative list of candidates who are likely to be eligible for registration with the Health and Care Professions Council as Practitioner Clinical Psychologists and as Chartered Psychologist with the British Psychological Society.

The Autumn Programme Board of Examiners will consider students' performance across the whole programme and determine whether to recommend to the Board of Studies the award of the degree of Doctor of Clinical Psychology and confirm their opinion regarding eligibility for registration with the appropriate professional bodies.

During the Programme Board of Examiners meeting in September of Year 3, the board will also consider any corrections as required by the decisions of the preceding Board of Examiners meeting, and to consider assessments from units C6 and A3. If all assessments, including any post-viva corrections, are not completed by this stage then trainees may not be able to graduate in the Winter graduation ceremony of that academic year.

***Viva voce* examination**

The *viva voce* examination for final year students will usually be carried out in June of each year by two examiners, one external to the University with expertise in the area of the main research paper and the other a member of staff (full or honorary) of the University who has not been involved in anything more than a cursory way with the research. The external examiner in the viva voce exam may also be one of the Programme External Examiners but would not be the cohort examiner, or someone else recruited for the purpose on the basis of specialist expertise. They will have prepared brief independent preliminary reports on the portfolio prior to the viva and will meet briefly beforehand to exchange views and agree a structure for the examination.

Questions may be asked on <u>any</u> component of the research portfolio and other submitted work but the examiners will usually tend to focus on the main project. You will be given the opportunity to clarify and expand upon sections of the portfolio that the examiners either find problematic or are particularly interested in. The viva will last for approximately one hour but may take longer if required. You will then be asked to leave whilst the examiners discuss their recommendations. The following are the possibilities, these being recommendations to the Programme Board of Examiners:-

1. Recommend that the examination be passed without further amendment

2. Recommend that the examination be passed subject to minor amendments (typographical

amendments) to be made within one month and to be scrutinized by one examiner, usually the internal

3. Minor amendments (more substantive then typographical amendments) to be made within 12 weeks of the viva date, and to be scrutinized by one examiner, usually the internal.

4. Major amendments to be made within 6 months, and to be scrutinized by both examiners without a further oral examination.

5. Resubmit an amended version of the portfolio to the examiners within 6 months and a further oral examination to be held.

6. Resubmit a revised version of the portfolio to the examination board within 12 months so that the examination board may determine whether a further viva voce examination should be held.

7. Fail. A candidate who fails will not be permitted to re-enter for the examination.

8. Uncertain and/or disagreement between examiners, requiring referral to the BEP. (This means that the matter requires discussion at the Board of Examiners' Meeting after completion of all vivas, and then a decision from 1-5 above selected.)

The examiners at the oral examination will inform the candidate of their recommendations once they have consulted privately immediately afterwards. Examiners' recommendations are subject to ratification at the Exam Board Meeting. For options 2, 3, 4 and 5 above, candidates will be informed in writing as soon as possible of the changes that are required, usually no later than two weeks from the viva date and earlier if possible.

A re-examination of a re-submitted portfolio can take place any time during the maximum time allocated for resubmission, subject to the maximum time allowed for the Programme in its entirety, which is six years.

Post viva voce procedures

All Examiners must be present when the candidate is informed verbally of the recommendation following the *viva voce* examination. It should be made clear to the candidate that the oral communication has no authoritative significance until the recommendation of the Examiners has been approved by the Programme Board of Examiners and the Board of Studies.

Special Circumstances

It is the student's responsibility to bring forward, at the earliest opportunity, details of any reasonable adjustments they may require to enable them to participate fully in a *viva voce*examination. The University is responsible for ensuring that appropriate facilities are made available in such circumstances.

17 Academic Misconduct

QA53 Examination and Assessment Offences in the University's QA Code of Practice defines misconduct and the university procedures for dealing with these. These include exam misconduct such as cheating, which apply to all formal assessments. The full disciplinary procedures in QA53 follow from sections in University Regulations, which can be seen at http://www.bath.ac.uk/regulations/

REFERENCING, PLAGIARISM AND CHEATING

Plagiarism involves presenting work that is not your own for assessment. Plagiarism occurs when a student 'borrows' or copies information, data, or results from an unacknowledged source, without quotation marks or any indication that the presenter is not the original author or researcher.

A particular form of plagiarism (and hence cheating) is auto-plagiarism or self-plagiarism. This occurs when a student submits work (whether a whole piece or part of a piece) without acknowledging that they have used this material for a previous assessment.

If you use someone else's pre-existing work – say, by summarising it or quoting from it – you must reference the original author. This applies to all types of material – not only text, but also diagrams, maps, tables, charts, and so on. Be sure to use quotation marks when quoting from any source (whether original or secondary). Fully reference not only quotations, but also paraphrases and summaries and ensure that you sufficiently reword any material. References should then be included in a bibliography or reference list at the end of the piece of work. Note that the need for referencing also applies to web-based material; appropriate references according to the type of work or image should always be given.

There are several acceptable methods of referencing material; for the Review paper and research paper, referencing style should follow that of the target journal. For all other referencing and style matters, students should follow the APA publication manual (Sixth Edition) style. Copies are available in the reference section of the Library. See also http://www.apastyle.org/.

Guidance concerning referencing and plagiarism is available from several sources. They include:

- the University Library's guides, 'A Guide to citing references' and 'Plagiarism: What it is and how to detect it' (http://www.bath.ac.uk/library/infoskills/referencing-plagiarism/)
- courses run by library staff, and the Students' Union's SORTED programme (http://www.bathstudent.com/sorted/home/)
- courses delivered by the Academic Skills Centre (www.bath.ac.uk/elc)

Any student who is found to have used unfair means in an examination or assessment procedure will be penalised. 'Unfair means' here include:

- cheating (for example, unauthorised use of notes or course material in an examination);
- fabrication (for example, reporting on experiments that were never performed);
- falsification (for example, misrepresentation of the results of experimentation);
- plagiarism (as discussed above);
- self-plagiarism (duplication of one's own work, as discussed above);

- unfair collaboration or collusion (representation of work produced in collaboration with another person or persons as the work of a single candidate).

Penalties for unfair practice will be determined by the Department or by the Faculty Board of Studies. They may include failure of the assessment unit or part of a degree, with no provision for reassessment or retrieval of that failure. Proven cases of plagiarism or cheating can also lead to an Inquiry Hearing or disciplinary proceedings. If unfair practice is confirmed, this may also raise questions about fitness to practice which will be investigated by the Programme Team.

If you are accused of an offence, the Students' Union's welfare services are available to support you when your case is being examined.

ACADEMIC INTEGRITY TRAINING AND TEST – MANDATORY

All students registered on an award at the University are required to undertake training and a test aimed at providing a common baseline of knowledge and understanding of good academic writing practice. This includes an understanding of plagiarism and other assessment offences, and the skills necessary to reference your work appropriately.

You will find an online tutorial and test, for this purpose, on Moodle at http://moodle.bath.ac.uk. Once you have accessed Moodle using your username and password, clicking on the link entitled Academic Integrity Initiative will take you to the training module and test. The training can also be accessed directly at: http://www.bath.ac.uk/learningandteaching/BathEpigeum/epigeum2011.bho/index.html

When you have completed the training tutorial – perhaps a couple of times - and are confident that you have understood it, you should undertake the mandatory test of understanding.

The test must be taken and passed by the end of October of your first year. To pass the test you will need to achieve a mark of 85%.

RESEARCH INTEGRITY COURSE FOR POSTGRADUATE RESEARCH STUDENTS

The University provides a Moodle course for all researchers to ensure compliance with the UUK Concordat to Support Research Integrity. You are expected to have undertaking training in research integrity within the first month of the programme. The training can be found on Moodle at: http://moodle.bath.ac.uk/course/view.php?id=56559

If you do not pass these tests, you will need to re-visit the training and/or look at the other guidance available to you via the Student Skills site: www.bath.ac.uk/students/support/academic/index.html or as required by your Director of Studies, and then re-take the test.

You can take these tests as many times as necessary until you pass.

You will not be able to progress beyond the next progression point in your studies, irrespective of your programme marks, until you pass this test. Ultimately this means that, if you have not passed the tests, you will not be able to receive your award. Your Director of Studies will be able to confirm when the next progression point occurs for your stage of your programme.

Once you have passed the test it will be assumed that you understand the concept of plagiarism and its consequences. Therefore, after this point, if you are found to have plagiarised in your work, you will not be able to claim ignorance of plagiarism or its consequences in mitigation.

The University's QA Code of Practice, QA53 Examination and Assessment Offences, sets out the consequences of committing an offence and the penalties that might be applied.

Further information
http://www.bath.ac.uk/students/support/academic/academic-integrity/index.html
http://www.bath.ac.uk/quality/documents/QA53.pdf

Plagiarism detection and personal data

The University uses the JISC Plagiarism Detection Service, Turnitin. This service checks electronic, text-based submissions against a large database of material from other sources and for each submission, produces an 'originality report'. It makes no judgement on the intention behind the inclusion of unoriginal work; it simply highlights its presence and links to the original source.

The service complies with European Data Protection legislation. When you registered with the University, you gave it permission to process your personal data for a variety of legitimate purposes. This includes allowing the University to disclose such data to third parties for purposes relating to your studies. The University, at its sole discretion, may submit the work of any student to the Plagiarism Detection Service (in accordance with Regulation 15.3e) and may make, or authorise third parties to make, copies of any such work for the purposes of:

i. assessment of the work;

ii. comparison with databases of earlier work or previously available works to confirm the work is original;

iii. addition to databases of works used to ensure that future works submitted at this institution and others do not contain content from the work submitted.

The University will not make any more copies of your work than are necessary, and will only retain these for so long as remains necessary, for these purposes.

Please note that, if at any time the University submits any of your work to the JISC Plagiarism Detection Service, the service will be provided with, and will retain, certain personal data relating to you – for example, your name, email address, programme details and the work submitted. Such data may be transferred by the Plagiarism Detection Service to countries worldwide (some of which may not be governed by EU Data legislation) in order for the work to be checked and an originality report generated in accordance with the proper workings of the Plagiarism Detection Service. Personal data is retained indefinitely by the JISC Plagiarism Service upon submission of work. You may ask for your personal data to be removed by contacting the University's Data Protection Officer.

Further information
From 1 October 2011, the University's procedures on Examination and Assessment Offences (QA53) are described at: http://www.bath.ac.uk/quality/documents/QA53.pdf

18 Clinical placements

Clinical practice placements in 4 core and 2 specialist (elective) areas are ordinarily completed during the course of training. The procedure for *Approval and monitoring of practice placements* can be found in the Appendices.

All placements must conform to the British Psychological Society guidelines, which set out the minimum standards necessary to achieve good practice in the supervision of clinical trainees. For more information please see the guidance document:
http://www.bps.org.uk/system/files/documents/pact_guidelines_on_clinical_supervision.pdf

All documentation relating to clinical placements referred to in this section can be found on the Moodle page 'Doctorate in Clinical Psychology Placements'.

Trainees are allocated to clinical placements based on the Personal Planning and Training Needs Assessment and this can also be used to shape the clinical placement contract.

18.1 Clinical components of the 1st year

The first clinical placement begins at the start of the first term in year 1 and is in the area of Working Age Adult Clinical Psychology. The first placement begins gradually, with an initial placement visit then, from week five, two days per week on placement until week nine. Following half-term, 3 days per week are spent on clinical placement gradually increasing levels of independence in clinical work. In April trainees then begin their second placement, Clinical Psychology of Later Life/Older Adult and 3 days per week are spent engaged in clinical work. These first two practice placements are core placements and sufficient quality and quantity of clinical experience must be gained in these areas.

18.2 Clinical components of the 2nd year

Practice placements will be in the areas of Child and Adolescent Mental Health (CAMHS) and Intellectual Disability (ID). These are considered core placements.

18.3 Clinical components of the 3rd year

Trainees will plan the 3rd (final) year clinical components in collaboration with their clinical tutor. They will develop a proposal following review of their training needs as assessed by the PPTNA, progress in developing core competencies and skills across the core placements, specific progress with BABCP requirements, clinical interests and career aspirations. Final year placements may be specialist, further gathering of core experience and can include placements in Clinical Health. In terms of structure, the two placements in the 3rd year can take the form of 2 X 6 month placements or 2 x 12 month placements depending on supervisor preference. Some clinical specialities offer a more realistic experience across 12 months e.g. Dialectical Behaviour Therapy Services. If an elective or specialist placement in the final of training is spread across 12 months, placement reviews and assessments will be timed accordingly, but the placement assessment for C5 or C6 will need to be submitted at the 6 month point to ensure appropriate progress is being made and 5 case studies are available for submission in the portfolio.

18.4 Clinical Health Psychology and other placement flexibility

The Programme has a strong commitment to the development of Clinical Health Psychology training. Although such a placement is not defined as core by the British Psychological Society, it is anticipated that the majority of trainees will elect to complete a clinical health placement, providing clear rationale for not doing so.

18.5 Time allocated for clinical placements

Please refer to Appendix 23.

18.6 Clinical supervision

The primary placement supervisor must be a clinical psychologist with HCPC registered practitioner status or another suitably qualified professional with a core profession registered with a statutory body subject to a code of ethics, accreditation processes and established disciplinary procedures. The primary placement supervisor should have at least two years post qualification experience, have attended supervision training/induction and have an ongoing programme of continuing professional development. Supervision should meet the British Psychological Society (BPS) minimum standards for supervision with at least one hour allocated for formal supervision each week plus additional (up to 3 hours) contact time. It is possible that additional case supervision will be provided by other suitably qualified and skilled health professionals such as a CBT therapist or another qualified psychologist. Placements will normally include

(a) Observation of and by the placement supervisor. Trainees will be required to complete 2 structured observations of their supervisor(s) using placement observation forms developed for this purpose. Additionally, the supervisor will complete at least 2 structured observations of the trainee in a clinical situation and provide feedback during supervision. Supervisors may make use of the placement observation forms or may prefer to provide feedback in a less structured format. Opportunities for observation can be widely sought via joint-working as well as direct observation of an individual.

(b) Supervision with live material e.g. sessions in which video (or, if video is not permissible, audio) of the actual sessions is included in the supervision process. Trainees will be encouraged to routinely bring material to supervision

(c) In CBT focused placements, the use of the Cognitive Therapy Scale-Revised (CTS-R) and its specific variants will be used to rate clinical skills demonstrated during sessions. Where the CTS-R does not apply, then other instruments or strategies will be used to formally and directly assess clinical competence.

18.7 Part-time supervisors and supervision by professionals other than Practitioner Clinical Psychologists

In cases where there is more than one supervisor involved in a trainee(s) placement (team supervision) a primary supervisor should be identified for each trainee who will take responsibility for the planning

and co-ordination of that trainee's placement, supervision and liaison with Programme staff. This allows part-time staff to be involved as supervisors. Other professionals can also be designated as co-supervisor, but in such instances the first/responsible supervisor must undertake to ensure that all aspects of the placement and its supervision will fully observe Programme and BPS/HCPC requirements.

18.8 Support for supervisors

It is expected that supervisors have their own supervisory arrangements in place for their own clinical work. The Bath Programme will work with the Regional Supervisors committee to provide a range of other support, including, but not confined to:

1. A supervisor induction/ personal support tutor course; this is a requirement for all supervisors.
2. Access to continuing professional development courses to ensure that supervisors have a good understanding of the material being taught on the Programme
3. Where supervisors wish this, personal support tutor in clinical and research matters. This may include co-supervision with Programme staff of research and components of the trainees' experience
4. Development and training to assist supervisors to attain BABCP accreditation at the level of clinician, supervisor and/or trainer as appropriate. This may, where wished and appropriate, include clinical supervision sessions for the supervisor's own clinical work.

18.9 Clinical tutors

Clinical tutors' duties include the monitoring of clinical training and placement reviews (see Role of Clinical Tutor appendix 15). Each trainee will be allocated to an individual clinical tutor who will meet them early in the programme to continue the process of training needs assessment which began prior to commencing training. The clinical tutor will visit and review each practice placement at the mid-point and meet with the trainee at the end of placement to review and plan for the next placement. Early placement visits can also be carried out if needed to feed forward training needs or issues or to further familiarise the supervisor with the programme requirements. This may be a telephone contact with the supervisor or a site visit. The clinical tutor will also carry out an annual appraisal with the trainee (see Appraisal Form Appendix 12)

Additionally, the new intake each year will have an allocated clinical tutor(s), who will become their cohort tutor.

18.10 Placement contracts

At the beginning of each placement, a trainee and their supervisor will draw up a placement contract (see Appendix 4*).* This outlines the specific clinical experiences to be gained on that placement as well as the general structure of the placement including time allocated for annual leave, carry-over cases, and establishing the date for the mid-placement and end of placement review meetings.

18.11 Mid-placement and End of Placement Feedback and Review Meetings

These are outlined in detail in the Clinical Tutor role outline (see appendix 15). In brief however, there will be a formal scheduled meeting between the trainee and placement supervisor at the middle of the placement and at the end of the placement to review the progress of the clinical contract, to provide feedback about the trainee's progress in respect of skills and competencies and feedback about the supervisory aspects of the placement. (***see*** Key Documents on Practice Placements: Placement feedback forms).

Mid-Placement Review

Once the trainee and placement supervisor have completed their mid-placement ratings, the tutor will make a visit to the placement and review progress.

The review meeting is structured in a way that both trainee and supervisor can provide individual feedback to the clinical tutor on the progress of the placement. This will enable a supervisor to comment upon the trainee's clinical performance and general progress and allow the trainee to comment on the adequacy of the placement. The Programme tutor will then hold a 3-way meeting summarising the findings and formalising the plans for the remainder of the placement. This will include identifying any action that needs to be taken should there be difficulties within the placement. Following the review meeting, the Programme tutor will provide a written summary of the meeting to both the trainee and the supervisor.

End of Placement Feedback

Towards the end of the placement, the trainee and placement supervisor should meet to review the trainee's progress. The placement supervisor will use the end of placement feedback form to provide the trainee with an overall rating for the placement (either Pass, or a recommendation to the Board of Examiners that the trainee Fail the placement). The clinical tutor would not usually attend the end of placement review, unless there was an explicit need to do so (see section 16.13 on placement failure). Instead, the trainee and clinical tutor will meet separately at the university base once the end of placement feedback has been completed to consider issues which should be fed forward to the subsequent placement.

18.12 Log of clinical experience

You will be required to 'log' all clinical experiences gained (***see*** Clinical Placement Log Book, Appendix 7). This is to ensure that you are gaining sufficient experience with a range of clinical problems across the lifespan. It also allows you and your tutors to keep track of other professional experiences such as delivery of teaching, consultation work, etc. You will complete a log book for each clinical placement, ensure it is signed and agreed by your clinical supervisor for that placement. You should then submit a signed copy to the programme team at the end of the placement.

The clinical logbook allows you to record the experiences you gain. Over the three years of training, you will use information from each clinical log book to complete a 'Cumulative Log. This is available as an Excel Spreadsheet on Moodle. The Cumulative Log includes the following:

- The Personal Planning and Training Needs Assessment (PPTNA), a useful checklist of the experiences to be gained and core clinical competencies to be attained throughout the course of training. This will be reviewed at each annual appraisal.
- The Cumulative CBT log, where you will record all CBT-specific work that you complete each placement, and which will provide evidence that you have met the criteria for BABCP accreditation. You can also record your development on the CTS-R on this page.
- The Cumulative Systemic log, where you will record all systemic-specific work that you complete each placement, and which will provide evidence that you meet criteria for systemic accreditation. You can also record your development on the Systemic Practice Scale on this page.
- The Cumulative Neuropsych log, where you will record all neuropsychological work that you complete each placement. You can also record your development on the Neuropsychology rating scales on this page.
- The 'Other Therapy' log, where you can record any work that you engage in using other therapy models.
- The General Cumulative Record, where you can record the various types of individuals, groups, familis and presentations that you have worked with.

After each placement, you will use your Clinical Placement Log to update your Cumulative Log. This will allow you and your tutor to track your experiences and skills development over the three years, and to identify any areas where you may need additional experience prior to qualification.

In addition, trainees are asked to complete a Professional Practice Log (see Appendix 8). The aim of the professional practice log is to supplement the clinical log by briefly documenting placement and educational experiences which provide evidence of the development of clinical psychology leadership competencies as outlined by the British Psychological Society (Division of Clinical Psychology – Sept. 2010). These are derived from the NHS Institute for innovation and improvement which highlights the role of personal qualities (e.g. self-awareness, CPD), setting direction (e.g. applying knowledge and evidence, evaluating impact), working with others (e.g. developing networks), Improving services (e.g. critical evaluation) and managing services (e.g. managing people) as integral to leadership competencies in clinical professionals.

18.13 Placement assessment

In placement ("C") units, the clinical placement review must be passed. The student will be judged on their clinical performance as assessed at the end of placement review with the supervisor and separately with their clinical tutor, taking into account the overall placement ratings, the direct assessment of clinical competency (e.g. the CTS-R), the placement specific single case study and the placement specific cognitive/developmental assessment.

18.14 Placement failure

Placement failure is rare, but it does occur. A placement can be failed on the grounds of serious or gross professional misconduct, a lack of fitness to practice or a failure to demonstrate the clinical

competencies required by that placement. If a trainee is at risk of failing a placement for the latter reason, this must be outlined clearly to them no later than the mid-placement feedback and review. Typically placement failure will be considered when ≥ 2 of the mandatory skills and competencies for that placement are rated as 'not satisfactory' by the clinical supervisor at the feedback meeting. A written remediation plan should be agreed between the placement supervisor, tutor and trainee at the review meeting which clearly states the specific competencies and skills which are implicated in the failure and a clear plan to allow opportunity to develop and demonstrate those skills and competencies in the remainder of the placement.

If the remediation plan is not successful and the trainee remains at risk of failing the placement at the end of placement, the programme team will recommend that the specific placement or clinical experiences requiring those skills and competencies should be repeated in the next placement period. At this point, the employing authority's Human Resources team will be advised of the placement failure and concurrence with Taunton and Somerset's Maximising Capability Policy will be sought and liaison with the Human Resources Department. Failure of two placements will constitute a programme failure.

If a placement failure on the grounds of not demonstrating the requisite skills and competencies is indicated at the end of placement but was not identified at mid-placement, then the placement will be extended with the same supervisor by the period corresponding to the time between that placement's mid placement review and the end of placement with a clear remediation plan. If the student is then failed following the extension, then a failure of the unit is registered and an immediate repeat of that Unit is required with a new field supervisor.

Gross professional misconduct or fitness to practice issues will be dealt with according to the requirements of the employer and regulatory body.

18.15 Carry over cases

In some settings, longer term cases are an integral part of the way of working. Supervisors and trainees should discuss this option at the pre-placement meeting with a view to setting these up as cases which are tapered in and/or out earlier and later than the designated placement time. This is because it is the nature of some placements that longer term working may be a feature of the clinical work being done. These periods need to be discussed and agreed by all supervisors affected and the Clinical Director/Tutor responsible, including the rationale. Appropriate induction and supervision has to be built into any direct clinical work, so it is anticipated that tapering in sessions may usually (but not invariably) be more assessment/observation linked. Cases where work commences after the mid placement review should not be carried over; such cases should be planned for earlier in the placement.

19 Personal Planning and Training Needs Assessment (PPTNA)

Overview

Clinical Psychology trainees will be recruited on to the Programme with an extremely wide range of prior experience, training and ability. This may vary from those who have been accepted on to the training Programme with little experience beyond their undergraduate degree through to people who have a PhD, are qualified IAPT high intensity therapists and so on. Beyond admission, trainees will develop and gain experience, competency and expertise at different rates not only towards the final award of the Doctorate, but also towards particular career pathways. Often, trainees develop particularly rapidly and well because of strong personal interests. The Bath Programme will therefore deploy a training needs assessment which will play a key role in personal training planning and monitoring for each trainee, and link into their career development pathway. The training needs assessment will be cumulative, and will be an important tool in identifying the suitability of placements and priorities within placements, and will be taken into consideration in the evaluation of performance on placement. Personal Planning and Training Needs Assessment is a process running through the programme, formalised in terms of documentation; it will be available through the Placement Moodle pages,) A supplementary checklist document is also available which outlines at what stages the PPTNA should be reviewed over the course of training.

Stage 1: prior experience assessment

The personal planning and training needs assessment process will begin prior to the trainee beginning the Programme. A detailed self-assessment form (a sub-set of the full PPTNA in appendix 11) will be sent once the offer of a place has been accepted, to be returned within 1 month, and will form the basis of this first stage planning. This version will be primarily based on the trainee's evaluation of their prior experience (or absence of such experience) and, if appropriate, their aspirations for training. Note that trainees at this stage may have no particular preferences for specialism. Allocation to the first placement will take account of this first self-assessment.

Stage 2: discussion and amendment in consultation with the Programme

As early as possible during the first few weeks of term 1, each trainee will meet with a member of the Programme team in order to discuss their PPTNA self-assessment, and begin to complete it in greater detail, particularly the "personal planning" component. The Personal Development Plan (PDP) section provides a focus for a discussion of the trainee's career aspirations as these develop. The Programme team will support the trainee to develop their training experience consistent with these aspirations whilst ensuring consistency with the general requirements of the Programme and its professional regulating bodies. This review is also intended to begin to identify strengths which can be built upon and areas where more development is needed or where there are complete gaps. Part of the intention is that when trainees have particular strengths in terms of skill and experience these are either taken account of in terms of the way the Programme allocates assignments and placements or can become the focus of more specialist and in depth training, including advanced placements potentially during all years of the Programme (not only in the third year). Clearly, it is important that such expressions of special interest are treated as tentative and flexible, to avoid the risk of "pigeon holing" the trainee too early. It would be acceptable for a trainee to identify multiple interests or agnosticism at this stage.

Stage 3: incorporating competencies and reflective practice

Prior to placement the commencement of each placement, trainees are encouraged to use the PPTNA to inform their placement contract; identifying areas of need and incorporating this into the agreed goals of placement and experiences to be gained on placement.

In preparation for the mid placement and end placement, trainees are invited to review the PPTNA to help identify areas of development and need that have accumulated through each placement. This complements the mid-placement and end of placement documentation which specifies mandatory competencies to be achieved on each placement.

At mid placement, a review with the trainee, clinical tutor and placement supervisor will be used to identify actions required by the trainee to meet identified needs for the remainder of the placement. Training needs are expected to be mostly positive goals, but may at times be areas for skill development. Identified needs will be linked to specific plans so that they can be met.

The intention of the PPTNA is also to allow the identification of training objectives for future placements, the need for particular types of supervision and training and/or experience and so on. Note that completion and review of the PPTNA will be in addition to and complement formal placement evaluation, which will have a more evaluative emphasis, and which will have a pass/fail component.

In the final year of training, the PPTNA will include sections on professional standards, which includes the HCPC standards of proficiency.

Annual review

The PPTNA will be reviewed with the trainee by Programme staff at the beginning of year 2 and 3, linked to the trainee's annual appraisal (see section 8.1 for full details on the appraisal and use of PPTNA within the appraisal procedure).

The review at the beginning of year 3 will, in addition, focus on the extent to which the trainee has met or will meet the learning objectives and other criteria set out by the University and Professional Accrediting/Approving bodies (i.e. the Health and Care Professions Council, the British Psychological Society and the British Association for Behavioural and Cognitive Psychotherapy). In the unlikely event that a problem in meeting such objective or criteria is identified, the person undertaking this review should agree with the trainee measures required to ensure full compliance with the standards set by these bodies, referring the plan for review by the Programme Executive.

The PPTNA will be reviewed with the trainee by Programme staff at the end of year 1 and end of year 2, as part of the trainee's annual appraisal (see section 8.1 for full details on the appraisal and use of PPTNA within the appraisal procedure).

The review at the end of year 2 will, in addition, focus on the extent to which the trainee has met or will meet the learning objectives and other criteria set out by the University and Professional Accrediting/Approving bodies (i.e. the Health and Care Professions Council, the British Psychological Society and the British Association for Behavioural and Cognitive Psychotherapy).

In the unlikely event that a problem in meeting the learning objectives or other criteria is identified, the person undertaking this appraisal should agree with the trainee a plan for the remainder of the training period to facilitate full compliance with the standards set by these bodies. Specific action points set against each standard or criteria of the Health and Care Professions Council, British Psychological Society and the British Association for Behavioural and Cognitive Psychotherapy where appropriate. This plan will be incorporated into placement contracts and other educational developments as relevant. It will be reviewed at 3 monthly intervals (linked usually to placement visits and meetings by the clinical tutor) to ensure progress towards accreditation/approval is on track, triggering further intervention where necessary to ensure attainment of all relevant standards and criteria.

This review should therefore ensure that placements have been appropriately supervised by HCPC registered practitioner clinical psychologists, and the requisite number of cases and supervised hours with BABCP accredited practitioners will be attained.

19.1 Completing the PPTNA

The PPTNA is primarily intended as an aid to self-monitoring although we suggest that trainees might consider completing their review of the PPTNA with the placement supervisor. An outline and checklist for the review of the PPTNA is available on the Placements Moodle page. This should be completed with your clinical tutor at each identified stage.

The log is divided into three broad areas:

- Core skills – such as how to engage clients or how to formulate cases
- Advanced and specific skills for particular interventions – ranging from specific methods such as cognitive behaviour therapy through to areas which will require a broad range of skills, such as consultation.
- Professional Standards- to be completed in years two and three.
- Work specific to particular client groups

This division reflects the likelihood that all placements will include work in the area of core skills and foundation skills, which are broad-based and generic. Work with some client groups requires additional more specialised skills, and this fact is reflected in the last section of the log.

The PPTNA consists of a list of clinical competencies which, ideally, you will acquire by the end of the Programme. Trainees are not expected to be an expert in everything; some areas will be better practised than others.

Guidelines on the completion of the PPTNA:

At the end of each placement scan the totality of your experience on the placement. Much of this will have been recorded on the clinical log book and professional practice log.

Go through the relevant sections of the PPTNA and give yourself a rating for each dimension, use the rating guidelines which precede each section. It is anticipated that on some placements there will be no or limited opportunity to gain a particular competency.

Review and update ratings in preparation for the mid-placement and end of placement review with your clinical tutor.

Review your ratings in preparation for the appraisal, (see section 8.1.) You should also take your updated PPTNA with you when you meet your new supervisor, as it will help you to plan the placement contract.

20 Personal Safety, & Professional Conduct

It is not common to encounter high risk situations in general. However there are a number of possible risk situations which trainees should be aware of including risk to themselves or others of violence or assault, risk of patients suffering acute medical conditions, and threats of suicide.

Placement planning sessions will include a discussion of risk assessment.

20.1 Guidelines for Home Visits

All visits outside clinics should be discussed and planned with your clinical supervisor following the policies for that clinical team/area. However some general guidelines about personal safety which are available for research students may be helpful to read when thinking about planning any type of home visit (see Appendix 18 - Risk assessment for research with human subjects).

20.2 Policy for trainees dealing with threats of suicide or violence

If the patient has a history of serious violence, it is recommended that trainees only see him/her accompanied by another staff member or in a room, preferably ground floor, where there is a panic button. Inform reception staff that you may encounter risky behaviour. You should discuss these issues with your supervisor prior to seeing the patient, and the outcome of this discussion noted in your training log. Note that the Trust you are placed in will have risk and suicide prevention policies; these should be followed as appropriate.

20.3 Personal appearance on placement and in teaching sessions.

It is important to consider your personal appearance and be aware that you need to present as a professional person. Your appearance should not distract from a person's ability to discuss their mental health issues and concerns with you. To this end, consideration to how the people with personal experience in a particular area, wider public and other agencies may view your appearance should be given. Similar considerations apply to teaching sessions. Broadly speaking, issues about appropriateness of dress and safety considerations are the main areas of concern.

For example one should consider the following;

- Very casual clothing, for instance denim jeans, track pants and casual shorts are not usually considered professional dress.

- Skirts should not be unduly short.
- Blouses or tops with low-cut necklines, strappy tops or cut-off shoulders are not advisable.
- Crop tops are inadvisable, particularly in cases where a midriff is shown if an individual reaches upwards,
- Hooded tops or tops with strings are considered inadvisable for safety reasons
- In some settings, jewellery should be kept to a minimum, staff should be mindful of the fact that some jewellery such as neck chains could be used as a weapon. Items such as chunky bracelets may cause injury during restraint situations. Dangly or hooped earrings, and some body piercings such as nose or eyebrow piercings are considered to present a risk as an individual may be harmed by a patient pulling them
- In certain service settings, name badges on long chains are considered to be a risk and only pin and clip-on I.D. badges are permitted
- With respect to footwear it is suggested when working in certain settings that shoes should not be open-toed for security reasons. (Some other settings have restrictions on type of heels, also due for security reasons, so it is worth checking policy.)
- Hair should not get in the way of direct observation

In some situations the following points should also be considered:

- The safety of patients, staff and members of the general public
- The possibility of damage to personal possessions
- The requirement to be in close physical contact with others
- The need to move freely, particularly in restraint situations

Any uncertainties about appropriate dress or appearance should be discussed with your clinical supervisor and guidance will be given. Be aware that senior clinical staff responsible for a service setting may also provide you with guidance about your dress if they consider it inappropriate.

20.4 Professional Indemnity Insurance

The British Psychological Society strongly advises psychologists doing clinical work to take out professional liability insurance to ensure they are covered for 3rd party liability for their actions as psychologists.

The DCP report notes that there are a number of circumstances in which NHS cover alone may be unclear and insufficient[2]:

- NHS Indemnity does not extend to people employed by a GP practice and the practice may well attempt to recover damages from the psychologist
- A vindictive claimant may sue in order to generate distress and not just to obtain financial recompense, and may, therefore, sue the psychologist as well as the employer
- Depending solely on the NHS lawyer may be unwise as it may mean there is a lack of personal representation and the lawyer may defend another employee more stringently, rather than the psychologist,
- In addition there may be a need to defend one's professional reputation

[2] 'Working in Teams' A report by the Division of Clinical Psychology, The British Psychological Society – October 2001.

On the British Psychological Society Website, insurance firms specializing in indemnity for psychologists are recommended.

21 Failure Procedure for the Doctoral Programme in Clinical Psychology

21.1 Academic components

1. A candidate may fail the Programme by failing to reach the required standards in academic work or clinical work.

2. Academic standards are assessed by the examinations at the end of the first year, and the presentations, research portfolio, case studies and other examinable assignments. External examiners will review all of these.

3. If either of the two papers in the first year examination is failed, then that paper will require a re-sit in July of that academic year. If both papers are failed, then both will require a resit.

4. If a candidate fails any resit examination paper or summative assessment specified in the programme regulations, this will constitute programme failure. No further attempts are usually given.

5. If research supervisors consider that it is likely that the student may fail any research component, then they should inform the student and the research team as soon as possible.

6. If the research portfolio is unsatisfactory, this will normally lead to minor or major revisions, and the degree being awarded upon such revisions being completed satisfactorily. The examiner may choose to refer the portfolio for major amendments with a specified time limit, either with or without further examination at their discretion. If a portfolio is fully rejected by the examiners, this constitutes programme failure *if the supervisory team have warned the student as in section 5 above*. If no warning was issued, the student is entitled to a further attempt which must be submitted no later than four months after notification of the first failure.

7. In clinical work, a candidate is deemed to have failed the programme if they have failed two clinical placements following the procedure below. This could be two attempts at the same placement or two different placements.

8. All non-placement assignments can usually only be re-submitted once.

Usually the first failure of two entire non-placement units or individual failure of four assessment components (rated at over 5% of the total of any individual Unit assessment) will represent a failure of the Programme as a whole.

21.2 Procedure for failing a placement

If it seems likely that the trainee may fail a placement, the following steps are taken:

a. If the supervisor considers that a candidate is likely to fail, the candidate should be warned of this and the appropriate Clinical Tutor alerted. Primarily if 2 or more of the mandatory skill/competency categories for that placement have been rated as ‘needs attention’, the

possibility of placement failure should be raised with the candidate. This should be done as soon as possible, certainly by the mid-placement review, except where serious problems only emerge later.

b. There will then be a joint meeting between the candidate, the supervisor and the Clinical Tutor, at which the problems will be fully discussed. The mid-placement review may be an appropriate forum for this discussion. Where difficulties occur early on in a placement, the mid-placement review may be brought forward in order to resolve the difficulties as soon as possible. When difficulties occur after the mid-placement review an additional review meeting will be required.

c. The meeting should aim to conceptualise the difficulties and draw up a plan to address them. If the candidate disputes the supervisor's views, the advice and opinion of another supervisor from the same area of work will be sought.

d. At the joint meeting, goals will be set for the rest of the placement. Any support that the candidate might require should be outlined at this stage. A follow up meeting should be arranged with the candidate, the supervisor and the Clinical Tutor to review the candidate's progress.

e. If the difficulties continue into the second half of the placement and the supervisor feels unable to pass the candidate on the placement the supervisor should make a recommendation to the Board of Examiners that the placement be failed.

f. Supervisor's judgments form a recommendation to the Board of Examiners, which considers the appropriateness of their judgments. For this reason supervisors cannot fail a placement. The Examination Board will take into account evidence from the supervisors feedback form, MPR reports and feedback from the trainee's programme tutor and (if a different individual) MPR visitor. The Board of Examiners can ratify a decision to fail a placement, or not uphold the supervisor's recommendation, and pass the placement.

g. The criteria used for evaluating clinical competence are those contained in the Supervisor's Feedback form. The supervisor's recommendations of "PASS" or "FAIL" constitute advice to the Board of Examiners.

    - Placements may be judged a "FAIL" by the Board of Examiners because of serious or persistent shortcomings in any of the areas covered by the Supervisor's Feedback Form; that is, failure on the part of the trainee to reach minimally acceptable levels of clinical competence judged in the context of the stage in training (≥ 2 mandatory categories for that placement rated as 'needs attention) and the opportunities provided in the placement.

    - A trainee may not pass a placement if insufficient experience has been gained. If this is the fault of the supervisor (e.g. due to ill health, unavailability or very poor supervision)

then the Programme will make every effort to ensure that the trainee is not penalised and every effort will be made to provide appropriate work during the third year. Nevertheless, a delay to the completion of training may be unavoidable.

h. A candidate failing one placement may be asked to undertake extra clinical work after the scheduled end of the programme in order to develop any missing competences. The nature of this extra work will be decided by the members of the Practice and Placement committee.

i. Failure in two placements will constitute programme failure.

j. In the event of a candidate failing two placements, leading to programme failure, the relevant external examiner will also be informed.

k. A candidate will fail the programme if there is evidence of serious professional misconduct (e.g. violation of patient/therapist boundaries, gross incompetence/ negligence or abuse of patients). In such cases, the Programme Director and another senior member of staff will make the decision to refer to the University's fitness to practise procedures. Should a trainee be dismissed from their employment for serious professional misconduct, they would automatically be withdrawn from the programme.

In the event of a trainee failing either an examination or a placement, or the programme, the employer will be notified within 2 weeks.

In the event of a trainee not passing the DClinPsy programme, either through ill health or programme failure, the University may consider the award of an MPhil. Because Clinical Psychology is a protected title, this will be in Psychology not "Clinical Psychology".

These provisions are subject to the University of Bath Regulations

http://www.bath.ac.uk/regulations/Regulations.pdf

21.3 Appeals procedure

PROCEDURES FOR ACADEMIC REVIEWS (APPEALS)

Students wishing to submit a request for an academic review should refer to Regulation 17 (www.bath.ac.uk/regulations). Students are also strongly advised to read the online guidance provided by the Academic Registry (http://www.bath.ac.uk/registry/appeals/).

Regulation 17 outlines the decisions and results that students can request to be reviewed. The regulation also lays out the grounds under which a review request can be made. All students should note that dissatisfaction with a mark or set of marks, or any other aspect of the properly exercised academic judgement of the examiners, is not valid grounds for an academic review.

Students considering a request for an academic review may first wish to informally discuss the matter with their Director of Studies or their Personal Tutor. Independent guidance about the academic review process is offered by the Students' Union Advice and Representation Centre (http://www.bathstudent.com/advice/guides/academic/appeals).

All formal review requests must be submitted within the timescales set out in Regulation 17. Students must provide the required information and evidence, including a completed AR1 form (http://www.bath.ac.uk/registry/appeals/academic-review-form.pdf).

Complaints are dealt with under separate procedures:
http://www.bath.ac.uk/regulations/Appendix1.pdf

A student may request that the Board of Studies review a decision relating to a failed final examination or formal course assessment or failure to progress to the next part of a degree. University Regulation 17 (Conduct of Student Academic Reviews and Appeals) explains in which circumstances this may be requested. The grounds under which such a review may be permitted are:

(i) that circumstances exist affecting the performance of the candidate of which the Board of Examiners have not been made aware and which the student could not reasonably have been expected to have disclosed to the Director of Studies in accordance with the Regulation on individual mitigating circumstances (Regulation 15.3 d);

(ii) that there were procedural irregularities in the conduct of the examinations or formal course assessments (including administrative error) of such a nature as to cause reasonable doubt whether the Board of Examiners would have reached their decision had the irregularities not occurred;

(iii) that there is positive evidence of prejudice, bias or inadequate assessment on the part of one or more of the examiners.

Any student seeking a review on any of the grounds indicated above must notify the Chair of the Board of Studies in writing within fourteen days of being notified of the decision of the Board. The request should be submitted on the appropriate form (available at www.bath.ac.uk/registry/appeals/acad-review-appraisal.htm). The request for a review must include:

a) a statement specifying which of the grounds set out in Regulation 17.4 apply to the case for review;

b) a statement of the circumstances leading to the case for review;

c) any additional documentary evidence;

d) a statement of the student's desired outcome;

e) an explanation as to why the student was previously unable to provide any new information disclosed to the Board of Studies at this stage.

The Chair of the Board of Studies, in consultation with the Head of Department, has the discretion to decide that there are insufficient grounds to warrant holding a review. The student will be advised of this decision and their right to submit an appeal in accordance with Regulation 17.11.

Where the Chair of the Board of Studies, in consultation with the Head of Department, agrees that there is a *prima facie* case for an academic review, the Chair may consult with the Director of Studies and internal examiners to determine whether or not the student's desired outcome is the most appropriate action in view of the circumstances and the student's academic profile. Where this is the case, the Chair may take executive action to approve the outcome without the need for a review hearing. It should be noted that executive action cannot be invoked in cases where the review relates to the conferment of an award.

Where the Chair, in consultation with the Head of Department, agrees that there is a *prima facie* case for a review but executive action is deemed inappropriate, the Board of Studies will conduct a review hearing. The student will be expected to be present at the hearing, accompanied by a friend or adviser (such as a Students' Union Sabbatical Officer).

A student who disagrees with the outcome of a review hearing may submit a request for a review appraisal for which the relevant procedure is set out in Regulation 17.12.

Students considering lodging a request for an academic review or a review appraisal should discuss the matter with the Director of Studies, their Clinical Tutor or the Students' Union (Vice President (Education) or Advice and Representation Centre, email: *suadvice*@bath.ac.uk) as soon as possible.

Students should consult the University's guide to academic review and review appraisal procedures at www.bath.ac.uk/registry/appeals/acad-review-appraisal.htm and the Regulations governing these procedures at www.bath.ac.uk/regulations/

22 Appendices

Appendices: Internal Programme documents, records and assessments

The following documents were previously included as appendices to the handbook. They are now available on the Doctorate in Clinical Psychology Placements page on Moodle.

- Guidelines for the Preparation of Clinical Placement Contracts
- Induction checklist for DClinPsy placements
- Placement Assessment Forms
- Sickness and absence recording
- Instructions for completing clinical placement log book
- Placement Log Book
- Professional Practice Log
- Case Study Review Form
- Personal Planning & Training Needs Assessment
- Questions to promote reflection on clinical cases
- Procedure for approval and monitoring of practice placements
- Supervisor's Confirmation of Consent Form

The following documents were previously included as appendices to the handbook. They are now available on the General Information for Trainees page on Moodle.

- Appraisal documents
- Role of the Clinical Placement Tutor
- Role of the Disability Lead
- Role of the Cohort Tutor
- Personal Support Tutor Information Sheet
- Buddy Scheme information sheet
- Procedure for monitoring attendance and dealing with absence
- Health Education South West Special Conditions of Service

The remaining appendices are listed below. The original numbering has been retained to ensure consistency with the handbook.

Appendix 18: Risk assessment for research with human subjects
Appendix 19: Management of Serious Untoward Incidents
Appendix 20: Examination Marking Procedure
Appendix 23: Summary of placement and academic timings
Appendix A: Programme Specification
Appendix B: Programme Regulations
Appendix D: Matrix of learning outcomes
Appendix E: UNIT A1
Appendix F: UNIT A2
Appendix G: UNIT A3
Appendix H: UNIT P1
Appendix I: UNIT R1
Appendix J: UNIT R2
Appendix K: UNIT C1
Appendix L: UNIT C2
Appendix M: UNIT C3
Appendix N: UNIT C4
Appendix O: UNIT C5
Appendix P: UNIT C6