

**Improving Access to Psychological Therapies**

**Postgraduate Certificate in Low Intensity Psychological Interventions**

**Psychological Wellbeing Practitioner (PWP)**

**Course Handbook**

October 2022

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**Resource list**

Please find the documents below on Blackboard. Additional documents may be added to Blackboard during the training year.

* Coursework Cover Sheet
* Extension Request Form
* Supervisor Sign-off Form
* Service Learning Contract
* Service Information Report
* CMS Process Report
* Catch-up Form
* Template for recording patient hours
* 15 days resources
* Reading List via Leganto on Blackboard
* Jacobson Plot Guide
* APA Referencing Guide
* The University Library services
* PSYT15 Programme Specifications

# **Introduction**

**Welcome to the PG Cert in Low Intensity Psychological Interventions.** This handbook provides the context for, and general information about, the methods of the University of Sheffield Psychological Wellbeing Practitioner (PWP) training course. This handbook is the primary resource for trainees and clinical supervisors, detailing the academic requirements, structures and processes of the Sheffield IAPT PWP course. Please ensure that you put some time aside to acquaint yourself with the timings and expectations of the training programme, and also the expectations of you as a trainee PWP. As the course requires you to demonstrate both clinical and academic competencies, understanding what these are and when they happen is essential to your success. If, **after reading the handbook**, you still feel unsure, do feel free to contact a member of staff. Contact details for staff are included in this handbook. The contact details of trainees, supervisors and services are required by the course and trainees need to submit the Service Information Report (Blackboard) by Week 2 of teaching.

If you have a disability and have declared this on the application form it is important that the course is made aware of this in order for any support needs to be discussed. If a previous assessment has been made (e.g. of dyslexia), this is often taken into account by the **Disability and Dyslexia Support Service (DDSS)**. If you feel that you require an assessment for an identified need, please discuss this with the course team or make a self-referral. Please note, the University policy on such issues states that criteria for marking cannot be changed to reflect disability needs, but that relevant adjustments to help and support with preparation can be agreed and implemented. Many previous HIPIs with disabilities have successfully completed the course – clear communication has been a factor in those successes. The course recommends all trainees use the QuickScan tool to highlight any learning needs and study skill recommendations (<https://www.sheffield.ac.uk/ssid/disability/spldtest>).

The course has been established to meet the demands of the national IAPT educational agenda and therefore follows the PWP National Curriculum, which was reviewed in 2014/15. The overall purpose of the course is to train PWPs to deliver safe, helpful and competent guided self-help at step 2 of the stepped care model (for clients with common mental health problems). This is in order to meet the service needs of various IAPT service providers across Yorkshire and Humber. The course is funded by Education Yorkshire and Humber and trainees completing the Certificate will hold posts as IAPT PWP trainees in their Trusts and work in the IAPT services. The course is accredited by the British Psychological Society (BPS).

The course is based within the Clinical Psychology Unit at the Department of Psychology, which has an excellent research record and outstanding facilities. The course team at the University of Sheffield contribute regularly to the research evidence base for low intensity interventions. This is highly unusual compared to other course teams across the country. Opportunities exist for contact with the PG Diploma High Intensity Course via joint teaching. Trainees are paid employees of their sponsoring NHS Trusts and 3rd Sector Employers and the clinical context of PWP training during the course is provided by the IAPT services at which the trainees are based. Particular emphasis is placed on the skill and competency development of PWP trainees to meet the service demand of these employers. As PWP trainees are employees, funded by public monies, expectations of the attitude and behaviour of PWPs are calibrated accordingly.

# **The IAPT Course Team**

The IAPT course team (teaching across the PG Cert in Low and PG Dip in High Intensity Psychological Interventions) is comprised of clinicians who have been selected due to their experience of working clinically using low and high intensity cognitive behavioural methods for many years across many mental health settings. Further details of staff interests can be found on the CPU Website:

<http://www.sheffield.ac.uk/clinicalpsychology>.

The Course Administrators are

Sarah Brecknell (Postgraduate Support Officer) and Dan Barrow (Administration Assistant)

Monday to Friday, 9am - 4:30pm

Email - [iapt@sheffield.ac.uk](mailto:iapt@sheffield.ac.uk)

They are situated on the 4th Floor of Cathedral Court in the Clinical Psychology admin office. You will receive a lot of emails from the course administrators so please check your University email regularly. These emails may concern, for example, your marks, a change to teaching or a change of room for a tutorial. Please send correspondence to [iapt@sheffield.ac.uk](mailto:iapt@sheffield.ac.uk) in the first instance or to the appropriate tutor with [iapt@sheffield.ac.uk](mailto:iapt@sheffield.ac.uk) copied in.

**Course team contact details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Role** | **Email Address** | **Working days** |
| Jennie Hague | Programme Director/ IAPT Teacher | [Jennie.hague@sheffield.ac.uk](mailto:Jennie.hague@sheffield.ac.uk) | Tuesday - Friday |
| George Miles | Deputy Programme Director/ IAPT Teacher (PWP) | [g.miles@sheffield.ac.uk](mailto:g.miles@sheffield.ac.uk) | Tuesday, Wednesday and Friday |
| Helen Ellerington | IAPT Teacher (PWP) | [h.ellerington@sheffield.ac.uk](mailto:h.ellerington@sheffield.ac.uk) | Thursday and Friday |
| Mike Goodchild | IAPT Teacher | [m.goodchild@sheffield.ac.uk](mailto:m.goodchild@sheffield.ac.uk) | Thursday and Friday |
| Saniya Rabbani | IAPT Teacher | [s.rabbani@sheffield.ac.uk](mailto:s.rabbani@sheffield.ac.uk) | Thursday and Friday |

**Teaching team information (including Thursday/Friday team)**

**Louise Crawley**

Louise has been working as a PWP since 2014 and began her PWP career at Hertfordshire Partnership and Foundation Trust (completing her PWP training in Essex). Louise moved to the Sheffield IAPT service in 2016 and currently works as a Senior PWP and supervisor within the service 3 days a week.  Louise is an advocate for the step 2 IAPT role and enjoys supervising and supporting PWPs. She has been involved in the production of a step two guide for working with OCD.

**Helen Ellerington**

Helen has worked in Sheffield IAPT for 6 years as a PWP, a Senior PWP and is now one of the Team Leaders within the service three days a week. She has been involved in delivering psychoeducational courses and has also supported patients to use online CBT programmes. She has worked in a diverse range of GP practices for 1:1 clinics over the years and now is leading on some of the promotion and outreach aspects of the service. Helen is enthusiastic about the PWP role and the positive impact this can have for patients with low mood and anxiety.

**Mike Goodchild**

Mike has worked as a PWP in Sheffield since 2016. He currently works for the IAPT service in the city 3 days per week, in local GP surgeries and a range of community venues. Mike is actively involved in the delivery Stress Control psychoeducational groups and Improving Wellbeing workshops for both low mood and anxiety. He is also a supervisor. Mike has a keen interest in developing the PWP role and promoting this with other health care professionals and the public. Before working in IAPT Mike worked with both adults and young people as a Probation Officer.

**Jennie Hague**

Jennie worked as a PWP then a CBT therapist and supervisor in the Sheffield IAPT for 12 years giving her frontline experience of the CBT and PWP roles alongside the pragmatic application of stepped care and service delivery. She is a BABCP accredited Cognitive Behavioural Psychotherapist. Jennie has recently joined the University Counselling Service\* working with a small caseload of CBT clients and delivering supervision, 1 day per week.  Jennie joined the university in 2015 as a tutor and has progressed to the Deputy Programme Director role in 2018 and more recently is acting up into the Programme Director role for the IAPT training courses. Jennie has clinical interests in Behavioural Activation, the assessment of PWP competency and the delivery of transdiagnostic protocols at step 3.

\*Please note Jen does not receive any referrals for any students within the Psychology or Clinical / Applied Psychology Unit as part of her role with UCS.  Trainees can be assured that the strictest procedures of confidentiality are in place, should they need to access the UCS.

**George Miles**

George joined the team in 2016. She has worked in the Sheffield IAPT service as a PWP since 2012 and as a supervisor since 2014. She has previously worked within Substance Misuse for many years and also within Adult Mental Health in an assistant clinical psychologist role. More recently she has been delivering the LTC top up training for PWPs and supervisor’s training as well as being part of a new team responsible for training EMHPs (Education Mental Health Practitioners).

**Ian Mitchell**

Ian has worked within the NHS since 2009 and within IAPT as a PWP since 2012. He is currently working for Sheffield IAPT as a senior PWP in the Health and Wellbeing Team, which looks to integrate physical and mental health. Areas of interest include the development and delivery of step two groups (including health anxiety and managing stress) and working with long term conditions using PWP interventions. He has been involved in the production of a step two guide for working with OCD. He is currently involved in developing a pathway working with tinnitus. He is passionate about the PWP role and its development. Prior to working in IAPT Ian worked in smoking cessation and is a trained counsellor.

**Saniya Rabbani**

Saniya has worked for Leeds Community Health since 2019 and has been a practicing Psychological Wellbeing Practitioner for approximately 3 years. Saniya helped to develop the Postgraduate Certificate in Psychological Interventions Programme at the University of Bradford before joining the teaching team at the University of Sheffield. Saniya graduated from the University of Leeds in Advanced Psychology with a Masters in Health Psychology (BSc, MPsych) in 2018. She then trained at the University of Sheffield and has additional Supervisor and Long Term Health Conditions training from the University of Sheffield.

**Matthew Taylor**

Matt works as a CBT therapist in the Doncaster IAPT Long Term Conditions Service three days a week, and provides supervision to PWPs in the service. Prior to this, Matt worked as a PWP for several years and is an advocate for step 2 interventions in IAPT. Matt has also worked as an assistant psychologist where he spent time conducting research on digital psychological interventions for common mental health problems. Matt’s clinical areas of interest include CBT for social anxiety, and the design and delivery of psychoeducational courses in IAPT.

**Ryan Thornton**

Ryan has worked as a PWP since 2016. He is currently working two days a week as a senior PWP in the Sheffield IAPT service. His main areas of interest are improvement of group clinical supervision sessions and developing step two psychoeducational groups. Most recently Ryan has worked on creating a group to support people experiencing distress as a result of the Covid-19 pandemic. Prior to joining IAPT Ryan worked supporting homeless young people. Ryan is an advocate for step two interventions and enjoys providing support for other PWPs.

**Guest Teachers**

The Programme invites guest lecturers to run workshops during the course for some sessions. The may work in local Trusts or teach in other Universities, and they come to share their particular expertise in a specific area. Trainees are expected to be warm and welcoming to any outside speakers. This is particularly the case in Module 2.

**Roles of the Teaching Team**

The members of the teaching team have various roles: (1) teaching, (2) marking, (3) facilitating a reflective practice/self-practice group, (4) academic tutoring, and (5) pastoral support.

**Teaching and marking**

The teaching team facilitate the majority of the lectures, workshops and tutorials across the course. They are responsible for preparing, developing and delivering teaching materials and learning resources. They design lectures that incorporate theoretical and skills based learning in line with the PWP National Curriculum and the relevant evidence base. The teaching team mark and provide feedback on all submitted assessments and clinical tapes.

**Tutor Roles**

Each trainee will be allocated a tutor. The tutor will fulfil 3 roles for the trainees through the training year.

**Clinical Skills**

Tutors will facilitate the clinical skills groups. They will support and provide feedback on clinical skills practice and development. They will also be the trainee’s academic tutor.

**Academic Tutorial Support**

The role of the academic tutor is to help the trainee navigate the academic assessments of the course and also provide pastoral support as needed. Tutors may also signpost trainees to student support services, such as the Dyslexia and Disability Student Support service. Tutorials are group based and occur throughout the duration of the course. Trainees should email their tutor a week prior to the tutorial in order for tutors to prepare answers. Trainees are encouraged to request one-to-one tutorials with their academic tutor on a needs basis. Your academic tutor may not mark your work as the marking process is anonymised. When a piece of work has been failed, it is more helpful to seek a tutorial (if needed) with the marker, if this person is different to the trainee’s assigned academic tutor. Trainees are advised to seek help with any academic difficulties as soon as possible. Trainees are encouraged to inform their academic tutor of any personal circumstances that may be affecting their abilities whilst training as soon as possible. Please refer to the extenuating circumstances guidance as needed. Tutors may request a one-to-one meeting with a trainee if they are concerned about a particular matter. When a specific training plan is necessary to support any trainee, this will typically be drawn up in liaison with the Programme Director/ Deputy Programme Director and representatives from the clinical service.

**SP/SR Groups**

During module two, the clinical skills groups change into self-practice self-reflection groups wherein trainees will use GSH processes and techniques in their own self-care and personal development. Tutors will facilitate these sessions and may participate in the group. Trainees will typically have the member of the course team as their academic tutor, their clinical skills tutor and SP/SR tutor.

**Course Structure**

The PWP teaching programme is delivered within a competency-based framework and contains two core modules. The University Regulations for the course are in Appendix 12.

|  |  |  |
| --- | --- | --- |
| **Module Title** | **Number of Credits** | **Credit Level** |
| **Low Intensity Psychological Interventions for Mental Health**  Part 1A: Engagement and assessment of patients with common mental health problems  Part 1B: Evidence based low intensity treatment for common mental health problems | 30 | 7 |
| **The Social and Healthcare Context**  **(Values, Diversity & Context)** | 30 | 7 |

The two modules of the PWP course are structured to follow the national PWP curriculum guidance. Delivery entails 30 days of teaching (f2f, live online and pre-recorded) and 15 days of practice-based learning (please see the 15 Days Supervised Learning in the Workplace Document). There is a 50/50 split between didactic teaching in lectures and clinical skills. Trainees should be aware that their practice-based learning needs to be completed throughout the year and the Practice Portfolio needs to be started early and completed throughout the training year. At the start of the course, there is an introductory teaching block (please see timetable) which explains the workings of the course and prepares trainees for their first academic assessment. This is followed by teaching which takes place weekly on a Friday in the University, and is concurrent with four days per week of clinical practice at the IAPT service sites. It is vital that trainee PWPs shadow qualified PWPs in their IAPT services from the beginning of the course in order to understand the role/method and see the competencies being modelled. Supervisors are made aware of this need via the Supervisor’s Handbook. Trainees will have scheduled group tutorial times during the academic year, which are designed around the academic assessment structure. PWP trainees will be allocated to a tutorial group and provided with a timetable of academic tutorials. Trainees and teaching staff can request one-to-one tutorials as they see fit.

**Service Learning Contract**

This document must be completed and submitted as per the assessment schedule. The purpose is to ensure that the service, University and trainee have a sufficient awareness regarding their expectations for the course. This agreement aims to facilitate a positive training experience for trainees. **This form is submitted via Pebblepad.**

**Service Liaison**

Trainees should be aware that the Programme keeps in close communication with each clinical service throughout the year and that trainee results, attendance and other relevant information relating to the trainees’ progression on the course are shared with the service to ensure swift action when support is needed. Three-way communication is actively encouraged between the trainee, the University team and the service manager/site clinical supervisor to support the trainee in their learning role. This is to ensure that information about trainee progress or any pertinent issues that may arise during training is shared effectively, to allow for problem solving to take place.

The clinical and organisational performance of PWP trainees is reviewed jointly by the University and IAPT services on one occasion during the year via the submission of the **Service Liaison Form on Pebblepad.**

This is an opportunity for you to raise any concerns you have regarding your employment or study. Information on this form will be discussed and addressed in a sensitive and appropriate manner. It is impossible for us to try to address ongoing issues if we are not made aware of them. As such, please do not see this as a box ticking exercise.

The trainee and Service Supervisor/Line Manager sections will be completed by the submission date and then reviewed at the Internal Exam Board. Following this, the academic tutor will add further comments and suggestions for any appropriate actions to be taken forward.

If this review process reveals any issues or problems, it may trigger a 3 way meeting between the trainee, service and tutor to allow for a more detailed assessment of the situation. Such reviews can occur more frequently and on an informal basis as needed or demanded. When a trainee is particularly struggling clinically and/or academically, efforts will be made to liaise more closely with the service and produce a training plan to suit the needs of all parties.

# **Meeting Structures**

The IAPT programmes have a rolling meeting structure. There is an IAPT Course Committee Meeting which is the liaison committee for the course and meets on (roughly) a 6-week basis. This committee requires a representative from the PWP course and coordinates teaching strategy and reviews trainee progression on a regular basis. There are regular Internal Exam Boards (IEB) at which assessment grades are agreed and moderated, and a final External Exam Board (EEB) at which trainees are signed off as passed or failed by the External Examiner.

An IAPT Business Meeting will take place each Wednesday between the Course Administrators, Course Director and Deputy Course Director. The purpose of the business meeting is to address the day to day running issues of the course, consider training issues and review extension requests.

**IAPT Course Committee**

The Course Committee Meeting is responsible for liaison with both IAPT services and trainees on the PWP course. Its purpose is to provide a forum in which stakeholders associated with the IAPT Courses meet to plan, implement and review all aspects of Course policy. The primary functions of the Committee are:

1. To promote and review a coherent IAPT teaching philosophy.
2. To oversee the academic curriculum and maintain high academic standards appropriate to professional training.
3. To monitor the provision of clinical experience in the IAPT services to ensure that high standards of clinical experience and supervision are achieved.
4. To ensure that PWP trainees' needs for personal and professional development are met by the courses.
5. To formulate and overview the methods of assessment of academic and professional performance as required by the formal examination regulations of the Courses.
6. To monitor the selection of trainees to the courses.
7. To promote good practice throughout Yorkshire and Humber, via the support of applicable research and continuing professional development.
8. To disseminate information and actively seek the views and involvement of all relevant stakeholders (University, local Psychology and CBT Services, service supervisors, Trusts).
9. To liaise with appropriate Regional bodies associated with CBT concerning relevant training issues (e.g. BABCP, Regional Special Interest Groups).
10. To monitor the quality of the Course and to prepare an annual review, together with necessary documentation associated with contracting and/or BPS accreditation.
11. To review these 'Terms of Reference' regularly and to make any such changes thought appropriate by the Committee.

**Membership of the IAPT CCM**

**Chair**: Programme Director or nominee

**Secretary**: Course Administrator

**University staff**: IAPT teachers

**Trainee representatives**: HIPI course and PWP course

**NHS representatives**: High and low IAPT service supervisors and service managers (when necessary and indicated to attend).

Any of the above may be invited to a particular CCM or co-opted onto the Committee. Similarly, they can request to place a specific item about the Course on the agenda of the committee and attend the relevant meeting. The CCM aims to make decisions on a consensual basis. However, in the absence of agreement, the CCM will be able to reach a final decision via a simple majority vote of the representatives present, including trainees. Items for the agenda will be received by the Chair/Secretary up to two weeks prior to the meeting. Minutes are prepared and documented by the Course Administrator and will be available upon request. Trainees will be provided with a timetable of CCM meetings and asked to select two trainee representatives to feedback on behalf of the cohort. The trainee representatives will change at week 21 of the course for two new reps.

The Committee coordinates teaching strategy and reviews trainee progression on a regular basis, therefore two representatives from the PWP course are required to attend CCMs. This is a collaborative role to consider what is going well on the course, in addition to what is not going as well, from the perspective of both the trainees and the teaching team. Course representatives are responsible for gathering feedback from other trainees and presenting this feedback to the meeting in a way that gives an overall perspective of the group, not a list of individual grievances. In the service of two-way feedback, a ‘You said, we did’ Google document will be created. This document will summarise feedback brought to the CCM by the trainee representative. Following the CCM the course team will update this document with their response and actions taken in line with the feedback provided. Please be aware that it may only be possible to implement changes made as a result of trainee feedback for the following cohort. This is due to the Course Handbooks being established for the current training year and any amendments can only be made when the handbooks are reviewed annually.

The responsibilities of the trainee representatives are:

1. to attend the course committee meeting;
2. to take time to survey the cohort before the meeting for feedback and bring that feedback to the meeting;
3. to update the ‘You said, we did’ online Google document – guidance will be provided by the admin team;
4. to ensure that the feedback brought to the meeting represents the thoughts and feelings of the group as whole and not certain individuals;
5. to ensure that the feedback brought to the course committee is balanced;
6. to act as a nominated link between the trainees and the teaching team;
7. to feedback to the trainees from the team where necessary.
8. to attend the IAPT Training committee meetings

**Reserved Business**

Reserved Business may include:

1. Matters concerning the progress or welfare of individual HIPI or PWP trainees.
2. Matters concerning individual, named cognitive behavioural therapists or others associated with the IAPT Courses, may at the discretion of the Committee, be treated as Reserved Business.
3. Matters concerning contracting between the University and the SHA, may at the discretion of the Committee be treated as Reserved Business.

Under Reserved Business, the trainee representatives and others thought appropriate by the Committee may be requested to withdraw from the meetings. Minutes of Reserved Business will be circulated separately to all members of the Committee, with the exception of those requested to withdraw or their associates.

**IAPT Training Committee**

The IAPT PWP Training Committee provides an opportunity for liaison between the course, the trainees, service managers and supervisors. Its purpose is to provide a forum in which stakeholders associated with the IAPT PWP programme meet to plan, implement and review all aspects of course delivery and policy. The committee will meet biannually in February and September.

The primary functions of the Committee are:

* The promote and review a coherent IAPT teaching philosophy
* To oversee the academic curriculum and maintain high academic standards appropriate to professional training
* To monitor the clinical experience in IAPT services to ensure high standards of clinical experience and supervision are achieved
* To ensure tPWPs needs for personal and professional development are met
* To formulate and overview the methods of assessment of academic and professional performance as required by the formal examinations of the course
* To monitor and review recruitment and selection processes and outcomes
* To promote good practice throughout Yorkshire and Humberside by the support of applicable research and continuing professional development
* To disseminate information and actively seek views and involvement of all relevant stakeholders
* To liaise with appropriate regional bodies with relevant training issues (e.g BPS)
* To monitor the quality of the course and feedback into annual review process
* To contribute to accreditation of the programme
* To review the ‘terms of reference’ regular to make any such changes agreed by the committee

**Internal Exam Boards**

The Internal Exam Boards (IEB) sit throughout the year and are planned to coincide with submission dates and marking time. These dates are provided at the start of the year within the course submission dates table. At these meetings the marks, feedback and extension requests are discussed and ratified.

All outcomes are distributed to trainees by email **within two weeks** of the board. Feedback will not be available before the Course Administrator has distributed the information so **please do not approach members of the team** to ask for outcomes of the IEB during this time period.

**External Exam Board**

The External Exam Board (EEB) sits annually, at the end of the course following all submissions, and is attended by the named External Examiner for the course. At this meeting the overall marks and feedback for all course participants are discussed and ratified. Following this meeting trainees will receive a letter to indicate their overall PASS of the course. Please note, even if you have passed each submission necessary for the course, the overall PASS mark is not distributed until it has been ratified at the EEB.

**IAPT Programmes Business Meeting**

**Membership of the Meeting**

IAPT Programme Director: Jen Hague (Chair)

PWP Deputy Programme Director: George Miles

HIPI Deputy Programme Director: Maggie Spark

IAPT Course Administrators: Sarah Brecknell and Dan Barrow

**Terms of Reference**

The purpose of the IAPT Programmes Business meeting is to provide an opportunity for regular communication between the IAPT Programme Director, Deputy Programme Directors, and Course Administrators, to facilitate the effective running and development of the IAPT Programmes.

The primary functions of the meeting are:

* To enable information relevant to the running of the courses to be shared efficiently between members.
* To promote collective awareness and understanding of current developments and issues across both courses.
* To enable learning/best practice to be shared between HIPI and PWP courses.
* To ensure that any issues related to the day-to-day running of the course are addressed in a timely manner.
* To enable collaborative and consistent decision making around trainee issues, including extension requests, in line with course regulations.
* To monitor and review course processes and systems to ensure these continue to be effective, and to implement any changes or updates as agreed by the group.
* To monitor and review recruitment and selection processes and outcomes.
* To feed into course planning days and monitor implementation of agreed actions from planning days.
* To feed into and monitor implementation of agreed actions from Course Committee Meetings, HIPI and PWP Training Committees, and the Programme Directors meeting, as appropriate.
* To review the ‘terms of reference’ regularly to make any such changes agreed by the meeting.

# **Teaching and Learning Strategies**

The teaching and learning strategies used on the PWP course have been specifically designed to integrate theory with the practice of PWP self-help psychological interventions. The use of the best available evidence-based practice underpins all teaching and learning activities.

The course has a strong emphasis on problem-based learning and will include lectures, skills development workshops and experiential learning, including role-plays and fishbowls. PWP trainees are encouraged to consider the experiential aspects of the course as opportunities to learn and develop new skills (or practise old skills) in a safe environment. The expectation of the course is that trainees engage fully in all experiential learning exercises. Though the course acknowledges that this approach to learning may generate anxiety, it is not an option for trainees on a clinical training course to avoid such activities.

**Teaching Structure**

On a Friday morning, teachers will facilitate theoretical teaching with the whole group and demonstrate various aspects of the PWP clinical methods.

Trainees will be allocated to **Clinical Skills Practice Groups** (CSPG) in **Module 1**, which will take place on Friday afternoons. These groups provide the context for trainees to practise the competencies they have observed in the morning. There is a teacher to trainee ratio of around 1:10 in CSPGs, and the facilitator and group members will (as far as possible) remain consistent across the course. The group will also consist of trainees from a range of service groups. Trainees should be aware that there will be some differences in the way that teachers model techniques. There is an expectation that trainees engage with the learning methods employed in the skills practice groups and that failure to do so would be considered a Fitness to Practise issue.

In **Module 2**, the CSPGs change their focus to supporting and developing resilience in trainee PWPs by having a **Self-practice and Self-reflection** (SP/SR) group. A separate document will be distributed to use in these sessions, which includes the homework and preparation required to participate in the group. This document will include personal information and we do not expect you to submit this as part of your Practice Portfolio. However, you will be required to submit an **SP/SR engagement form** as part of the 15-day learning document which must be signed off by your group facilitator and included in your Practice Portfolio. The purpose of this is to encourage trainees to contribute to and engage with the important process of SP/SR. Engagement with and attendance of the SP/SR groups is an essential part of the course.

A variety of teaching methods are used across the PWP course and these include the following:

1. Experiential and skill-based workshops providing PWP trainees with a foundation in the clinical procedures and processes of self-help psychological interventions.
2. Skills based competencies which are assessed through: an Observed Structured Clinical Examination (OSCE), small group experiential role plays, clinical skill workshops, direct individual and group observation by the teaching team, submission of taped treatment sessions, and supervised practice through direct patient contact.
3. Self-directed study including guided reading and activities.
4. Lectures
5. Problem-based learning
6. Flipped Classroom whereby trainees will be set assignments prior to lectures to enhance the opportunity for learning and skills practice while at university.

**Tutorials**

Tutorial support in a number of forms is available for trainees throughout their training year. Trainees are expected to actively participate in academic tutorial support; this means you are expected to attend the tutorial well prepared as you will get out what you put in.

Tutorials need to be pre-booked with tutors. Please do not expect tutor and room availability without booking the tutorial. Individual tutor contact details are available in the IAPT Course Team section of the handbook.

**Group academic tutorials**

Prior to the deadline, there is a timetabled tutorial for the whole cohort specifically related to each course assignment. The tutorials provide trainees the opportunity to ask the course team questions about the assignment. It is compulsory for trainees to be prepared, having reviewed course documentation related to the assignment and bringing pre-prepared questions to pose to the course team. Attendance is compulsory and a summary of what is discussed is not routinely circulated to the cohort.

**One to one tutorials**

Following a failed submission, trainees are entitled to a tutorial with the first marker to discuss the assignment and any changes that need to be made or areas to work on in preparation for a successful resubmission. It is the responsibility of the trainee to proactively take on-board and learn from feedback provided. This may involve watching a tape and making notes on what did/did not go well, or reading through a written assignment in line with the marking criteria. For one to one tutorials, the team will aim to offer this within one week of the request.

**Pastoral support**

If you are experiencing any personal issues and are concerned about their effect on your wellbeing or progress on the course, you are strongly encouraged to request a tutorial with your tutor in order to access support from the course. If there is a reason why this is not possible, please speak to the Programme Director or Deputy Programme Director directly. Tutors aim to be as helpful and supportive as possible. Part of the tutor role is to signpost trainees to services through which trainees can access further support, rather than providing help directly. If you want a tutor to listen to your situation rather than offer advice on how to solve the problem, please clearly identify this to the tutor at the beginning of the tutorial.

**DDSS tutorials**

Trainees who have self-referred to DDSS will receive a Specific Learning Plan which is shared with the trainee and IAPT Disability Liaison Officer (DLO). The DLO will send the plan to the trainee’s tutor who will approach you for a one to one tutorial to review the plan and advise on the support mechanisms in place.

**Course Expectations**

Securing a place on the PWP course is difficult and the course is challenging. The University provides an adult learning environment with the following expectations for the course (based on previous student and staff feedback):

* Punctual attendance for sessions, including returning after breaks and lunch, and staying until the end of sessions.
* Please expect to be at University 9.30-4.30pm on Fridays. Some sessions will start earlier or finish later (please consult timetable regularly). Sometimes sessions will run over, so allow yourself enough time when considering travel plans.
* No use of mobile phones during teaching.
* Focus on the teaching. Talking to your neighbour can distract the lecturer and those around you.
* Have a ‘give it a go’ attitude and participate when the opportunity arises.
* If you have concerns or difficulties, discuss them with a tutor.
* Please view attendance at University in the same way you would for any paid, professional role.
* It is your responsibility to mark your attendance on the register.
* Try to plan holidays and annual leave to coincide with reading weeks.
* Push yourself and don’t be afraid to make mistakes.
* Please don’t email the Course Administrators to ask for results. These are available within 2 weeks of the relevant exam board.
* Be aware that some queries about the course may not have definitive answers, and therefore feedback from tutors may differ slightly.

**Covid 19**

This course will be delivered face to face (subject to government and university guidance). Please view the document *Campus Guidelines for IAPT Trainees*. This is available as a separate document on Blackboard. It is important you are familiar with the content as it outlines your responsibilities as a student. We will email with any changes to these guidelines. Also, please see <https://www.sheffield.ac.uk/coronavirus> for University wide information.

There may be times when lectures may be cancelled at short notice due to staff absence and/or restrictions. The teaching team will work to prevent this where possible, but there are limitations to what is possible. Trainees will need to check their emails prior to travelling Sheffield for any updates. There may be unavoidable circumstances where trainees with long commutes may have begun their journey to Sheffield before we are able to notify them of a cancellation of a session. In those circumstances trainees are able to make use of campus facilities such as the library and should follow recommendations communicated by the course with regards to study time.

**We are not delivering a hybrid course**, but some elements will be timetabled for remote delivery. These will be delivered through Blackboard (online platform), which you will be able to access once you have a computer account and are registered. You will receive training on how to access and use Blackboard. You will need a laptop/desktop, microphone and camera, and Google Chrome web browser. Blackboard does not work well through other web browsers, often resulting in your mic/camera not working. If you have a work computer which will not let you download Google Chrome, you will need to get in touch with your employers as soon as possible to find a solution to this as it is essential to engage in the teaching.

Please also follow these top tips for the remote elements of the course:

* Set up your computer on a flat surface. A computer (PC or laptop) is best due to the bigger screen, but a tablet can work too.
* Ensure your internet connection is stable and make sure your device is charged and/or your charger is near.
* Make sure your webcam and microphone are working.
* Headphones are encouraged for the best sound quality.
* Have a pen, notebook and teaching slides to hand.
* Find a quiet, safe, private space where you won’t be interrupted.
* Be available for the full length of the teaching session.
* Minimise distractions and noises and avoid multitasking.
* Silence or turn off your phone.
* Get comfy. Consider your posture. Look after your body.
* Ensure lighting is adequate so your face is clear and make sure your face is fully in the frame (if using camera).
* Connect as normal. Treat it like a face to face teaching. Look at the teacher/peer not the camera or your own face.
* Keep calm. Tech issues are normal. Keep in touch via phone/email.

**Attendance at University**

Although predominately taught on a Friday, there are some circumstances when attendance at University may be required on another day. This may be in the case of OSCE practice, specialist lectures or teaching, personal tutorial sessions, or in the event of an OSCE resit or coaching session. Therefore, it is the student’s responsibility to negotiate with the service lead to allow attendance on these occasions.

**Lunch break**

There is a one hour lunch break scheduled for every training day. This is in line with employment law and is a necessary break for both trainees and IAPT staff. Furthermore, this time can be used for meetings and tutorials. The lunch break cannot be reduced to shorten the training day.

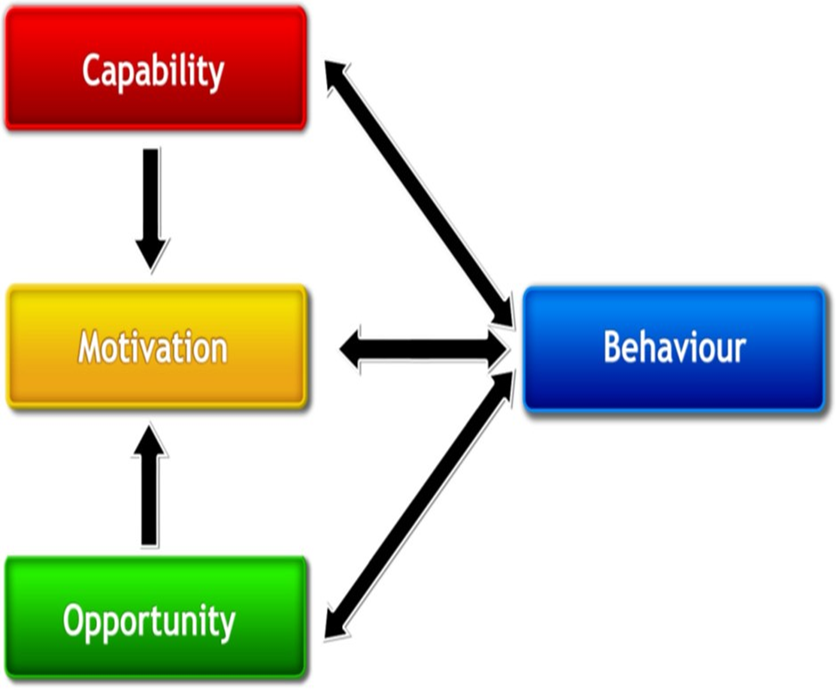
**Reading weeks**

Reading weeks are scheduled throughout the course to give you time away from lectures and clinical skills groups to complete assignments. All though these are termed ‘reading weeks’ they actually ONLY cover the one day you would normally be attending the university.

**Theoretical Underpinning for the PWP Course and Role**

A major focus of the work of the PWP is the assessment and engagement of patients with mild-to moderate common mental health problems and the delivery of evidence based low intensity self-help interventions. Therefore, it is crucial that PWPs are competent both in assessment and engagement of patients, and in the knowledge of and delivery of treatment options and interventions at step 2. It is also crucial that PWPs understand the differences between step 3 interventions and the step 2 self-help role. This is to ensure clinical role boundaries are adhered to, in order to prevent therapeutic drift and ensure fidelity to the PWP clinical method. The key theoretical approach underpinning the PWP role is behaviour change, in particular the integrative behaviour change COM-B model (Michie et al., 2014, 2011). This incorporates and builds on previous behaviour change theory and frameworks designed to improve health beliefs and behaviour change.

This demonstrates that three factors are necessary for any behaviour and that behaviour is influenced or determined by an interaction between capability, motivation and opportunity. The COM-B model aids in the PWP clinical method of information gathering, information giving and shared decision making, and its use enhances patient centred assessment and collaborative treatment planning.



**Capability**: the physical capacity or psychological capacity of the patient to perform the behaviour or to change behaviour. In terms of the PWPs this means they will need to work with people to ensure they have the relevant knowledge and understanding of their problem, what maintains it, and what is required in order to make the behavioural changes. This will be relevant for effective and collaborative information gathering, information giving and shared decision making.

**Motivation**: the person needs to be motivated enough to be able to undertake the necessary stages to change a behaviour. The PWP can enable the person to make changes by working with the patient to enhance understanding of what determines and influences motivation and what impacts on motivation. This will be relevant for effective and collaborative information gathering, information giving and shared decision making. For example, this may be enabling a patient to reduce alcohol intake, engaging in exposure activities for the management of panic attacks, or behavioural activation activity to reduce depression.

**Opportunity**: The person needs to have access to support and resources to be able to undertake the required behaviour or indeed to reduce or stop an unhelpful behaviour. PWPs can help the person to work on their resources and support by signposting, or working with the person in sessions to make improvements to enable them to access more opportunities to foster change and promote social support and social inclusion.

# **Module 1: Low Intensity Psychological Interventions for Mental Health**

**Part 1a: Engagement and Assessment of Patients with Common Mental Health Problems**

**Aims**

PWPs assess patients with common mental health problems to enable the self-management of their recovery. To do so, PWPs must be able to undertake ‘patient-centred assessments.’ These identify the main areas of concern, impact and the targets for change and make an accurate assessment of risk through the use of good interpersonal skills. PWPs need to have knowledge of and be competent in the application of PWP assessment across a range of different assessment formats and settings. These can include risk assessment, psychometric assessment, problem focussed assessment and intervention planning. PWPs need to be able to engage patients and establish a therapeutic alliance, whilst gathering information to begin assisting the patient to choose and plan a collaborative treatment programme. PWPs can only do this if they possess sound knowledge of mental health disorders and the evidence-based PWP intervention options available – which need to be communicated in a collaborative, clear and unambiguous manner so that patients can make informed treatment choices. This module will, therefore, equip PWP trainees with a good understanding of the incidence, prevalence and presentation of common mental health problems and how these can be effectively assessed and treated. Skills teaching will develop PWPs’ core ‘common factor’ competences of active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision making.

**Learning Outcomes**

1. Demonstrate knowledge and understanding of behaviour change theory and the COM-B model as applied to low intensity patient centred assessment.
2. Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health, and a range of social, medical and psychological explanatory models.
3. Demonstrate knowledge of and competence in using ‘common factors’ to engage patients, gather information, build therapeutic alliance with people with common mental health problems, manage the emotional content of sessions and grasp the patient’s perspective or “world view”.
4. Demonstrate knowledge of, and competence in ‘patient-centred’ information gathering to arrive at a succinct and collaborative definition of the person’s main mental health difficulties and the impact this has on their daily living.
5. Demonstrate knowledge of the principles and competences underpinning the effective assessment of common mental health disorders and their application in a range of different settings.
6. Demonstrate knowledge of and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorder from a patient-centred interview and is able to assess and recognise any risks to self and others posed by patients.
7. Demonstrate knowledge of and competence in recognition and accurate assessment of the risk posed by patients to themselves or others.
8. Demonstrate knowledge of and competence in the use of standardised symptom assessment tools and other psychometric instruments to aid problem recognition and definition and subsequent decision-making.
9. Demonstrate knowledge of and competence in giving evidence-based information about treatment choices and in making shared decisions with patients.
10. Demonstrate understanding of the patient’s attitude to a range of mental health treatments, including prescribed medication and evidence based psychological treatments.
11. Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record-keeping systems.

**Part 1b: Evidence Based Low Intensity Treatment for Common Mental Health Disorders**

**Aims**

PWPs help through the provision of information and support via evidence-based low-intensity self-help and also regularly support pharmacological treatments of common mental health problems. Low-intensity psychological treatments place a greater emphasis on patient self-management and are designed to be less burdensome than traditional psychological treatments. The overall delivery of the range of low intensity interventions should be guided by Behaviour Change Theory. Examples of interventions include providing support for a range of low intensity CBT based self-help interventions (often with the use of written self-help materials such as behavioural activation, exposure, cognitive restructuring, panic management, problem solving, sleep hygiene and CBT, as well as supporting physical exercise and medication adherence. Support is specifically designed to enable patients to optimise their use of self-management recovery information and pharmacological treatments and may be delivered through face-to-face, telephone, email or other contact methods. PWP’s must also be able to manage any change in risk status. The module will, therefore, equip PWPs with a good understanding of the process of low intensity therapeutic support. Skills teaching will develop workers’ general and disorder-defined ‘specific factor’ competences in the delivery of CBT-based low-intensity treatment and medication adherence.

**Learning Outcomes**

1. Demonstrate knowledge and understanding of behaviour change theory and the COM-B model as applied to (and informs) low intensity interventions.
2. Critically evaluate a range of evidence-based interventions and strategies to assist patients to manage their emotional distress and disturbance.
3. Demonstrate knowledge of and competence in developing and maintaining a therapeutic alliance with patients during their treatment programme, including dealing with issues and events that threaten the alliance.
4. Demonstrate competence in planning a collaborative low-intensity psychological and / or pharmacological treatment programme for common mental health problems, including managing the ending of contact.
5. Demonstrate in-depth understanding of, and competence in the use of, low-intensity, evidence based interventions for common mental health problems.
6. Demonstrate knowledge of and competence in low-intensity competences such as behavioural activation, exposure, guided self-help, problem solving and the individualisation of low intensity evidenced based approaches.
7. Critically evaluate the role of case-management and stepped-care approaches to managing common mental health problems in primary care, including ongoing risk management appropriate to service protocols.
8. Demonstrate knowledge of and competence in supporting people with medication for common mental health disorders to help them optimise their use of pharmacological treatment and minimise any adverse effects.
9. Demonstrate competency in delivering low intensity interventions using a range of methods including face-to-face, telephone and electronic communication.

**Reflective Writing**

Reflection is an important part of the PWP course. During the year there are a number of reflections submitted for assessment. **These MUST use the Gibbs model of reflection** (as per the marking grids). There is a lecture early on in the course about reflective writing. Below are links where more information about Gibbs can be found:

<https://my.cumbria.ac.uk/media/mycumbria/documents/ReflectiveCycleGibbs.pdf>

<https://www.ed.ac.uk/reflection/reflectors-toolkit/reflecting-on-experience/gibbs-reflective-cycle>

**Module 1 Assessment Guidelines**

**Patient Centred Assessment OSCE and Reflection**

This is a 45-minute Observed Structured Clinical Examination (OSCE) and is a clinical simulation used to measure the PWP trainee’s skills in patient engagement, information gathering and information giving/shared decision-making. An actor will play the role of the patient and PWPs will receive a ‘referral letter’ concerning the patient details before the OSCE. The assessment conducted will be videotaped and assessed by teaching staff using the Assessment Competency Measure and accompanying Assessment Manual (provided separately on Blackboard). The possible mark range is 0-36. To pass the assessment, trainees need to achieve a mark of ≥18 and score a minimum of 3 on each section of the measure. A trainee could score more than 18 and still fail, if they fail one of the sections. An automatic fail is recorded if the risk assessment is graded as incompetent or absent, or any of the six sections scores lower than 3. Half marks can be awarded for sections. The marker will stop trainee PWPs that overrun the 45 minutes and marking stops at 45 minutes prompt.

**It is expressly forbidden for PWP trainees to share information about the content of the OSCE once it has been completed. This will be considered a Fitness to Practise issue.**

After it has been marked, trainees will receive a recording of the simulation from which they write a 2000-word reflective commentary on their performance. Trainees may choose to focus on one aspect to reflect on, but need to provide a rationale for this choice. Reflections will be marked according to the marking grids in the Appendix 2. Reflections must be written on the first attempt regardless of pass/fail outcome. **In IAPT services, trainee PWPs do not see patients on their own (under normal circumstances) until they have at least passed the patient centred assessment OSCE. Trainees must pass both the OSCE and the reflection to proceed on the course.**

Following successful completion of the OSCE, trainees will be given a copy of the actor’s feedback on the Patient Session Review form (see Blackboard). This is to provide the trainee with an assessment and feedback on their performance in the OSCE from the perspective of the ‘patient’.

**OSCE Recording/Technical Failure**

Unfortunately, sometimes recording equipment fails despite our best efforts. If this is the case, enhanced OSCE feedback will be given to the student (from the marker and actor) which can be used to help write the reflection. This will come from the marker and will provide further details alongside the competency mark sheet.

**Treatment Tape and Reflection**

This is a video-taped treatment session from routine PWP clinical practice. This **MUST** be a session with a genuine patient. The University allows up to 35 minutes for a treatment tape, however if a different timing is stated in the session agenda, marking will be contained within this time frame. The session can be an example of any one of the interventions that are listed in the PWP Treatment Competencies manual (see Blackboard). If a treatment has yet to be taught by the University team but the trainee has received sufficient guidance from their service supervisor, the session should still be fine to be submitted. However, in this case, trainees cannot then appeal a fail mark on the grounds that the intervention had not been taught before they submitted the session recording. Sessions need to contain a single GSH change method. It cannot be an assessment or the final (relapse prevention) session. This is to test the PWP trainee’s skills in the planning and implementation of a low intensity treatment session consistent with the appropriate GSH protocol for treating the problem/disorder the patient presents with. This will be assessed by teaching staff or trained external markers using the PWP Treatment Competency Measure and accompanying Treatment Manual (provided separately on Blackboard). The possible mark range is 0-36. Trainee’s need to score ≥18 to pass and need to score at least 3 on the change method item. Theoretically therefore, a trainee may drop below 3 in another section but still pass overall if they score at least 18 overall and 3 in the change method. An automatic fail is recorded if the risk assessment is not re-visited, the treatment drifts into a high intensity approach or an unrecognisable (i.e. not taught on the course) low intensity treatment approach is used (for example, Cognitive restructuring is carried out with a behavioural experiment). As described in the Treatment Competency Manual, the session should include aspects of the following:

* Agenda setting
* Progress review and measures
* Risk
* Homework review
* Change method
* Homework agreement

The session need not cover all of the stages of the GSH intervention, but should demonstrate good fidelity to the stage of the intervention that the session is planning to deliver. Alongside this, trainees will write a 2000-word reflective commentary on the session in which they also connect to relevant theory and evidence. Trainees may focus on one aspect of competency to reflect on, but need to provide a rationale for doing so. Reflections will be marked according to the marking grid in Appendix 3. Trainees are encouraged to use the marking grids in preparation of their reflection. The reflection will be marked separately to the treatment tape, so each can be passed or failed independently. In the event of a borderline pass/fail the reflective essay may be used to consider the trainee’s awareness of the problems evident and their ability to reflect on these. As such, each piece may influence the mark of the other so the essay will be marked by the same marker as the tape, not anonymously. Although they are still passed and failed independently, feedback may cover both submissions.

**In the event that a trainee fails both the tape and reflection, they will be required to submit a new treatment tape and a write a new reflective essay on that tape for resubmission.**

**Trainees must pass both the treatment tape and the reflection to proceed on the course.**

**Tape submission instructions and recording guidance**

Trainees are required to submit an audio-visual recording of the treatment session. It is the responsibility of the trainee to ensure they have adequate access to audio-visual recording equipment. This should be addressed early in the course to ensure the trainee has sufficient opportunity to record clients for this assignment. It is recommended that trainees record a number of clients during treatment sessions over a period of time to ensure that they have a selection to choose from for their submission. Please speak to a tutor as soon as possible if encountering problems.

In order to give the marker context about the treatment session submitted, trainees need to record an introduction section to camera before the session outlining:

* Where they are at in terms of the treatment contract (e.g. 3 sessions out of 6)
* Treatment approach used
* Previous homework agreed
* Trainees need to clearly state what the change method is.

Trainees need to submit their tape by uploading it to the IAPT secure server. The secure server is password protected and only the course team have access. Trainees will be set up as users for their own individual folder where they can upload the treatment tape. The tape will only be viewed by the markers from the course team (and the external examiner where applicable). Instructions on how to upload tapes to a secure server can be found in Appendix 6. If trainees have any issues regarding the process for submitting the tape, please inform a member of the course team prior to the date of submission, as technical failures are not considered grounds for extensions (please see Appendix 8 for course policy on technical difficulties).

**Treatment Tape Practice**

In order to provide useful and relevant feedback prior to submission of the treatment tape, trainees are required to bring a treatment tape (audio-visual recording) to the ‘Treatment Tape Practice’ session as specified in the timetable. Tapes will be viewed by peers and marked by the tutor (using the competency measure) and feedback for development given. This is a crucial opportunity for trainees to receive formative feedback on their tape, therefore it is expected that all trainees take part. In the rare event that a trainee does not have a tape from an authentic treatment session to bring to the practice, the trainee will be required to record a role play with a colleague in service which will be viewed by the group. This session should be based on presentation from your real caseload. We ask that trainees prioritise bringing an authentic taped session as the feedback will be more useful for their summative submission. The practice treatment tape can be using any PWP intervention as is taught on the course but MUST be a different tape to the tape that is submitted for the assignment. A tape with the same patient is allowed as long as it’s a different session. The session rated on the practice day CANNOT be used as one of the 6 supervisor rated sessions in the portfolio.

**Telephone Screening Formative Assessment**

Telephone skills are an important element of PWP work. The BPS curriculum highlights the need to address this on training courses. We teach telephone screening skills as part of this module, through role plays with feedback. Although not formally assessed this will provide a key opportunity for development.

**Disorder-specific Jacobson Plots**

One of the aims of the course is that PWP trainees learn to appreciate the value of patient feedback in terms of clinical outcomes and also be able to understand and reflect upon the outcomes they are facilitating. Trainees needs to produce two Jacobson plots for all completed treatment cases. A completed example on how to plot the outcomes is included on Blackboard. Teaching is provided on how to produce and interpret the plots. More information is included on Pebblepad.

# **Module 2: Social and Healthcare Context**

**(Values, Diversity & Context)**

**Aims**

PWPs must operate at all times from an inclusive values base, that actively promotes recovery and both recognises and respects diversity. Diversity encompasses the range of cultural norms, including personal, family, social and spiritual values, held by the diverse communities served by the service within which the worker is operating. PWPs must respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture, taking into account any physical and sensory difficulties people may experience in accessing services. They need to be able to respond to people’s needs sensitively with regard to all aspects of diversity, and to demonstrate a commitment to equal opportunities for all and encourage people’s active participation in every aspect of care and treatment. Trainees must also demonstrate an understanding and awareness of the power issues in professional/patient relationships and take steps in their clinical practice to reduce any potential for negative impact these may have. This module will, therefore, work with PWPs on the concepts of diversity, inclusion and multi-culturalism and equip them with the necessary knowledge, attitudes and competencies to operate in an inclusive value-driven service. This will include them reflecting on their own beliefs, attitudes and assumptions.

PWPs are expected to operate in a stepped-care, high-volume environment carrying as many as 45 active cases at any one time, with workers completing treatment of between 175 and 215 patients per year. PWPs must be able to effectively manage caseloads, operate safely and to high standards, and use supervision to aid their clinical decision-making. PWPs need to recognise their own limitations and direct people to resources appropriate to their needs, including step-up therapy; and they must focus on social inclusion – including return to work and meaningful activity or other occupational activities – as well as clinical improvement. To do so they must have knowledge of a wide range of social and health resources available through statutory and community agencies. In order to prevent therapeutic drift and unsure safe clinical practice it is very important PWP’s and their services have a clear understanding of what constitutes the range of Step 3 psychological treatments which includes CBT, psychotherapy, counselling and other IAPT approaches and how Step 3 treatments differs from Step 2 PWP self-help. This module will, therefore, also equip PWPs with an understanding of the complexity of people’s health, social and occupational needs and the services, which can support people to recovery. It will develop PWPs decision making abilities and enable them to use supervision and to recognise when and where it is appropriate to seek further advice, or for the patient to access a signposted or step-up service. Skills teaching will develop PWPs clinical management, liaison and decision-making competencies in the delivery of support to patients, particularly where people require intervention or advice outside the core low-intensity evidence-based interventions taught.

**Learning Outcomes**

1. Demonstrate knowledge of, commitment to non-discriminatory, recovery oriented values base to mental health care and equal opportunities for all and encourage people’s active participation in every aspect of care and treatment.
2. Demonstrate respect for and the value of individual differences in age, sexuality, disability, gender, spirituality, race and culture, and show that these differences are valued.
3. Demonstrate knowledge of and competence in responding to people’s needs sensitively with regard to all aspects of diversity, including the use of translation services.
4. Take into account any physical and sensory difficulties patients may experience in accessing services and if required refer to appropriate services.
5. Demonstrate awareness and understanding of the power issues in professional / service user relationships.
6. Demonstrate knowledge of and competence in using supervision to assist the worker’s delivery of low intensity psychological and/or pharmacological treatment programmes for common mental health problems.
7. Demonstrate and appreciation of the worker’s own level of competence and an understanding of how to work within a team and with other agencies with additional specific roles which cannot be fulfilled by the worker alone.
8. Demonstrates a clear understanding of what constitutes step 3 IAPT interventions and how these differ from PWP self-help at Step 2.
9. Demonstrates clear cultural competency and the ability to operate from an inclusive values base fostering equal opportunities

**Module 2 Assessment Guidelines**

**Case Management Supervision Process Analysis**

This will be a 2000-word process analysis of a **recorded session of case management supervision**. This submission is used to index a trainee’s skills in the participation in, and effective use of, case management supervision. The session is conducted in your service with your service supervisor and needs to be a routine case management session. The tape of the session is NOT submitted. Trainees need to transcribe sections of the session in order to complete the process analysis. The submission form template is available on Blackboard and describes in detail what is and what is not included in the word count. The process analysis will be marked according to the marking grid in Appendix 4 and trainees are encouraged to use the marking grids in preparation of the process analysis. It is very important that trainee PWPs and supervisors are familiar with case management supervision, in order to provide the material for the process analysis. No patient identifiable information should be on the written process analysis and so trainee PWPs should make some content anonymous in the process analysis. Trainees should note that including the supervisor sign-off form as part of the Turnitin upload is considered a breach of anonymity.

If trainees have any concerns about their supervisor or them not following the appropriate case management structure that might affect their supervision process analysis, then please inform a member of the course team prior to the submission. This is so that any apparent issues or misunderstandings can be resolved. In the unlikely event of a trainee’s analysis being failed, but it is felt by the Board of Examiners that it was due to their performance being affected by an unhelpful or obstructive supervision or the supervisor not applying the appropriate PWP case management structure, the Board could award a Null mark (mark not given). The trainee would then submit another analysis as their first attempt. Feedback would also be provided to the supervisor. **Trainees must pass the case management process analysis to proceed on the course.**

**Treatment Case Study: A patient with diverse needs**

The PWP trainee is required to submit a case study of 2,500 words on working using an established (i.e. taught on the course) PWP treatment approach with a patient with a diverse need. The patient must be different to the patient used in the Treatment Tape assessment. Diversity is defined in terms of the normal range of cultural norms including personal, health, family, social and spiritual values held by the communities within which the trainee is operating. The PWP, the patient and the service **must all** be anonymised. Where this is breached, then will result in a FAIL. Trainee PWPs are encouraged to diligently read their case studies (including any appendices) before submission to check for any breaches of confidentiality. Trainees should note that including the supervisor sign-off form as part of the Turnitin upload is considered a breach of anonymity.

In the case study, the PWP trainee needs to accurately and succinctly demonstrate how they have adjusted their clinical practice to meet the needs of the patient, whilst simultaneously showing fidelity with and competence in the low intensity guided self-help assessment and treatment approach, i.e. what did you do that made treatment accessible when otherwise it wouldn’t have been? The case study must use a reflective model and be connected to the low intensity policy and evidence base – and show awareness of relevant policy/evidence for the diversity need of the client. Of the 2,500-word limit, 500 must be used discussing the use of CLINICAL supervision with the case, in developing a treatment plan and delivering the low intensity guided self-help. This needs to be in a separate section and needs to include reference to the wider clinical supervision literature. Trainees may focus on one aspect of clinical supervision, but need to provide a clear rationale for doing so. Case studies will be marked according to the marking grid in Appendix 5. Trainees are encouraged to use the marking grids when they are preparing their diversity case study.

The patient should have attended a minimum of **3** sessions with the PWP (1 assessment and 2 follow up) and **does not need to have a successful treatment outcome** at step 2. The outcome of treatment should be reflected on.

The PWP trainee needs to convey how they have adjusted their clinical practice to meet the diverse need(s) and reflect on this. For example, did the adaptations make it easier for the patient to benefit? Did the adaptations minimise the impact of the treatment (drift)? It must be connected to the relevant low intensity evidence base and show awareness of relevant policy/evidence for the diversity need of the patient. It also needs to include consideration of a potential diagnosis, relevant policies and guidance, MDS outcomes, and demonstrate fidelity to the chosen PWP intervention.

The diverse needs could be based on health, family, social and/or spiritual values held by the communities in which the patient identifies. The **suggested** format for the submission is as follows:

* Case presentation (i.e. description):
  + Diagnosis
  + Diversity
  + Treatment plan and adaptations
  + Outcomes
  + Links to relevant policies and guidance
* Feelings
* Evaluation
* Analysis
* Role of supervision:
  + Description
  + Evaluation and analysis:
    - Use of supervision skills
    - Helpful/unhelpful
    - Benefit to the patient
* Conclusion and action plan

**Trainees must pass the diversity case study to proceed on the course.**

**Group Presentations**

To facilitate the learning of the range of Step 3 interventions within IAPT and how these differ from Step 2 Guided Self Help, trainees will be required to write and deliver a presentation as allocated below:

Jen’s group: EMDR

George’s group: IPT

Helen’s group: HI CBT

Mike’s group: Counselling for Depression (CfD or PCET)

Saniya’s group: Couples Counselling

The presentations are an opportunity to practice skills that are a core part of the PWP role and should inform colleagues about Step 3 treatment options available in IAPT. You will need to discuss the treatments with appropriate colleagues in your service as part of your preparation for the presentation. The date for the presentations can be found on the timetable.

Content to include:

* + - Theoretical underpinnings and evidence base
    - What the treatment involves / what the patient can expect
    - Who is the treatment suitable for
    - Referral pathways and policies (e.g. NICE guidance)
    - Any other information that may be of interest or help

How you present the information is up to you, but each member of your clinical skills group must take part in the presentation. You will be allocated 30 minutes for your presentation and it is suggested that you allow the final 10 minutes for feedback and questions from the cohort.

# **Guidelines for the Practice Portfolio (PP)**

**All relevant documentation and guidance for the Practice Portfolio can be found on Pebble Pad.**

The Practice Portfolio is an essential component of the PWP training programme, as it records the clinical and supervision activities of trainee PWPs, knowledge outcomes and also assessments of competency by clinical supervisors. All aspects of the Practice Portfolio must be passed in order to achieve the award of the Postgraduate Certificate in Low-Intensity Psychological Interventions (IAPT). Trainees will only receive one further opportunity to submit should the first submission be failed.

The Practice Portfolio is submitted on Pebblepad which can be accessed via MUSE. In the resources section on Blackboard you will find detailed instructions about how to access Pebblepad and submit your work using this platform.

The following must be completed and submitted on Pebblepad within the sections provided:

* Front sheet signed by you and your clinical supervisor
* A signed supervision contract for case management
* A signed supervision contract for clinical supervision
* Evidence of the required **80 hours** of clinical practice **(a template for recording clinical hours and case recording is available on Blackboard)**
* Completed and signed supervision logs and records
* Record of Clinical hours and case recording
* Associated analyses of change (i.e. change rates, Jacobson plots)
* Completed 15 days supervised practice and SP/SR engagement form (not workbook)
* Evidence of the required **40 hours** of supervision (**20 hours of case management and 20 clinical supervision**)
* Completed and signed Service Liaison Form
* Completed and signed copy of the mid-year Interim Supervisor’s report
* Completed and signed copy of the end of year Final Supervisor’s report and the final statement of achievement
* **6 sessions rated by your supervisor** on the assessment and treatment competency ratings sheet – all 6 must pass.
* Catch-up forms from missed teaching sessions
* Declarative knowledge exercises
* Completed course Learning Log (3,000 words)

**FAILURE TO SUBMIT ALL OF THE ABOVE BY THE SUBMISSION DATE WILL RESULT IN A FAIL**

\*\* It is strongly recommended that all PWP trainees and clinical supervisors plan for the Practice Portfolio submission throughout the year. Therefore, the PWP should take this document to an early supervision session for discussion and subsequent sessions when appropriate for updates. The Practice Portfolio should be completed contemporaneously throughout the year. This will prevent any problems close to the hand in date, as extensions will only be granted for clear extenuating circumstances according to University Policy. \*\*

**Clinical Hours and Clinical Supervision**

**1. Amount**

**Requirements for PWP Trainees**

Trainees must receive a minimum of **40 hours total** of supervision to pass the course. This comprises **20 hours of clinical supervision** and **20 hours of case management supervision**. Case management is a minimum of **one hour per week** as recommended in IAPT Guidance and **one hour per fortnight** of clinical supervision. Clinical supervision can take place in a group, where the maximum group size is 12. In addition, PWP trainees should receive a **further 1 hour per fortnight** individual and group supervision, focussed on case discussion and skill development (in addition to case management supervision). The documentation requirements for supervision are detailed on Pebblepad and in the Supervisors Handbook.

Trainees must complete a minimum of **80 hours of clinical practice and a suggested maximum of 150 hours** in the provision of the recognised evidenced-based PWP interventions that are taught during the course. For the minimum of 80 clinical contact hours, a suggested minimum of 60 hours should be obtained through face-to-face, video or telephone sessions. The remaining 20 can be accessed through other routes (e.g. online cCBT, groups). Sessions must be 15 minutes or more. We expect to see a range of modes of delivery and a balance between assessment and treatment sessions.

Trainee PWPs should slowly build up their hours and slowly increase the amount of patient contact. It is recommended that **trainee PWPs see a maximum of 5 patients per day for full assessment or full treatment sessions**. This is in order to provide space for trainee reflection and learning. Shadowing does not count towards clinical hours and role-plays with supervisors do not count in terms of the 6 rated clinical sessions. In the recently published IAPT Manual, it is stated that a full time qualified PWP should carry out 18-20 hours of clinical contact time per week. They should NOT exceed 20 hours per week. It is expected that a trainee PWP holds a caseload of 80% of that of a qualified PWP.

**Shadowing**

Shadowing is a requirement of the course, as set out by the curriculum and accreditation standards outlined by the BPS. We expect this to happen early in the course and then continue. Shadowing of sessions with qualified PWPs is a vital learning experience for trainee PWPs. Trainees must shadow 6 full assessment sessions and 6 treatment sessions completed by a qualified PWP within the IAPT service. They may or may not be their supervisor. Evidence of the completion of the shadowing of these sessions is required as part of the 15 days supervised learning document.

**2. DVD/Audio Work**

Included in the above, a proportion of the supervision must be live or audio/audio visual tapes. These PWP treatment sessions need to be rated by the trainee’s clinical supervisor on the assessment and treatment session competency rating sheets included in the Supervisor’s Handbook. The ratings are submitted as an aspect of the end of year course Practice Portfolio on Pebblepad. It is likely that supervisors may use clinical supervision sessions as a means of watching/listening to trainee performance and facilitating feedback. Therefore, trainee PWPs need to plan effectively with their clinical supervisor how and when they will achieve the required number and type of observed and rated sessions, to ensure that the supervisor has time to watch the trainee live or to mark the recording and effectively feedback. It is useful when submitting tapes for feedback to your supervisor that each tape is clearly marked with the name of the PWP trainee and the anonymous case number of the client - not their personal name.

**Requirements for PWP Trainees**

A minimum of **6 clinical sessions with genuine patients** recorded or live are required to facilitate learning and assessment of the PWP clinical method. These need to be assessed using the PWP assessment and treatment competency tools (on Blackboard). To evidence this for the portfolio, trainees must submit 6 completed competency rating scales signed by their supervisor.

The six tapes observed or live sessions **must include at least one each** of the following PWP assessment and low intensity interventions:

* An assessment session
* A behavioural activation session
* A cognitive restructuring session
* A problem solving session
* Exposure for Panic, OCD, Specific phobia or Agoraphobia
* A worry management session

Details of the PWP interventions can be found in the National Programme Materials for Supervisors and trainees must follow the evidenced based taught course structure and steps for each for the Step 2 PWP interventions. The PWP trainee can usefully review the tape before it is seen by the supervisor and indicate exactly where on the tape each assessed item can be found. All sessions must be rated as a pass.

**3. Documenting Clinical Supervision**

It is the trainee’s responsibility to ensure that an adequate supply of all supervision documents is available for their clinical supervisor’s use. These are included in the Supervisor’s Handbook and on Pebble Pad. The trainee holds responsibility for ensuring that all completed forms are contemporaneously compiled in the Practice Portfolio on Pebblepad in order to facilitate effective submission by the end of the academic year.

\*\* The Supervisor’s Handbook is provided on Blackboard and contains all the Supervision Documents required by your clinical supervisor. It is the trainee’s responsibility to ensure they make this available to their supervisor. \*\*

**Guidelines for completing your PWP Learning Log (Reflective Diary)**

**Introduction**

As practising and professional helpers, it is vital for trainee PWP’s to be self-aware and capable of reflective practice. This underlines an aspect of the course philosophy that during PWP training, we hope to do more than simply teach the body of PWP knowledge and skills. We aim for PWP’s during the training to become more effective as practitioners, by increased self-awareness of how they help patients through use of the PWP clinical method.

The use of the low intensity PWP method, like any helping behaviour, is heavily influenced by the thoughts, attitudes, beliefs and values held the PWP. Through the learning log, trainee PWPs are therefore encouraged to explore, examine and make explicit their personal learning journey during the year regarding such factors, and in particular the influence of such factors on their self-concept and the manner in which they occupy their clinical helping roles.

PWP trainees are expected to usefully structure their reflective account. The trainees may choose various approaches to structuring their log (e.g. they may wish to reflect on key milestones throughout their learning and training, or they may which to organise their reflections into themes that reflect their learning and experience). It expected that there will be regular entries in the log which provide a picture of the trainee’s experience and learning for the duration of the course. There should sections that bring together themes from such diary entries. An established reflective model should be used to organise the reflective account. The log should demonstrate cycles of learning and reflections with conclusions drawn from learning evident throughout and action plans clearly outlined.

The content of your learning log **must be anonymised**, in that no staff, trainee or patient details are included. The word length of the Learning Log is up to 3,000 in total (excluding references).

Your log is a place to reflect upon course material and your clinical activities, and your response to them. The log provides you with the opportunity to reflect upon your responses to the PWP low intensity self-help work that you do with patients, acknowledging the attitudes and beliefs that bring you to PWP work and training. The log may provide an outlet to reflect on the challenges of the course and role, but it is expected that there are culminations to the reflections wherein the trainee develops action plans outlining the conclusions of their reflections and the log. The log should be reflective, not ruminative and therefore should demonstrate learning, conclusions and action plans. Trainees should remain professional throughout the learning log, whilst being personal and reflective.

**Purpose of the Learning Log**

**The Learning Log forms part of your course portfolio and should be submitted as part of that document.**

Your learning log will enable you to:

* Examine and express your feelings about work and training in the PWP role
* Clarify your PWP learning goals
* Make and evaluate your decisions
* Reflect on your relationships in staff teams
* Reflect on your relationships with patients
* Work through difficult situations and feelings
* Rehearse effective future behaviour
* Work towards clarity and order in the PWP role
* Exercise responsibility for yourself and your own wellbeing
* Examine things you find hard to raise with others
* Apply psychological wellbeing practitioner interventions to yourself

Writing needs to be carried out as a regular activity preferably, though not imperatively, with some time being spent on it weekly. Your experiences with fellow staff, patients, course lecturers, course material and other trainees are for exploration within your log. It is primarily a means of communicating with and reflecting on yourself. It will only be seen by the Lecturers involved in the PWP course as an aspect of the Clinical Practice Outcomes Document.

Your reflections can be explored from a variety of levels. Here are some suggestions:

**Basic Level**

At a basic level, you could list the number of patient hours conducted, give a brief description of your patients’ main problems, and make a note on the kinds of issues they present personally for you. Again **any material, which contains client details must be kept strictly anonymous**. You can also note down any issues that arise for you when working with staff or other trainees.

**Deeper Clinical Level**

At a deeper level, you could reflect critically upon how you work with your patients when using your PWP skills and how you manage patient diversity. Comment on how you are applying the training from the course, and how useful or otherwise you find it. Make observations on what you do well, what you could do differently, and how you would do so.

Explore and describe your work values, beliefs and assumptions.

**The Personal Level**

At a personal level, you could reflect upon the following issues:

* What are the challenges that your patients present you with and how do you respond to them? (E.g. are you fearful or anxious? Do you feel overloaded or under-valued? Do you feel skilled and in control or de-skilled and panicking?) What are the current challenges working with colleagues, staff and other trainees?
* What is it that you enjoy or find difficult about working with a particular patient? What is the enjoyment or the difficulty related to: the presenting issues, the client's manner, race, gender, class, culture, beliefs, values and politics? What is it that you enjoy or find difficult working with a particular colleague or staff member?
* What have you been taught, told or experienced in the past, or what do you think and believe today, which affects how you now work with your patients, or other colleagues?
* How do you feel about your patients in the sessions and following the sessions (angry, frustrated, happy, sad)? As a consequence, is there anything you would like to say to your patient, and for professional reasons cannot say? How do you feel about your colleagues and other staff?
* Overall do you do good work with your patients or do you feel negative about what you have to offer? How could this be modified? Does this affect the objectives you have set yourself?

**You may find it useful to keep some activity schedules and thought records as a way of populating the learning log and to facilitate reflection.**

**Process**

The structure and techniques for personal development through this type of writing can follow the following path in a three-stage form as outlined below. This is not a concrete requirement for structuring the log and you may prefer to use an alternative model of reflection to guide you. You will not be penalised for not following this suggested process, as long at the log is well structured and follows a reflective model of some description.

**Stage 1 - Exploring and Expressing**

As suggested, writing is not the only means of completing a log, though it is probably the most accessible one, and the one which 'speaks' a relatively common language. You may decide to write in a structured way or to just write freely. You may also use art, sketches and doodles; feel free to play with your imagination at times. Whatever form it takes, the log should be free and uncensored. To write in an uncensored way, you quite simply view the log 'as if' it is for you alone to read. The aim of this practice is to help you maximise the Personal Learning Log process, and to broaden, where appropriate, your approaches and techniques. It is not intended to be a critical reading nor discussion. This provides a start to the reflection process however the reflection should eventually evolve into a more structured and considered range of conclusions and action plans.

**Stage 2 - Reassessing and Challenging**

Immediately afterwards, (or several days or weeks after), examine any 'broad issues' or 'recurring themes' in your approach to work and learning. You might again ask a number of questions:

* Does something always seem to happen to you at work or when learning?
* Do you have a characteristic way of responding to work and learning?
* Do you have recurrent feelings whilst at work or at University?
* What do you do when you feel this way?
* Is what you do useful or not useful?
* Is there something you do habitually at work or when learning, even though you know it is not productive?
* What is it you believe about yourself, others and the world?
* If there was a rule or assumption, which could explain your behaviour, what could it be?

Monitor changes, and if relevant, think through appropriate forms of 'action' you could take. In other words, in addition to meaning behaviour modification, action also refers to modifying thoughts and feelings for which you are also responsible.

**Stage 3 - Implementation and Evaluation**

1. At this stage you are looking for a suitable plan of action. It need not be perfect, since you can make modifications later. Plan for small actions at each stage - you may be discouraged if you 'fail' as a result of taking on too much. Take account of any 'low frustration tolerance' (your inability to cope with short term discomfort or change-related discomfort; avoidance of anxiety-provoking situations) you may experience. Treat it as an issue and write about it.
2. Be 'creative' and use 'divergent thinking'. One-way of doing so is to contemplate how others, real or imagined (perhaps someone more confident than you), might deal with the situation. List all possibilities. Consider changes you can make in relation to yourself, others and the world. Consider alternative ways of construing, thinking, feeling and behaving. Try to anticipate what will facilitate and what will hinder your action plan.
3. Having surveyed your resources, take risks and try it out, preferably in small stages. Having done so come back to your log and reflect on it. Observe and write about how it went, and your views on this. Build in some way of rewarding yourself for achieving your goals. These rewards do not have to be material in nature, and they should not be a part of the 'problem'. Do not be over hard on yourself if you do not achieve your goal. It may be you aimed too high or the plan of action was not appropriate for the particular problem. Look again.

**References and Further Reading**

Baldwin, C, (1992). One to one: self-understanding through journal writing. Evans Publishing.

Bridges, W. (1980). Transitions: making sense of life's changes. Addison Wesley, Massachusetts.

Capicchione, L. (1979). The creative journal. Newcastle Publishing, California.

Jacobs, B. (2005). Writing for emotional balance. New Harbinger Publishers.

Rainer, T. (1979). The new diary: how to use a journal for self-guidance and expanded creativity. NY; Tarche

# **The Course Assessment Process**

The overall aims of the programme are for trainee PWPs to have:

1. The skills, knowledge, values and competence to understand behaviour change theory and how to use the COM-B model to inform low intensity assessments and interventions.
2. The skills, knowledge, values and competence to effectively assess patients with common mental health problems.
3. The skills, knowledge, values and competence to deliver PWP evidence-based self-help interventions.
4. To effectively signpost patients to other services where appropriate.
5. The skills, knowledge and values to work effectively with patients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives and mental health.
6. The skills, knowledge and values to work within a diverse social, work and healthcare context.
7. Skills in managing personal learning agenda and associated self-care.
8. Skills in engaging in clinical supervision and case management supervision.
9. An understanding of outcome measurement.
10. An understanding of stepped care.

The assessment process is designed to set standards for the Certificate against which trainees’ clinical skills and knowledge may be measured. The assessment structure functions to ensure that trainees’ academic and clinical performance is worthy of the award of a Certificate in Low Intensity Psychological Interventions at the University of Sheffield, and that trainees are competent and safe to clinically practice as a PWP. Trainees receive individual marks (0-100%) for the two reflections, one case study and the one single process analysis. All competency assessments are scored between 0-36. The Practice Portfolio is marked as a pass or fail. On completion of the PG Cert, trainees will be awarded an overall PASS or a FAIL grade following ratification by the External Examiner. Each assessment is marked using a University standardised marking scheme. The reading for the PWP Course to support trainees in their work can be found on Blackboard.

Group academic tutorials will be made available to facilitate trainees’ academic and clinical development, and teaching on reflective writing is provided. Trainees are encouraged to request one-to-one tutorials as needed, and these are in no way judged by the course. The failure of an assignment would (in normal circumstances) trigger a one-to-one tutorial in order to support the trainee with their resubmission. Coursework can be discussed in personal tutorials, but tutors are not able to read and comment on drafts of work.

The assessment process also offers the opportunity for feedback and discussion of the progress of each trainee towards meeting the course learning objectives. As trainee PWPs are employees, marks and progress are shared with Service Leads so that progress can be tracked and any problems with progression highlighted quickly. PWP trainees must pass ALL assessed aspects of each module (including the Practice Portfolio) in order to pass the module and both modules have to be passed in order to be eligible for the award.

**Competencies**

All competencies outlined in the document linked below (both general and specific) are described core competences for the PWP role.

<http://webarchive.nationalarchives.gov.uk/20130105063655/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078535.pdf>

Each module contains general and specific learning outcomes. It is anticipated that the learning outcomes and competencies will accumulate as trainees’ progress through the modules. Trainees may often be faced with the dilemma of needing to see a patient using an intervention that has not yet been taught on the course. The role of the clinical supervisor is vital in this regard. The criteria for assessment are based on the objectives of the course and individual modules. Trainees will need to provide evidence demonstrating their competence and knowledge, as applied to the delivery of PWP Interventions, in **all** the following:

* Relevant knowledge and understanding and implementation of behaviour change theory based on the COM-B integrative behaviour change model.
* Assessing and bringing together assessment details of a person’s mental health, social and employment needs.
* Competence in assessing risk.
* Competence in planning, shared decision-making, and carrying out a range of low intensity psychological treatment packages for common mental health problems, using a range of methods based on behaviour change theory.
* Competence in low-intensity intervention specific and problem specific self-help facilitation.
* Competence in not drifting into other interventions or beyond the treatment contract.
* Competence in the effective management of issues of difference, diversity and the inherent power imbalance in clinical practice.
* Competence in managing a large caseload of people with common mental health problems.
* Competence in working within a team, including an awareness of own level of competence and liaising with other agencies.
* Competence in keeping accurate, timely and appropriate records.
* Competence in using case management and clinical supervision.

These criteria will be assessed through the Practice Portfolio, an OSCE, live treatment session rating, reflections and a process analysis of case management supervision.

**Marking and Moderation Policy**

**What is Moderation?**

The purpose of moderation is to ensure that markers are making consistent judgments about the academic standards of completed assessments with accuracy, consistency and fairness. In order to do this, they must have a shared understanding about the expectations of each of the applied standards, as per the marking criteria, to ensure that the same level of achievement is awarded to assignments that have the same characteristics, regardless of who marks them.

**Anonymous marking**

Wherever possible, trainees’ work will be marked anonymously. This means that markers are not aware of the identity of the trainee whose work is being assessed. The exceptions to this, due to the nature of the assignments, are the marking of Treatment Tapes and Practice Portfolios (for both High Intensity and PWP). However, these assignments will not be marked by the trainee’s group supervisor/clinical skills tutor.

**Type of moderation**

The IAPT courses will use a double-blind second marking technique. Once the assignments have been marked anonymously by the first markers, a sample of the work will be marked by a second marker (minimum 10%). The second marker will mark double blind. This means that they will not know the identity of the trainee or the first marker. The advantage of this technique is that the second marker is not influenced by the first mark, which arguably provides a more accurate verification of the mark when both markers arrive at the same conclusion.

**External Examiners**

There is one External Examiner assigned to the PWP course. For each piece of course assessment the EE reviews a sample of the work submitted by trainees. These samples are selected by the course administrator and a range of marks, including fail marks and low, mid and high-range pass marks, should be included. The purpose of this is to assess whether the marking range has been fairly applied. The External Examiner also looks at a range of Practice Portfolios. The External Examiner looks specifically at the quality of the marking by individual internal markers to assess whether there is comparability and consistency of marks and feedback from the markers.

**Appeals**

The University has two appeals procedures. The first allows a trainee to apply for a reconsideration of a recommended grade for any module or degree classification or examination. Trainees must apply in writing within 14 working days of receiving their marks. The second allows a trainee to appeal, on specified grounds, against a decision of the Faculty Student Review Committee to the Senate Appeals Panel.

(<https://www.sheffield.ac.uk/ssid/complaints-and-appeals/appeals>)

## **Timetable of PWP Course Assessment Deadlines**

## **October 2022-2023**

**Improving Access to Psychological Therapies**

**PG Certificate in Low Intensity Psychological Interventions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Module 1 (1a assessment, 1b treatment)** | | | |
| **Assignment** | **Tutorial Date** | **Submission date** | **Internal Exam Board** |
| Service Learning Contract | N/A | Week 5  11/11/22 | Week 10  16/12/22 |
| Patient Centered Assessment OSCE | Week 4  04/11/22  Mock Week 5  10&11/11/22 | Week 7  \*Resit  Week 10  TBC | Week 7  25/11/22  \*Resit  Week 10  16/12/22 |
| 2000 Word Reflection on the Patient Centered Assessment OSCE | Week 8  2/12/22 | Week 13  06/01/23 | Week 17  17.2.23 |
| Service Liaison form | NA | Week 20  13/01/23 | Week 26  17/02/23 |
| Case Management Supervision Process Report | Week 15  20/01/23 | Week 21  03/03/23 | Week 26  06/04/23 |
| Supervisor Interim Report | NA | Week 25  31/03/23 | Week 30  04/05/23 |
| Assignment Resubmissions & Extensions | NA | NA | Week 38  15/06/23 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Module 2 Health and Social Care Context** | | | |
| **Assignment** | **Tutorial Date** | **Submission date** | **Internal Exam Board** |
| Patient Centered Treatment Tape and reflection | Tutorial Week 13  06/01/23  Treatment tape Practice Week 18  9&10/02/23 | Week 30  05/05/23 | Week 36  15/06/23 |
| Case Study: A patient with diverse needs | Week 30  05/05/23 | Week 37  23/06/23 | Week 42  27/07/23 |
| Practice portfolio | Week 09  09/12/23  and Week 37  23/06/23 | Week 41  21/07/23 | Week 47  31/08/23 |

**Please submit by 1.30pm on the above dates.**

## **Preparation and Submission of Assessments**

All pieces of written coursework must adhere to the following APA format:

* Word processed
* Times New Roman font
* A4
* Include page numbers
* Double-spaced
* 12pt font
* 2cm margin all round
* Have appropriate APA referencing (see Blackboard). Should work be incorrectly referenced the assessment may be marked as a fail.
* Have a typed cover sheet (Blackboard). Hand-written cover sheets are not acceptable and will result in the piece of work being returned to the trainee.

**Word count**

The word count limit for the Assessment OSCE Reflection, Treatment Tape Reflection and the Case Management Supervision Process Report is 2,000 words. The word count limit for the Case Study: A patient with diverse needs is 2,500. Every word in the body of the essay, including those used in headings, tables and diagrams, contributes to the word count. The cover sheet, references and appendices do not contribute to the word count. Information in the appendices should only be used to supplement the assignment and give context to the work (e.g. examples of completed self-help materials in the diversity treatment session may be in an appendix).

**The content of the appendices are not marked so all key information should be included in the body of the essay.**

Trainees are permitted 10% over the stated word count; **any further variation will result in a** **deduction of marks which is relative to the percentage the word count has gone over**. For example, if an essay is 20% over the permitted word count, the trainee will lose 10% of their overall mark, i.e. for a piece of work awarded 60, the mark will be reduced to 54.

**Confidentiality and Anonymity**

PWP trainees are required to protect patient confidentiality and anonymity according to NHS requirements, the British Association for Behavioural and Cognitive Psychotherapies’ (BABCP) guidelines for good practice, Data Protection requirements, and the requirements for any professional registration body with which individuals are registered. Any breaches of confidentiality will be regarded as serious breaches of professional conduct **and the piece of coursework will receive a FAIL mark**. In written assignments all patients, PWPs, institutions/services, names/locations and professionals/relatives should be referred to by pseudonym and type in order to protect anonymity. Trainees should read through their work carefully prior to submission to check for any anonymity omissions, **including in the appendices**. Trainees should note that including the supervisor sign-off form as part of the Turnitin upload is considered a breach of anonymity.

**Submitting the Assignment**

Trainees are required to submit **TWO** electronic copies of every written assignment. One copy must be submitted via Turnitin on Blackboard (see link below for guidance) **AND** a second copy (Word document format) must be sent via email to iapt@sheffield.ac.uk.

Trainees must also submit a Supervisor Sign-off Form (Blackboard) for each piece of coursework via email to [iapt@sheffield.ac.uk](mailto:iapt@sheffield.ac.uk). Two sign-off forms must be submitted for the Treatment Tape and Reflection assessment, one for the tape and one for the essay. All Supervisor Sign-off Forms submitted must include an original or electronic signature, not typed, to be accepted. If a signature cannot be obtained, the form must be sent by the supervisor directly to confirm that the assessment submitted reflects the trainees’ work. Please note that a sign-off form is not required for the OSCE Reflection.

**BOTH** copies of the coursework **AND** the Supervisor Sign-off Form must be submitted by **1.30pm at the latest** on the given deadline.

When submitting your assignment to Turnitin, you must ensure that you enter your **registration number** **only** as the assignment title. This is to allow the marker to identify the piece of work anonymously. If the registration number is not visible to the marker, the trainee will be asked to submit their assignment again correctly.

When submitting tapes for assessment, please refer to Appendix 6 for guidance on uploading files to the University’s secure server.

The coursework deadlines should be strictly adhered to and it is the PWP trainee’s responsibility to ensure that their work is submitted correctly and on time. If a trainee misses the deadline for a piece of assessed work, the assignment will be awarded an automatic FAIL mark (failure due to non-submission). This includes non-submission due to technical failures (Appendix 8). A failed piece of work due to late submission can be resubmitted, but will only be considered for a 50% pass on resubmission. Only when a trainee has been formally granted an extension will their assignment be accepted after the deadline, in line with the agreed extended deadline.

Please go to the following web-page for Turnitin Help Guides, including how to submit assignments and how to access feedback:

<https://www.sheffield.ac.uk/apse/digital/turnitin/menustudents>

**Deadline Extensions**

The purpose of the extension process is to allow trainees to inform the course of circumstances that affect the length of time needed to submit an assessment, and request an extended deadline.

Extensions are granted only in consultation with the IAPT Programme Director and Deputy Course Director. It may be helpful to discuss any potential extension requests with your Personal Tutor in the first instance. Trainees will not be penalised for requesting an extension. Extensions to deadlines are only given in the following two circumstances:

1. Extenuating **clinical circumstances** (e.g. significant illness of at least seven days and requiring a doctor’s certificate).
2. Extenuating **organisational circumstances** (e.g. service issues out of your control preventing work completion and requiring clinical supervisor/service lead support). You are required to outline the circumstances and include an action plan to address how you will meet the extended deadline proposed on the Extension Request Form.

Service issues do not include technical failures such as computer problems. Requests for extensions due to technical failures will not be considered (see Appendix 8 for course policy on technical difficulties). Nor will an extension be granted due to a report of insufficient feedback or access to tutorial support.

Annual leave/ holiday is not grounds for an extension.

If a trainee is experiencing personal circumstances that are affecting their ability to complete an assessment successfully, they should follow the Extenuating Circumstances process in the following section.

When coursework is submitted by an extended deadline it will be out of sync with the Course Assessment Deadline and IEB schedule. Extended work will be marked for the next available IEB, which may no longer correlate to the trainee’s assessment timetable, resulting in the possibility that the trainee will not receive feedback before their next assignment deadline. **It is important to note that a previous extension which has reduced the time between course assessment deadlines will not be considered acceptable grounds for an extension on a subsequent submission.**

In the event of staff absence, a procedure will be put in place for extension requests to be processed, and this will be conveyed through the Course Administrator’s automatic “out of office” email. It is the trainee’s responsibility to follow the process outlined to them and make sure their extension request has been received for consideration.

**Applying for an Extension**

The Extension Request Form can be found on Blackboard.

In order for an extension request to be considered, trainees must submit the form (with any supporting documentation) to the Course Administrator **by no later than one week prior to the assignment deadline**. All extension request forms must be signed by the trainee’s service supervisor before they are submitted. Signatures must be original or electronic, not typed; if a signature cannot be obtained the form must be sent by the supervisor directly with confirmation of their support. If the Course Administrator receives an unsigned form from the trainee it will be returned.

If, under any circumstances, an extension request is not formally granted in writing and a trainee does not submit the assignment by the stated deadline, they will automatically receive a FAIL by non-submission mark. This will be ratified at the relevant IEB and the trainee will be asked to resubmit without receiving feedback on their first submission, with marks capped at 50%.

Extension requests will be discussed and considered **once a week** (usually Wednesdays) by the Course Administrator and Programme Director. Trainees will be informed of the outcome of their extension request via email by the end of the following working day.

The submission of an extension request form does not guarantee an extension will be granted; only appropriate requests with suitable supporting evidence (e.g. a doctor’s certificate or letter, report from a mentor, student counselling report, request from supervisor on organisational grounds, etc.) will be provisionally granted by the Programme Director or Deputy Course Director in consultation with the Course Team. The final ratification of an extension will be made at the appropriate Internal Exam Board meeting.

There are two standard extension periods that may be granted:

* Tape submission – 4 week extension
* Written submission – 2 week extension

Where the clinical or organisational circumstances warrant a period of time greater than that stated above, this will be ratified on a case-by-case basis at the relevant Internal Exam Board.

**Practice Portfolio extensions**

If an extension is required on a specific section of the portfolio, the trainee must clearly identify the section they need more time on and why when completing an extension request form. **If an extension is granted, it is for the specified section only**. The trainee must submit the Practice Portfolio by the assessment deadline, , with a note in ‘supplementary documents section’ to identify to the marker that an extension has been granted. If any element of the portfolio is excluded for which an extension has not been granted, the trainee will receive a FAIL mark.

**Extenuating Circumstances – Prevention of Failure**

The purpose of the Extenuating Circumstances process is to allow trainees to inform the course of ongoing, personal circumstances that are affecting their ability to perform and complete a piece of course assessment successfully.

The University defines extenuating circumstances as:

“Extenuating circumstances are exceptional, short-term events (e.g. personal or health problems) which are outside of your control and have a negative impact on your ability to prepare for or take (sit) an assessment.”

Extenuating circumstances must meet the following criteria:

1. Non-academic – Problems with the management of the degree programme or with academic staff should be raised appropriately via the Course Committee Meeting.
2. Out of your control – You could not reasonably have done anything to prevent them from happening.
3. Impact – The circumstances had a negative impact on your ability to prepare for or sit an assessment. (This must be recorded on your extenuating circumstances documentation.)
4. Relevant – Occurred at the time of the assessment or in the period immediately leading up to the assessment.

The following is a non-exhaustive list of circumstances which are likely to be accepted as extenuating circumstances:

1. Bereavement - death of close relative/significant other (which in an employment context would have led to a period of compassionate leave).
2. Serious short term illness/accident/hospitalisation (which in an employment context would have led to a period of sickness absence).
3. Deterioration or fluctuation of a disability or long term health condition.
4. Significant adverse personal/family circumstances.
5. Other significant exceptional factors for which there is evidence of stress caused, i.e. victim of crime. Evidence (police crime reference, letter from hospital/doctor treating condition, social worker letter, etc.) of any of these is likely to be required by the department.

Trainees can find more information on the University’s general Extenuating Circumstances process here: https://students.sheffield.ac.uk/extenuating-circumstances. Please note, for the 22/23 session the Extenuating Circumstances process is reverting back to its pre-pandemic approach.

We ask that trainees follow the Extenuating Circumstances process below.

In the first instance, trainees are advised to arrange a one-to-one tutorial to discuss their ongoing circumstances with a member of the course team, who will discuss a possible training plan and offer pastoral support.

Trainees can submit extenuating circumstances by sending a letter and documentary evidence to the Course Director (cc. Course Administrator) **by no later than two weeks prior to the assessment deadline**. The letter should outline the trainee’s exceptional circumstances and the impact of these on their ability to complete the assessment to a suitable standard during the period of preparation and submission. The letter should include supporting evidence, such as: personal account, GP's report, student counsellor's report, letter from academic tutor or report from clinical supervisor, etc. It is the trainee’s responsibility to ensure that this happens. In the letter the trainee must include a declaration that they are fit to submit the assessment when an adjusted deadline is decided. Extenuating circumstances will be considered on a case by case basis and may result, for example, in an adjusted training plan being put in place for the trainee. Feedback will be provided as soon as possible and any decisions made regarding a trainee’s progress or assessment schedule will be ratified at the next appropriate Internal Exam Board meeting.

**Marking Arrangements**

Wherever possible coursework is blind marked. In order to facilitate this, trainees must include their registration number on the typed cover sheet of all submissions and in the assignment title on Turnitin. It is acknowledged that it is impossible to blind mark submitted recordings of sessions and OSCEs.

A 10% portion of each batch of work submitted is double marked and all fails of OSCEs and treatment tapes are double marked. If there is a failure to agree between the markers, the work will be sent to the External Examiner.

Marking schemes are employed for all pieces of coursework to provide trainees with structured feedback on their performance and to record decisions at IEBs. Descriptive marking criteria are presented in Appendix 1 and detailed marking grids for each written assessment are provided in Appendices 2-5. Trainees should use the marking grids to prepare for the assignment.

**Results Process**

Trainees will only receive feedback on their marks following ratification of the mark at an Internal Exam Board and trainees are advised that results will not be discussed in any manner until the Board has met. Trainees will receive online confirmation of their mark and written feedback on assessments via Turnitin, no later than **two weeks** after each Internal Exam Board (for guidance, see:

https://www.sheffield.ac.uk/apse/digital/turnitin/menustudents). Letters will be issued electronically to trainees who have not passed an assessment, with guidance on resubmission requirements. **Trainees should not ask for their marks** as they will not be released until appropriate feedback has been prepared after the Examiners’ Board meeting.

If a trainee fails a piece of work, they will be allowed to resubmit that piece of work on **ONE** further occasion (under normal circumstances). Should a trainee fail a written piece of work and their grade is less than 40%, they will be asked to submit a completely new piece of work. In respect to the Diversity Case Study this would require a new case for the case study accompanied with a new reflection. In respect to the Case Management Supervision Process Report this would require the recording and transcription of a new supervision session and re-write of the process analysis. If the mark is between 40-50%, the trainee will be asked to resubmit the original essay having made changes that are compliant with the corrections and additions noted in the feedback. Failed OSCEs are sat with a new case.

Any resubmitted work will go through the next available Internal Exam Board after it has been marked. Resubmitted work is capped at 50% for written assignments. If the resubmitted piece of work is deemed a failure, the course will seek to address whether there were any extenuating circumstances that adversely affected the trainee’s ability to submit successful work or display appropriate competencies at the time, which may mitigate the fail mark. If the Internal Exam Board finds no evidence of mitigating circumstances, the trainee’s progression on the PWP course will be then considered. Discontinuation of training would be considered via a referral to the Student Engagement and Progress (SEP) team or a case review.

A major aspect of assessment is the **Practice Portfolio** which details the work of the trainee PWP in the service. It contains two assessments (mid-year and end of year) of trainee competence by the clinical supervisor in the IAPT service. The Practice Portfolio spans across the two modules and is marked as a PASS or a FAIL by the Programme Team at an Internal Exam Board. If there are problems with the content or quality of the portfolio, it will be marked as a FAIL at an Internal Exam Board. The trainee will receive a letter stating what modifications are required for the resubmission. Please note that the resubmission will be considered the second (and final) submission under normal circumstances. If at the point of the Exam Board the trainee has outstanding elements of the portfolio for which they have been granted an extension, and the work submitted is of suitable standard, they may be awarded a grade of ‘Pass Pending’. This mark reflects that the work submitted has passed, but the portfolio cannot be fully passed until all work has been submitted and ratified.

**Provision in the Event of Failure**

To qualify for the Certificate in Low Intensity Psychological Interventions, PWP trainees must pass **ALL** aspects of assessed work. Any Internal Examiner can recommend the failure of a piece of assessed work. Under normal circumstances if an assessment is failed, arrangements will be made by the Board of Internal Examiners for the trainee to resubmit the piece of work on one further occasion by a specified deadline.

**Please note that should a trainee carry two fails on one assignment or in any one module, their progression will be discussed at an Internal Exam Board and appropriate action will be taken**. This could include a learning review meeting with a member of the course team or an exclusion hearing with the Student Engagement and Progress Team.

**Mitigation**

Should a trainee be asked to provide mitigating circumstances for any reason (for example, in the event that a trainee fails an assignment on two occasions), this provides the trainee an opportunity to present an account of any circumstances during the period of assessment preparation and submission, that the trainee was unable to present before the assessment deadline, which may be considered as mitigation by the Board of Examiners. In this case, trainees need to follow the Extenuating Circumstances process (above) and their account will be considered at an Internal Exam Board, at which appropriate action will be agreed upon. Please note that extenuating circumstances which have previously been considered and agreed as resolved prior to a submission cannot be used as mitigation for subsequent failed piece of course assessment.

It is also important to note that if a trainee is granted an extension on an assignment, the grounds for that extension will not then be accepted as mitigating circumstances should the assignment be unsuccessful. The purpose of the extension process is to grant the trainee sufficient time to submit their assignment, in light of the circumstances outlined on the form. If a trainee feels that their circumstances are affecting their ability to submit a successful assignment, they should request a one-to-one tutorial with a tutor and consider submitting extenuating circumstances to the Board of Examiners.

Reports of insufficient feedback or access to tutorial support do not constitute grounds for mitigation.

**Use of Unfair Means**

**The basic principle underlying the preparation of any piece of academic work is that the work submitted must be the student’s own work.**

Plagiarism, submitting bought or commissioned work, double submission (or self-plagiarism) collusion and fabrication of results are not allowed because they violate this principle.  Cheating in examinations is also classed as using unfair means.

The following six examples of unfair means in non-invigilated examinations are serious academic offences and may result in penalties that could have a lasting effect on a student´s career, both at University and beyond. These are the formal University definitions and should be used in information and documentation provided to students.

1. **Plagiarism (either intentional or unintentional)** is the using of ideas or work of another person (including experts and fellow or former students) and submitting them as your own. It is considered dishonest and unprofessional. Plagiarism may take the form of cutting and pasting, taking or closely paraphrasing ideas, passages, sections, sentences, paragraphs, drawings, graphs and other graphical material from books, articles, internet sites or any other source and submitting them for assessment without appropriate acknowledgement.
2. **Submitting bought or commissioned work** (for example from internet sites, essay “banks” or “mills”) is an extremely serious form of plagiarism. This may take the form of buying or commissioning either the whole piece of work or part of it and implies a clear intention to deceive the examiners. The University also takes an extremely serious view of any student who sells, offers to sell or passes on their own assessed work to other students.
3. **Double submission (or self-plagiarism)** is resubmitting previously submitted work on one or more occasions (without proper acknowledgement). This may take the form of copying either the whole piece of work or part of it. Normally credit will already have been given for this work.
4. **Collusion** is where two or more students work together to produce a piece of work, all or part of which is then submitted by each of them as their own individual work. This includes passing on work in any format to another student. Collusion does not occur where students involved in group work are encouraged to work together to produce a single piece of work as part of the assessment process.
5. **Fabrication** is submitting work (for example, practical or laboratory work) any part of which is untrue, made up, falsified or fabricated in any way. This is regarded as fraudulent and dishonest.
6. **Facilitating the use of unfair means** is where any student assists a fellow student in using any of the forms of unfair means defined above, for example in submitting bought or commissioned work.

Source: <https://www.sheffield.ac.uk/apse/apo/quality/assessment/unfair/constitute>

All pieces of course assessment must be the trainee’s own individual work. **The use of unfair means will automatically result in the failure of the relevant piece of course assessment and Disciplinary or Fitness to Practise procedures may be actioned.**

Please see the University of Sheffield’s advice on the use of unfair means in the assessment process here:

<https://www.sheffield.ac.uk/research-services/code/thesis/preparation/unfair-means>

All written assignments submitted to Turnitin are checked against a database for their similarity to external and internal pieces of work and sources. An Originality Report is then produced which records all the sources that have been matched to the content of the work, and to what degree (see Appendix 7). This database includes the work of current and past trainees who have completed IAPT training courses at the University of Sheffield.

The marker will check the originality report for all assignments. If an originality report concerns the marker, it will be reviewed and discussed at an IEB, where appropriate action will be agreed. Following the exam board, the trainee will be asked to attend a meeting with the Director of the Clinical Psychology Unit to discuss the content of the report.

While it is acceptable to discuss coursework with your peers, **we strongly advise that trainees do not hand out their work to other trainees or read the work of current/past trainees when preparing for a piece of course assessment**. If any content of a trainee’s assignment matches to the content of an assignment submitted by a current or past trainee, it will be flagged in the Originality Report. This function identifies the individual trainees who authored the work – both original and matched – and appropriate action will be taken.

The Board of Examiners will decide the appropriate action on a case by case basis. This may be in line with Disciplinary and/or Fitness to Practise procedure. Trainees can find out more information on these procedures via the links below.

**Disciplinary**: <https://www.sheffield.ac.uk/sss/sas/conduct>

**Fitness to Practise**: <https://www.sheffield.ac.uk/sss/sas/progress>

Any action taken by the University will be in conjunction with both the trainee and representatives of the service they work for.

# Competency Concerns Flowchart

This flowchart illustrates the step by step process which the course will follow in the event of any concerns about a trainee’s progress. Please note that it is not unusual for trainees to fail components of the course – this process is followed both to support the trainee to successfully complete the course wherever possible, and for the safety of all service users.

Failed assignment

University Concerns /failure to progress

Trainee carrying two or more fails in one module

Meeting with academic tutor/ Learning Review Meeting with Programme Director or Deputy Programme Director/

Three-way meeting with service

Trainee carrying two or more fails

Discussion at Internal Exam Board (IEB)

Declined/fail 3rd attempt

Accepted

Service Concerns

Referral to SEP for either:

* Letter from a faculty officer
* Faculty officer Review
* Recommendation for exclusion

IEB consider viability to continue the course

Unable to Demonstrate Competency

Demonstrate Competency

Continue Course

Fail Assignment re-submission

Ongoing concerns/failure to progress

Meet Learning Need and competence

Invite trainee to submit mitigation

Learning Review Meeting with

Programme Director/Deputy

Programme Director

Learning Action Plan Agreed

Automatic opportunity to re-submit

Tutorial available on request

**PGT Overall Results Process**

Overall results are ratified at an **External Exam Board** at which the Programme Team and External Examiner decide on an overall PASS or FAIL mark for each trainee. Failure to complete all pieces of course assessment in time for the External Exam Board, due to ongoing extensions or amended deadlines, will generally result in a postponement of a decision from the Examiners. In this case a trainee’s registration with the University will have to be extended.

A trainee will not be able to progress to a higher pay banding until they have successfully completed all elements of the programme. All marks must be ratified at an exam board and then processed outside the department by the University exams office.

Overall passes are processed by the Student Administration Service. Trainees will receive their statements of results electronically, via a secure online Sheffield Authorised Records (ShARe) System. Trainees will be issued with transcripts when this process is completed, and trainees who need to re-submit work will have their transcripts updated again at a later point once their full set of results is available. Once a transcript has been issued, an email will be sent to the trainee’s University of Sheffield account from verify@sheffield.ac.uk which provides a link to log in to ShARe and view the transcript. Trainees awarded with a Postgraduate Certificate will be contacted directly and advised to complete an online form to request their certificate. Further information about ShARe, how to log in and use the system, can be found on the following web page: https://www.sheffield.ac.uk/ssid/share. Please note that students who have previously accessed the ShARe system will need to use their existing credentials to view their transcripts. Questions about ShARe should be sent to [share@sheffield.ac.uk](mailto:share@sheffield.ac.uk).

# **Post-Qualification Preceptorship and Continued Professional Development**

When Psychological Wellbeing Practitioners complete their training they transition into a new role as a qualified practitioner. That can mean:

* A change in support and supervision arrangements
* Saying goodbye to the student peer group
* A perception that they should have fully formed competences in all areas of practice
* A perception that they can immediately take on a full caseload
* Learning opportunities are less obvious and co-ordinated, and less directly targeting PWP competences.

A preceptorship is a structured period of transition for the newly qualified practitioner, during which they are supported by an experienced practitioner to develop their confidence and refine their skills. Evidence has shown that this is an important way to improve PWP experience and resilience.

There has been recent guidance published around this and potential sources of CPD. For the full guidance please refer to the Guidance on Preceptorship and Continued Professional Development for Psychological Wellbeing Practitioners available on Blackboard.

**PWP Registration**

The British Psychological Society (BPS) and British Association for Behavioural and Cognitive Psychotherapies (BABCP) offer individual registration for PWPs who have successfully completed an accredited PWP training programme. This register is for individuals who commit to maintain high quality standards in clinical practice, supervision and CPD and will adhere to a fitness to practice framework.

Further information can be found on their websites including details of the requirements and process for registration.

# **Practical Information**

**Trainee Wellbeing**

IAPT training programmes are nationally recognised as intensive and demanding courses. The physical and mental wellbeing of our trainees is paramount and, with this in mind, the national IAPT team and the University share the same motivation to protect and support trainees during their training year. The workload during the training year can be intense, stressful and pressured, particularly when managing study, work and busy home lives. The course endeavours to support trainees via a number of mechanisms throughout the training year. These include timetabled lectures on resilience and self-care, regular SP/SR groups, allocated academic tutors who provide pastoral support and close liaison with services. Additionally, extenuating circumstances and extension request procedures are in place for trainees to inform the course of any circumstances affecting their completion of coursework.  Finally, the University offers a range of services that are able to support trainees during their time on the course, these include:

**301: Academic Skills Centre:** https://www.sheffield.ac.uk/ssid/301/study-skills

**Disability and Dyslexia Support Service:** http://www.shef.ac.uk/disability/

**Health Service:** https://www.sheffield.ac.uk/ssid/health-service

**Mental Wellbeing:** https://www.sheffield.ac.uk/mental-wellbeing/index

**Sheffield Students’ Union:** https://su.sheffield.ac.uk/

**Student Support Services:** https://www.sheffield.ac.uk/ssid

In addition to the efforts made by the University, we encourage you as trainees to actively manage your personal wellbeing throughout the training year.  Please take time to notice and reflect on your emotions and recognise any warning signs that you may be having difficulties, starting to struggle or feel unsupported or alone.  The course recognises that seeking help is a challenge for some, however we recommend that you are proactive in response to these signs and access support via your peers, friends, colleagues and tutors. The course is a testing time and is littered with assignments and assessments. Therefore, watch out for the temptation to compare yourself to others or to hold unrealistic expectations. Try to share your experiences, both the ups and downs, acknowledge fears and share successes.

Support and sharing is encouraged amongst new trainees, including sharing resources, information, advice and time in and outside of university.  IAPT has many past graduates working in services who are happy to offer support, advice or an empathetic ear.

**Professional Responsibilities & Attendance at Teaching Sessions**

IAPT trainees are employees of respective Trusts and attendance at all teaching sessions is **compulsory**. Non-attendance and attendance is fed-back to employers. Any problematic attendance issues or persistent lateness will be addressed with the trainee and the service lead. **PWP trainees need to attend 90% of the course teaching to pass the course**. If a trainee has any reason for not attending a teaching session a formal approach in advance in writing, stating reasons, should be made to the Programme Director and Course Administrator. In the event of ill health or other unpredictable reason for non-attendance, trainees should inform one of the IAPT Course Administrators (via iapt@sheffield.ac.uk) by 12.30pm on the day of the session. Notes/certificates of extended absences are required.

If a session is missed, the PWP trainee must complete a catch-up form and ensure their tutor signs it off by emailing them once this is completed on the relevant Pebblepad section. All catch up forms must be signed off **prior** to the Portfolio submission date. It is trainee’s responsibility to keep track of the teaching sessions that are missed. If a trainee’s PWP needs to take some sick leave from their employer, then it is the trainee’s responsibility to inform the course on their return to work in terms of the days missed.

**Attendance Monitoring on Teaching Days**

**Rationale**

Lecture attendance monitoring is now routine throughout Sheffield University for all students, which the IAPT course has to comply with. The following information outlines the procedures which are in line with University attendance policy and NHS employment.

**Procedure**

1. The attendance monitoring resgiter will be left clearly visible and be readily available within teaching rooms prior to the beginning of the teaching session in the mornings and afternoons. All IAPT trainees present will be expected to log their attendance via the paper register prior to the start of the teaching session. It is the trainee’s responsibility to ensure they have logged their attendance. Trainees cannot log attendance on the behalf of other trainees.
2. Any IAPT trainee arriving late will need to go to the IAPT administrator to give a reason for their lateness.
3. Lateness will be monitored by admin staff and if any trainee is late on three occasions within the academic year, this information will be passed to the Programme Director for action. The action will be a consideration of Fitness to Practise issues and prompting liaison with the relevant service lead. The Course acknowledges that some trainees travel some distance to attend teaching, but nevertheless this is a not a reason for persistent lateness.
4. Trainees are expected to be punctual in their attendance at teaching sessions, meetings and appointments. The course team will also try to ensure that lecturers are punctual and do not over-run.
5. For remote or online teaching sessions, a report will be downloaded directly from Blackboard with respect to who has signed in to the session and when.

**Professional behaviour during teaching and groups**

Trainees are being paid with public monies to train and therefore the Trusts and University have associated expectations with regard to conduct and attitudes. Persistent problems in either area will result in Fitness to Practise concerns being raised. Trainees are expected to demonstrate the following professional behaviour throughout their learning and training:

* The use of mobile phones in lectures and group work is prohibited unless the trainee negotiates this (e.g. waiting for an urgent call). All devices must be turned off or put on silent mode. If you are seen to be using your mobile phone in a lecture or during group work, you may be asked to leave the session, unless the issue is an emergency.
* The start and end times of the lectures and groups should be adhered to. If you are running late, you should inform a member of the admin or teaching team. Trainees are required to stay until the end of the teaching and group work session, as timetabled (normally 4:30pm).
* Trainees should demonstrate a positive attitude to learning. This includes not talking during lectures and engaging and participating in group tasks. Listening and observing others in a respectful and adult manner during group work and responding positively to feedback, are beneficial ways to enhance your learning.

**Dress**

Dress whilst in NHS practice should be in keeping with the role of a trainee PWP. Different clinical settings make different demands. Trainees need to be sensitive to the requirements of the situation and dress in a way which will not inhibit their effectiveness. For the OSCEs, it is recommended that trainee PWPs dress as they would when they are working in clinical practice.

**Adverse Weather Conditions**

In the event of snow or other adverse weather conditions, trainees are expected to attend the training day as normal unless they are advised otherwise by the University. The Course will endeavour to make a decision the evening before a teaching day when adverse weather conditions occur, and trainees are asked to check their University email account in case of any cancellations. If it is not possible to inform trainees the day before, a decision will be made and sent via email as soon as possible on the day. If teaching has not been cancelled, trainees are expected to attend. Even when the usual forms of transport are unavailable, trainees should make every reasonable effort to reach the University campus using alternative means, provided it is safe for you to do so. In the event of sessions being cancelled, the Course will make every effort to reschedule, which may involve using reading weeks. When adverse weather conditions occur during a teaching day, the Course may decide to cut sessions short if appropriate.

**IMPORTANT: Use of Course Lectures and Materials**

Teaching materials are not to be circulated, reproduced or used outside of University or delivered elsewhere, which includes your workplace.

The course materials provided on Blackboard are the property of the University of Sheffield and are strictly for trainees’ learning. Recordings from teaching sessions will be saved on to Blackboard for trainees to access during their training year. Circulating the footage on the internet would be treated as a Fitness to Practise issue.

**Exclusion from the Course**

Either the annual External Board of Examiners or the Board of Internal Examiners, with the External Examiner(s) present, or following consultation with External Examiner(s), the Programme Director can recommend to the Faculty of Science that a trainee be excluded from the course. This could be due to either failure to meet the relevant coursework requirements or because of concerns over fitness to practise, poor attendance or other relevant disciplinary issues.

Should a trainee be excluded from the programme due to failure under any grounds, HEE will not fund further training on any IAPT PWP training courses nationally.

When PWP trainees have been absent from the course due to illness or other personal difficulties for a period of time long enough to disrupt their training, the Course will endeavour to reschedule academic deadlines following consultation with the employer, via a training plan. However, if in the judgement of the Internal Examination Board, the trainee has had no good cause to be absent from the Course, in line with the University policy on non-attendance, this will result in a trainee failing to graduate until they have made good their attendance. Poor attendance will also constitute grounds for review by the Faculty Progress of Students committee. (See University Penalties Policy on non-attendance).

**Disciplinary procedures**

If there is evidence that a trainee may have engaged in actions which could be deemed to be Gross Professional Misconduct, the Programme Director may take action to have the trainee’s registration immediately suspended prior to investigation and any subsequent referral to the University’s Discipline Committee. University procedures related to disciplinary issues are outlined in the Regulations as to the Discipline of Students (<https://www.sheffield.ac.uk/sss/sas/conduct>). If the matter is a Fitness to Practise issue, then the relevant University Fitness to Practise Procedure will be followed (<https://www.sheffield.ac.uk/sss/sas/progress>).

**Fitness to Practise Standards**

Trainees must uphold appropriate standards of behaviour in **all** aspects of their training as indicated below. Where trainees fail to meet these standards they will not be allowed to complete the PWP course.

1. During the course, PWP trainees must liaise in a positive and constructive way with many different people including patients, supervisors, other staff on placement, course staff, teachers, administrative staff, peers and others. Where fitness to practise concerns are raised in relation to this aspect, the trainee’s interpersonal difficulties should be clearly demonstrated and documented with a variety of different individuals and typically across several different settings.
2. Training requires individuals to acquire new skills and knowledge and take on new roles. It requires respect for others’ opinions, openness to learning and an ability and willingness to use feedback constructively. Concerns relating to fitness to practise may involve an inability or unwillingness to acknowledge and use feedback on practice issues or interpersonal difficulties in a constructive way. Any feedback given and the responses of the trainee should be clearly documented.
3. PWP trainees are required to demonstrate throughout their training, attitudes and behaviour in keeping with the statements of values and standards of respect, competence, responsibility and integrity.
4. In addition to (c) there are specific additional implementation issues in the training context. In particular, the domain of integrity requires that honesty must underpin all aspects of training in relation to documentation, assessed work and liaison with staff and supervisors.
5. Concerns may be raised about fitness to practise under any of the above areas. However, a series of more minor events may have occurred usually across settings and with more than one person which call into question the suitability of a candidate through their attitudes or behaviour to continue their training.
6. As a condition of acceptance onto the course, trainees must undergo and have received a satisfactory DBS check from their Trust or 3rd Sector employer. It is a condition of continued registration that any police cautions or criminal convictions occurring after offer of a place but prior to termination of the course are notified to the Programme Director as soon as possible and within 7 days of occurrence. Failure to do so will be considered as a fitness to practise concern. The content of any disclosure may lead to University Fitness to Practise or Disciplinary Procedures being invoked

(<https://www.sheffield.ac.uk/sss/sas/conduct>/ <https://www.sheffield.ac.uk/sss/sas/progress>)

1. The course, wherever possible, attempts to ensure that candidates successfully complete their training. The Course Team is committed to helping trainees who encounter difficulties through (i) clear communication about the identification of problems and (ii) provision of support to a trainee in their attempts to meet the requirements of change.
2. Should concerns be raised about a trainee’s fitness to practise then procedures outlined in General Regulations relating to Student Fitness to Practise will be followed.
3. Where the University upholds concerns over Fitness to Practise a trainee may be excluded from the course and their registration terminated.
4. The University has a duty of care to inform current and subsequent supervisors of any referrals for Fitness to Practise and their outcomes, since the NHS Trust is liable for the clinical work conducted by trainees.

**Contractual dual status as a service employee and a university student**

Trainees are contracted employees of their specified service and registered postgraduate students of the University of Sheffield. The contract of employment and registration with the University are co-terminus. As such, the employment contract is conditional upon the trainee being both satisfactorily registered with the University and employed by the service.

In all circumstances, the University retains the right to terminate University registration if the NHS or relevant employer no longer employs a trainee PWP. The same applies in the event that a contract of employment is terminated on grounds of ill health.

There may be occasions in which a trainee wishes to terminate their employment with their employer and this would terminate their registration as a trainee. This is because trainees need to be employed in an IAPT service in order to undertake the training. Should a trainee wish to terminate their training contract, then it is highly advised that they first meet with their supervisor, tutor or the Programme Director. This is in order for any necessary support to be put in place in order to support continuation; however personal decisions will, of course, be respected.

**Trainee salary**

Please be aware that you will remain on a trainee pay grade until you have successfully completed and been awarded the qualification for the course. This may extend beyond the course’s 12 month duration if you have not passed every piece of course assessment.

**Withdrawal from the Course**

Withdrawal from the training course is a significant decision that will impact a trainee’s life and career. Therefore, we want any trainee considering this course of action to adhere to the following procedure. In the first instance, we would strongly advise that the trainee attends an informal meeting with their tutor or supervisor to outline their concerns and motivations for wanting to leave the course. Following this meeting, if the trainee remains set on this course of action, a formal meeting with their tutor, the programme director or deputy programme director must take place. During this formal meeting the trainee is required to produce a statement that outlines what information they want to be shared with the rest of the cohort about their departure from the course.

**University Appeals**

There is a process to appeal a decision made by the Faculty Student Review Committee or Fitness to Practice Committee to the Appeals Committee of the Senate, and information about the procedure is supplied to any student affected by a decision to exclude.

**Complaints**

The University has a comprehensive system for dealing with complaints. The emphasis of the procedure is on informal resolution of problems at a local level. If a complaint remains unresolved, there is a formal stage involving submitting a written complaint in this case to the Course Director. Again if there were failure to resolve the complaint, the next recourse would be the Head of Department. Further stages would be via writing to the Registrar and Secretary as University Statutes give the University Council the power to investigate and if thought fit, redress student grievances. The University of Sheffield website has a section devoted to Complaints and Appeals Procedures: <https://www.sheffield.ac.uk/ssid/complaints-and-appeals>. This covers in detail complaints procedures, as well as appeals relating to academic work and discipline.

**Discrimination and Harassment**

The University is committed to supporting anyone who has experienced any form of discrimination such as harassment, abuse, bullying, or sexual violence that may be based on race, gender, sexuality, disability or other characteristics. The dedicated report and support platform <https://reportandsupport.sheffield.ac.uk/> can be used to report your concerns, anonymously or with your details and access support from dedicated and trained staff across the University.

We also encourage you to contact your personal tutor and or the Deputy or Programme Director should you have any concerns or experiences of this nature.

**IAPT Leave of Absence (LOA)**

A leave of absence is a when a trainee takes time off from studies due to either personal or medical circumstances. A leave of absence should be considered if a trainee requires a prolonged absence from study due to an illness/medical condition or personal circumstances that may last for several weeks or months, where such circumstances are likely to have a significant impact on ability to work and study. Impact on ability to study means that the trainee is either unable to attend and/or participate fully and effectively in all taught elements of the course, including clinical skills and SP/SR. Furthermore, if a trainee is unable to engage in coursework and related course assignments (including recorded clinical sessions) and self-directed study.

The course can use extenuating circumstances as outlined in the handbook, to support trainees and provide reasonable adjustments to aid successful progression on the course. However, where the adjustments needed are outside of what may be deemed reasonable, or where a trainee remains unable to study with reasonable adjustments in place, a leave of absence should be considered. Consultation with the DDSS service may be sought to support development of reasonable adjustments.

As employees in local IAPT services trainees **must** discuss the contractual implications of a leave of absence with their employing service as any leave of absence is likely to lead to a delay in qualification and a requirement to extend the training contract.

A leave of absence is negotiated between the trainee, course, service and faculty. Departmental support is required for a leave of absence request to be approved. In instances where the course believes a leave of absence will negatively impact the viability of the trainee completing the course or will make the awarding of the qualification academically unviable, the course reserves the right to decline a request for a leave of absence. In this instance the course will provide a clear and comprehensive rationale to outline why the leave of absence has not been approved and the trainee will be required to continue with the course or to withdraw.

When on a leave of absence, a trainee is not expected to work on any academic assignments during their time away from their course. This includes all written assignments, case studies and recorded clinical sessions. The LOA itself is a recognition that the trainee is not ‘fit to sit’ the assignments and therefore they should not be engaged in any academic work. All deadlines are put on hold until the trainee formally returns from the LOA. At the point of which the trainee returns from LOA a Learning Review Meeting will be held with a course tutor and a suitable leaning plan will be agreed with deadlines and tutorial support arranged. A strategy to catch up any missed teaching, skill sessions or SP/SR will be devised.

**Clinical Work and LOA**

In most cases a LOA will be taken in conjunction with sick leave from employment. In this instance the trainee would be ‘signed off’ from their employment and also on leave of absence from study. On very rare occasions, it may be appropriate for a trainee to continue to practice clinically, but take a leave of absence from the course. This arrangement should be carefully considered by the trainee and their manager, supervisor and service to ensure that the trainee is fit to practice and that safety of the trainee and their clients is maintained at all times.

During the LOA, where a trainee continues to work clinically in their service the following conditions should be observed. Trainees should continue to work on a reduced caseload appropriate for a trainee. They should continue to see suitable training cases. They should continue to be provided with the required minimum levels of supervision for their clinical practice.

The supervised clinical hours with clients and supervision hours accrued in this time can be counted towards the requirements of the Practice Portfolio (PP). Additionally, any live supervision, or supervisor rated sessions can be counted for the PP. The trainee should also continue to make entries into their reflective journal to collect data for their reflective log. Clients seen in the period of the LOA may be used for future case studies or reflective assignments.

The trainee should not be working on the other academic components of the course such as case studies or reflective assignments. In the portfolio the trainee should not be working on academic components such as the Declarative Knowledge Exercises, reflections, data analysis or synthesis. Shadowing and experience towards the 15 days learning can be accrued, however, the formal reflections should be reviewed and written once formally returned to study. Although the trainee can continue to use a reflective journal to collect data for their reflective log, they should not analyse or synthesise that until they have formally returned to study.

Trainees are encouraged to record and review their clinical sessions and supervision for the purpose of reflection and supervision during their period of LOA but should not submit recorded sessions from this time frame for assessment. This is due to the fact that the LOA has been implemented in the knowledge that the trainee is not currently ‘fit to sit’ the assignment.

Trainees can find out more information about LOA and download the form from

<https://www.sheffield.ac.uk/ssid/leave-of-absence>

# **Facilities and Resources**

**Access**

Access to the IAPT Office is only possible during office hours (9.00 - 5.00).

IAPT trainees should ensure that they familiarise themselves with the University's Health and Safety Procedures (<https://www.sheffield.ac.uk/hs>).

**Phone Calls**

Messages for IAPT trainees can be left with the Course Administrator. **No personal calls should be made from the University phones**. All calls are billed and monitored by the Departmental Manager.

**Secretarial Support**

All clinical correspondence (e.g. letters to clients, GPs, clinical reports etc.) should be produced on Trust or 3rd Sector Employer premises, where adequate secretarial support should be available. The IAPT administrator is unable to provide any typing for trainees. The only exception will be for work produced by trainees concerning the organisation of the course (e.g. Course Training Committee). Trainees should be aware of the need to ensure that confidential information is secure on any computer that they use.

**Parking**

The University has a policy on car parking; students can apply for a parking permit on a needs assessed basis. Permit details and an application form are available at the following web page (<http://www.sheffield.ac.uk/parkingservices/information>).

**IT Resources**

Corporate Information and Computing Services (CiCS), provide over 1300 PCs for students to use and many of them are located in Library sites, including the Information Commons. Trainees should contact CiCS with any IT and Blackboard 2 queries via the helpdesk (0114 222 1111 or helpdesk@sheffield.ac.uk). There will be scheduled teaching on computing skills and the Psychology IT support team (Joshua Swift j.swift@sheffield.ac.uk) is available to give advice.

**The University Libraries**

IAPT Trainees have lending rights at the Main University Library and the Hallamshire and Northern General Hospital Libraries. The STAR and Web of Science bibliographic systems can be accessed via the computers in the Psychology Department. Please see full details of the library services with useful links on Blackboard.

**Your UCard**

Trainees are issued with a UCard. This enables the following:

* Entry to Library sites, including the Information Commons
* Ability to borrow books and other items
* Ability to use printing and photocopying facilities
* Eligibility to use the Library’s electronic resources

**MUSE account**

MUSE, the University of Sheffield Portal, is a web facility designed to give staff and students of the University personalised access to the University’s digital resources. These are available 24 hours a day, regardless of your location. When you register as a student or member of staff you will be given a username and password, allowing you to use MUSE to:

* Access Star, the Library catalogue to locate the material you need using the Search or Advanced Search tab and request items that are on loan
* View Leganto, your online reading lists via Blackboard
* Access myLibrary Account to view your requests, check your account details and renew your loans
* Access the Library’s electronic resources, including ebooks, ejournals, databases, films, images and maps
* Access the Library’s Information Skills Resource through My Online Learning Environment (Blackboard)
* Obtain your Library PIN to enable you to use self-service issue (you can also get your PIN from any member of Library staff)
* Book a group study room or individual PC in the Information Commons

**Other Services Available through MUSE**

* Send and receive emails from anywhere in the world using Google mail
* Access your Novell file store easily from off campus
* Check the status of your pre-pay account, used for services such as photocopying and printing
* Access information provided by Student Services, including your personal details and examination results
* Access your course information through My Online Learning Environment (Blackboard)

**Photocopying and Printing**

Black and white photocopiers and printers are available at all Library sites. A colour photocopier is available in Western Bank Library and a colour printer is available at the Information Commons, Western Bank Library, St George’s Library and the Royal Hallamshire Hospital Library. You’ll need your UCard to access these facilities. There is a printer in the psychology computer lab (D Floor) (accessible when it is not in use for teaching). Once you have sent documents to the printer, you will need to swipe your Ucard at the machine by the printer for your printing to be released and your printing account will be debited.

**Student Services Information Desk (SSiD)**

SSiD is a 'one-stop shop' student information service that can answer the majority of your questions. They can offer guidance on issues such as exams, changing course and extenuating circumstances, and provide a range of administrative services including:

* UCards
* Transcripts
* Bank letters
* Student status documents
* Council tax exemption letters

If they can’t answer your question, they’ll refer you to the relevant service or department who can.

You can also browse their web pages for information, support and guidance on all aspects of University life: [students.sheffield.ac.uk/ssid](https://students.sheffield.ac.uk/ssid)

Location:

Level 3, Students' Union Building.

Opening times:

(Closed on Bank Holidays)

Mon, Tues, Weds, Fri: 9am-5pm

Thurs: 10am-5pm

**Disability and Dyslexia Support Service (DDSS)**

The Disability and Dyslexia Support Service (DDSS) is a friendly and confidential service at The University of Sheffield. They provide support and advice to students with disabilities, with the aim of enabling all students to access their studies and university services. It is the responsibility of the trainee to alert the course to any apparent disability of dyslexia assessment and associated support needs. The information on these web pages describes the facilities and services available to disabled students and students with Specific Learning Difficulties. You may be eligible for disability support if you have an impairment or condition that has a substantial and long-term adverse effect on your ability to carry out study-related tasks, such as:

* reading
* sitting exams
* attending classes
* taking notes in class
* delivering presentations
* planning and writing assignments

DDSS can provide guidance and advice on setting up disability support, including how to organise exam support adjustments.

For more information, please visit:

[students.sheffield.ac.uk/disability](https://students.sheffield.ac.uk/disability)

The Hillsborough Centre

Alfred Denny Building

The University of Sheffield

Western Bank

Sheffield S10 2TN

0114 2221303

[disability.info@shef.ac.uk](mailto:disability.info@shef.ac.uk)

**Mental Wellbeing**

**Student Access to Mental Health Support (SAMHS)**

If you need mental health support during your studies, you can register online with SAMHS and book an initial 'triage' appointment.

They will consider your suitability for one-to-one counselling with the University Counselling Service, as well as a wide range of other available interventions.

[students.sheffield.ac.uk/mental-health/registration](https://students.sheffield.ac.uk/mental-health/registration)

**Events and workshops**

The University Counselling Service offers a range of online support sessions on a regular basis, including regular sessions delivered in conjunction with the NHS (IAPT). We usually deliver a programme of free drop-in workshops, including sessions for mindfulness and hypnosis for inner calm and positivity.

[students.sheffield.ac.uk/mental-health/home/workshops](https://students.sheffield.ac.uk/mental-health/home/workshops)

**External support**

As a student, you have free international access to Togetherall, an online mental health community providing 24/7 support from peers and trained counsellors.

[students.sheffield.ac.uk/mental-health/online-support](https://students.sheffield.ac.uk/mental-health/online-support)

To find out more about our psychological support, visit:

[students.sheffield.ac.uk/mental-health](https://students.sheffield.ac.uk/mental-health/online-support)

**Student Welfare Support**

If you’re experiencing personal difficulties that are impacting on your University experience and ability to study, our Student Welfare team can help.

They can provide support and advice to help you deal with welfare issues resulting from situations, including but not limited to:

* Harassment
* Sexual Violence
* Housing/finance issues
* Serious ill health/hospitalisation
* Sexual violence (current or historic)
* Victim of a crime
* Bullying and harassment
* Housing/relationship issues
* Relationship abuse
* Bereavement
* Missing students
* Forced marriage and honour violence

Tel: +44 114 222 4321

Email: [support@sheffield.ac.uk](mailto:support@sheffield.ac.uk)

**Student Wellbeing Service**

If you’re experiencing difficulties and challenges, our Student Wellbeing Service offers short-term, tailored one-to-one support to help you manage your wellbeing and succeed at University.

If you’re feeling down, overwhelmed or struggling to adjust to student life your Faculty Wellbeing Advisor can assist you in improving your wellbeing and help you get back on track

The Student Wellbeing Service:

* provide a confidential space for you to explore and understand your difficulties
* offer guidance, practical advice, interventions and self-help techniques
* signpost you to other relevant support services
* be a supportive friendly face to check in with throughout your time at university

Please visit the page below for more information and to book an appointment.

[students.sheffield.ac.uk/wellbeing](https://students.sheffield.ac.uk/wellbeing)

**Chaplaincy for Students**

The Chaplaincy Centre at the University can provide care and support, regardless of whether you have a religious or belief identity.

The Chaplaincy also offers social opportunities and provisions for worship, prayer and spiritual guidance. For more information, visit:

[sheffield.ac.uk/chaplaincy](http://www.sheffield.ac.uk/ssid/chaplaincy)

The Octagon Centre

Western Bank

Sheffield S10 2TN

Telephone: 0114 2228923

**Ramadan**

To discuss an individual situation please contact the Muslim chaplain:

[ameena.blake@sheffield.ac.uk](mailto:ameena.blake@sheffield.ac.uk)

# **Appendices**

## **Appendix 1: Descriptive Marking Criteria**

|  |  |
| --- | --- |
| **70-100%** | A **distinguished performance at postgraduate level**, which demonstrates a generally innovative and creative approach. The meaningful use of a depth of knowledge and a wide range of source material. Critical analysis of relevant concepts from a range of perspectives. Has the ability to interpret and synthesise ideas and recognise and deal with complexity. Skilled use and critical analysis of appropriate analytical and research methods. Exceptional ability to link and critically analyse theory and practice. |
| **60-69%** | A **good performance at postgraduate** level has recognition and understanding of the key issues in the area of study. There is use of a wide range of source material. Clear and well organised argument. An awareness and ability to analyse and present theoretical perspectives. Good use of appropriate critical evaluation of source material. Effective linking of theory and practice. |
| **50-59%** | A **satisfactory** performance at postgraduate level shows understanding and grasp of the concepts. Evidence of relevant reading. An argument that includes some theoretical discussion and is more than a descriptive account. Demonstrates an ability to set personal opinions into a wider setting. Attempts to use and evaluate appropriate processes of enquiry. Recognition of the link between theory and practice. |
| **49-40%** | A **failed** submission shows only some evidence of understanding of the concepts. There is only limited use of source material. A largely descriptive and unreflective account. Uncritical presentation of a personal viewpoint. Poor connectivity to evidence, theory and research. Poor or piecemeal linkage of theory and practice. Resubmission will require changes and alterations of the original work as outlined by feedback from the marker. |
| **39% and below** | A **failed** submission shows little evidence of understanding of the concepts at hand. Very limited use of source material. A wholly descriptive and unreflective account. Uncritical presentation of a personal viewpoint. Little or no evidence of connectivity to research, theory and evidence. Failure to effectively link theory and practice. Resubmission will require a completely new piece of work. For the Diversity Case Study this will mean a new patient for the case study and new reflection. For the Case Management Supervision Report this will require a new recording and transcription for the supervision and re-write of the process analysis. |

## **Appendix 2: Marking Grid - Reflective Commentary on Patient Centred Assessment Clinical Simulation – Reflection 1**

**1. Demonstration of theoretical knowledge, understanding and application of theory to assessment practice (25%)**

*Students should display knowledge and understanding of theories and concepts relevant to engagement and assessment of patients with common mental health problems, suitably integrated and linked into their commentary.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Theoretical Framework or Model. Including key concepts and research/evidence** | No discussion of the model or framework used to guide assessment  Relevant theories and concepts re engagement and assessment are not included | Unclear or inadequate description of the model or framework used to guide the assessment  Key theories/ concepts are summarised in a superficial way. | Basic description of the model or framework used to guide the assessment  Key theories are included and summarised in a basic, correct and clear way. | Clear and coherent description of the model or framework used to guide the assessment  Theories, concepts and research are discussed in a clear, coherent, factually accurate manner and summarised thoroughly and thoughtfully | Clear and coherent description of the model or framework used to guide the assessment  Good understanding demonstrated of the model and how it links to the case  Wide range of relevant theories and concepts. Theories, concepts and research are discussed in a clear, coherent, factually accurate manner and summarised thoroughly and thoughtfully.  This is transferred to clinical practice. |
| **Critique of relevant literature (policy, clinical)** | No evidence of critical evaluation or synthesis of relevant literature included.  No conclusions drawn from literature. | Limited use of appropriate literature, which lacks critical evaluation and synthesis.  Vague or confused conclusions drawn from the literature. | Some basic evidence of ability to critique relevant literature and synthesis of different evidence and ideas.  Some basic conclusions drawn from literature. | Clear evidence of the ability to critique relevant literature demonstrating thoughtful synthesis of different evidence and ideas  Coherent and comprehensive conclusions drawn. | Clear evidence of the ability to critique relevant literature, demonstrating highly original synthesis of literature.  Breadth and depth of critique allows novel conclusions to be drawn. |
| **Guidelines and legislation** | Absence of relevant guidelines / legislation | Vague, limited discussion of guidelines/ legislation | Basic summary of relevant guidelines and legislation | Clear and coherent summary of relevant guidance and legislation | Clear and succinct summary of relevant literature and guidance and how this is relevant to clinical practice |
| **Applicability to the case assessment** | Does not link relevant concepts, literature to the case. | Unclear or confused links between the literature and the case study | Accurate but basic links drawn from literature to the case study | Clear and coherent links drawn between literature and case study, thoughtfully completed. | Clear and coherent links drawn literature and case study.  Clear considerations and implications to clinical practice explored |

**2. Structure and Organisation (10%)**

*The commentary should be logically and systematically structured. It should be legible, error-free and clearly presented in accordance with APA guidelines.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Clarity of expression** | Ungrammatical and/or incomprehensible writing throughout | Confusing or unclear writing in several places that made it difficult to grasp what was being meant | Clearly written throughout with very few difficulties grasping what was meant | Clearly and coherently written throughout with no difficulties grasping what was meant | Clearly written throughout with a very high level of clarity and expressiveness |
| **Structure and flow of sections** | Confusing or unclear structure throughout  No use of headings | Confusing or unclear structure in several places with insufficient links between sections  Some unclear use of headings | Logical structure throughout with appropriate links between sections  Clear use of headings with very few exceptions | Coherent structure throughout  consistently good links between different sections  Clear use of headings throughout to aid understanding and reading | Clear sequencing of sections that created a natural flow and/or compelling sense of narrative  Use of headings facilitated the flow between sections |
| **Diagrams, tables and figures** (if included) | Poor use and presentation of diagrams, tables or figures with no links to the main text. | Confusing or unclear diagrams, tables or figures with insufficient labelling  Very few links to the main text | Basic but comprehensible diagrams, tables or figures with generally clear labelling  Some explicit links to the main text | Clear and coherent diagrams, tables or figures with helpful labelling  Explicit links to the main text that add to the written account | Clear and attractive diagrams, tables or figures with consistently helpful labelling  Explicit links to the main text that complement the written account in a persuasive or innovative way |

**3. Summary of assessment (25%)**

*The commentary should include key elements of assessment*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Assessment summary**  **(Presenting problem, symptoms and relevant background/history)** | No summary of outcome of assessment | Unclear or irrelevant summary of outcome of assessment | Basic summary of relevant aspects of outcome of assessment | Coherent and clear summary of outcome of assessment | Clear and succinct summary of outcome of assessment  Identification of key problem, symptoms and relevant background information |
| **Diagnostic criteria** | Diagnosis is absent, no consideration of diagnostic criteria | Reference to the diagnosis but not explained or justified | Basic consideration of diagnostic criteria  Co-morbidity considered but not in depth  Use of ICD 11 code | Coherent consideration of diagnostic criteria fully justified  Good discussion of co-morbidity and differential diagnosis  Use of ICD 11 code | Clear description of diagnosis persuasively justified  Full discussion of co-morbidity and od differential diagnosis with consideration to clinical practice  Use of ICD 11 code |
| **Skills and techniques employed**  **(Information gathering, information giving, shared decision making)** | No description of relevant assessment skills techniques | Unclear or inaccurate description of assessment skills and their application | Basic summary of assessment skills, their application.  Demonstrates fidelity to the PWP assessment approach | Coherent and clear summary of assessment skills.  Fidelity to the model and approach demonstrated | Good summary and description of relevant assessment skills  Ability to reflect on their role in the assessment process  demonstrates fidelity to model. |
| **Conceptualisation**  **(ABC, 5 areas, COM-B)** | No conceptualisation of the presenting problem. | Unclear or confused conceptualisation- inaccurate application of framework or model. | Basic, accurate and relevant application of framework or model to conceptualise problem. | Clear and coherent application of framework or model to conceptualise problem. | Clear and coherent application of framework or model to conceptualise problem.  Consideration given to the patients presentation and the conceptualisation introduced |

**4. Critical reflection (30%)**

*The commentary should be balanced, detailing what went well, what was learnt from the session, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Use of a Reflective Model** | Absence of a reflective model. | The trainee refers to a reflective model, but there is little/no evidence of its application to learning. | The trainee outlines and includes a reflective model.  There is basic application of the model with clear evidence of learning. | The trainee applies a reflective model to demonstrate coherent and thought provoking reflections and learning. | The trainee applies a reflective model to demonstrate coherent and thought provoking reflections  Key learning identified and considerations regarding how this could be implemented |
| **Linkage to concepts and Theories** | There are no links to theory or key concepts. | The trainee demonstrates some evidence of knowledge of key concepts and/or theory but this is vague and loosely linked to the reflection. | The trainee links key concepts and theories to substantiate and elaborate upon their reflections. | The trainee links a range of key concepts and theories to substantiate and elaborate upon their reflections. | The trainee skillfully links a wide range of key concepts and theories to substantiate and elaborate upon their reflections in an insightful way. |
| **Action Plan and Conclusion** | No action plan or conclusion drawn. | Brief action plan, lacking in detail. | A basic action plan is outlined and conclusions to learning discussed. | A clear action plan is developed with clear and coherent conclusions drawn from learning. | A detailed action plan is demonstrated with insightful conclusions drawn from learning for example skill techniques, process issues or the evidence |
| **Cultural & ethical factors** | No reference to cultural factors relevant to case.  Identifying details of the trainee or service included in the essay or appendices.  Ethical aspects relevant to case not explored or professionally managed | Insufficient consideration of cultural factors relevant to the case or assessment process.  Insufficient reference made to professional or service guidance.  Ethical issue/s identified but insufficiently or inappropriately addressed | Sufficient consideration of cultural factors relevant to the case or treatment process.  Reflection on cultural or ethical factors relevant to the case | Cultural and ethical aspects are well considered and included where relevant in reflections and analysis of the case.  Consideration given to possible adaptions during the process of assessment to meet cultural or ethical factors  Consideration of the ethical principles used to inform clinical decisions | Good evidence of highly responsive and detailed consideration of cultural factors and context  Critical analysis and reflections includes sensitive consideration of individual cultural aspects and ability to synthesise within the overall analysis.  Consideration given to possible adaptions during the process of assessment to meet cultural or ethical factors  Reflection of how the trainee’s own cultural norms may impact on the process of treatment. |

**5. Use of source material (10%)**

*The commentary should be supported by a good depth and breadth of relevant source material, referenced in line with APA referencing system.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **References** | No references included | Incomplete or inaccurate references | Complete and accurate references concentrating on well-known articles and/or relevant secondary sources | Complete and accurate references with mainly primary sources and some that are highly relevant to this specific topic | Complete and accurate references with mainly primary sources and several that are highly relevant to this specific topic |

## **Appendix 3: Marking Grid - Reflective Commentary on Treatment Session – Reflection 2**

**1. Demonstration of theoretical knowledge, understanding and application of theory to treatment practice (25%)**

*Students should display knowledge and understanding of theories and concepts (relevant to evidence based low-intensity treatment for common mental health disorders relevant to treatment of patients with common mental health problems) suitably integrated and linked into their commentary.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Theoretical Framework or Model.**  **Including key concepts and research/evidence** | No discussion of the model or framework used to guide treatment planning and delivery  Relevant theories and concepts of treatment are not included | Unclear or inadequate description of the model or framework used to guide treatment planning and delivery  Key theories/concepts are summarised in a superficial way. | Basic description of the model or framework used to guide treatment planning and delivery. Connected to evidence base.  Key theories are included and summarised in a basic, correct and clear way. | Clear and coherent description of the model or framework used to guide treatment planning and delivery.  Well connected to evidence base.  Theories, concepts and research are discussed in a clear, coherent, factually accurate manner and summarised thoroughly and thoughtfully | Clear and coherent description of the model or framework used to guide treatment planning and delivery.  Evidence base integrated in treatment summary.  Good understanding demonstrated of the model and how it links to the case  Wide range of relevant theories and concepts. Theories, concepts and research are discussed in a clear, coherent, factually accurate manner and summarised thoroughly and thoughtfully.  This is transferred to clinical practice. |
| **Critique of relevant literature (policy, clinical)** | No evidence of critical evaluation or synthesis of relevant literature included.  No conclusions drawn from literature. | Limited use of appropriate literature, which lacks critical evaluation and synthesis.  Vague or confused conclusions drawn from the literature. | Some basic evidence of ability to critique relevant literature and synthesis of different evidence and ideas.  Some basic conclusions drawn from literature. | Clear evidence of the ability to critique relevant literature demonstrating thoughtful synthesis of different evidence and ideas  Coherent and comprehensive conclusions drawn. | Clear evidence of the ability to critique relevant literature, demonstrating highly original synthesis of literature.  Breadth and depth of critique allows novel conclusions to be drawn. |
| **Guidelines and legislation** | Absence of relevant guidelines / legislation | Vague, limited discussion of guidelines/ legislation | Basic summary of relevant guidelines and legislation | Clear and coherent summary of relevant guidance and legislation | Clear and succinct summary of relevant literature and guidance and how this is relevant to clinical practice |
| **Applicability to the case assessment** | Does not link relevant concepts, literature to the case. | Unclear or confused links between the literature and the case study | Accurate but basic links drawn from literature to the case study | Clear and coherent links drawn between literature and case study, thoughtfully completed. | Clear and coherent links drawn literature and case study.  Clear considerations and implications to clinical practice explored |

**2. Structure and organisation (10%)**

*The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with APA guidelines.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Clarity of expression** | Ungrammatical and/or incomprehensible writing throughout | Confusing or unclear writing in several places that made it difficult to grasp what was being meant | Clearly written throughout with very few difficulties grasping what was meant | Clearly and coherently written throughout with no difficulties grasping what was meant | Clearly written throughout with a very high level of clarity and expressiveness |
| **Structure and flow of sections** | Confusing or unclear structure throughout  No use of headings | Confusing or unclear structure in several places with insufficient links between sections  Some unclear use of headings | Logical structure throughout with appropriate links between sections  Clear use of headings with very few exceptions | Coherent structure throughout  consistently good links between different sections  Clear use of headings throughout to aid understanding and reading | Clear sequencing of sections that created a natural flow and/or compelling sense of narrative  Use of headings facilitated the flow between sections |
| **Diagrams, tables and figures** (if included) | Poor use and presentation of diagrams, tables or figures with no links to the main text. | Confusing or unclear diagrams, tables or figures with insufficient labelling  Very few links to the main text | Basic but comprehensible diagrams, tables or figures with generally clear labelling  Some explicit links to the main text | Clear and coherent diagrams, tables or figures with helpful labelling  Explicit links to the main text that add to the written account | Clear and attractive diagrams, tables or figures with consistently helpful labelling  Explicit links to the main text that complement the written account in a persuasive or innovative way |

**3. Summary of assessment and treatment session (25%)**

Summary of relevant aspects of the assessment and treatment session

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Assessment Summary**  **(presenting problem, symptoms and relevant background/history)** | No summary of outcome of assessment | Unclear or irrelevant summary of outcome of assessment | Basic summary of relevant aspects of outcome of assessment | Coherent and clear summary of outcome of assessment | Clear and succinct summary of outcome of assessment  Identification of key problem, symptoms and relevant background information |
| **Treatment Summary**  **(relevant to specific intervention)** | No summary of relevant treatment/ intervention skills | Unclear or inaccurate description of clinical intervention skills and their application | Basic summary of clinical intervention skills, their application.  Demonstrates fidelity to the PWP treatment approach | Coherent and clear summary of clinical intervention skills,  fidelity to the model and approach demonstrated. | Good summary and description of relevant clinical intervention skills  Ability to reflect on their role in the treatment process  fidelity to model and approach demonstrated. |
| **Diagnostic criteria** | Diagnosis is absent, no consideration of diagnostic criteria | Reference to the diagnosis but not explained or justified | Basic consideration of diagnostic criteria  Co-morbidity considered but not in depth  Use of ICD 11 code | coherent consideration of diagnostic criteria fully justified  Good discussion of co-morbidity and differential diagnosis  Use of ICD 11 code | Clear description of diagnosis persuasively justified  Full discussion of co-morbidity and od differential diagnosis with consideration to clinical practice  Use of ICD 11 code |
| **Conceptualization**  **(ABC, 5 areas, COM-B)** | No consideration of conceptualisation of the presenting problem. | Unclear or confused conceptualisation- inaccurate application of framework or model. | Basic, accurate and relevant application of framework or model to guide treatment. | Clear and coherent application of framework or model to guide treatment. | Clear and coherent application of framework or model to guide treatment  Consideration given to the patients presentation and the conceptualisation introduced |

**4. Critical Reflection (30%)**

*The commentary should be balanced, detailing what went well, what was learnt from the session, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Reflective Model (Gibbs)** | Absence of a reflective model. | The trainee refers to a reflective model, but there is little/no evidence of its application to learning. | The trainee outlines and includes a reflective model. There is basic application of the model with clear evidence of learning. | The trainee applies a reflective model to demonstrate coherent and thought provoking reflections and learning. | The trainee applies a reflective model demonstrate coherent and thought provoking reflections  Key learning identified and considerations re how this could be transferred to clinical practice |
| **Links to concepts and Theories** | There are no links to theory or key concepts. | The trainee demonstrates some evidence of knowledge of key concepts and/or theory but this is vague and loosely linked to the reflection. | The trainee links key concepts and theories to substantiate and elaborate upon their reflections. | The trainee links a range of key concepts and theories to substantiate and elaborate upon their reflections. | The trainee skillfully links a wide range of key concepts and theories to substantiate and elaborate upon their reflections in an insightful way. |
| **Action Plan and Conclusion** | No action plan or conclusion drawn. | Brief action plan, lacking in detail. | A basic action plan is outlined and conclusions to learning discussed. | A clear action plan is developed with clear and coherent conclusions drawn from learning. | A detailed action plan is demonstrated with insightful conclusions drawn from learning for example skill techniques, process issues or the evidence |
| **Cultural & ethical factors** | No reference to cultural factors relevant to case.  Identifying details of the trainee, patient or service included in the essay or appendices.  Ethical aspects relevant to case not explored or professionally managed | Insufficient consideration of cultural factors relevant to the case or treatment process.  Insufficient reference made to professional or service guidance.  Ethical issue/s identified but insufficiently or inappropriately addressed | Sufficient consideration of cultural factors relevant to the case or treatment process.  Reflection on cultural or ethical factors relevant to the case | Cultural and ethical aspects are well considered and included where relevant in reflections and analysis of the case.  Consideration given to possible adaptions during the process of assessment and treatment to meet cultural or ethical factors  Consideration of the ethical principles used to inform clinical decisions | Good evidence of highly responsive and detailed consideration of cultural factors and context  Critical analysis and reflections includes sensitive consideration of individual cultural aspects and ability to synthesise within the overall analysis.  Consideration given to possible adaptions during the process of assessment and treatment to meet cultural or ethical factors  Reflection of how the trainee own cultural norms may impact on the process of treatment. |

**5. Use of source material (10%)**

*The commentary should be informed by reference to relevant source material, suitably acknowledged utilising the APA Referencing system.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **References** | No references included | Incomplete or inaccurate references | Complete and accurate references concentrating on well-known articles and/or relevant secondary sources | Complete and accurate references with mainly primary sources and some that are highly relevant to this specific topic | Complete and accurate references with mainly primary sources and several that are highly relevant to this specific topic |

## **Appendix 4: Marking Grid - Case Management Supervision Process Analysis Report**

**1. Demonstration of theoretical knowledge, understanding and application of theory to case management supervision (25%)**

Students should display knowledge and understanding of theories and concepts (relevant to giving information and shared decision making in PWP case management supervision), suitably integrated into their commentary.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Key concepts, theories and research.** | Relevant theories and concepts are not included | Relevant theories and concepts are included, however are described in a superficial way | Relevant theories and concepts are included and are described in a basic, correct and clear way | Relevant theories and concepts are described in a clear, coherent, factually accurate manner.  Consideration and discussion of relevant theories, concepts and research described thoroughly and thoughtfully | Wide range of relevant theories and concepts are considered and discussed thoroughly and thoughtfully.  Consideration is made how this can be transferred to clinical practice |
| **Critique of relevant literature** | No evidence of critical evaluation or synthesis of relevant literature.  No conclusions drawn from the literature | Limited use of appropriate literature, which lacks critical evaluation and synthesis.  Vague or confused conclusions drawn from literature. | Some basic evidence of ability to critique relevant literature and synthesis of different evidence and ideas. Some basic conclusions drawn from literature. | Clear evidence of the ability to critique relevant literature demonstrating synthesis of different evidence and ideas.  Coherent and comprehensive conclusions drawn. | Clear evidence of the ability to critique relevant literature.  Demonstration of highly original synthesis of literature.  Breadth and depth of critique allows novel conclusions to be drawn. |
| **Theoretical Framework or Model** (Reach Out) | No discussion of the model or framework used to guide supervision. | Unclear or inadequate description of the model or framework used to guide supervision. | Basic description of the model or framework used to guide supervision. | Clear and coherent description of the model or framework used to guide supervision. | Clear and insightful description of the model or framework used to guide supervision. |
| **Guidelines** | Absence of relevant guidance | Vague, negligible discussion of guidance | Basic summary of relevant guidance | Clear and coherent summary of relevant guidance | Clear and succinct summary of relevant literature and guidance and the implications for clinical practice |

**2. Structure and Organisation (10%)**

The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with APA guidelines.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Clarity of expression** | Ungrammatical and/or incomprehensible writing throughout | Confusing or unclear writing in several places that made it difficult to understand what was being meant | Clearly written throughout with very few difficulties understanding what was meant | Clearly and coherently written throughout with no difficulties expressing what was meant | Clearly written throughout with a very high level of clarity and expressiveness |
| **Structure and flow of sections** | Confusing or unclear structure throughout  No use of headings | Confusing or unclear structure in several places with insufficient links between sections  Some unclear use of headings | Logical structure throughout with appropriate links between sections  Clear use of headings with very few exceptions | Coherent structure throughout that with consistently good links between different sections  Clear use of headings throughout | Clear sequencing of sections that created a natural flow and/or compelling sense of narrative  Use of headings facilitated the flow between sections |
| **Diagrams, tables and figures** (if used) | Inappropriate and poor use of diagrams, tables or figures  No links to the main text | Confusing or unclear diagrams, tables or figures with insufficient labelling  Very few links to the main text | Basic but comprehensible diagrams, tables or figures with generally clear labelling  Some explicit links to the main text | Clear and coherent diagrams, tables or figures with helpful labelling  Explicit links to the main text that add to the written account | Clear and attractive diagrams, tables or figures with consistently helpful labelling  Explicit links to the main text that complement the written account in a persuasive or innovative way |

**3. Summary of case management supervision (25%)**

Discussion of the students practice performance should be substantiated with reference to particular skills and techniques, with a rationale for their use.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Supervision session summary** | No summary of outcome of supervision | Unclear or irrelevant summary of outcome of supervision | Basic summary of relevant aspects of outcome of supervision | Coherent and clear summary of outcome of supervision | Sophisticated summary of outcome of supervision |
| **Use of CMS skills** | No consideration of relevant supervision skills | Unclear or inaccurate description of supervision skills and their application and adaptation. Vague consideration of adaptations. | Basic summary of supervision skills, their application.  Demonstrates fidelity to the PWP case management approach and consideration of appropriate adaptations to practice. | Coherent and clear summary of supervision skills, demonstrating fidelity to the model and approach with thoughtful consideration around adaptations to practice | Clear and insightful summary and description of relevant supervision skills demonstrating fidelity to model will thorough consideration of skills adaptation of practice.  Ability to reflect on their role in the treatment process |

**4. Critical reflection (30%)**

The commentary should be balanced, detailing what went well, what was learnt from the session, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Reflective Model (Gibbs)** | Absence of a reflective model. | The trainee refers to a reflective model, but there is little/no evidence of its application to learning. | The trainee outlines and includes a reflective model. There is basic application of the model with clear evidence of learning. | The trainee applies a reflective model to demonstrate coherent and thought provoking reflections and learning. | The trainee applies a reflective model to demonstrate their learning in an open minded and insightful way.  Key learning identified and considerations re how this could be transferred to clinical practice |
| **Links to concepts and theories** | There are no links to theory or key concepts. | The trainee demonstrates some evidence of knowledge of key concepts and/or theory but this is vague and loosely linked to the reflection. | The trainee links key concepts and theories to substantiate and elaborate upon their reflections. | The trainee links a range of key concepts and theories to substantiate and elaborate upon their reflections. | The trainee skillfully links a wide range of key concepts and theories to substantiate and elaborate upon their reflections in an insightful way. |
| **Action Plan and Conclusion** | No action plan or conclusion drawn. | Brief action plan, lacking in detail. | A basic action plan is outlined and conclusions to learning discussed. | A clear action plan is developed with clear and coherent conclusions drawn from learning. | A detailed action plan is demonstrated with insightful conclusions drawn from learning.  For example; skill techniques, process issues or the evidence |
| **Cultural & ethical factors** | No reference to relevant cultural factors.  Identifying details of the trainee, supervisor, patient or service included in the essay or appendices.  Ethical aspects relevant to case not explored or professionally managed | Insufficient consideration of relevant cultural factors.  Insufficient reference made to professional or service guidance.  Ethical issue/s identified but insufficiently or inappropriately addressed | Sufficient consideration of relevant cultural factors.  Reflection on relevant cultural or ethical factors. | Cultural and ethical aspects are well considered and included where relevant in reflections and analysis.  Consideration of the ethical principles used to inform clinical decisions | Good evidence of highly responsive and detailed consideration of cultural factors and context.  Critical analysis and reflections includes sensitive consideration of individual cultural aspects and ability to synthesise within the overall analysis.  Reflection of how the trainee’s own cultural norms may impact on the process of supervision. |

**5. Use of source material (10%)**

The commentary should be supported by a good depth and breadth of relevant source material, referenced in line with APA referencing system.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **References** | No references included | Incomplete or inaccurate references | Complete and accurate references concentrating on well-known articles and/or relevant secondary sources | Complete and accurate references with mainly primary sources and some that are highly relevant to this specific topic | Complete and accurate references with mainly primary sources and several that are highly relevant to this specific topic |

## **Appendix 5: Marking Grid - Case Study on a patient from a diverse social and cultural background, with consideration of the role of clinical supervision**

1. **Assessment (25%)**

*Students should demonstrate fidelity to a PWP assessment process, including conceptualization of the problem, problem statement and goals. Provisional diagnostic criteria and guidelines and legislation need to be discussed. Diversity needs clearly stated. Students should demonstrate a good understanding of the principles of diversity management.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear fail**  **(<40)** | **Borderline fail**  **(40-49)** | **Pass**  **(50-59)** | **Good pass**  **(60-69)** | **Distinction**  **(70>)** |
| **Relevant information regarding presenting problem, informed by relevant evidence and theory** | Marked omissions or insufficient information on presenting problem  No connection to evidence or theory. | Incomplete, inconsistent or irrelevant information.  Lack of clarity or confusion regarding problem  Insufficient connection to evidence and or theory | Sufficient detail provided regarding presenting problem  Satisfactorily connected to evidence base. | Presenting problem details clearly outlined.  Good use of evidence. | Presenting problem/s and possible comorbidities clearly outlined enabling a sensitive portrayal of the case.  Evidence very well integrated and well used. |
| **Relevant information regarding diverse need** | Marked omissions or insufficient information on diverse need.  No connection to evidence or theory relating to diverse need. | Lack of clarity or confusion regarding diverse need.  Insufficient connection to evidence and or theory relating to diverse need. | Sufficient detail provided regarding diverse social cultural need.  Theory and evidence presented relating to diverse need. | Diverse need details clearly outlined.  Theory and evidence relating to diverse need is well used. | Diverse needs and possible comorbidities clearly outlined enabling a sensitive portrayal of the case.  Theory and evidence integrated effectively with insightful considerations made |
| **Provisional diagnosis** | Diagnosis is absent, no consideration of diagnostic criteria | Reference to the provisional diagnosis but not explained or justified | Basic consideration of diagnostic criteria - comorbidity considered but not in depth | Clear and coherent consideration of provisional diagnostic criteria fully justified  Good discussion of co-morbidity and of differential diagnosis | Clear description of provisional diagnosis persuasively justified.  Full discussion of co-morbidity and differential diagnosis with consideration to clinical practice of how diagnosis may impact on the process of engaging in guided self-help |
| **National guidelines, policy and legislation relating to mental health needs and diversity issue** | Absence of relevant policy, guidance and legislation | Vague, negligible discussion of policy, guidance and legislation | Basic summary of relevant policy, guidance and legislation | Clear and coherent summary of relevant policy, guidance and legislation | Clear and succinct summary of relevant policy, legislation and guidelines and how this is relevant to clinical practice |
| **Problem statement, conceptualization (5 areas, ABC and COM-B) & goals.** | No presentation of problem statement  No consideration of conceptualization of the presenting problem  No outline of treatment goals or these not related to case | Confused, unclear or non-specific description of problem statement and treatment goals  Unclear or confused conceptualization- inaccurate application of framework or model | Satisfactory problem statement  Treatment goals clear, but not SMART  Basic, accurate and relevant application of framework or model to conceptualize problem and develop consistent adaptations to treatment that is connected to evidence | Coherent and clear identification of the problem via problem statement  SMART treatment goals Clear and coherent application of framework or model to conceptualize problem and develop consistent adaptations to treatment  Theory and evidence well used. | Excellent problem statement and SMART goals.  Clear and coherent application of framework or model to conceptualize problem and develop consistent adaptations to treatment  Theory and evidence integrated effectively. |
| **Cultural & ethical factors** | No reference to cultural factors relevant to case.  Identifying details of the trainee, patient, supervisor or service included in the essay or appendices.  Ethical aspects relevant to case not explored or professionally managed | Insufficient consideration of cultural factors relevant to the case or assessment/treatment process.  Insufficient reference made to professional or service guidance.  Ethical issue/s identified but insufficiently or inappropriately addressed | Sufficient consideration of cultural factors relevant to the case or assessment/treatment process.  Reflection on cultural or ethical factors relevant to the case | Cultural and ethical aspects are well considered and included where relevant in reflections and analysis of the case.  Consideration given to possible adaptions during the process of assessment and treatment to meet cultural or ethical factors  Consideration of the ethical principles used to inform clinical decisions | Good evidence of highly responsive and detailed consideration of cultural factors and context  Critical analysis and reflections includes sensitive consideration of individual cultural aspects and ability to synthesise within the overall analysis.  Consideration given to possible adaptions during the process of assessment and treatment to meet cultural or ethical factors  Reflection of how the trainee own cultural norms may impact on the process of treatment. |

1. **Implementation and Use of Supervision (25%)**

*Discussion of the students practice performance should be supported by reference to the literature on the skills involved in collaborative treatment planning with rationales for how these were adapted and implemented (ensuring fidelity to low intensity approach) to meet diverse patient needs. They should consider the ways in which they used clinical supervision within their treatment planning and within the preparation of adaptations to meet the patient’s needs.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear fail**  **(<40)** | **Borderline fail**  **(40-49)** | **Pass**  **(50-59)** | **Good pass**  **(60-69)** | **Distinction**  **(70>)** |
| **Treatment summary**  **(relevant to specific low intensity intervention and the adaptations made to practice)** | No summary of relevant treatment/ intervention skills  No adaptations of relevant treatment/ intervention skills | Unclear or inaccurate description of clinical intervention skills and their application and adaptation.  Vague consideration of adaptations. | Basic summary of clinical intervention skills, their application.  Demonstrates fidelity to a low intensity treatment approach and consideration of appropriate adaptations to practice. | Coherent and clear summary of clinical intervention skills, demonstrating fidelity to the low intensity model and treatment approach  Thoughtful consideration around adaptations to practice. | Excellent summary and description of relevant low intensity clinical intervention skills  Demonstrating fidelity to low intensity treatment model, but with sufficient flexibility to meet the diverse need. |
| **Clinical supervision used in treatment planning, treatment delivery and endings.** | No consideration of the application of clinical supervision to the case.  No reference made to supervision theory or evidence. | Unclear, vague or incomplete considerations of clinical supervision and links to the case.  Insufficient reference made to supervision theory or evidence. | Basic consideration of the role of clinical supervision within the treatment planning and with regards to the adaptations outlined in the case, treatment and discharge.  Satisfactory reference made to supervision theory or evidence. | Clear and coherent evidence of the effective use of, and application of learning gleaned from, clinical supervision.  Good reference made to supervision theory or evidence. | Insightful and consistent application of engagement and learning from clinical supervision within the treatment planning and with regards to the adaptations outlined in the case and treatment.  Excellent use of supervision theory or evidence. |
| **Outcome measures (IAPT MDS) and changes in general functioning** | No presentation (or interpretation) of results from sessional measures over time.  Measures unreferenced  No reference made to changes in functioning. | Not all measures for all sessions are included  No overview of general post-treatment functioning  Measures unreferenced | Measures for all sessions are included and interpreted  Basic overview of general post-treatment functioning or up to time point in treatment  Referenced measures | Measures for all sessions are included and clearly presented and interpreted.  Coherent and clear overview of general post-treatment functioning with some links to the conceptualisation and treatment  Referenced measures | Measures for all sessions are included and clearly presented and interpreted (e.g. use of graphs and RCI analyses).  Thorough and thoughtful exposition of general post-treatment functioning with clear links between conceptualisation and treatment  Referenced measures |

1. **Critical reflection (30%)**

*The commentary should be analytical in nature and should document what went well and why, and also identify any areas for improvement and saying how and why these might be achieved. There needs to be evidence of engagement with and clear use of clinical supervision (and associated learning) and the analysis should make reference to key supervisory concepts and theories.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Use of a reflective model** | Absence of a reflective model. | The trainee refers to a reflective model, but there is little/no evidence of its effective use or application to learning. | The trainee outlines and includes a reflective model. There is basic use and application of the model with clear evidence of learning. | The trainee applies a reflective model to demonstrate coherent and thought provoking reflections and learning. | The trainee applies a reflective model to demonstrate their learning in an open minded and insightful way. |
| **Links to concepts and theories** | There are no links to treatment theory or key concepts. | The trainee demonstrates some evidence of knowledge of key treatment concepts and/or theory but this is vague and loosely linked to the reflection. | The trainee links key treatment concepts and theories to substantiate and elaborate upon their reflections. | The trainee links a range key of treatment concepts and theories to substantiate and elaborate upon their reflections. | The trainee skillfully links a wide range of key treatment concepts and theories to substantiate and elaborate upon their reflections in an insightful way. |
| **Action plan and conclusion** | No action plan or conclusion drawn. | Brief or unrealistic action plan, lacking in detail. | A basic realistic action plan is outlined and conclusions to learning discussed. | A clear realistic action plan is developed with clear and coherent conclusions drawn from learning. | A detailed (but realistic) action plan is demonstrated with insightful conclusions drawn from learning.  for example skill techniques, process issues or the evidence |

1. **Structure and Organisation (10%)**

*The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with APA guidelines.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Clarity of expression** | Ungrammatical and/or incomprehensible writing throughout | Confusing or unclear writing in several places, that made it difficult to understand what was being meant | Clearly written throughout with very few difficulties understanding what was meant | Clearly and coherently written throughout with no difficulties expressing what was meant | Clearly written throughout with a very high level of clarity and expressiveness |
| **Structure and flow of sections** | Confusing or unclear structure throughout  No use of sub-headings | Confusing or unclear structure in several places with insufficient links between sections  Some unclear use of sub-headings | Logical structure throughout with appropriate links between sections  Clear use of sub-headings with very few exceptions | Coherent structure throughout that with consistently good links between different sections  Clear use of sub-headings throughout | Clear sequencing of sections that created a natural flow and/or compelling sense of narrative  Use of sub-headings facilitated the flow between sections |
| **Diagrams, tables and figures** | No use of diagrams, tables or figures | Confusing or unclear diagrams, tables or figures with insufficient labelling | Basic but comprehensible diagrams, tables or figures with generally clear labelling | Clear and coherent diagrams, tables or figures with helpful labelling | Clear and attractive diagrams, tables or figures with consistently helpful labelling |

1. **Use of source material (10%)**

*The commentary should be supported by a good depth and breadth of relevant source material, referenced in line with APA referencing system.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Clear Fail**  **(<40)** | **Borderline Fail**  **(40-49)** | **Pass**  **(50-59)** | **Pass**  **(60-69)** | **Pass**  **(70>)** |
| **Referencing** | No or too few references included | Incomplete or inaccurate references that are poorly presented | Complete and accurate references concentrating on well-known articles concerning the treatment and diversity need and/or relevant secondary sources | Complete and accurate references, with mainly primary sources and some that are highly relevant to the specific diversity topic. | Complete and accurate references with mainly primary sources and several that are highly relevant to this specific diversity topic |

## **Appendix 6: CAPU – use of Google for sharing files**

**The problem**

In February 2022 the University changed its access requirements in relation to the UniDrive. There is now an additional level of security in place that requires trainees to install a VPN to be able to access UniDrive.

This change creates significant problems across the portfolio of programmes in the Clinical and Applied Psychology Unit (CAPU), with the majority of NHS & 3rd sector organisations not being able to download the VPN software.

**The solution**

The University Information Security team have performed an in-depth Information Security review and have confirmed that we are able to use Google Drive to manage the submission of assessments, without breaching any legal regulations.

* So that you are clear that you are not violating any NHS or other requirements, included in these assurances are Google’s ISO/IEC 27001:2013, ISO/IEC 27017:2015, ISO/IEC 27018, SOC 1, 2 & 3 certifications for the scope of the services provided to the University; and clarification that, by default, Google staff cannot access University data through their services. If you are asked by your NHS IT team, please pass on those details.

In line with the above, Google Drive folders for assessment submission will be created (using limited EU data roaming, rather than worldwide), and all CAPU staff accounts and generic programme accounts will be set up with the same restrictions.

**What will be different and what will be the same?**

Only the process of file transfer has changed, for each tape submission you should upload your submission to the Google Form available on Blackboard for your submission.

Please do not upload directly to your Google Drive folder.

Results for tape submissions/recorded sessions/portfolio submissions will be shared with you via your GoogleDrive folders.

Storage of data will continue to be managed in line with the University retention policy.

## 

## **Appendix 7: Uploading Tapes to Google Drive**

Trainees will be set up as users for their own individual folders on IAPT’s secure shared Google Drive. This will be used to host tapes for assessments, which can then be accessed by the markers. It will also be used to provide written feedback for trainee assessments. For assessed tape submissions, please **clearly label the file with the submission title and the date**. The secure Google Drive is password-protected and only the Course Team has access. Data security regulations mean that trainees are not able to upload directly to their shared Google Drive folder, but the process for uploading a tape is simple. It is the same whether you are uploading from a networked University computer or a remote or unnetworked device.

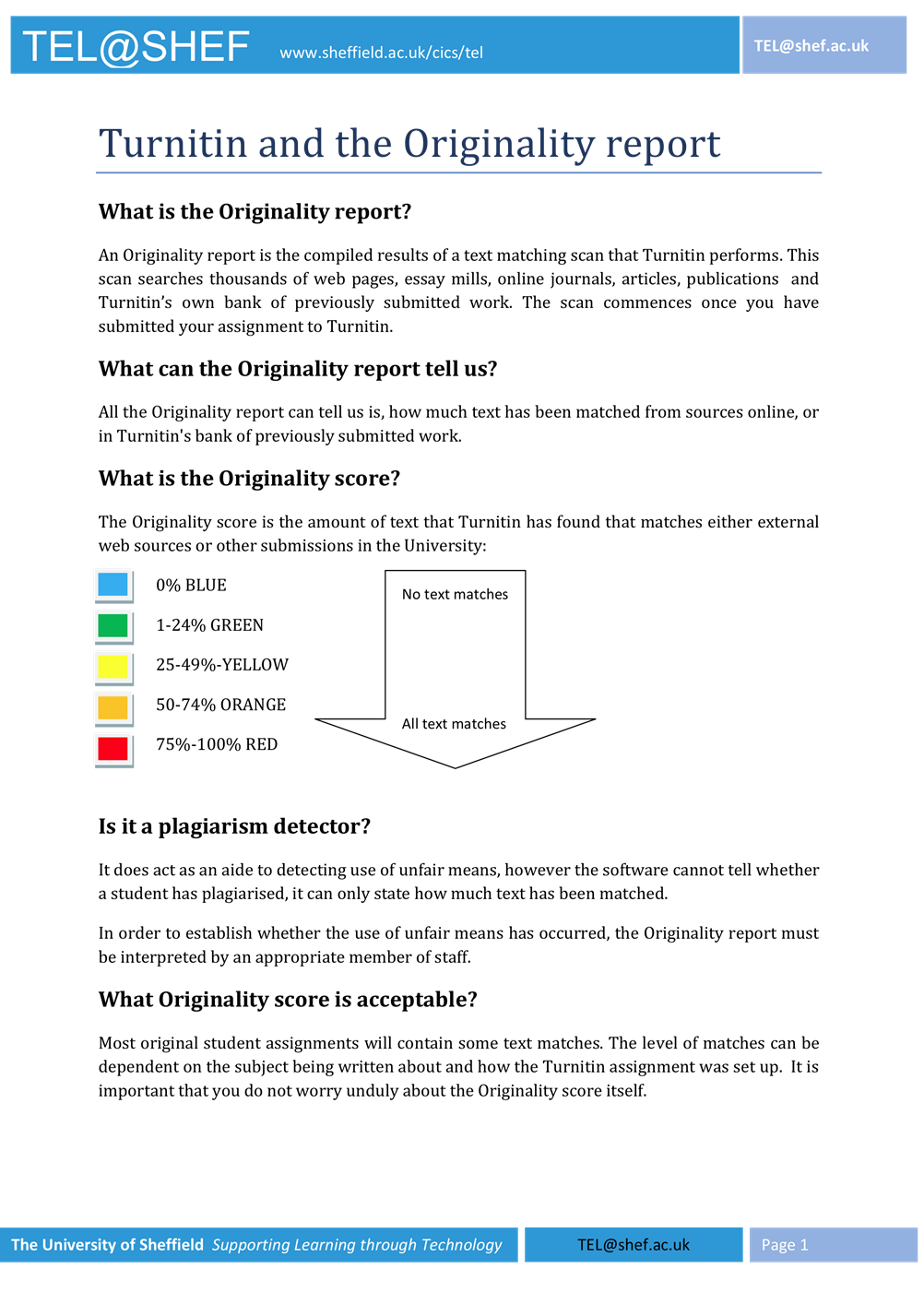
1. Go to <https://www.sheffield.ac.uk/> and log into MUSE.
2. Go to My Services, click “View all services”, then go down the list and select “Blackboard”.
3. Go to your course site, and go to the tab used for Turnitin submissions – this may differ between courses but it is usually titled ‘Assessment Submission’.
4. You should see a submission folder titled ‘Treatment Tape’. Click it.
5. In this folder you should now see just one link, ‘Google form for Treatment Tape upload’. Click it.
6. This will take you to a Google Form. From here, you can upload files from your computer or an encrypted memory stick. Click the ‘Add File’ button below ‘Upload your tape here’ and you can either drag-and-drop a file or select a file from your device. Once selected click ‘Upload’.

Please note that it is not possible to upload more than 5 files at a time, or to upload files that exceed 10GB. If your tape is a very large file, you could compress it to a smaller size before uploading (you may need to download some software to do this, e.g. “HandBrake”). You may also find the uploading process slow, particularly when working from a computer within your service.

Some trainees experience problems uploading due to limitations on service-provided laptops or NHS wifi networks. If you experiencing severe difficulties uploading your tape due to these, you must bring your tape on an encrypted USB stick and upload your tape from a University networked computer. Your deadline will be at 1.30pm on your teaching day or reading week to enable you to submit your tape on a University computer if you cannot submit from a remote location. **Please do not ask the admin staff to upload your tape for you before using a University computer.**

For information relating to the data security of Google Drive as it pertains to NHS data protection regulations, please refer to the advice given in Appendix 6. You should provide this to your service if they have any queries.

## **Appendix 8: Turnitin Originality Report**



## **Appendix 9: Course Policy regarding Technological Difficulties in relation to Coursework Requirements**

Computer malfunction or accidental deletion of information has created difficulties for trainees in the past. According to the regulations, non-submission of work at the appropriate time will normally be graded as failure, with the work, once submitted, treated as a resubmission. Computer failure, accidental deletion of material or some other technological difficulty will **not** be considered as grounds for an extension.

Guidelines for trainees, which should avert this type of difficulty, are outlined below.

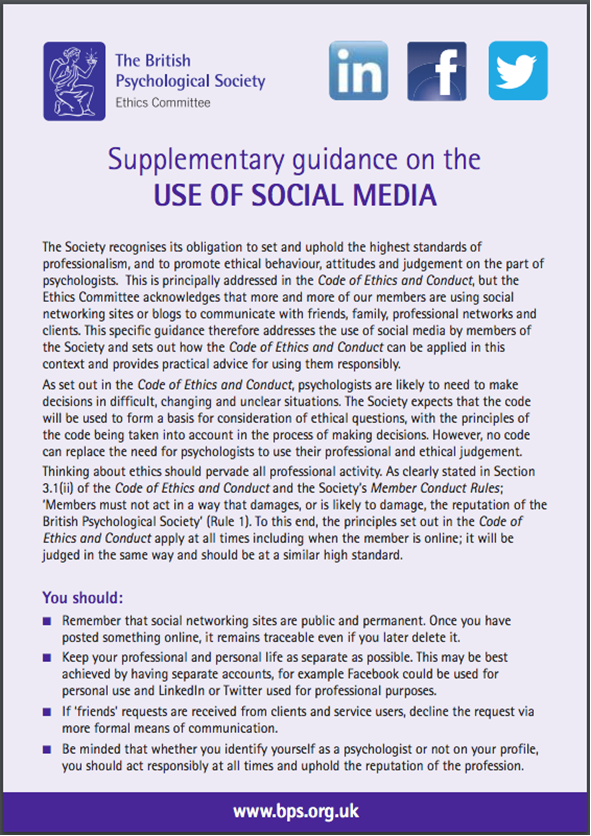
**Computing hints**

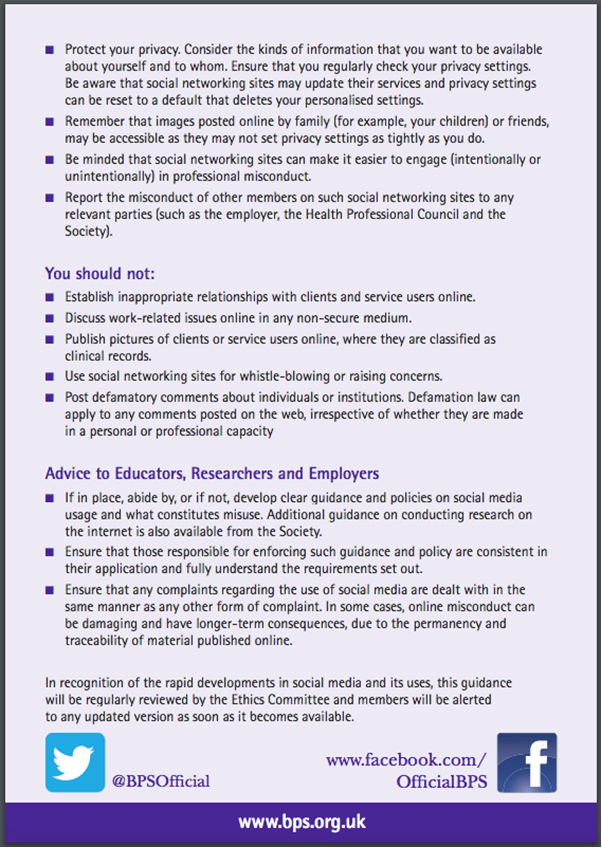
* Ensure that you always back up your file on CD or memory stick.
* Clearly label versions of the document to avoid erroneously deleting the required version.
* Consider using Automatic Save: Tool / Options / Save / Automatic Save Every 10 minutes (This creates a backup file every 10 minutes. It doesn’t change your original until you close the document).
* If you suddenly think you’ve lost a file don’t switch off or quit the program or close anything. There’s a good chance that your file is still there. Get help from the nearest competent person!
* If you have opened an old document, modified, and then unintentionally saved it over the old version, don’t close the program in which it was created. Instead, save the new one with a second name and then use ‘edit’ ‘undo’ multiple times to completely undo all changes to the document. You will then have retrieved the original document.

**Other practical hints**

* Keep a copy of the disk in a different place.
* Make corrections to drafts in pencil so that they can be erased if necessary.
* Print out hard copies of the assignment at draft stage, when close to the final version.
* Print out the final version with at least one or two days to spare.

## **Appendix 10: Social Media Advice**





In addition to the above guidance outlined by the BPS, the University recommends adherence to the following guidance on the use of social media.

Social media can be useful and provide many functions such as support, information sharing and social interaction amongst others. The course encourages the responsible use of social media during training. A particular consideration for trainees is the use of social media messaging groups such as WhatsApp. Please note that social networking sites, including WhatsApp, are public and permanent. Once posted online, information remains traceable even if it has been deleted. Please remember that conversations in forums such as WhatsApp groups are public and are therefore very different to privately held conversations. Therefore, consideration about what are appropriate topics for discussion should be made by all members of social media messaging groups. For example, clinical issues should not be disused, nor should grievances regarding service placements or the University course. During periods of high pressure on the course these groups can become an outlet, which can be helpful or unhelpful. Please be aware that you are responsible for what you share and for whether you chose to participate in these groups or not.

## **Appendix 11: Teaching Recording Policy**

**The Context**

The University of Sheffield has a learning and teaching policy that highlights audio recording of teaching as a means to support access to the taught contact of teaching. Under the Equality Act (2010) the University has a legal obligation to provide reasonable adjustments to enable students with certain disabilities to fully access material provided in lectures. Having access to recording is considered to be such a reasonable adjustment as referenced from <https://students.sheffield.ac.uk/disability/learning-support-plan/teaching>

Rather than this serving as an alternative to attendance to teaching, it is meant to compliment live teaching as another means to continue self-directed study time. Recording of teaching has thus become more normalised through the University of Sheffield.

Developing means of supporting student access to teaching is becoming increasingly important as the number of students with identified learning needs increases. Across the programmes we have a number of trainees with specific learning disabilities (e.g. dyslexia). Trainees with specific learning needs will receive an individualised learning plan from the Dyslexia and Disability Support Service (DDSS), which often includes the recommendation to record teaching. Recordings can facilitate engagement in the teaching session as the student may not need to take concurrent notes, and it provides access to the teaching content for review outside of the teaching session.

**The process**

At the commencement  of their programme of study students sign a consent form agreeing to recording during teaching.

Each of the large teaching rooms within CAPU (Cathedral Court and Solly Street) have [Encore](https://staff.sheffield.ac.uk/it-services/encore) facilities available for recording sessions.

It is an expectation that the majority of teaching sessions will automatically be recorded when using these teaching spaces; however, a speaker will have the right to opt out of having this process. This will be at the discretion of the speaker; for example due to the confidential nature of a session, or having an expert by experience involved who does not consent to being recorded.

Information regarding using Encore will be available in the teaching rooms.

The Encore system should automatically transfer recordings onto the programme’s specific Blackboard sites within 24 hours of a teaching session being delivered for trainees to be able to view.

Recording should not be regarded as a right, and trainees should be sensitive to requests not to record, and bring any concerns regarding such requests to a nominated member of the programme team.

**Confidential and sensitive information**

CAPU programmes will include discussion of confidential and sensitive information (e.g. clinical examples, contribution of experts by experience, and trainee contributions of their experiences). The workshop-style of teaching encourages and supports these contributions. The programme teams would like to continue to retain these valuable elements of teaching whilst supporting trainees with identified disabilities.

It is only theoretical content and didactic aspects of the teaching sessions that we expect to be recorded. Confidential or experiential content will be recorded at the discretion of trainees, speakers or guests. Any party who wishes to opt out must make the speaker aware before sharing. The University Dyslexia and Disability Support Service (DDSS) support the Unit in this decision. The University Dyslexia and Disability Support Service (DDSS) support the Unit in this decision.

**Encore Privacy Policy**

Encore/Echo360 is hosted using the Amazon Web Services cloud, where lecture captures are all held; the datacentre used for this is within the EU. Encore has been rigorously checked over by the University InfoSec team and has been **Data Protection Impact Assessment (**DPIA) approved prior to use.

The system accounts for security by only allowing applicable students/staff of the University to view the content relevant to them. If you have shared a capture to an Encore module, only students/staff assigned to that module on Blackboard/Encore will be able to view the recording; University of Sheffield sign in/credentials are needed in order to access either of these, therefore limiting access to UoS members only. This permission can be revoked at any time by the programme or University by making the video private/inaccessible, or by deleting the web link access.

There's some general Privacy Policy on Echo360's pages here;

<https://echo360.com/privacy/>

<https://echo360.com/platform-privacy-policy/>

If you have any questions please contact your programme administrator.

## **Appendix 12: Department of Psychology Health & Safety Policy**

The Department of Psychology operates its Health & Safety Policy in conjunction with that of the University.

Psychology H&S Handbook is available to view in the Psychology Virtual Office under ‘Health and Safety’.

University of Sheffield, Health & Safety Policy is available on the UoS website at <https://www.sheffield.ac.uk/hs>

The Department operates a Health & Safety Committee, which reports directly to the Head of Department and to the Psychology Staff Committee. It is a conduit for any H & S issues.

Its membership is:

**CHAIR - Head of Department** – Glenn Waller, ext 26624, email g.waller@

**Department Manager** – Annette Butler, ext 26517, email a.n.butler@

**Technical/ Biosafety officer/ Alfred Denny representative** - Melanie Hannah, ext 24670, email m.hannah@

**Department Safety Officer** – Sharon Keighley, ext 26570, email s.keighley@

**DSE assessor** – email psy-safety@

**Workshop representative/ Building Safety** – Andy Ham, ext 26542, email psy-workshop@

Student Representative - tbc

**Laser Safety** – Claire Howarth, ext 26511, email c.howarth@

**Solly Street representative** – Sharon Keighley, email psy-safety@

**Other contacts for H & S issues:**

**Display Screen Equipment: -** email psy-safety@

**Electrical Equipment Testing: -** Andrew Ham, ext 26542, email psy-workshop@

**First Aiders: Cathedral Court-** Sharon Keighley, ext 26570

**Alfred Denny**: - Clare Howarth, ext 26511

Or call Security, ext 24085

**In case of emergency dial ext 4444 or 0114 222 4444**

## **Appendix 13: University Regulations for the Course**

PSYT15 Postgraduate Certificate in Low Intensity Psychological Interventions

1. A student will take: PSY6014 F7 Low Intensity Interventions for Mental Health Problems SPR SEM 19 30; PSY6015 F7 Social Healthcare: Values, Diversity and Context AUT SEM 19 30
2. A person may be admitted as a student who: (a) has a recognised degree at 2:2 or above in a health related discipline or (b) has extensive experience of work in a mental healthcare setting and a demonstrated capacity to work at a master’s level, and will either be employed in a primary care setting or have managerial support for access to patients in primary care settings. Except with the permission of the Faculty it will be a condition of registration that a student is to be an employee of the National Health Service or of an employer deemed to be equivalent.
3. The programme of study will be pursued for one year full-time. Supervised clinical practice will be for a minimum of four days per week in the students’ work place throughout the programme of study with a combined total of 40 hours clinical and case management supervision and 80-150 hours’ clinical practice.
4. A student who fails in any part of the examination may be permitted to retake that part of the examination on one occasion only. Should the second submission fail, the student will be asked to submit mitigating circumstances for the Exam Board to consider. If the Board upholds the presence of mitigating circumstances, then a third and final submission is requested. The second submission will be deemed not assessed and does not count towards the accrued fail total. If mitigating circumstances are not upheld, then the second submission stands. The Exam Board will then take action under the Progress of Students regulations. Should a trainee accrue three fails in any one module at any one time then the Exam Board will take action under the Progress of Students regulations.
5. A student will undertake clinical work including the production of a Practice Portfolio. The Practice Portfolio needs to be passed to pass the course.
6. The student will undertake: a) case management supervision b) clinical supervision c) assessment of clinical competence in the workplace d) reflective writing e) a process review of case management supervision f) assessment of clinical competency in the University and g) observed structured clinical exams.
7. The programme of study will be pursued for one year by a full time student. A single extension to registration of one year is the maximum. Supervised practice in low intensity work in IAPT services will be for a period of four days per week throughout the programme of study.
8. A student who contravenes the standards of conduct, performance and ethics for the British Association of Behavioural and Cognitive Psychotherapy or the Generic Professional Practice Guidelines of the British Psychological Society may be dealt with under General Regulations as to Progress of Students, the General Regulations relating to Student Fitness to Practice or the General Regulations as to the Discipline of Students.
9. No aegrotat award can be made from this programme.