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Please refer to website https://www.sheffield.ac.uk/clinicalpsychology or MOLE for any updates to this Handbook
Introduction

Welcome to the Sheffield Doctorate in Clinical Psychology training programme.

This handbook provides you with information about the programme and comprises four parts: 1) Introductory Handbook, 2) Academic Handbook, 3) Assessment Handbook and 4) Research Handbook. The Clinical Handbook can be found on MOLE. Together these handbooks provide you with most of the information you will need about processes and procedures during your training. The handbooks are updated annually and are available on line.

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1. Introduction

In this section we describe our core purpose as a Unit and our strategy for involving experts by experience in the training programme.

Core Purpose

The vision of the Clinical Psychology Unit that guides all our activities in training and research is

To be an internationally renowned research and training centre in the clinical applications of psychology, and through this, to enhance the psychological health and wellbeing of people across the life span

The core purpose of the DClin Psy Programme is to improve the lives of people who have mental or physical health problems through training high quality evidence-based practitioners whose training is underpinned by innovative approaches to applied clinical and psychological services research. We aim to train high quality future practitioner clinical psychologists who are able to meet and influence the future client and organisational needs of the National Health Service underpinned by innovative approaches to applied clinical and psychological services research. The Programme strives to integrate theory with practice and places importance on conducting and utilizing applied research.

We are committed to valuing diversity, working in partnership with service users and engaging with all our stakeholders in order to provide leadership in developing and applying the complementary paradigms of evidence-based practice and practice-based evidence. We operate in equipoise in relation to the research and clinical paradigms to always ensure the application of the best methodologies to answer the clinical questions at hand. Our expectation is that trainees will leave the programme (1) competent in the delivery of evidence-based, patient-oriented and safe psychological interventions, (2) capable of creativity in applying novel, theory-based approaches to treating psychological disorders where necessary, (3) ready to contribute to the clinical governance agendas of employers, and (4) willing to offer clinical and team leadership in the provision of the highest quality psychological services.

Experts by Experience Involvement

The Programme has established close links and relationships with a wide range and service users and carers over many years. Now regarded as 'Experts by Experience, our colleagues outwith the training course are involved in many co-produced activities. These activities include: Teaching Trainee Clinical Psychologists, which extends beyond more traditional telling one's story as a patient to co-teaching as an expert in their own right. Experts by Experience are also involved in the Selection of Trainee Clinical Psychologists, as an interview panel member. There is involvement in research where appropriate. Trainees are required to demonstrate as part of the research protocol review process, how they have involved experts by experience in their research proposals. Course team staff and Experts by Experience have also co-presented workshops at local and national conferences, providing examples of good practice within the wider training community.

Clinical Psychology Unit vision of ‘Expert by Experience’ Involvement:

- **Value**: To recognize the value of involvement in clinical psychology training (during training and preparation for life as a qualified clinician) and to continue to be open to, reflect on, and learn from the process of involvement

- **Promote involvement**: To continue to develop meaningful, collaborative working partnerships with local community groups, agencies and individuals, and to continue to develop and maintain relationships with Experts by Experience within Sheffield Health and Social Care Trust and other Trusts in the region.

- **Inclusivity**: To continue to consider and implement realistic ways to widen and broaden ‘Expert by Experience’ representation and inclusivity, bearing in mind issues of power, tokenism and institutional barriers to involvement – and in ways that are sustainable over time
• **Intention to change:** To continue to consider, develop and revise methods of involvement on the training course (e.g. teaching, placement feedback and mentoring, attendance at Course Training and sub-committee meetings) and to strive to address, wherever possible, any constraints to involvement (e.g. financial).

• **Impact:** To evaluate the impact of involvement / co-production. We envisage creating a link in with the existing pool of Experts by Experience within Sheffield Health and Social Care and to implement feedback mechanisms for Experts by Experience; to gain feedback from Trainees

**For Experts by Experience:**
- To value the unique contribution of individuals and groups, regardless of disability, ethnicity, gender, age sexuality and all other relevant protected characteristics

- To value and support Experts by Experience by providing clear structures for providing information and gaining feedback; to provide an induction; to provide payment at the standard teaching rate agreed by the University of Sheffield

- To identify the learning and development needs of Experts by Experience and to provide training, support or mentoring as appropriate

**For Trainee Clinical Psychologists:**
- To have direct contact within the University setting with people who use, or who have used, or who support others in using, mental health and psychological health care services

- To provide Trainees with an understanding of what clients may want and need from psychological services – the client experience, the patient journey

- To experience the value and importance of co-production and collaborative working

- To promote a Community Psychology approach and a holistic view of psychological health care and recovery
2. Programme Structure
During the first year, trainees participate in an introductory block (three weeks) consisting of academic teaching and clinical observation/familiarisation. This is normally followed by two five-month placements, separated by a two-week teaching miniblock although there are also a number of year-long placements in the first year. Whilst on placement, trainees attend the University for between one and three days a week during semester time. In subsequent years, trainees attend the University one day a week during semester time, the remaining four days being for private study (1) and clinical work (3). The second year consists of two 5-month placements, and the final year has two five-month specialist placements, which may be combined. In the second year a three-week teaching miniblock precedes the first placement and a one-week teaching miniblock precedes the second placement. In the third year there is a single two-week teaching miniblock at the beginning of the year. The overall structure and important dates are listed in the Programme of Dates (see Appendix 1) and Table 1 provides information on the distribution of time for academic and clinical activity.

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
<th>% over 3 years</th>
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<tbody>
<tr>
<td>Teaching Days</td>
<td>73 (28%)</td>
<td>43 (17%)</td>
<td>38 (14%)</td>
<td>154</td>
<td>20%</td>
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<tr>
<td>Placement days</td>
<td>148 (57%)</td>
<td>144 (56%)</td>
<td>152 (58%)</td>
<td>444</td>
<td>57%</td>
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<tr>
<td>Study days</td>
<td>40 (15%)</td>
<td>68 (26%)</td>
<td>52 (20%)</td>
<td>160</td>
<td>20%</td>
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<tr>
<td>Research days</td>
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<td>4 (1%)</td>
<td>20 (8%)</td>
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<td>3%</td>
</tr>
<tr>
<td>Total days</td>
<td>259</td>
<td>259</td>
<td>262</td>
<td>784</td>
<td>100%</td>
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</tbody>
</table>

Note: Bank holidays are not excluded from placement time – the programme of dates indicates how many bank holidays fall within each placement.

![Balance of Days per year 2018-19](image-url)
3. Organisation

Trainee status

The contract of employment/License to Operate and registration with the University are co-terminus and the trainee signs an Entry Agreement when the offer of training place is made. Trainees are therefore contracted employees of (or hold a License to Operate with) Sheffield Health and Social Care NHS Foundation Trust (SHSC) and are registered as postgraduate students of the University of Sheffield. The employment contract is conditional on being satisfactorily registered with both the University and SHSC. The License to Operate is also conditional on trainees fulfilling both University and placement requirements.

Staff Year Teams

Each cohort of trainees has a staff year team consisting of academic clinical staff and clinical tutors who will oversee their training throughout the 3 years. Staff in the team act as personal and clinical tutors and attend year group meetings for their year group. The aim is to develop strong and sustained relations for each trainee with a small number of the programme team. It may be required that trainees are reassigned academic tutors after research supervisors have been selected to ensure these roles remain separate.

Committee Structure

The Programme Training Committee is the management committee for the Programme and meets twice a year. In addition, the Unit staff meet regularly on Monday mornings either as a whole team, in their year teams or in clinical tutor or academic staff meetings.

The Programme Training Committee (PTC) is responsible for the long-term strategic planning and management of the Doctorate of Clinical Psychology at the University of Sheffield. Its purpose is to provide a forum in which stakeholders associated with the Programme meet to plan, implement and review all aspects of Programme policy. The detailed implementation of the Programme policy is devolved via a sub-committee structure. The latter also includes regular meetings of the Programme Team. The Terms of Reference and membership of PTC are provided in Appendix 2.

The detailed implementation of Programme policy is achieved through the following sub-committees:

- Curriculum
- Selection
- Personal and Professional Development
- Clinical Practice
- Research

Sub-committees are constituted by the PTC, and each has its own terms of reference and membership. Each sub-committee is directly accountable to the PTC and reports back regularly at its meetings. Other sub-committees may be formed at the discretion of the PTC. In addition the Board of Internal Examiners reports back to PTC about general issues regarding assessment and the academic performance of trainees but its business and minutes are kept confidential from the PTC.

The PTC is accountable to the University through the Programme Director, the Head of the Department of Psychology, and the Pro Vice Chancellor of the Faculty of Science. The University is accountable to the purchaser through the training contract.

Other relevant committees and organisations:

Departmental

There is a Psychology Department Staff Meeting, which meets every three weeks each semester and includes a postgraduate representative. The Unit Director also sits on the Department's management group.

Health and Care Professions Council (HCPC)

At the end of training trainees will need to register with HCPC in order to practise as a clinical psychologist. HCPC is the profession's regulatory body. HCPC also approve and monitor practitioner
psychologist programmes. The Programme is currently approved by HCPC. HCPC require the Programme to have trainees’ consent for aspects of teaching; this is set out in the form that trainees sign at the beginning of training.

**British Psychological Society (BPS), the Division of Clinical Psychology (DCP) and the DCP Affiliates Group.**
The BPS functions as both a learned society and also a professional institution. It is responsible for maintaining a voluntary Charter of Registered Psychologists. The profession of clinical psychology is represented by DCP. Trainees can be associated with the DCP either via the local regional branch, which organises regular scientific meetings or via the DCP Affiliates Group, which represents trainee clinical psychologists. Clinical Training programmes within the UK are also accredited through partnership by the BPS via the Committee for Training in Clinical Psychology (CTCP).

In order to enable professional development and to keep abreast of contemporary developments within the profession, trainees are recommended to become members of the BPS and to register provisionally as Chartered Psychologists. There is a local branch of the DCP that meets throughout the year and organises a series of scientific meetings and other CPD activities.

In Summer 2017, the Association of Clinical Psychologists (ACP-UK) was established as an independent professional organisation for clinical psychologists.

**Unite**
This staff association represents the interests of clinical psychologists, and other graduate scientists, within the NHS. Trainees are eligible to join the union.

**How do trainees influence the Programme?**
Trainees contribute to the PTC either through their representatives or by sitting on the various sub-committees. Similarly, supervisors have access to the committee via their Service/Specialty Representatives, membership of the sub-committees or their Special Interest Groups who are represented on relevant sub-committees.

The PTC is the appropriate formal venue for trainee feedback and suggestions for changes in Programme operation and policy. However, there are less formal but, hopefully, equally effective channels. These include informal contacts with Programme staff, and through representations to Personal Mentors, Personal Tutors and Clinical Tutors. There are specific opportunities within the Year Meetings and teaching feedback forms to provide feedback and feedforward information on the academic teaching and other aspect of the programme.
4. Personal and Professional Development
This information provides an overview of the Programme’s policy regarding personal support and professional development as discussed and agreed by the Programme Training Committee. Implementation of the components of the policy is monitored and evaluated by the Personal and Professional Development (PPD) Sub-Committee. We wish to emphasise that there are opportunities for trainees to strongly influence the discussion and implementation of policy changes and this can be achieved through representation on the PPD subcommittee.

The Programme is committed to enabling the personal and professional development of trainees throughout the three years, and regards this area of training as an essential foundation for future professional development and practice. Programme staff recognise that throughout the three years of the Programme, trainees face a variety of challenges that are an ordinary consequence of professional training as a clinical psychologist and that these issues are relevant to both trainee and qualified psychologists.

The Sheffield Programme aims to meet some of these needs via the PPD teaching, which is overseen by the PPD Sub-Committee. Membership of the Sub-Committee comprises an academic programme team member, a clinical tutor representative, a representative from local NHS services, and trainee year representatives. People offering PPD teaching and other programme team members are welcome to attend.

To be effective, aspects of the PPD training require confidentiality for trainees so that individual concerns can be freely expressed without fear of adversely affecting the trainee’s standing with the Programme. On the other hand, it may also be necessary for the Programme Team to be made aware of specific issues arising for trainees out of the training process and to have the opportunity to influence the contents and conduct of the teaching. This balance between confidentiality and communication is an integral part of the PPD process and the PPD Sub-Committee is a useful forum to discuss the way safe and appropriate information is exchanged between the PPD parts of the Programme and the Programme Team.

At the centre of PPD teaching lie three interconnected aims: the importance of learning about self; learning about self in systems and groups; and learning the professional requirements of working as a clinical psychologist. With the first aim, it is considered that the role of the clinical psychologist involves actively working alongside people and systems in distress. Learning about such processes will undoubtedly affect the personhood of the trainee as they develop strategies and skills to manage these processes. Personal development in the role of the clinical psychologist is therefore considered an essential focus of training. The second aim, which underpins PPD is to provide trainees with an opportunity to learn about different types of relationships and people in systems and our responses to them. The final aim is to ensure that trainees know the professional requirements of a clinical psychologist.

These aims are supported through the following:

a) Informal support
The Programme staff hope that by adopting a positive and open attitude to personal support, trainees will feel able to approach any member of the Programme Team or their supervisor for advice on both professional and personal issues. It is up to the trainee to negotiate and establish how confidential or open these discussions can be. For new trainees either prior to or at the very start of their training, a "buddy" system of existing Sheffield trainees is available and organised by the trainees themselves.

b) Personal mentors
The Programme recognises the need for both trainee and qualified psychologists to have opportunities to discuss personal and professional issues, which arise from clinical practice in a confidential and non-evaluative setting. Accordingly, the Personal Mentor scheme has been designed to provide trainees with the opportunity to meet regularly to discuss such issues with an individual who is outside of the formal framework of the Programme but who as a qualified clinical psychologist is aware of, and sympathetic to, the needs of trainees. It should be emphasised that Personal
Mentors are an additional source of support for trainees, and should not replace the usual relationships or functions offered by supervisors, Clinical Tutors and other members of the Programme Team. **Meeting with a Personal Mentor is a mandatory part of the training process.**

The following notes are intended to answer questions about the scheme:

**Aims of the Personal Mentor Scheme**

The aim of the scheme is to provide trainees with the opportunity to meet regularly with a qualified clinical psychologist throughout training to discuss their personal and professional development, in a confidential and non-evaluative setting. The content of these discussions is to be negotiated but might include: professional development, placement experiences, personal issues, academic progress, and difficulties with the Programme etc. It is meant to be a source of personal support, which is available throughout training rather than a crisis support system for trainees experiencing difficulties. However, it is hoped that trainees who are encountering such difficulties will feel able to approach their Personal Mentor for additional support. It should be stressed, however, that Personal Mentors are not available as personal therapists, but might act as an advocate for the trainee to ensure an appropriate referral via the Programme if such action is required.

**Who are Personal Mentors?**

Personal Mentors are qualified clinical psychologists who have expressed an interest and willingness to act in this capacity. Eligibility to occupy the role of mentor includes both a commitment towards supporting trainees through the training process and that the mentor has at least a year's experience of working within the NHS. New trainees are allocated a Personal Mentor by the Chair of the Personal and Professional Development Sub-Committee and/or a Clinical Tutor. The process by which mentors are linked up with trainees is done on the basis of a number of factors, e.g. practical considerations such as minimising travelling time.

**Who manages the process?**

Once Personal Mentors have been allocated, the Chair of the PPD Sub-Committee will inform both parties. The trainee should then take the initiative in contacting their mentor and arranging the initial meeting. It is recommended that particularly during the first year of training, trainee and mentor should meet at least twice a term. It is the trainee's responsibility to arrange meetings and keep in touch with their mentor. We suggest you make first contact within 2 weeks of receiving their details.

Experience suggests that initially it is useful to meet regularly every one or two months so that the trainee and Personal Mentor can have a chance to get to know each other. This might prevent the trainee feeling that there has to be a major problem before they can meet with their Personal Mentor. After the first year of training, meetings should be arranged on the basis of trainee needs and the need to maintain the supportive relationship. It is important that the trainee’s needs in relation to the frequency of meetings be discussed with their Personal Mentor. The trainee should take responsibility for negotiating this with their Mentor.

It is expected that the Mentoring meetings will last throughout training. The boundaries of the relationship and frequency of meetings after the first year are negotiable between mentor and mentee, but discussion of, and agreement on, these are essential. Sometimes trainees have found email contact helpful. Trainees are invited to discuss any difficulties with their personal tutor and/or the Chair of the PPD Sub-Committee.

The expectation is that trainees will visit their mentor during placement time. It is recommended that this is negotiated between trainee and supervisor during the Initial Placement Visit and included in the Placement Contract. Travel expenses can be claimed in the usual way.

**Can a Trainee change his/her Personal Mentor?**

Yes, if difficulties arise between the mentor and the mentee, which cannot be satisfactorily resolved, another mentor can be allocated via the Chair of the PPD Sub-Committee.

**What about confidentiality?**

The Personal Mentor / Mentee relationship is considered a confidential, distinct relationship. Exceptions to this might be when the Personal Mentor, after a full discussion and negotiation with the
trainee, contacts a member of the Programme Team to raise an issue which the trainee is unable to deal with him/herself. Similarly, at the trainee's request, a member of the Programme Team may alert the Personal Mentor to issues affecting the trainee.

In addition, Personal Mentors and trainees have a professional responsibility to break confidentiality should any risk or professional malpractice issues arise. These should be discussed with the trainee’s clinical tutor in the first instance.

*Mentoring around specific minority group issues*
Trainees from a minority group may wish to receive mentoring around specific issues from a clinical psychologist from that group. If this is the case, trainees should approach the Chair of the PPD Sub-Committee.

**c) Peer consultation/supervision**
For a number of years, trainees have been paired with another trainee in their year group for the purpose of peer consultation.

Peer pairs, for the first year of training, are usually initially allocated by the clinical tutors and can remain constant throughout training or can be changed by the trainees or by the clinical tutors. Pairings are usually made on the basis of geography with the aim of minimising the travelling time required for the trainees to meet. It is also important to minimise any disruption to placement/study time.

Trainees must discuss peer supervision arrangements with their placement supervisor. Frequency, length and timings of meetings can be negotiated by the trainees; as a guide, meeting for one to two hours a month would be usual.

In addition to providing a source of support for clinical work and an opportunity to explore issues in training with a peer who does not have a formal evaluation role, peer consultation also offers the opportunity to develop skills in the role of consultant/supervisor. One key aim of taking on the role of facilitating the learning of others is for trainees to explore/develop their clinical leadership and supervision skills.

Trainees may therefore wish to introduce some structure to the sessions, and perhaps use some time at the beginning for contracting, which might include the following points:

- How to divide up the time, e.g. half each or alternate sessions in the role of supervisor/consultant.
- How to agree on the focus of the session (e.g. on a ‘theme’ or on the consultee’s thinking about a person they are working with, what happened in the session, or the feelings induced).
- Exploration of what the consultee finds more helpful – for example, questions, listening or sharing of ideas.
- At the beginning of the session, trainees may want to agree on how to construct an agenda; a useful issue to address is “What does the consultee want to achieve from the consultation session?” The consultant/supervisor can keep checking that they are progressing in this direction.
- Trainees may want to use the session to check out with each other, e.g. “Do you think this work is appropriate for a trainee at my stage of development or should I be asking my supervisor to take a bigger role in it?”
- It is important not to use the consultation sessions instead of the usual supervision arrangements. They should help trainees to use supervision better, for example by gaining confidence in peer consultation to raise an issue with the supervisor and/or practicing how to do this.
- In addition, to inform development as a potential supervisor in the future, peer supervision could be used to potentially explore models and approaches trainees might use and to explore any shifts in power dynamics from being in a peer ‘supervisor’ role.
- It is likely to be helpful to develop a relationship of open communication without fear of negative evaluation by the other. For instance, one person may hold back their own ideas for fear the other will think them poor. It is probably worth discussing this if it seems to be an issue. It may
be particularly pertinent in ‘live’ supervision or joint work. It may also be worth discussing apparent similarities and differences (e.g. interests in different approaches, different backgrounds/cultures etc.) and how these might be used helpfully.

d) Personal and Clinical Tutors
Each trainee is also allocated a Personal and Clinical Tutor. The Personal and Clinical Tutors will be members of a trainee’s Staff Year Team and their roles are to help and support the trainee, to facilitate successful completion of training and act as a first point of contact for the trainee, should an issue arise. Clinical Tutors, who are usually the trainee’s line manager, also help plan and arrange placements and will visit the trainee and supervisor on placement to facilitate the trainee’s learning.

Personal Tutor provide general academic guidance and personal support to the trainee. They also act as a gateway to other support services provided within the Programme Team or by the University and undertake the annual Personal Reviews of a trainee’s progress together with the trainee’s Clinical Tutor.

**Personal and Clinical Tutor Meetings**
The initial meeting between a Trainee and their tutors will be an individual meeting and will usually take place within the first two weeks of term in the first year. Meetings with Clinical Tutors take place at placement visits and can be arranged at other times in addition to this. Personal Tutor sessions will be arranged external to the timetables, with tutors and trainees on an individual basis, with an agreement to meet at least once per semester. Trainees are free to arrange individual meetings with their tutors or to initiate contact via email as necessary.

Personal and Clinical Tutors may also read and comment on draft work. Trainees are required to give at least two weeks for a Tutor to read and comment on drafts. Personal and Clinical Tutors do not normally mark the work of their tutees.

Personal and Clinical Tutors will be responsible for regular review meetings. They are based upon a self-review format and focus on clarifying individual training objectives, providing feedback on performance, overviewing professional development, advising on career options and eliciting feedback from the trainees on the Programme. Personal tutors, if requested, can act as advocates for trainees.

Wherever possible, a trainee will have contact with the same Personal and Clinical Tutors throughout their training. There are circumstances, however, where this is not possible (e.g. study leave, staff changes). In these circumstances, the Programme will allocate the trainee another academic member of the Programme Team who will take on the Personal Tutor Role or another NHS employed staff member as Clinical Tutor.

**Confidentiality**
Personal and Clinical Tutors will provide brief reports to the Programme Team and Exam Board about the progress of individual trainees and may take on the role of advocate if necessary. In relation to more personal information, a Personal/Clinical Tutor would normally always discuss with the trainee the sharing of information. It may be necessary to share information with the Programme Director, Director of Clinical Practice and the Chair of the Exam Board. All information will be handled in a sensitive way. In the event that information is shared with members of the Programme Team, information will remain confidential within the team. Trainees are free to discuss the issue of information sharing with their Personal and/or Clinical Tutor at any time.

**Can a Trainee change his/her Clinical or Personal Tutor?**
Occasionally, difficulties may arise in the relationship between a trainee and their Tutor. In such cases it would normally be expected that these difficulties would be discussed and resolved as far as possible so that the relationship can continue. Indeed, the ability to develop relationships in the presence of difficulties would be considered a fundamental part of the training process. Because of this and because of the practical difficulties involved, a change would not be considered routinely.
However, in exceptional circumstances, where difficulties cannot be resolved satisfactorily, the Programme would wish to support a trainee in changing their Tutor.

- If a trainee is experiencing significant difficulties in the relationship with their Clinical or Personal tutor they can approach the Programme Director or Director of Clinical Practice to discuss possible ways forward
- The aim, wherever possible, would be to address and attempt to resolve the particular difficulty.
- If it is not possible to resolve the difficulty, it may be necessary to change a trainee’s Tutor.
- It should be noted that trainees are encouraged to seek input about any matter from any member of the Programme Team. If a Personal Tutor does not have the knowledge or expertise to address a particular matter, they will be able to re-direct a trainee to an appropriate Programme Team member and this would not constitute grounds for changing a Personal Tutor.

e) Academic Support Sessions
There are academic support sessions timetables within the curriculum. These are meetings focusing on particular pieces of coursework and with the agenda set by Trainees. Trainees are also free to bring academic queries relating to wider coursework or programme completion to these group meetings. The meetings are also a place for discussion of common issues associated with carrying out academic work (such as time management, reading drafts etc.). The discussion in the first year typically focuses on assisting Trainees to successfully complete the Short Answer Questions, begin the ACP1 Literature Review, and to set up single case data collection (in preparation for ACP2). Discussion in later years moves on to focus on the remaining coursework and research.

f) PPD teaching
Several teaching sessions within the Professional Issues Theme will be directly relevant to personal and professional development. These include background sessions about the roles and organisation of clinical psychologists within the NHS, ethics, management issues etc. The PPD teaching runs across the three years of training and is based on a developmental model comprising didactic and experiential teaching in year one, Balint-type groups in year two, and a confidential ‘reflective-practitioner’ (RP) group in year three. Professionals external to the Programme Team who have expertise in working with groups facilitate the Balint and RP groups. For both the Balint and RP components, two parallel groups are run, thereby making the groups smaller. The developmental aim is to move trainees from an awareness of self (year one), through how this interacts with our clinical work (year two), and finally to how we feel, react, and respond when working in teams and with other people more generally (year three). Hence, the teaching provides trainees with a facility that, year on year, promotes mutual support, allows them time to share their experiences, and encourages the integration of personal and professional learning. The teaching objectives are to:

- Help trainees to develop a "tool kit" of personal and professional skills to enable them to function effectively as professionals and for their professional work to be personally beneficial rather than detrimental.
- Facilitate trainees' development of the capacity to integrate personal learning and self-understanding with skill acquisition and with academic knowledge; this integration is seen as central to effective performance of the clinical psychologist's role.
- Provide working insight into the interplay between individual, group and organisational factors in the healthcare delivery system.
- Enhance the trainee group as a source of mutual support, both within the teaching sessions and via informal contacts throughout training.

g) Reflective Practice
Reflective practice involves thinking about personal experiences including feelings, thoughts and actions, both whilst they are taking place and in later review, with the objective of using the reflections to improve upon and develop practice skills.

Background Knowledge in Reflective Practice and Understanding Groups (Year 1)
During the first year, trainees are introduced to the idea of reflective practice during sessions taught by Programme Team staff. In these sessions there is discussion of, and experiential exercises based on, theories of individual learning processes. Trainees are encouraged to develop the capacity to reflect on clinical practice and to create an atmosphere with their peers in which there can be open discussion of the effect of work on emotions; the values, beliefs, life histories and ideas that each group member is bringing to their work; and the personal qualities that can help and hinder them in their work. The implicit rules by which the group is interacting are reviewed from time to time in these sessions.

The Balint Groups (Year 2)
A Balint group is an applied reflective practice tool that draws on concepts from psychoanalytic and open systems theory to provide a structured personal professional development experience. They have been traditionally used in health care settings to strengthen people in their work role, thereby increasing the potential for creative or innovative intervention and thoughtful response when working under pressure. A Balint Group values, makes use of and places each participants’ unique subjective work experience at the heart of the learning in order to develop an increased capacity for personal professional awareness and thus thoughtful response. The aims of the Balint groups are:
- To provide a structured and consistent reflective practice framework for the exploration of personal – professional development whilst in a training role.
- To introduce participants to a deeper understanding of factors occurring “under the surface” when working with clients in distress.
- To help facilitate an effective understanding of the basic elements required in containing the psychological health and safety needs of self and others.
- To help trainees understand the impact of working with ‘fragmented’ states of mind and body on individuals and staff teams – i.e. think about the “emotional toxicity” of the work task.

In the Balint groups each member will have the opportunity to ‘muse’ about a challenging work situation of their choice (e.g. with a particular client or staff group or training experience). Led by experienced facilitator (s) the group reflects upon what they have heard with the aim of deepening understanding of factors impacting on the work task. Each group member will have the experience of, and opportunity to reflect upon, being in the multiple roles of witness, participant and observer.

The Reflective Practitioner (RP) Groups (Year 3)
The group provides an opportunity for trainees to meet regularly with their peers to reflect on their experiences in professional practice. The facilitator’s role is to help the group members to create a relatively safe space in which people can be open about their emotional, intellectual and behavioural responses to their work as clinical psychology trainees. This can include work with clients, responses to the Training Programme and Programme staff, experiences of supervision and NHS contexts and to each other as peers in the training process. Groups also offer an opportunity for trainees to learn together about the emotional experience of training, and of working alongside others with different perspectives. It is the intention that the group should provide an opportunity for trainees to express their uncertainties and reveal their vulnerabilities during the training process. It is to this end that the facilitator plays no other major role in training and confidentiality is maintained within the group except where personal safety might otherwise be compromised. Despite these intentions, participants may experience the full range of emotions and sometimes feel uncomfortable. This in turn might be seen as an opportunity to reflect on the role we might commonly play within groups and on our responses to discomfort should it arise.

The aims of the RP groups are:
- To provide a regular opportunity for trainees to meet to discuss the impact of training and clinical work on their own personal development as professionals.
To provide an opportunity to reflect on and learn about groups, self within a group and team working, including learning about the ways in which each trainee participates in professional groups, what roles they adopt, and how these affect and are affected by the group process.

To provide an opportunity to discuss training issues in a context in which the facilitator is not directly involved in the Programme. This might involve problem solving around issues seen as difficult or problematic within the Programme.

The RP group is not intended as a therapy group for trainees.

Roles

Everyone
The tasks of the facilitator and trainee include:
- Helping to create a kind and thoughtful environment

Facilitator
The tasks of the facilitator include:
- Creating a climate of trust and safety
- Ensuring that ground rules and frameworks for working together are discussed and agreed in a timely fashion and revisited when necessary
- Keeping the group to its agreed session focus and tasks
- Encouraging critical reflection
- Suggesting alternative views/ new ways forward

Trainee
The tasks of the trainee include:
- Discussing and agreeing ground rules and frameworks for working in the group
- Being prepared to talk about and reflect on problematic aspects of training
- Considering cultural, social, ethical and personal issues that may impact on the above
- Listening to and considering others’ ideas in relation to one’s own material
- Reflecting/engaging and participating in discussion regarding what roles they might adopt, and how these affect and are affected by the group process.
- Suggesting alternative views/ new ways forward

h) Personal Therapy
Although the PPD teaching aims to provide opportunities for mutual support and for trainees to learn about how personal concerns interact with professional development and activities, this does not entail personal therapy. Whilst the Programme cannot resource personal therapy, trainees who require individual therapy can approach any member of the Programme Team directly or indirectly who will consult and advise on taking this forward. Any such approach will be treated in confidence and not construed as a sign of weakness. Some circumstances will require communicating to placement supervisors and/or other staff and this will usually take place in negotiation with the trainee. The Programme will also endeavour to be flexible in order to help trainees who are experiencing personal difficulties to meet their training objectives wherever possible. Trainees are encouraged to inform Programme Staff if they are experiencing such difficulties. Under these circumstances trainees are, of course, also free to approach the University Counselling Service or Workplace Well-Being (available to SHSC employees).

The Programme Training Committee has endorsed the following Personal Therapy statement:

- We acknowledge that there are disparate views in the profession about the appropriateness of personal therapy as a component in clinical training.
- The Programme wishes to support those trainees who take the responsibility for engaging in individual therapy.
- The choice of the therapist is a matter for the trainee concerned but staff, mentors and other trainees may be approached for discussion.
• The Programme does not envisage providing financial support for therapy but may advise trainees with negotiation for reasonable fees.
• We acknowledge that therapy may only be available during office hours but we expect trainees to think through the implications of the timing of therapy in relation to professional issues.

i) Disability
We aim to be proactive in supporting trainees with a disability or long term health condition, which affects capacity in relation to work, to access all aspects of the Programme where possible. We strongly encourage trainees to make early contact with the University Disability and Dyslexia Support Service, for an assessment of support needs. The principle is that the support enables the trainee to access the Programme and the standards for assessment and successful completion remains the same as for any trainee.

Within the Unit we offer a meeting between trainee, clinical tutor and personal tutor, facilitated by the Disability Liaison Officer to assess what reasonable adjustments can be made across all areas of the Programme. This is subject as a minimum to annual review but can be reviewed at any point in terms of appropriateness of implementation at the instigation of trainee or Programme team. This process is also available to trainees who develop a disability or long-term health problem at any point during training.

Summary
We are aware that these systems are flexible and adaptable and that different trainees will use them differently at different times. However, the PPD system is considered a mandatory part of the training experience and should not be considered an optional 'add-on', to be used solely in times of personal crisis. Rather, the personal and professional development process is seen as providing trainees with space and opportunity to reflect on self in work. It is considered a lifelong process that will be continued throughout the career of the individual. Finally, the Programme also acknowledges that the PPD system is not perfect and will be influenced each year by the needs, views and experiences of each training group. Accordingly, the Personal and Professional Development Sub-Committee will review the PPD procedures annually. Please keep us informed as to whether these systems are meeting your needs, through you trainee representatives on the PPD subcommittee.
5. Practical Information

Professional Responsibilities

Attendance for teaching sessions

Attendance at all teaching sessions (including PPD sessions, seminars, year meetings, selection interviews etc.) is compulsory. 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 Director of Clinical Practice. It is the trainee’s responsibility to ensure they have obtained any notes or handouts relevant to the teaching session(s) missed. In the case of illness on academic, placement or study days a trainee should notify Jacquie Howard by telephone NOT e-mail (0114 2226576). On placement days supervisors should also be contacted and, in all cases, the relevant clinical tutor must also be notified. If any period of absence extends to a period requiring a sick note to Sheffield Health and Social Care Trust, then the University must also be informed, even if this is out of term time. Trainees must also inform the clinical tutors (via Jacquie Howard) of their return to work on the day of return.

Attendance Monitoring on Teaching Days

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

Procedure:

1. The register will be left clearly visible outside both teaching rooms prior to the beginning of the teaching session in the mornings and afternoons. All trainees present will be expected to sign the register prior to the start of the teaching session. A member of the administrative staff will collect the register after each teaching session.

2. Any trainee arriving late will need to go to the office in CPU to sign the register and give a reason for their lateness.

3. Jacquie Howard will liaise with other admin staff and confirm any trainee’s authorised absences (sick, annual or carer leave). The trainee must ring Jacquie directly (tel no: 0114 222 6576) if they are off sick and also on their return. Jacquie must also be informed of any doctor’s appointments. Trainees must not e-mail Jacquie with this information as, if Jacquie is away, no one else is able to access her e-mails.

4. If the trainee is not present and does not have authorised leave, this will be classed as unauthorised leave. In this situation, action must be taken that day to ensure trainee safety. Jacquie will therefore inform the relevant manager/clinical tutor to take this action. If the clinical tutor is unavailable that day, Jacquie will inform Liza Monaghan. If Liza is not available, Jacquie will inform one of the other clinical tutors. To ensure the safety of the trainee, the following action will be taken. If the first action is not successful, the second will be implemented and so on:
   i) Year group members will be contacted for any information on the trainee’s whereabouts.
   ii) Every effort will be made to contact the trainee (trainees must ensure the office has complete and up-to-date information on home/mobile phones).
   iii) Emergency contact numbers and next of kin numbers will be utilised. A decision regarding any further action will be taken, taking into account the individual circumstances of the trainee.

   We hope that these situations will rarely/never arise and to avoid this, trainees should be aware of their responsibilities as NHS employees, and inform the University of their whereabouts.

5. 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 trainee’s clinical tutor for action. The tutor will discuss any reasons for lateness and any support needs for the trainee, and also help ensure the appropriate coverage of any missed teaching.
The only information recorded on the register will be annual leave, authorised leave, late or unauthorised leave. Jacquie will hold any further relevant details.

Programme policy on taking holiday leave during term time- See Appendix 3 for details

Travel expenses / Annual Leave / Study leave / Carer Leave
It is part of the professional responsibility of trainees that they liaise appropriately with their clinical tutor in the first instance. It is important that trainees follow the correct procedures when applying for all types of leave and that they have discussed the reasons for the leave request and have gained formal clinical tutor support. Arrangements for taking leave, claiming expenses etc are usually in line with NHS policies and procedures. See Trainee Information Pack for more detail.

Timekeeping
Trainees are expected to be punctual in their attendance at teaching sessions, meetings and appointments.

Dress
Dress while on placement should be in keeping with the role of a trainee professional. Different clinical settings make different demands. Trainees need to be sensitive to the requirements of the situation and dress in a way that will not inhibit their effectiveness.

Facilities
Access
The CPU is based on F Floor of Cathedral Court, trainees will have access to this building between 8.00am and 6.00pm. Swipe access will be granted to each of the floors via trainees’ student Ucard. Trainees can access the Psychology building to use the computers on Floor D between 8.00am and 6.00pm, if you wish to stay later then you will need to apply for Out of Hours access. Further information is available from the Unit Administrator.

Access to the Admin Staff is only possible during office hours (9.00am – 4.30pm), you will need to knock and be granted entry due to this being a staff access only area.

Trainees should also ensure that they familiarise themselves with the University’s Health and Safety Procedures https://hs.shef.ac.uk/). Departmental Health and Safety details are provided in Appendix 4.

Mail
Individual pigeonholes are available for trainees in the social space adjacent to the entrance.

Secretarial Support
All clinical correspondence (e.g. letters to clients, GPs, clinical reports etc.) should be produced on placement premises where adequate secretarial support should be available. Secretarial staff are unable to provide any typing for trainees. Trainees should be aware of the need to ensure that confidential information is secure on any computer that they use.

IT Resources
Trainees have access to a range of IT resources within the Psychology Department. There is a large PC suite on D floor with a couple of additional machines on F floor within the CPU. All PCs are connected to MSP printer which allows trainees to photocopy, print and scan documents. PGR trainees can print free of charge from the MSP machines in the Psychology department. In addition, there is a laptop available to book through Rachel Hill with access to Sheffield Health & Social Care’s intranet.

Supported software in the CPU includes analysis packages to support qualitative and quantitative research. Trainees also have access to a database of local supervisors and specialist placement opportunities.
The University’s Corporate Information and Computing Services (CICS) issue trainees with a computer account, including University email. Trainees can access the University portal ‘MUSE’, which gives secure access to online university resources from any computer inside or outside the University, including email; a file store for saving work; library resources (see below) and the programme’s ‘MOLE’ pages.

A large amount of information and documentation relating to the programme is available online via ‘MOLE’ (My Online Learning Environment) - including General Office forms, copies of teaching timetables and detailed information about the DClin Psy research process. In addition, the CPU website contains some useful resources, as well as DClin Psy staff pages and general information about the programme (www.sheffield.ac.uk/clinicalpsychology).

Scheduled teaching on computing skills, as well as an introduction to using MOLE and the University web portal ‘MUSE’ is provided. The Psychology IT support staff can best be contacted by email (psy-it@sheffield.ac.uk).

Library Resources
Trainees have lending privileges at all University libraries, including the Information Commons, The Diamond, the Main University Library and the Hallamshire and Northern General Hospital Libraries. Library holdings can be searched online, via the STAR library catalogue. Guideline for use of the Document Supply services can be found on MOLE.

A number of library resources are available online (accessible via MUSE), including electronic journals and literature searching databases such as PsycINFO and Web of Science. Teaching on electronic searching is provided in the first year of the programme.

Further information about University library resources, and access to the STAR library catalogue can be found at: http://www.shef.ac.uk/library/index.html

Loaning Equipment
Within the CPU, there is a Resource Library, which includes a range of psychometric tests and clinical resource materials, DClin Psy theses and publications from past trainees are available to view on MOLE.

The CPU has a stock of recording equipment that is available for loan to trainees. Equipment for loan includes encrypted digital recorders, encrypted memory sticks, and encrypted tablets and should be borrowed via the Research Support Secretary. Guidelines on digital recording and informed consent are available in the Trainee Information Pack on MOLE

Useful names and addresses
These are provided in Appendix 5.
Academic Handbook

Teaching
Curriculum Design
The Programme’s required learning outcomes are grouped into four areas: Knowledge and Understanding; Transferable skills; Subject Specific skills; Personal and Professional skills.

The overall aim of the Sheffield DClinPsy curriculum reflects these learning outcomes, and supports trainees’ to understand the application of psychological theory and science to the promotion and improvement of mental health and well-being. The curriculum is structured to support learning and skills development in relation to the following three domains: direct clinical work; indirect and organisational work; research and service evaluation.

Each of the three domains runs through the three years of training, to varying degrees of emphasis in accordance with the level of training and placement structure. Such that, in year 1 the intended learning outcomes primarily focus on working with adults, mostly via direct clinical work; in year 2, the intended learning outcomes extend to indirect working at the systems and organisational level, developing this work with children, families and people with a learning disability; and in year 3 intended learning outcomes include working with more complex issues, and extension and consolidation of learning and skills achieved in years 1 and 2. In this way, the curriculum is designed to be developmental; the second year builds on skills and knowledge gained in the first year, and the third year similarly builds on first and second year teaching.

Teaching Administration
The curriculum co-ordinator is responsible for overseeing the content of the curriculum. The timetable administrator, Sharon Keighley, is responsible for managing teaching arrangements and for maintenance of online information/ materials and can be contacted on 0114 2226570.

The curriculum is response to HCPC and BPS accreditation criteria, developments in the evidence-base, local clinical expertise and need, and feedback on teaching. The integration and coherence of the timetables is realised by appropriate links between external speakers and Programme team members. Specialist topic areas, that represent local service structures, are nested within the themes. These specialisms allow programme team members to liaise with appropriate advisors within the NHS (see Table 2). Each specialism represented in the timetable has a designated programme link from the programme team. This team member maintains links with relevant Faculties and Special Interest Groups where appropriate, ensures appropriate coverage and advises the curriculum co-ordinator on appropriate external speakers.

NHS Advisors
To ensure the curriculum reflects current best practice and service developments, NHS advisors drawn from services, specialities, Faculties and SIGs are invited to sit on the CSC. Specifically these advisors aid in the setting of teaching objectives and planning teaching content. They advise on identifying speakers and allocating teaching hours. NHS advisors also provide an additional link to local Faculties/ SIGs where appropriate.

Table 2. CSC and NHS Advisors

<table>
<thead>
<tr>
<th>Service/ Speciality</th>
<th>Programme Team Link</th>
<th>Advisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental health</td>
<td>Jaime Delgadillo</td>
<td>Teresa Hagan</td>
</tr>
<tr>
<td>Child/ Adolescent</td>
<td>Shona Goodall</td>
<td>Fiona Myles</td>
</tr>
<tr>
<td>Forensic</td>
<td>Georgina Rowse</td>
<td>Rhodri Hannan</td>
</tr>
<tr>
<td>Clinical Health Psychology</td>
<td>Andrew Thompson</td>
<td>Maria Jarman</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Katherine Hildyard</td>
<td>Nigel Beal</td>
</tr>
<tr>
<td>Neuropsychology</td>
<td>Gillian Hardy</td>
<td>Hazel Reynders/ Pete Walpole</td>
</tr>
<tr>
<td>Older Adults</td>
<td>tbc</td>
<td>Jo Hawker</td>
</tr>
<tr>
<td>Psychosis &amp; Recovery</td>
<td>Georgina Rowse</td>
<td>Sue Martindale</td>
</tr>
</tbody>
</table>
How the timetable is organised
Timetable content relating to clinical specialisms is reviewed by relevant Programme Team Links in consultation with NHS Advisors, Special Interest Groups/Faculties and Teachers. Proposed alterations and updates to timetable content are reviewed each year at the beginning of the Spring Semester, and reported at the June meeting of the Curriculum Sub-Committee. Changes to the timetable will also be made as a consequence of trainee feedback. Provisional timetables, together with a programme of dates, are circulated to Programme staff during April. Changes to the timetable are co-ordinated by the Curriculum Administrator. A final timetable is circulated to trainees and supervisors by the start of the semester.

Programme feedback from trainees and speakers
The aims of the feedback system are:
• To enable Programme team members and teachers to adjust the teaching programme appropriately, bearing in mind responses to structure, teaching style, organisation and presentation of content etc.
• To facilitate a more formal feedback process for trainees enabling them to highlight their perception of strengths and weaknesses of the teaching programme with the potential for making good any significant deficits or repetitions.

The feedback process is as follows:
• Trainees complete electronic feedback forms within 1 week of the teaching session. Trainees are emailed a link to an online survey immediately after each teaching session. A reminder email is sent after 3 days to those who have not yet completed the feedback.
• Trainees are reminded to keep in mind the aims of the feedback i.e. for comments to be constructive and helpful to the process of adjustment.
• The completed feedback data is collated and reviewed by the programme team link. After review, the feedback is sent to the speaker. If for any reason feedback is not sent to the speaker, then the programme team link or curriculum co-ordinator will contact the speaker to discuss the feedback.
• The programme retains an electronic copy of all feedback.

Trainee feedback is anonymous. However, if concern is raised with regard to inappropriate or unprofessional (directly offensive or derogatory comments), then the programme team may decide to trace the feedback of individual trainees. This situation is extremely rare, and trainees are encouraged to make honest and constructive feedback. All feedback will always remain anonymous to speakers.

The feedback and teaching content are reviewed by the programme team links and curriculum co-ordinator to ensure that the teaching is of a standard in line with University quality assurance. Where consistent issues are identified with any one specific teaching session (consistent feedback over three consecutive years; or an urgent issue raised within one year), the curriculum coordinator will liaise directly with the speaker regarding this feedback and their contribution to the programme curriculum. This may also involve a direct observation of this teaching session. Further support within teaching would be provided to the speaker where any specific needs were identified.

Feedback about the overall teaching programme, gaps and overlaps etc. is obtained by year tutors within the year group meeting at the end of each semester and by the CSC representatives for the year group. This information is fed back to the CSC to allow any relevant action to be taken.
External teachers are also invited to complete feedback on the planning and co-ordination of their input with the programme team link or curriculum co-ordinator, and the adequacy of the background information and facilities required for their teaching. They are also asked about the interaction with the trainees, and whether they are happy to teach subsequent years. This feedback is collated to allow general themes to be identified and where appropriate acted on.

These formal policies will enable staff to know and act upon any areas where the quality of teaching is in doubt. In addition, the member of staff who is responsible for a specialist area of teaching will hold review meetings at least every three years with all people involved in teaching this topic to update and consider new teaching methods etc. The University provides high quality workshops on up to date teaching methods. All teachers, including external teachers are able to access these workshops.

**Year Meetings**

*Purpose*

Year meetings serve two main functions. Firstly, they are a regularly scheduled opportunity for all trainees to give feedback to staff about the programme and raise any issues of concern in an informal atmosphere. Secondly, they provide an opportunity for staff to give information about any changes being contemplated, to raise any of their concerns and to ask for trainee comments on specific issues. The aim is to facilitate open, effective and constructive communication. Issues raised by trainees in this forum will subsequently be discussed by the programme team and any decisions fed back either prior to or at the next year meeting.

*Frequency of meetings*

Two meetings are scheduled each year, one in each semester for years one and two, and one for year three. Members of the staff year team will be present at these meetings throughout the programme for each group of trainees. Any other member of the programme team may also attend (given sufficient notice and taking account of other commitments) if there are specific issues, which require their input.

*Organisation of the meetings*

Trainees should choose a chair and secretary among themselves for each meeting if possible. Items for discussion would need to be submitted to the secretary a week before the meeting. The secretary will need to circulate the agenda by lunchtime on the day of the meeting. A copy of word processed minutes should be emailed to the Unit Administrator within 7 days of the meeting and these will be circulated to the Programme Team. The functions of the chairperson are to summarise the discussions and keep the meeting to time.

**Clinical Psychology Seminars**

A programme of seminars is organised throughout the year normally on a Monday or Tuesday from 4.00 - 5.00 pm. University staff and NHS psychologists from local services are also invited. All trainees and programme staff are encouraged to suggest names of speakers and appropriate topics (suggestions to Sharon Keighley) **Seminars form a standard part of the teaching programme and as such attendance is mandatory for trainees on a teaching day. Other trainees are also encouraged to attend if a seminar falls on their study day or at the end of their placement day.** Further details of forthcoming seminars are available on the CPU website: http://www.shef.ac.uk/clinicalpsychology/news.

http://www.shef.ac.uk/clinicalpsychology/news.
Trainee presentations

Introduction
Several different seminar slots and meetings are incorporated into the timetable. Their overall purpose is to provide more informal opportunities for learning and also to facilitate communication within the programme. During all three years trainees participate in case presentations.

Guidelines for Case Presentations
Case Presentations are a mandatory part of the programme. They provide an opportunity for trainees to develop their presentation skills and to benefit from discussion of clinical work within a peer group setting. A member of the staff year team also attends the case presentations. Trainees will be required to assess their own performance and will receive formative feedback from the staff member. Whilst this is not part of the formal assessment process, trainees’ self-evaluation and the tutor’s comments can be used to inform the annual Personal Review process.

The aims of the case presentations are to provide an opportunity to present and share clinical work with other trainees. Specifically to:
- present clinical formulation embedded within the available evidence based literature
- facilitate discussion of clinical work, allowing new ideas to be considered
- self-evaluate and obtain feedback on presentation skills

Presentations will be timetabled according to the following structure:

Year 1
Trainees will present to their own year and will also receive timetabled slots to hear case presentations from Year 2 trainees in mixed groups (Yr1 & Yr2).

Year 2
Trainees will present to a mixed group of Year 1 and Year 2 trainees and will also hear case presentations from Year 3 trainees in mixed groups (Yr2 & Yr3).

Year 3
Trainees will present to a mixed group of Year 2 and Year 3 trainees.

Procedure
- Select a piece of work to be presented. This would usually be a piece of individual work although one of the three presentations may be focused on group interventions, staff training or consultation (see note regarding third year presentations below). Normally this work should not overlap with ACP or Clinical Practice Report submissions. If in doubt please seek advice from your personal/clinical tutor. The presentation should last about 15-20 minutes, allowing 10 minutes at the end for discussion.
- Trainees should complete the self-evaluation form (available on MOLE) within a week of their presentation and return this to the member of staff who will add their feedback. This form will then be returned to the trainee and a copy will be kept on file as evidence that this part of the programme has been completed, and for use in the Personal Review process. Trainees can arrange to meet with staff members if they would like to discuss the presentation or feedback. Trainees may also if they wish seek feedback from the trainee group and include this on their form.

Choosing work to present
- The case presentations are designed as opportunities to practice presenting to others and to share and discuss clinical work. Any case can be suitable. The work does not have to be perfect, with a successful outcome, and extensive notes. An early or provisional formulation may be sufficient (although some attempt at a formulation should be presented). An unsuccessful case, or one where a therapist is feeling ‘blocked’, or progress differs from what is expected on the basis of the available evidence base, may be a good basis for discussion. A ‘good’ case is one with opportunities for the presenter and the group to learn mutually from the presentation. Appropriate self-disclosure and consideration of issues of diversity and inter-professional issues is encouraged.
- The case presentation session should be used to explore work other than that described in the reports of clinical practice, as the case presentations are conceived of as being independent from
the case study. The presentation provides an opportunity to focus in depth on an additional piece of coursework, explore dilemmas, gain ideas and enhance the breadth of training.

Structure
Presentations should usually be on PowerPoint but other methods of presentation can also be arranged with prior consultation with the office staff and facilitating member of staff. **Trainees should ensure that presentations are appropriately anonymous.** There is not a set structure to the presentations and the following headings can be used as a guide for preparation:

**Assessment only work:**
- Reason for selection of this work for presentation and aims
- Referral - method of referral; referral agent; information available; reason for selection of this work for presentation.
- Assessment - rationale for selection of assessment procedures; what alternatives were considered but rejected and the rationale for this; the construction and development of instruments where appropriate, any literature suggesting that they might be effective in answering the assessment questions posed.
- Assessment findings and interpretation. Identification of problem(s) and strengths - major and subsidiary problems; problems not identified upon referral; problem for whom; existing coping strategies; diversity issues?
- Formulation(s) in psychological terms (with reference to the literature and relevant NHS or BPS guidelines). Rationale for future intervention and implications for the client (in terms of risk management or/and treatment choice).
- How information was communicated (e.g. letters, reports, verbally) to others (including client, colleagues, referral agent, significant others).
- Perspective of the service user(s) on the work carried out.
- Summary of what has been learnt.

**Assessment & intervention work:**
Any of the above plus:
- Intervention options considered - relationship to formulation(s) and to the literature and relevant guidelines.
- Nature of any intervention process; nature of the therapeutic relationship.
- Reformulations and revisions of intervention where appropriate.
- Maintenance - how planned; what follow-up expected; preparation for relapse.
- Evaluation of outcomes - how measured; how effective and in what way; side effects (positive and/or negative); present data to back up your conclusions.
- Any communications back to referral agencies.
- Critical assessment of the case – what might be different in hindsight; any alternative formulations or strategies that might have been considered; could work have been more effective; how unsuccessful work is accounted for; was choice of outcome measures the best?

All case presentations should include some consideration of relationships and process issues, as well as diversity and interprofessional issues evident in the work. Time should be available for discussion at the end of the presentation. The trainee who is presenting would normally facilitate this.

**Note regarding Year 3 case presentations.**
In Year 3 trainees may choose to present an overview of clinical work in a specialist placement. The aim of these presentations would be to provide trainees with the opportunity to learn more about ways of working in different specialties enabling them to make links between the ways which trainees work on their own placement setting and ways of working in other domains. The following may be considered when making such a presentation:
- information about the clinical settings/ team
- the nature of the referrals
- any indirect work or consultation
- discussion of any new theoretical models/ approaches that may be unique/ particular to the setting, e.g., physical health, forensic settings, etc.
• typical presenting clinical issues, which could be illustrated with case vignettes, or more detailed case formulations
• consideration of a service development or community psychology perspective

Please note that it is a programme requirement to do a presentation each year. If you are unable to present due to illness, annual leave etc., you should arrange an alternative presentation slot in consultation with your year group and staff team.

Guidelines for Research presentations

Introduction
Research Presentations are timetabled at the start of year 2 to facilitate the development of feasible protocols. They also provide an opportunity for trainees to further develop their presentation skills and to benefit from discussion of their planned research within a peer group setting. The year group will be divided into two groups for presentations slots in advance of the presentation dates. Presentations are also attended by an academic member of the programme team, usually one of the research tutors, who will also contribute to the discussion.

All trainees are required to present and will be required to complete a self-evaluation form following the presentation.

Aims
• To provide an opportunity to present the proposed thesis study.
• To provide an opportunity for peer and tutor support in the development of a feasible study.
• To provide an opportunity to further develop presentation skills.

Procedure
• The presentation should last about 15 minutes, allowing 10 minutes at the end for discussion.
• Trainees may use the space to request future peer support (for example if volunteers are needed for inter-rater reliability or auditing are required).
• Trainees should complete the self-evaluation form (available on MOLE) within a week of their presentation and return this to the member of staff who will add their feedback. This form will then be returned to the trainee and a copy will be kept on file as evidence that this part of the programme has been completed, and for use in the Personal Review process. Trainees may also if they wish seek feedback from the trainee group and include this on their form.

Structure
Presentations should usually be on PowerPoint. The structure of the research presentations is flexible but the following points of guidance will be helpful in considering what to present:
• a brief critical review of the extant literature
• a rationale for why the proposed study is worthy of being conducted (this might include theoretical and clinical implications)
• discussion of proposed methods. This would usually include:
• details of design
• proposed procedure (selection; inclusion/exclusion criteria; sampling)
• measurement options
• proposed analysis
• there would normally be consideration of service user involvement (how can this be, or how is this being facilitated?)
• there would normally be consideration of the ethical issues that might arise and how these will be addressed
Additional guidance as to what might be presented may be found in the notes on preparing a protocol. It is helpful to show your planned presentation to your research supervisor/s in advance of the presentation for feedback.

Assessment Handbook

Introduction
Coursework is one of the fundamental foundations of the training scheme and exists to fulfil several important functions. First, assessment provides a system of standard setting whereby trainees are judged whether their academic and clinical performance is worthy of the award of a doctorate from the University. It also serves a crucial role of professional gatekeeping to ensure that clients are not exposed to incompetent practitioners. The assessment strategy is designed to ensure that trainees successfully completing this programme can be shown to meet the standards of proficiency that are required by the Health and Care Professions Council for registration as a clinical psychologist.

The principle of a professional doctorate is the integration of the pursuit of academic knowledge with its application within fieldwork or practical settings. Essentially, trainees who pass the clinical doctorate will be examined and have been judged to demonstrate at least adequate competence within all the following areas:

i) Psychological knowledge and theory relevant to clinical psychology.
ii) Application of psychological knowledge to practice.
iii) Knowledge and understanding of professional issues.
iv) Clinical competence and professional conduct.
v) Research ability.

Areas i), ii) and iii) will be assessed mainly on the basis of Academic Clinical Projects (ACPs) and Short Answer Questions (SAQs). Area iv) will be mainly assessed via written Clinical Practice Reports (CPRs), Short Answer Questions, the Observed Clinical Skills Assessment (OCSA) and the Assessments of Clinical Competence (ACC) made by supervisors on placement. Consideration of professional aspects of practice is integral to each and all of these assessment processes. Area v) will be assessed via the research project and Academic Clinical Projects.

Marking criteria for coursework (ACPs, SAQs and CPRs)
Coursework is generally double-marked by members of the Programme Team. Wherever possible work is blind marked. If the Internal Examiners cannot agree a mark, a third internal marker can moderate. If there is still failure to agree, the script will be sent to the External Examiner. Objectivity is ensured by the use of a standard marking scheme. This is used to provide trainees with feedback on their performance and to record decisions for the external and internal examination boards. Work is graded according to the following scheme:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>P</td>
</tr>
<tr>
<td>Borderline pass</td>
<td>BP</td>
</tr>
<tr>
<td>Borderline fail *</td>
<td>BF</td>
</tr>
<tr>
<td>Fail*</td>
<td>F</td>
</tr>
</tbody>
</table>

*Work given a borderline fail may be subsequently resubmitted for examination. An outright fail will require the submission of a new piece of work. Resubmissions are marked either as Pass or Fail and no further written feedback is provided to the trainee.

PASS
Answers graded a PASS indicates a good level of competence and typically should possess the following qualities:
• generally accurate and well-informed
• reasonably comprehensive coverage
• well organised, structured and clearly presented
• evidence of appropriate reading/research
• critical evaluation of material or formulation
• good understanding of the material or formulation
• evidence of good use of supervision
• good understanding of professional practice issues

BORDERLINE PASS
An answer graded BORDERLINE PASS demonstrates some knowledge and understanding, but tends to be weak in at least one and maybe more of the ways indicated in the lower section of this list

• an adequate answer but based upon limited sources of information
• reasonable attempt at critique
• adequate organisation
• missed key points of information or poorly described formulation
• important points are inadequately elaborated or evidenced
• contains several inaccuracies
• little development of arguments or self-evaluation
• issues relating to professional practice require greater elaboration

Answers that demonstrate the majority of the above weaknesses would be deemed to have received a borderline fail (see below).

BORDERLINE FAIL (Suitable for resubmission)
This would be the first fail category and answers would typically be weak involving some of the following features:

• some appropriate material but poor coverage
• key points of information missed or poorly described formulation
• lack of organisation of material
• inappropriate material, major errors or omissions
• lack of argument or adequate assessment/ formulation /intervention.
• poor critique
• poor understanding of professional practice issues

Where a Borderline Fail grade (suitable for amendment for resubmission) is awarded trainees can choose to submit a new piece of work as their resubmission.

FAIL (Not suitable for resubmission - new work required)
This represents the bottom end of the Fail Category. Answers in this category are clearly highly deficient, though these deficiencies may be in a number of areas:

• misunderstanding of basic material
• complete failure to meet the requirements of the assessment
• incoherent presentation
• formulation or intervention unable to be supported by evidence
• evidence of reasoning/arguments potentially harmful to clients / inappropriate professional practice

All ACPs and CPRs will receive qualitative feedback – a minimum of 10 working days following the Exam Board meeting after the submission date. This feedback is presented to facilitate the trainees' learning from their coursework assignments and cannot be used as a sole basis for an appeal against any decision made by the Board of Examiners. Trainees should arrange a
tutorial with the first marker to obtain more detailed feedback. It is the trainee’s responsibility to instigate this meeting.

Coursework will not be routinely marked down for poor spelling or presentation. However, in extreme or persistent circumstances marks will be reduced at the discretion of the Board of Internal Examiners, even if this results in the failure of the work in question.

Breaching a client’s anonymity via their family name and/or significant aspects of their address will constitute grounds for work receiving a BORDERLINE FAIL. Other breaches (first name of client or family member, member of staff, trainee, supervisor, service) will receive a CONDITIONAL mark.

A CONDITIONAL mark may also be given if work contains significant errors (e.g. typographical errors, poor presentation) which whilst not affecting either the academic content or the grading, are sufficiently serious to require resubmission to the satisfaction of the Internal Examiners. Coursework with a Conditional mark has to be resubmitted within four weeks of the trainee receiving the mark. Failure to meet the requirements of the condition could result in reduction of the marks at the discretion of the Board of Internal Examiners, even if this results in the failure of the work in question.

A conditional grade is considered as evidence of poor quality control and where a repeated pattern emerges the number of conditional marks obtained by a trainee is formally monitored as an indicator of professional standards.

Marking criteria for Short Answer Questions
All answers will be marked by a first marker and graded as pass, borderline pass or borderline fail. In the case of borderline fail, an opinion from a second marker will be obtained. The focus of the assessment will be your familiarity with, and general understanding of the directed readings that you have been set. We will not be interested in the detailed contents of each reference nor any related articles. If a question is graded as borderline pass or borderline fail, you will be provided with written feedback.

Where 5 or more SAQ answers are graded as a Borderline Fail the overall assignment will be considered as a Fail. A new set of SAQ answers must be competed. All must normally be graded as a minimum of Borderline Pass for the resubmission to be graded as a Pass.

Where one to 4 answers in the original SAQ set are borderline failed then the overall assignment is counted as grading pending. If all borderline failed items are passed on resubmission then the assignment is graded as a Pass. If any individual SAQ is borderline failed on resubmission the SAQ set is graded as a Fail and the Board of Examiners will require a full set of new SAQs to be completed within a specified time frame. All must normally be graded as a minimum of BP on a single attempt for the submission to be passed.

Marking criteria for Observed Clinical Skills Assessment (OCSA)
Two members of Programme team staff will independently rate the role-play using the revised form of the Clinical Skills Assessment Rating Form (CSA – RF, revised; see MOLE for example), and then agree a pass/fail mark. Trainees will be assessed on the following domains of the CSA-RF:

- Demonstrating Professional Therapeutic Engagement
- Creating a Secure Base
- Formulation (sharing psychological ideas)
- Facilitating Mutual Understanding, and
- Session Structure.

Assessment of Clinical Competence (ACC)
The 6 clinical training placements are assessed using the ‘Assessment of Clinical Competencies’. The ACC is the learning contract and record of training drawn up between the supervisor and the trainee and overseen/facilitated by the trainee’s clinical tutor. It identifies the goals of learning and the process by which those goals will be assessed and met.
More specifically, the ACC identifies 8 core clinical competencies that are the focus of placement experience and assessment:

1. Personal & Professional Development
2. Therapeutic and Working Alliance
3. Psychological Assessment
4. Psychological Formulation
5. Psychological Intervention
6. Research & Evaluation
7. Service Delivery & Organisation
8. Supervision.

Each core clinical competency has a set of Specific Learning Objectives (what trainees aim to achieve on the placement) and a Placement Plan (how the objectives will be achieved). These guide the work that will be carried out on the placement. An ACC is completed for each placement.

**Criteria for passing a placement**
There are three stages in the assessment process of trainee performance on placement made by the supervisor: supervisor ratings for each of the core clinical competencies, an overall supervisor rating for the placement and a final stage in ratifying supervisor assessment of trainee learning which lies with the Board of Examiners.

i) The first stage is for the supervisor to rate trainee performance for each of the specific 8 competencies. The Supervisor is asked to make a recommendation of ‘Pass’, ‘Partially Achieved’ or ‘Fail’ for each competence.

ii) The second stage of the assessment process is on the basis of the total assessment of the competencies, the supervisor rates the trainee as either ‘Pass’ or ‘Fail’ for the placement overall. In exceptional circumstances, a recommendation of ‘Deferred’ may be used. The Supervisor is advised to discuss the overall recommendation at the end of placement with the Clinical Tutor in cases of ‘Fail’ or ‘Deferred’ recommendations. The overall decision to pass or fail a placement inevitably involves professional judgement - the supervisor's and that of the Director of Clinical Practice/ Clinical Tutor and other Programme staff.

iii) The final stage is the ratification of the evaluation at the Board of Examiners.

Guidance for the process and criteria that must be met in order to Pass or Fail a clinical training placement has been broken down into: Ratings for each of the 8 core clinical competencies; Ratings for the overall Placement Report, Procedures for Failing a Placement and Changes to the Placement Pathway.

**(a) Ratings for each of the 8 core clinical competencies:**

**PASS** - The Trainee has successfully completed the ‘Specific Learning Objectives’ for the core clinical competency.

**PARTIALLY ACHIEVED** - The Trainee has made some progress towards completing the ‘Specific Learning Objectives’ for the core clinical competency. However, the standard observed and achieved is lower than would be expected at the Trainee’s stage of training. Additional opportunity to consolidate this area of skill development is required.

**FAIL** - The Trainee has clearly not achieved the ‘Specific Learning Objectives’ for the core clinical competency to a standard appropriate to their level of training, and there is a clear need to re-assess the competency / competencies on their next clinical training placement. To gain a fail the trainee will have failed to demonstrate an acceptable general level of competence, bearing in mind the trainee’s stage of training OR failed to complete specified or sufficient work, as set out in the Placement Plan Section of ACC form OR has been shown to have undertaken work that has not met the standard required and where there is the potential to do harm to the client as a result (e.g., reports that could lead to the patient being denied access to appropriate and necessary services).

**(b) Ratings for the Overall Placement Report:**
PASS - The Trainee has successfully completed the 8 core clinical competencies as agreed at the start of the placement and as reviewed at the Mid-Placement Meeting.

FAIL - The Trainee has clearly Failed one or more core clinical competency OR has 3 or more partially achieved ratings within a single placement OR has 3 partially achieved ratings for the same competence over 3 placements OR has been suspended from the Programme through either University or NHS disciplinary/ Fitness to Practise proceedings.

DEFERRED - The Trainee has been unable to achieve one or more of the 8 core clinical competencies. This has been solely due to a lack of opportunity to demonstrate the competency/competencies or to a prolonged absence from the Trainee or the Supervisor. Where a trainee has completed insufficient work on a placement due to factors that may be assessed as beyond her or his control, (e.g. prolonged absence due to illness of supervisor or trainee, lack of suitable referrals) assessment of the placement may, at the discretion of the Examiners, be deferred until a later placement. Such a deferred placement is not counted as a fail, the trainee and clinical tutor will need to ensure that future placements are adapted to meet these unmet learning needs. In some limited circumstances this might require an extension or training beyond the normal three year period. Funding of such an extension would be at the discretion of the trainee’s employer or sponsoring body.

The Board of Examiners
The progress of trainees will be reviewed regularly at the meeting of the Board of Internal Examiners. The Board will consist of the Programme Team (full and part-time lecturers in clinical psychology, Directors of Clinical Practice and the Clinical Tutors). In the possible event of a recommendation being made for trainee to be excluded from the Programme, the Programme Director, Director of Clinical Practice and External Examiner must normally be present or have been consulted. The Board normally will be chaired by the Chair of the Board of Examiners, and its proceedings minuted, in confidence, by the Assessment Secretary. The Board of Internal Examiners will make recommendations to the External Board concerning the pass or failure of individual coursework assignments or placements. In addition, the Board of Internal Examiners will also make recommendations on assessment matters to the Programme Training Committee. However, the minutes of the Board of Examiners will remain confidential to the Board and the University, and will not be routinely revealed to the Programme Training Committee.

The Board of Examiners will consider the Supervisor’s recommendation on the placement, in the context of the trainee’s overall progress on the Programme to date. If a trainee has been consistently weak / has not met the standard expected on either previous placement assessments or clinically related coursework, the Board may decide to fail the placement, even if this might not be consistent with the supervisor’s recommendation. Similarly, if the Board considers a supervisor’s recommendation of a fail to be inappropriate, the Board will reserve the right to pass the placement.

Each trainee's progress will be formally reviewed annually at the External Board of Examiners. The Board will be composed of the Board of Internal Examiners, the External Examiner(s) and, if appropriate, the Head of the Department of Psychology or a representative. The role of the External Examiner will be mainly to moderate scripts at the marking boundaries, examine theses, adjudicate appeals/discrepancies, perform oral examinations and comment on general standards and procedures. The Board of Examiners meeting makes its recommendations to the Faculty of Science.

Annual Progression
To qualify for the Doctor of Clinical Psychology, trainees must pass all aspects of coursework, together with satisfactory assessments of clinical competence on placement. The following coursework assignments have to be passed for progression through the Programme, and usually in the following specified order:

<table>
<thead>
<tr>
<th>Year I</th>
<th>Year II</th>
<th>Year III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Answer Questions 1</td>
<td>Short Answer Questions 2 &amp; 3</td>
<td>Short Answer Questions 4</td>
</tr>
<tr>
<td>Academic Clinical Project 1</td>
<td>Academic Clinical Project 2</td>
<td>Academic Clinical Project 3</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Clinical Practice Report 1</td>
<td>Clinical Practice Reports 2 and 3</td>
<td>Clinical Practice Report 4</td>
</tr>
<tr>
<td>Assessment of Clinical Competence 1 and 2</td>
<td>Assessment of Clinical Competence 3 and 4</td>
<td>Assessment of Clinical Competence 5 and 6</td>
</tr>
<tr>
<td>OCSA1</td>
<td>Approval of research proposal*</td>
<td>Research thesis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completion of Log of Research Dissemination Activity (RDA)**</td>
</tr>
</tbody>
</table>

In the case of unsatisfactory coursework or a failed placement, trainees may be permitted to progress to the next year of the Programme at the discretion of the Board of Examiners. If, however, a trainee's coursework is unsatisfactory across several areas, the Board of Examiners may recommend that the trainee is suspended from the Programme until satisfactory work is submitted and graded. In such circumstances a trainee's registration will either be continued without attendance, or may be suspended.

*Whilst the research proposal is not formally marked, progression into the third year is normally on the basis of having had the research proposal approved by the Protocol Review Panel, as well as submitting evidence of applying for appropriate ethical approval to the RSO.

**The log of research dissemination activity is not formally marked. However, satisfactory completion of a record demonstrating that effort has been put into appropriate dissemination activity is normally a requirement of completion of the programme.

Provisions in the Event of Failure

**Coursework.** Any Internal Examiner can recommend the failure of a piece of coursework (ACP, SAQ, CPR or SAQ). If this decision is supported by the Board of Internal Examiners the trainee may be requested to resubmit that piece of work in the case of an BF or a new piece of work as a resubmission in the case of an F within a specified period of time, in addition to other existing coursework requirements. In the case of SAQs, an excess of 4 Borderline Fails in any one set will be considered as an overall fail for that assignment, and a new piece of work may be requested.

**Placements.** When an overall placement is failed, the trainee will normally be required to undertake a further placement to demonstrate competency.

**Observed Clinical Skills Assessment.** Where the two examiners recommend OCSA is graded as a fail and the Board of Internal Examiners support this decision, then the trainee will be given a single additional opportunity to successfully pass this assessment.

If a trainee disagrees with an assessment, she/he may request a review of the work by an External Examiner by writing to the Chair of the Board of Examiners within 14 days of notification of the decision.

**Extenuating or Mitigating Circumstances**

Written requests of extenuating circumstances will only be considered by the Board of Examiners provided that documentary evidence (e.g., GP's report, Student Counsellor's report, letter from personal tutor, placement or research supervisor, clinical tutor, mentor etc.) is submitted to the Chair of the Board of Examiners, prior to the submission date. It is the trainee’s responsibility to ensure that this happens. (To note: trainees may be asked to provide some sort of evidence in regards to bereavements.)

**Exclusion from the Programme**

The annual External Board of Examiners or the Board of Internal Examiners, with the External Examiner(s) present, or following consultation with the External Examiner(s), can recommend to the Faculty of Science that a trainee be excluded from the Programme due to failure to meet the relevant
coursework, placement or thesis requirements; or because of concerns over poor attendance; or
disciplinary issues; or fitness to practise (see below for details).

Normally a trainee will be recommended for exclusion from the Programme should any of the
following occur:

- A repeated fail or borderline fail of the same piece of work or placement
- Two failed placements during training
- The accumulation of 4 fail or borderline fail gradings in total of Academic Clinical Projects,
  Clinical Practice Reports, SAQs, placements or the OCSA.
- The accumulation of fail or borderline fail gradings for 3 Clinical Practice Reports or 3
  Academic Clinical Projects
- Repeated fail of the thesis

**Attendance**

Trainees are required to attend regularly all components of the Programme. These include all
timetabled lectures and seminars for that year group, relevant meetings (e.g. Programme meetings,
selection interviews, oral examination etc.), the Personal and Professional Development sessions and
clinical placements. When trainees have been absent from the Programme due to illness or other
personal difficulties for a period of time long enough to disrupt their training, the Programme will
endeavour to reschedule academic deadlines or defer placements, and consult with the employing
authority and the funding consortium as appropriate. However, if in the judgement of the Internal
Board of Examiners, the trainee has had no good cause to be absent from the Programme, in line
with the university policy on non attendance, this will result in a trainee failing to progress between
years of their degree or from graduating until they have made good their attendance. Poor attendance
will also constitute grounds for review by the Faculty Progress of Students. (See University Penalties
Policy on non-attendance: https://www.sheffield.ac.uk/sss/sas/progress-attendance. Disciplinary
procedures via employment channels will also be instigated. This may lead to dismissal from
employment or termination of sponsorship. In all circumstances the University retains the right to
terminate registration if a trainee is no longer employed by the NHS or relevant body or holds an NHS
License to Operate.

Trainees who have experienced periods of extended sick leave will need to follow the procedures of
their employer, which is usually Sheffield Health and Social Care Foundation Trust, and apply for
suspension of registration from the University. If a contract of employment or NHS License to Operate
is terminated on grounds of ill health or for any other reason, the University may, at its discretion, also
terminate a trainee’s registration if requested by the Board of Examiners.

A condition of registration on the Programme is that a trainee is in full or part-time employment with a
relevant NHS or other appropriate employer, or holds an NHS License to Operate. In exceptional
circumstances, a trainee may at the discretion of the Board of Examiners continue their training for a
short period of time (up to six months) without funding, if suitable arrangements can be agreed with
the Director of Clinical Practice regarding management and liability.

As part of the internal procedures prior to referral to the University’s Progress of Students, the Board
of Examiners will consider any mitigating or extenuating circumstances that had not been possible to
submit before the assessment submission deadline.

Should the Board of Examiners accept the mitigation request, then the one failed piece of coursework
will be counted as ‘not assessed’ and the trainee will be allowed a final opportunity to submit the failed
piece of coursework or to repeat a placement.

If mitigation is not accepted then the trainee will be referred to the University’s Progress of Students.
The University’s procedures can be found at https://www.sheffield.ac.uk/sss/sas/progress-attendance
and appeals procedures at https://www.sheffield.ac.uk/sss/sas/appeals-complaints-conduct.
**Disciplinary procedures**

In the event of actions which could be considered as serious professional misconduct, in terms of failure to adhere to (i) the Health and Care Professions Council Standards of conduct performance and ethics and the Guidance on conduct and ethics for students, (ii) the BPS Code of Ethics and Conduct, (iii) the BPS Generic Professional Practice Guidelines (iv) the DCP Professional Practice Guidelines, or (v) the BPS Guidance on the use of Social Media or as defined in the employing authority’s guidance on disciplinary procedures, the Chair of the Board of Examiners, in consultation with the Programme Director, may request the immediate suspension of a trainee’s registration. This would follow consultation with the Director of Clinical Practice, a relevant Officer at the relevant employing authority, the Head of the Department of Psychology, the External Examiner(s) and the Faculty of Science. Suspension may occur 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). The trainee’s relevant employer, sponsor or Head of Psychology Service would be notified accordingly.

Following University disciplinary procedures suspension or dismissal from employment or termination of sponsorship may commence. Similarly, the University reserves the right to exclude a trainee, if his/her employment is terminated with his/her employer or sponsor, either due to dismissal or resignation. It is also likely that the Board of Examiners would institute procedures under the Fitness to Practise Regulations.

**Fitness to practise standards**

The University of Sheffield has a policy of ensuring fitness to practise for those completing professional training courses including the DClin Psy. This policy is outlined in the General Regulations relating to Fitness to Practise in the University Calendar.

Trainees must also uphold appropriate standards of behaviour in all aspects of their training and in both the education setting and practice placement setting as indicated below. Monitoring of professional aspects of practice is integral to the assessment procedures for the Programme. Where trainees fail to meet these standards they will not be allowed to complete the Programme and enter the profession.

(i) During the Programme trainees must liaise in a positive and constructive way with many different people including clients, supervisors, other staff on placement, Programme staff, teachers, administrative staff, peers and others. This is a fundamental requirement of clinical psychology practice and must be consistently shown by individuals in training. Where fitness to practise concerns are raised in relation to this aspect then interpersonal difficulties should be clearly demonstrated with a variety of different individuals and typically across several different settings.

(ii) Training as a clinical psychologist requires individuals to acquire new skills and knowledge and take on new roles. It requires respect for others’ opinions, an openness to learning and an ability and willingness to use feedback constructively. Concerns relating to fitness to practice 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.

(iii) Trainees are required to demonstrate throughout their training, attitudes and behaviour in keeping with the statements of values and standards of clinical psychologists as outlined in HCPC Standards of conduct performance and ethics and the Guidance on conduct and ethics for students. They must also adhere to the standards of the British Psychological Society Code of Ethics and Conduct (2018). The Code is based on the principles of respect, competence, responsibility and integrity.

(iv) 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. Trainees must also adhere to the standards of behaviour as outlined in the Entry Agreement (see Appendix 6)
Concerns may be raised about fitness to practise under any of the above areas where a trainee's behaviour on placement may not itself have contravened (i) The Health and Care Professions Council Standards of conduct performance and ethics and the Guidance on conduct and ethics for students, (ii) the specific BPS Code of Ethics and Conduct, (iii) the BPS Generic Professional Practice Guidelines or (iv) the DCP Professional Practice Guidelines at a level of serious professional misconduct. 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 to enter the profession of clinical psychology. Such difficulties may lead to significant problems in training which by themselves have not led to repeated placement failure or failure of a resubmitted piece of work but may indicate lack of fitness to enter the profession.

As a condition of acceptance onto the Programme trainees must undergo and have received a satisfactory Disclosure and Barring Service (DBS) check. 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 Programme 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 concern about fitness to practise. The content of any disclosure may lead to University Fitness to Practise or Disciplinary Procedures being invoked (https://www.sheffield.ac.uk/ssid/complaints-and-appeals/fitness-procedures).

The Programme, wherever possible, attempts to ensure that candidates successfully complete their training. The Programme 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.

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.

Where the University upholds concerns over Fitness to Practise a trainee may be excluded from the Programme and their registration terminated. University registration on the DClin Psy Programme at the University of Sheffield is a contractual requirement with NHS trusts and any decision that upholds the recommendation for termination of registration will normally lead to the termination of the trainee's contract of employment and discontinuation of financial support. In the event of termination of the contract of employment, the usual NHS appeals procedures will be available to the trainee.

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.

University Appeals
There is an appeal from the decision of 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 then there is a formal stage involving submitting a written complaint in this case to the Programme Director. Again if there is a 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 web site has a section devoted to ‘Complaints, grievances and appeals regulations and procedures relating to students’ http://www.shef.ac.uk/ssid. This covers in detail complaints procedures, as well as appeals relating to academic work and discipline. It fully outlines
the contact persons, purpose, grounds and process for each channel. Sheffield Health and Social Care Trust also has a complaints procedure – see website www.shsc.nhs.uk.
Preparation and Submission of Assessments

Schedule of work
Approximate deadlines are given below. Please note actual dates for submission may vary – please check the individual list for your year group.

SAQ1: Specified date in February in year one
CPR1)Specified date in April/May in year one
ACC1) Specified date in September in year one
ACP1) Specified date in September/October year two

ACC 2 Specified date in September in year one
CPR2) Specified date in September/October year two
SAQ2) Specified date in September of the third year

ACP2 October or April in Year Two
CPR3) Specified date in March/April year two
ACC3) Specified date in September year two
SAQ3) Specified date in September/October year three or April/May year three.

ACP3 Specified date in September/October year three or April/May year three.
CPR4) Specified date in September/October of Year 3
SAQ4) Specified date in March/April of the third year

ACC5: Specified date in September of the third year
ACC6: Specified date in September of the third year
Thesis: Last working day of May

Research Dissemination Log: Specified date in September of the third year

Please note that only one ACP (ACP2 or ACP3) should be submitted for any one deadline. An additional deadline in mid-August may be available if ACP2 has been deferred.

The Programme may alter any of the individual deadlines provided trainees are given sufficient (i.e. 4 weeks) notice beforehand.

Deadlines for Single Case Studies
Trainees are strongly recommended to attempt their single case study during CP1 or CP2, even if they do not actually submit the clinical work conducted. The deadline for submission is either at the end of CP2 or CP3, although a submission for CP4 will be considered if there are good clinical reasons for the single case not having been successfully completed. However, the trainee will need to write to the Chair of the Board of Examiners requesting a deferment, providing detailed reasons why such an extension is justified. The submission should also include a letter of support from their supervisor. Trainees should normally wait until they have successfully collected the data for the Single Case Study, before attempting their Service Evaluation (ACP3) Project. The reasons for this are: that we do not recommend that you attempt both ACPs in a single placement since this might squeeze out routine clinical work and Deciding too early on your service evaluation methodology might constrain the methods available to you for your research thesis (see Procedure section for ACP3).
Deadlines for the Research process are provided separately and will be available on MOLE.

**Submitting Assessments**
Coursework must be submitted by 2pm at the latest on the given deadline, or earlier if completed. You should submit your coursework electronically to the Assessment Secretary. All coursework excepting SAQs must include the anonymity checklist as the second page. Clinical Practice Reports and ACP2 must be accompanied by one copy of the supervisor’s signing off form. The Programme will require submission of all SAQs and ACP1 via Turnitin in addition to the electronic copy of ACP1 and hard copies for SAQs, via the relevant Turnitin assignment on MOLE. Trainees are required to submit Turnitin receipt at the same time as they submit their coursework. All versions submitted must be identical. Any discrepancy will lead to automatic failure of the piece of work. Checks for word counts and plagiarism checks will be carried out. You should indicate your awareness of the University guidelines by ticking the relevant box on the coursework cover sheets (see appendices). All forms relevant to submission are available on MOLE.

You should keep everything contained in the one document, ie. the front cover sheet and anonymity checklist inserted at the front of the piece of work all in one document. The supervisor signing off form should also be submitted (please attach this to your email as a separate document).

All coursework should be submitted electronically with the exception of SAQs. Two hard copy sets of 8 SAQs, unstapled should be submitted to the Assessment Secretary.

**Accessible Sticker Scheme**
All trainees with a declared disability as with all registered students have the option to use the Accessible Sticker Scheme which allow them to identify work as submitted by a student with a disability. See [https://www.sheffield.ac.uk/ssid/disability/useful-info/yellow-stickers](https://www.sheffield.ac.uk/ssid/disability/useful-info/yellow-stickers) for more details. Please note the use of stickers is to enable markers to frame their feedback and standards remain unchanged. Trainees should note that choosing to use stickers might compromise their anonymity in blind marking.

**Preparation of assessments**
All coursework must be word processed (A4, double-spaced, font Times New Roman, Arial or Helvetica, 12pt, 2cm margins all round).

**Avoiding plagiarism**
All submitted work must be the trainee’s own individual work. Plagiarism will automatically result in failure (see Appendix 7 regarding advice to students for avoiding plagiarism, entitled ‘Use of Unfair Means in the Assessment Process’). Please note as the DClin Psy is a postgraduate professional training programme, use of unfair means is likely to result in Fitness to Practise procedures being applied in addition to implications for the marking of the work.

High similarity matches from Turnitin reports will be discussed at the board of examiners meetings. The board may require formal meeting with the trainee as an initial stage and action may be taken under the Discipline Regulations.

**Confidentiality issues**
The protection of clients’ rights to confidentiality and access to individual records or identities are important issues within the NHS. Trainees should respect clients’ confidentiality at all times and a failure to do so can constitute a breach of HCPC Guidance on conduct and ethics for students and the British Psychological Society’s Code of Professional Conduct. Similarly, trainees should also be aware of their obligations with respect to the General Data Protection Regulations (2018). The Programme, therefore, considers breaches of confidentiality either within clinical work or in the production of academic work as a serious breach of professional behaviour.

Coursework assignments obviously involve working with particular clients and in specific services. Nothing that would enable identification of the persons or services concerned should appear in any coursework assignments or their appendices. In addition to obliteration (do not use Tippex) of names
and addresses of clients, it is essential that names of hospitals, clinics and staff (including your own name and the name of your supervisor) are removed, although it may be helpful to retain a statement of the type of institution involved and the status of collaborating professionals. It is required that either arbitrary initials or a pseudonym are used and that this is clearly stated within a footnote in the report. Trainees should consider routinely informing clients that they may have their case written up as a case study at the commencement of therapy. It is good practice to remove the names and addresses of all people who have been contacted in relation to a piece of coursework, even if this is not in connection with clinical work. Trainees are also reminded that asking someone outside of the NHS and University to read coursework could be in breach of their contract of employment. The demonstration of appropriate professional practice standards is integral to all assessment processes within the Programme.

Inclusion of a client family name or significant aspects of their address will automatically lead to a borderline fail grade. Other breaches of anonymity will receive a conditional mark.

Coursework or thesis work may involve recording of clients or research participants (with appropriate consents). Audio or visual recordings must not be stored on digital media without appropriate encryption. All such media must be stored in conjunction with Caldicott guidelines for confidential information. Trainees must also operate within individual Trust requirements on this matter. In many cases trainees will complete their own transcription. Transcribers of tapes are required to sign a confidentiality agreement and follow the attached guidelines for transcribers (forms available on MOLE) before proceeding with the work. Trainees also must give consideration to the potential personal impact for transcribers of listening to material taped.

**Ensuring anonymity when submitting coursework electronically**

All details that would enable the identification of persons or services must be removed by hand, not through a computer programme. This includes all appendices. The coursework (with the exception of SAQs) should then be scanned before submission and sent as a PDF.

**Reading drafts**

Personal and clinical tutors are available to facilitate trainees’ academic and clinical development. They are willing to provide general comments on a single draft of an assignment prior to its submission as required by the trainee. This applies to first year Clinical Practice Reports (CPR1 and CPR2) and all ACPs. This feedback is to provide general guidance and further facilitate the trainee’s development of the work; it should not be considered as ‘premarking’. It is crucial that a minimum of 14 days is allocated by the trainee for this process of receiving feedback, and additional time before the deadline allowed in order to make use of feedback. It is the trainee’s responsibility to check the availability of the relevant staff member prior to the process. Provision of feedback is entirely at the discretion of the staff member and may depend on their availability; it is a resource for trainees not an entitlement. Failure to obtain feedback cannot be considered as grounds for an appeal under any circumstance. In terms of consultations, please ensure that you approach your personal or clinical tutor with regard to your coursework in general (personal tutor for ACP1 and SAQ1, clinical tutor for CPR1 and CPR2), Jaime Delgadillo for Service Evaluations (ACP3) and your Personal Tutor for Single Case (ACP2). Advice for writing SAQs is provided in Appendix 8. Guidance on preparing coursework in APA format is provided in Appendix 9.

In particular, where a piece of work received a Borderline Fail grading trainees are strongly advised to discuss the feedback with the first marker to ensure their understanding of the deficits and changes required. It is the trainee’s responsibility to ensure this meeting takes place. Staff are unable to comment on drafts of coursework to be resubmitted. Where a fail grading has been awarded and a new piece of work is required the personal tutor or clinical tutor depending on whether this is a clinical practice report or ACP may provide informal feedback on a single draft only.

Failure to obtain or receive feedback before a deadline cannot be used as grounds for appeal against failure of coursework.
**Supervisor's Signing Off of Coursework**

A copy of each Clinical Practice Report and Single Case Study (ACP2) submitted from a placement is routinely sent by the Assessment Secretary to the placement supervisor who is asked to sign that the work reported reflects that completed on the placement. A piece of work will not be formally graded without this confirmation but in these circumstances will receive a conditional mark.

**Deadlines and extensions**

The above deadlines should be strictly adhered to and it is the trainee's responsibility to ensure that work is submitted in time and that they present themselves for observed clinical skills assessments as required. Coursework that is submitted late will normally be failed unless the trainee has been formally granted an extension. A trainee who does not present themselves for an Observed Clinical Skills Assessment at the notified time will be deemed to have failed this evaluation. The procedures relating to deadlines and extensions are summarised below:

Extensions to deadlines are only given in extenuating circumstances and then only after consultation with the Chair of the Board of Examiners. Examples of extenuating circumstances are usually personal or health problems that we define as:

“Exceptional, short-term events which are outside of a student's control and have a negative impact upon their ability”:

a) significant illness of at least seven days and requiring a doctor's certificate,

b) in relation to a declared disability:

(i) significant lack of access to agreed facilities to support coursework beyond a trainee's control

(ii) significant worsening of scale or impact of an established disability

**Technological failures in terms of computer malfunction, accidental deletion of information, etc. do not constitute extenuating circumstances**

Trainees requesting an extension must normally make a formal application in a signed letter (not emailed) prior to the date of the deadline and with supporting documentation (see point below) to the Chair of the Board of Examiners, with a copy to the Assessment Secretary. Please note that email requests are not accepted. It may be helpful to discuss any potential request with your Personal Tutor in the first instance.

Extensions will be provisionally granted by the Chair of the Board of Examiners in consultation with the Programme Team. Final ratification of any extension will be made at the appropriate Board of Examiners’ meeting.

Extensions will only be granted if appropriate written evidence (e.g. doctor's certificate or letter, report from mentor, student counselling report etc.) is presented to the Board of Examiners to support a case of extenuating circumstances.

Extensions will normally only be granted for up to two weeks past the deadline. Where the extenuating circumstances warrant a period of time greater than two weeks, the assessment will be deferred until the next assessment deadline or 4 weeks prior to the External Board of Examiners as determined by the Internal Examination Board.

Extension applications can normally only be considered when submission of an assignment is required for that specific deadline.

Work which has not been submitted for a deadline will normally be failed unless appropriate and documented extenuating circumstances exist and an extension is ratified by the Board. The only exception to this is for ACP2 (Single Case Study) where the Board may grant a deferment if the trainee can present written evidence that clinical obstacles beyond their control prevented the submission of this piece of work.
A failed piece of work due to late submission can be resubmitted but will only be considered for an as a pass or fail. However, a qualitative feedback sheet will be provided in these circumstances.

Failure to submit the Research Thesis by the last working day of May in the final year will normally result in deferment of the oral examination by the External Examiner to the following January with an end of November submission date. If you are not going to submit your thesis by the date specified above you must inform the Chair of the Board of Examiners before the last working day of May.

Additional fees are payable by trainees who take longer than the normal period of registration to submit their thesis. For further information see https://www.sheffield.ac.uk/rs/code/fees

Failing a Placement
Trainees are expected to observe all relevant employment conditions and rules and be subject to the disciplinary procedures of SHSC and the host Trust in which they are working on a clinical placement. In the event of breaches of discipline, SHSC and University procedures apply. In the event of failed placements and/or academic submissions, Faculty of Science regulations apply.

Procedures for failing a placement
There is probably no task harder or more unpalatable for a supervisor than to fail a trainee after having worked hard to help her or him overcome difficulties. For a trainee, being recommended for a failed placement is also likely to be a difficult and painful experience and the issue is likely to engender a good deal of anxiety. For all these reasons there are detailed guidelines on the subject designed for those infrequent occasions when they are needed.

At the end of a placement the supervisor must decide whether to recommend that the trainee should be passed or failed on the placement. If the supervisor is considering recommending a fail or is undecided, it is expected this would be communicated to the Director of Clinical Practice/ Clinical Tutor at this stage to talk the matter over. This and any subsequent communication regarding the matter should be logged by both parties as they may be relevant to any later evaluation of the decision.

If the supervisor decides to recommend that the trainee should be failed the following procedures then apply:

- The supervisor should indicate on the Assessment of Clinical Competence form that the placement is recommended for a fail. This should be shown to the trainee and the reasons for failing clarified. It should be noted at this time that this is a recommendation from the supervisor and that the final decision rests with the Examiners. The report should then be sent as soon as possible to the Director of Clinical Practice/Clinical Tutor, and in time for the relevant Exam Board.

- Where he or she has not already done so, the Director of Clinical Practice/ Clinical Tutor will contact the supervisor, the trainee and (where applicable) the person responsible for placement monitoring, to discuss the reasons for the recommendation and to gather any additional information which may be relevant. If not already clear, an effort will be made to address such questions as: Was the trainee made aware of her or his shortcomings at the mid-placement meeting, or at any other time? Were there opportunities for the trainee to do something about these shortcomings? Were there any external factors beyond the trainee’s control which interfered with her or his progress? This ‘elaboration’ phase will be undertaken within as short a period as is reasonably possible.

- If the trainee wishes, he or she may also discuss the situation with his or her Personal Tutor and/or submit a written account to the Board of Examiners, via the Chair of the Board of Examiners. Trainees are also encouraged to discuss the matter with their Personal Mentor.

- At the meeting of the Board of Examiners following the above phase, the placement reports will be considered, together with any written submissions and any further information or views obtained from discussions/interviews with the trainee and supervisor by the Director of Clinical
Practice/Clinical Tutor and the Personal Tutor. The Board may also consider evidence from other placements, coursework or general performance on the Programme in making a decision. At this meeting the Examiners will make a decision to pass or fail the placement. If the placement is failed the Examiners will also decide what will be required of the trainee by way of rectifying the failure.

- It should be noted that the failing of a single placement by itself is usually followed by the opportunity to demonstrate competence on a further placement. The question of failing the Programme does not, therefore, normally arise at this stage, unless progress is generally unsatisfactory.

- The Director of Clinical Practice and Chair of the Board of Examiners will communicate the Board of Examiners’ decision to the trainee verbally and in writing as soon as possible by the Chair of the Board of Examiners.

**Consequences of failing a placement: changes to the placement pathway**

When an overall placement is failed, the trainee will normally be required to undertake a further placement to demonstrate competency. The content, duration and timing of this placement will depend on how best to meet the learning needs of the trainee and how best to assess those needs and the Board of Examiners will make this decision. A failed core clinical competency or competencies will normally result in this or these being specifically re-assessed on the next placement. The Trainee must pass this competency or competencies on the next placement. Failure to pass the competency or competencies on the next placement will usually be considered as grounds for exclusion from the training course.

In some cases this placement may be incorporated into one of the other placements already planned. In other cases a specific placement may be undertaken immediately following the failed placement; during the trainee’s third year instead of an optional placement; or may be added on at the end of the third year. Where an extension to the normal three-year training period is required, an extension to the trainee’s employment contract would normally be sought, but this would be at the discretion of the trainee’s employer. Extension may therefore be on the basis of an honorary contract without remuneration. Such an extension would be no greater than twelve months.

Trainee performance will be monitored at relevant University Exam Boards. Initial Placement Meetings will be held at the placement base and special placement measures can be used (for example, additional placement visits, a specific Training Plan developed with the Clinical and Personal Tutors, additional support put in place, as required).

If a trainee fails to pass the failed competency on the next placement this normally is grounds for exclusion from the programme. If a trainee fails two placements during their training this will normally be grounds for exclusion from the programme.

After following due process, if the decision is taken to exclude the trainee then this would then be communicated to the trainee’s employer and to the commissioners of training, and would normally lead to the termination of the trainee’s contract of employment and discontinuation of financial support.

In the event of serious professional misconduct or professional unsuitability, the Chair of the Board of Examiners may, with the agreement of the Pro-Vice-Chancellor and discussion with the Director of Clinical Practice, suspend the trainee from placement work and may include other requirements within the terms of the suspension within the Fitness to Practise regulations. The trainee’s relevant employer would be notified accordingly. At the same time, the relevant disciplinary proceedings of the trainee’s employer would also be set in motion, if appropriate.

If, as a consequence of exclusion from the Programme, the trainee’s contract of employment is terminated, the usual NHS appeals procedures will be available to the trainee.
Communication with Supervisors Regarding Failed Placements

In the case of a further placement following placement failure, the new placement supervisor must be informed of the failed placement and reasons for failure in order that she or he can help the trainee to address the identified points for competency development and in order that she or he understands the importance of Assessment of Clinical Competence to the future of the trainee on the Programme. The Director of Clinical Practice/Clinical Tutor will discuss with the trainee the means by which this is communicated. The failure and reasons for failure will be fully discussed at the Initial Placement Meeting and the issues to be addressed incorporated in the Placement Plan.

Where the trainee passes a further placement, the decision to inform future supervisors of the previous failure will normally be at the discretion of the Director of Clinical Practice/Clinical Tutor in discussion with the trainee. Where there continue to be concerns regarding the points which led to placement failure, these will be addressed in the Initial Placement Meeting in the usual way by reference to the continuation sheet and the identification of points for development.
Observed Clinical Skills Assessment
The Observed Clinical Skills Assessment is a formal, ‘live’ assessment of clinical skills, which usually takes place during the first year of training and is assessed by Programme team staff. The OCSA follows directly on from the ‘Clinical Skills’ teaching sessions at the beginning of Year 1. The clinical skills teaching sessions and trainees’ experiences with clients on their clinical training placements are usually considered to be preparation for the OCSA.

Each trainee will role-play an initial assessment session with a fictitious client (an actor in character). Trainees will be briefed, usually in the form of a referral letter. Actors will also be briefed with a scenario in the same way as in the ‘Clinical Skills’ teaching sessions. The role-play will usually last for 30 minutes and will usually be recorded.

Re-sits will be scheduled for any trainee/s needing to re-take the OCSA. The same process as above will be observed. An actor and trainee/s will be briefed with a new clinical scenario.
Short Answer Questions and Directed Readings

Short answer questions are completed as part of the process of continuous assessment on the Programme. The purpose is to link the academic with the clinical and professional practice, to assess breadth of knowledge, develop skills in critically reviewing papers and to encourage a process of reading round an area of interest whilst on placement. The topic and focus of the papers will mirror the trainees' placement experience. The rationale for the papers chosen is for their usefulness or clinical relevance and/or theoretical interest or excellence.

You will be required to write short answers to 8 questions selected from 12 directed readings. It is essential that you follow the instructions precisely and only answer the correct number of questions from each section of the directed readings.

Each answer should be no more than 500 words AND these must fit onto no more than 2 pages of A4 (double spaced). The word count must be included for each answer, alongside the title. Please ensure that each answer begins on a separate page.

For each paper you should complete either option (i) summarise the main issues and critically review the strengths and weaknesses of the paper (CR), or option (ii) summarise the main issues and comment on the paper's implications for your future clinical practice (ICP) with reference to your own thoughts about your work with future clients. For each set of eight SAQ answers four must address option (i) and four option (ii). Answers that adequately summarise the paper but do not address implications for clinical practice or provide a critical appraisal of the paper will be failed. It is essential that both aspects of each question are addressed.

You must complete equal numbers of papers from both sections, and in terms of ICP and CR, you can mix and match these.

Answers that deviate from the required length or are written in note form will not be acceptable. Each answer should begin on a separate sheet. In addition to candidate code each answer must include the following headings (not included in the word count): SAQ set and question number, title and authors of the paper and specification of option (CR or ICP). A separate summary sheet should also be completed identifying which papers you have answered and the options chosen (form available on MOLE).

Each answer should result from each trainee's own individual work. Collaborative answers will be treated as plagiarism and will automatically result in failure. Please be aware of the potential risks of plagiarism if you show your work to others. Further tips on completing the SAQs are provided in Appendix 7.

If you have any further queries about SAQs please contact your Personal Tutor.
ACP1: Clinical Literature Review
Length: 3,000 - 5,000 words excluding references and appendices only

Note: ACP1 should be submitted via Turnitin as well as an identical electronic copy – see separate guidelines on MOLE

You are required to review a body of literature arising from a clinical case or issue relevant to your current placement. The purpose of the ACP1 is to assess your ability to identify the relevant and appropriate literature, to critically assess its contents, and to relate it in a useful manner to clinical practice and experience. The area of focus of ACP1 should normally be different from the focus of Clinical Practice Report 1.

Before starting this ACP you will find it useful to discuss the topic to be reviewed with both your relevant supervisor and your personal tutor. It is intended that you conduct this assignment during the course of your placement. Accordingly, you need to agree a title and topic towards the beginning of the placement before you start on the literature review. After the ACP has been marked you should arrange to send a copy of the review to the clinical supervisor or service. The actual assignment can be written up after the placement during the study week. Guidance on conducting a literature review is provided during teaching and is also available on MOLE. The answer should be written according to the following format:

Title Short and specific. Avoid attempting to review vague or over-inclusive topics.

Introduction Include a brief description of how the topic was chosen and its relevance to the current clinical placement.

Method Include clear information on the search strategy adopted, demonstrating how the search conducted was systematic and replicable. A Prisma diagram is recommended. A recognized approach to appraising studies should be selected (trainees are advised to select a tool/approach from the Equator website).

The review The relevant literature is to be reviewed critically with respect to the topic/question identified. Examples of appropriate questions might be a review of theories and treatment efficacy relevant to panic disorder (prompted by a referral of a person experiencing panic), a review of the efficacy of cognitive training (prompted by spending time observing a continuing care ward setting), psychological approaches to dementia etc. The review should clearly evaluate the research, not merely describe it and the use of a critical appraisal tool is recommended. You should ensure you have included your search strategy at the beginning. The review must be based upon a search in the literature which you have conducted and must not duplicate a recent review in the published domain, e.g. published paper, web-based DoH consultation document.

Conclusions: Provide a detailed synthesis of what on the basis of your analysis of the literature you can and cannot conclude from your review. Finally, you should relate it back to the original clinical situation which prompted it, identifying any changes in clinical practice prompted by the review.

When approaching this question, please note the following:

• Consult and discuss with any member of the Programme Team and your Placement Supervisor. You should also ensure that your ACP title has been approved beforehand by your Personal Tutor. You should submit to the Assessment Secretary a form signed by your Personal Tutor approving your title 6 weeks prior to the deadline for this assignment*. Titles of different trainees must all be clearly distinct to be approved.
• Relate the review to an ongoing clinical case or issue on placement.

• Don not wait until the end of placement before starting assignment as undertaking initial scoping searching of the literature is likely to take some time

• Be specific and realistic in the scope of your review.

• Trainees should take care in preparing a final protocol to guide the literature search strategy and method. Generally, Scopus should always be the main database used and the use of other databases may be necessary. The use of comprehensive search terms (e.g. using all appropriate MeSH/thesauri and terms from the existing literature) are required. Appropriate truncation should be deployed.

• It is essential that the literature identified is appraised and related to personal clinical practice and based mainly on psychological principles and theories.

• Adhere to the length criterion. A word count for each ACP must be provided on the front title sheet.

If you fail to declare, or exceed the length criterion, or fail to submit the signed approval of your title, your ACP will not be accepted and a fail by non-submission will be recorded.

*The title of your submitted ACP1 will be checked against the signed form by the Assessment Secretary on submission.
ACP2  Single Case Experimental Study
Length:  3,000 - 5,000 words excluding references and appendices only

Introduction
The overall aim of this assignment is to produce a report of a single case experimental study conducted whilst on placement. Please note, this is a separate and additional assignment to your usual clinical practice report. Accordingly, the same client cannot be used for both. Typically, this study will constitute part of a trainee's ongoing clinical work on placement.

The format of the report should be similar to examples of single-case studies that have been published as "brief reports" in clinical journals. As with other clinical practice reports, it is not crucial that the case has resulted in successful clinical outcomes. However, unless your single case experimental study aims solely to report a detailed functional analysis, in which case only sufficient baseline data are required, it is essential that data pertaining to the case (both baseline and treatment phases) are collected. The data should comprise idiographic and nomothetic forms and be collected at three levels: 1. Idiographic data collected by the client at least once a day or more frequently); 2. Nomothetic data collected at key time points (this will comprise a short measure possibly administered weekly, but certainly collected at the start and end of baseline as well as the end of therapy). In addition, you must have formulated clear hypotheses which you have attempted to test. Please note that qualitative or biographical case studies are unsuitable for this particular assessment. Guidance on conducting a single-case study is provided during teaching and is also available on MOLE.

Ethical Clearance
The trainee is responsible for ensuring that the conduct of the evaluation is ethically sound, and to ensure that any relevant ethical permissions are granted prior to implementation of the project. If you have any doubts, please contact your personal tutor or the Department of Psychology Ethics Subcommittee.

Format
The single case experimental study should be written up according to the following format and not the usual case study guidelines:

<table>
<thead>
<tr>
<th>Title</th>
<th>Brief summary of case/issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Nature of clinical problem in general terms (do not include specific clinical details here), concise summary of relevant background literature and how it relates to the case. Consider and refer to relevant NICE guidance, provide justification for single case approach and background to method. Provide focus of present study briefly mentioning rationale and approach, and end with specification of experimental hypotheses.</td>
</tr>
<tr>
<td>Methods</td>
<td>Outline of rationale and design of study, brief and confidential description of client (participant), description of methods and choice of measures used in sufficient detail to allow replication by others. Provide evidence of the psychometric properties of measures used. Please note that it will probably be desirable to record several different process or outcome measures. It is useful to know whether procedures for calculating reliable and clinically significant change can be applied to the selected measures. Examples of data collection methods (e.g. observational schedules, self-monitoring diaries completed by the client) should be placed in an Appendix and care should be taken to ensure that they are anonymous. Details of any appropriate reliability checks should also be given in the Methods section. Briefly describe intervention and formulation (use diagrams as useful summary presentation). Set out summary of statistical and analytical approaches to data analysis.</td>
</tr>
</tbody>
</table>

1 N.B. Anonymised copies of actual completed versions are required
Consent for treatment

The process of attempting to obtain consent for treatment should be described. It is likely that this will be affected by the approach adopted in the particular service, age and capacity of clients to give consent. Approaches taken to ensure either that the client is giving informed consent or that issues around duty of care have been considered in relation to clients who are unable to give informed consent should be included.

Results

A concise summary of the findings of the investigation should be given, together with appropriate graphs, tables and statistical analyses within the body of the text. Please feel free to present data in several different formats, if appropriate. Consider idiographic data first. Subheadings to consider include the following: (1) baseline data (idiographic); (2) baseline and intervention phase (idiographic) – both these would primarily be graphical representations having checked for autocorrelations; (3) percentage of non-overlapping data analyses using more than one formula; (4) analyses of nomothetic measures at session and pre-post intervention levels. Additional analyses may be appropriate depending on the nature of the design. Consider weekly measures (if used) first and finally data comparing baseline and intervention phases (pre-post). Use criteria for determining reliable and clinically significant change. If driving the results by hypotheses, adapt the headings and structure above accordingly. Additional or supplementary data and graphs can be appended to the report after the reference section. If statistical analyses are reported, ensure sufficient details (t values, d.f., means and SDs of groups, etc.) for their interpretation are provided. Graphs within the body of the text should be of a high standard of presentation and clearly labelled.

Discussion

The findings should be discussed in relation to the original hypotheses. Please ensure that you relate the results obtained to the design employed. A critical review of the methods, design and analysis employed should be presented. Please comment on any relevant organisational and ethical issues surrounding this clinical study. The clinical significance of the study should also be addressed.

Other information

It is recognised that the work reported for ACP2 may not form the complete intervention. If the trainee is involved in other related work with the client at a different level of intervention this should be briefly acknowledged so that the contextual issues are clear. A Q&A page will be developed as a working document that will be continually updated and available on MOLE.

Conclusion

The purpose of this assessment is to provide an opportunity for trainees to apply quantitative methods to the study of single clinical cases. Please discuss the suitability of any clinical referral appropriate to this project with your relevant clinical supervisor before beginning to plan your study. If you require any further advice, please do not hesitate to contact your Personal Tutor.
ACP3 Service Evaluation Project
Length: 3,000 – 4,000 words excluding references and appendices only

Introduction to ACP3
Clinical psychologists are in a unique position in the NHS in that they are both clinically qualified and trained in research skills. They therefore have the opportunity (and are increasingly expected) to play a lead role in the development and evaluation of services. Research and evaluation skills will also play an important role in consultancy and working in teams. We think that the best way to equip trainees with the knowledge and confidence that they will need to fulfil this role is to give you the experience of doing it. The rationale for ACP3, then, is that it represents an integration of clinical skills, research skills, and clinical practice skills such as leadership and communication. It is a chance for trainees to use research expertise in an applied setting and to see how this can be of practical benefit in addressing meaningful questions about clinical practice or service delivery within the constraints of a real service. This kind of work is essential if we want services to meet the needs of the population, and to be as effective and efficient as possible.

The aim of ACP3 is to report on a small-scale project that evaluates some aspect of a service or programme. This will usually be an NHS clinical or health psychology service, but it may include the voluntary sector, training courses and other bodies such as HCPC or the BPS. The project must have the potential to be useful to the commissioning organisation and to be potentially publishable in a peer-reviewed journal or reviewed periodical. It should relate to some aspect of a current service or planned service development, and should always be driven by the commissioners of the project. It should fully consider in the context of the commissioning service/provider and will be limited by the time and resources that are available for it. ACP3 is therefore undertaken with an acceptance of the limitations that will be placed on the design by the demands of the situation and the acknowledgement that this is real life clinical practice (and not a tightly controlled laboratory paradigm). The aims of the assignment are to encourage trainees to see research skills as having a core role in routine evaluation of clinical practice or service provision. Service evaluation is vital because it is typically about decision-making: it aims to answer important questions about resource allocation and service delivery. The project also places an emphasis on the consumption of research findings and the written report produced is directed at a specified target audience (usually whoever commissioned the project or/and others who can use the information contained within it to make decisions).

The range of potential evaluation topics is very broad, and a comprehensive list would be impossible. There is a range of evaluation frameworks that offer guidance on developing suitable evaluation questions; a good starting point is to think about the different elements of a particular service that might be amenable to evaluation:
1. Service structure (e.g., appointment systems, referral pathways, case notes)
2. Process (e.g., treatment procedures, communication)
3. Outcome (e.g., clinical outcomes, satisfaction, quality of life, cost efficiency)
4. Organisational processes or structures (e.g., team working, recruitment)

In some instances commissioning services/charities may request specific evaluations. However, a key part of the task is assisting the commissioners is identifying realistic evaluation aims.

Identifying a Service Evaluation Project
The service evaluation project will constitute part of a trainee’s ongoing clinical work on placement 2, 3, 4 or 5 (the work cannot be submitted until year 2 or year 3). It can relate specifically to work carried out within the placement, or it may centre upon another service or charity although this needs to be negotiated with placement supervisors and the programme (see below). Trainees are not able to undertake ACP3 until they have collected their data for ACP2 and had that approved by their personal tutor. Consequently the data for ACP3 would normally be collected in year 2. If there is evidence of advanced progress towards completion of ACP2 approval may be sought to collect data for ACP3 during the second placement.
Trainees should discuss the opportunities for conducting a service evaluation early on in the relevant placement to give sufficient time to plan and implement an appropriate project. Some projects will also be advertised to trainees directly. Commissioners are asked to complete a commissioning form that is checked and approved by the service evaluation tutor (Jaime Delgadillo). Trainees would normally be expected to assist in the completion of this form. If a trainee is planning to conduct a service evaluation placement that is not based on their current placement, it is essential that they have discussed and agreed this with their placement supervisor and clinical tutor, as they will need to negotiate time away from placement to do this work.

**Time Allowed for Service Evaluation Projects**

We estimate that trainees can usually expect to allocate up to one half day each week from one placement to complete their service evaluation project. Any time taken out of a clinical placement must be by prior arrangement with the placement supervisor. It should be noted that this arrangement is purely for work on the service evaluation project: it is NOT an entitlement to additional study time and it ends when the evaluation project is complete. If the evaluation project has not been completed by the summer, it is expected that trainees will take any additional time needed from their existing study days rather than from the placement.

**Programme Requirements for ACP3**

The service evaluation project must involve the collection and/or analysis of data and the written report must include a set of recommendations for changes or improvements that have been clearly derived from the data. In some cases, trainees have analysed and reported on pre-existing data sets for their service evaluation projects. In these situations, the trainee should design the analysis protocol and must demonstrate sufficient intellectual input to the report in order to justify submission of the work to the Programme for assessment. On occasion, follow-up data collection is necessary and appropriate. If a large project has been identified, a trainee may consider working collaboratively with another trainee. Trainees must remember that this is an examined piece of work, and so they must each submit a clearly distinct and separate piece of written work. The best way to do this is usually for each trainee to take responsibility for a different aspect of the project from the outset and to focus on this in their submitted ACP3. The extent of the collaboration and limits of the trainee’s own contribution to the project must be clearly specified in a short ‘statement of contribution’ section that follows the title page.

**Your ACP3 must satisfy the following basic criteria:**

1. **Topic:** must be service-oriented (i.e., it must have implications for the effectiveness and efficiency of service delivery). The service must be relevant to clinical psychology practice in some way and the project must be either a service evaluation or an audit (i.e. not research)

2. **Methodology:** no methodology is specifically endorsed, but the project will be assessed on how well the chosen methodology attempts to answer the question(s) posed and how well the trainee communicates the implications for service delivery and/or development. The methodology must complement that chosen for the research thesis, so that if a trainee is undertaking a quantitative research thesis they must normally employ qualitative methods for their service evaluation (and vice versa). It is the trainee’s responsibility to ensure that this breadth is maintained, and where a piece of work does not fulfil the criterion, a new piece of work may be required. Trainees must also ensure that their data and analytic methods are appropriate to the question they are posing. As this is a small-scale project, it is likely that more descriptive methods of data collection and analysis will be most suitable (e.g., descriptive forms of qualitative analysis such as thematic analysis and content analysis are likely to be more appropriate than other methods such as grounded theory).

3. **Length:** The format of ACP3 is described below. It should contain an executive summary of no more than two pages (one page is preferable). A standalone report prepared to a specified journal format with a word count within the range of 2,000 – 4,000 words (excluding references). A set of brief appendices containing copies of materials used and of other dissemination outputs (see below).

4. **Trainees should take the major responsibility for the design and the methods employed for the project, but they should liaise closely with the commissioner with regards to the implementation.** Additional advice may be obtained from the service evaluation tutor (Jaime Delgadillo). The trainee is also responsible for ensuring that the conduct of the evaluation is ethically sound, and to ensure that
any relevant ethical or/and clinical governance permissions are granted prior to implementation of the project. If you have any doubts please contact the Chair of the Department of Psychology Ethics Sub-Committee or/and the person responsible for clinical governance within the commissioning NHS site.

**Financial Support for Service Evaluation Projects**
Costs incurred for service evaluation projects must be borne by the service and cannot be claimed against University research funds. You are encouraged to discuss with your supervisor/the commissioner how the service or Trust might benefit from your work, and whether sources of financial support might be available to you for this work.

**Dissemination of the Service Evaluation Project**
On completion of the project, you must ensure that the commissioner is presented with a copy of all sections of the evaluation and that they provide written approval for the results to be disseminated. Written approval to disseminate the findings of the evaluation must be contained in an appendix of ACP3. Written approval from the commissioners to disseminate cannot be considered as ensuring that the submitted piece of work will achieve a pass grade. Trainees should then take the appropriate steps to ensure that the report is fed into the relevant organisational structures or disseminated as suggested by the commissioners. Copies of posters or presentations conveying feedback from the evaluation should where possible be contained within an appendix. Where feedback has not yet taken place the plans for this should be contained within an appendix (this is likely to include a draft presentation). The programme requires trainees and commissioners to consider submitting completed versions of ACP3 for publication in professional periodicals or peer review journals and consequently the main report should be prepared in the format of a specified publication.

**Format of the ACP3**
- **Title page:** This must contain a statement of contribution (i.e. specify your role), and indicate which journal the report has been prepared for. In doing this please indicate the allowable article word count for the chosen journal as specified in the guidance for authors and include a web link to that guidance. Also include the word count for the piece of work.
- **Section one:** a prominent executive summary (a one to two-page outline of the work conducted and must identify the actual recommendations for action) written for a specific and defined audience (e.g. a sector or service manager, a purchasing group, a voluntary organization.
- **Section two:** a report for a specified periodical/journal (e.g. British Journal of Clinical Psychology, Clinical Psychology Forum, Behavioural and Cognitive Psychotherapy etc.) but using APA referencing style. The report would usually contain background or introduction to the evaluation (citing any standards, evidence or policies acting as drivers for the work); a description of the method (including details of participants, approvals gained, resources involved, and a description of any service user involvement (copies of surveys, questionnaires, or interview schedules should be contained within the Appendix); a summary of the findings (this may include the use of graphs or other pictorial forms of representation where this aids understanding of the findings. Use of percentages should be avoided when reporting findings from samples of less than 100); a clear statement of the practical recommendations arising from the evaluation (as well as containing recommendations for the subject area evaluated this section may also include recommendations for further evaluations); a list of references (in APA format regardless of journal format).
- **Section 3:** a brief set of appendices (containing copies of surveys etc., forms of feedback such as posters, summary leaflets, or powerpoint presentations that have been used or are in draft form, plus a signed statement from the lead commissioner stating that they are happy for the findings to be disseminated.

A trainee must have submitted their single case before submitting their service evaluation project. **Please note that only one ACP should be submitted for any one deadline.**
Clinical Practice Reports

Length: 4,000 - 6,000 words excluding references and appendices only
(Tables, diagrammatic formulations, headings and separate boxes are included in the word count)

Introduction
The purpose of clinical practice reports is to provide a structured opportunity for trainees to develop and demonstrate skills in communicating their clinical work. This will involve self-evaluation, including reflections on personal and professional development, making theory-practice links (e.g. through formulation and demonstrating understanding within psychological frameworks of the processes taking place in sessions with clients), and communication of their thinking and actions with respect to clinical work. This assignment offers a structured opportunity for the development of these skills and should flow from planning the work, clinical review and supervision. Particular emphasis is placed on knowledge of evidence-based interventions, formulation, self-evaluation, personal and professional development, use of supervision and written communication. Consideration of the organisational context around the client/the work might also be an important focus.

Preparation and presentation of Clinical Practice Reports
Trainees are required to submit one clinical practice report as an exemplar of their clinical work from each placement experience within the first two years of training. In the case of year long integrated placements, trainees should ensure that clinical practice reports from different client groups are submitted (e.g. an older age and a working age client).

Clinical practice reports provide an opportunity for the communication of in-depth clinical work. The number of contacts with the client or, in the case of indirect work, contacts with client, carers or health professionals should usually be a minimum of 7 sessions. We are aware that some services do not typically work with clients (or staff) for this many sessions. In this case, you may be able to write about more than one piece of work where you can highlight common themes or differences in your approach. It is only possible to submit one such piece of work each year and you should discuss this with your clinical tutor before writing.

The set of clinical practice reports presented throughout the programme should normally reflect work with clients across the life span and must cover more than one psychological approach. A client presenting with severe or long-standing difficulties should normally be included. The work need not have resulted in a successful clinical outcome from your perspective or that of the client. Reports where the trainee has experienced some difficulties in the work may also be submitted. As well as individual intervention work, an extended assessment and indirect client work that has an individual focus around a client may also be included. However, at least one clinical practice report from each of Years 1 and 2 must describe work in which the trainee has undertaken direct intervention(s) with the client(s), couple or family as the principal psychologist undertaking the work. If work is carried out jointly (e.g. with a supervisor or another trainee) then the trainee’s individual contribution should be clear.

Trainees should consult with the Clinical Tutors and their clinical supervisors about the potential suitability of any piece of work for a clinical practice report before it is selected and undertaken. A clinical practice report may fail if it is considered unsuitable within the context of previous submissions (e.g. a third assessment report). Trainees would normally need to gain consent from the client for the work to be written up as an anonymised clinical practice report. Supervisors and clinical tutors can advise on how best to do this.

Clinical practice reports should be organised and written in a style that is appropriate for a clinical psychologist operating in the frameworks of reflective-practitioner and scientist-practitioner. The knowledge and evidence base underpinning the clinical work should be discussed explicitly and supported by appropriate references both within the text and in a reference section at the end of the clinical practice report. Each clinical practice report should include within the appendices copies of ALL anonymised correspondence prepared. This should normally include a report sent back to the referrer, client or other agency. Clinical letters may be cut and pasted, scanned or re-typed with all potentially identifying information (including service details) removed first. All details in letters, and the
main body of the clinical practice report that could enable the identification of persons or services must be removed by hand, not through a computer programme. The reason for any absence of a clinical letter back to the referrer (and/or client) must be given in the body in the report.

Different models prescribe different approaches to clinical work and the following format is recommended to fit more or less neatly with the chosen approach or approaches. It may be adapted to suit the work carried out but should still emphasize the formulation (ideas and explanations for the presenting difficulties which are drawn from psychological models and which lead to proposals for intervention) and the critique in the light of outcome and self-reflection. In general, the clinical practice report should follow the following format:

Front Sheet
This must indicate 1) Focus of clinical practice report; 2) Whether the work is an Assessment or Assessment and Intervention; 3) If Assessment/Intervention then Psychological Approach used; 4) Word Count. (A example of the Clinical Practice Report Front Sheet is available on MOLE)

Title
The title should be succinct and (a) summarise the work, including any accompanying intervention and (b) identify the choice of focus for the particular clinical practice report.

Reasons for referral and service/setting description.
This may be brief or be a more detailed description of the service or organisational context where relevant

Assessment
The assessment will cover the person's initial presentation of their difficulties and your initial observations and preliminary hypotheses in relation to the client and significant others. Assessment should appreciate the importance of using the client's frame of reference and of taking time to understand any meaning/understandings the person may attach to their experiences. Where possible the person's own language in describing themselves and their situation can be used.

Include information, as appropriate, gained from the client and other sources. This might include home background and key attachment relationships, developmental, socio-economic factors, sexual, educational and occupational histories, attitudes to self and others, history of presenting problem, previous interventions and own ways of coping. Also relevant may be transitions in the client's life or cultural contexts, the onset of the difficulties and why the referral has been made at this time. Assessment may take place over a number of sessions and your observations about this process should be included.

Details, where appropriate, of preliminary investigations should be given. Central to these investigations should be an exploration of how the person understands their experiences and any narrative they have about why they are experiencing distress. Investigations might include reports of additional interviews, psychological tests (including their interpretation), questionnaires and rating scales and any inferences reached. The assessment should provide the data on which the formulation is based. Samples of completed questionnaires should be provided in an Appendix.

When the focus of the clinical practice report includes an organisational context around the person (e.g. on a ward based setting) a description of the system should take place in the assessment.

Formulation
The formulation of the client's difficulties should be a central element of the clinical practice report. A formulation is a summary of the explanatory concepts and hypotheses thought to be relevant in understanding the client's distress, derived from information collected from and about the client and/or the system around the client when this is relevant. Social, cultural and
organisational context should be taken into account. It will link this information with psychological theories and models derived from the literature (please cite relevant references) in an attempt to explain the origins and maintenance of particular clinical problems or issues. A formulation usually involves a shared understanding of the client’s distress and acknowledges their individual frames of reference. Formulation, meaning and/or narrative may be shared with the client and if not, the rationale for this should be given. The inclusion of a diagram usually helps to clarify complexity and may aid communication of the thinking behind the clinical work. If included this must be a part of the body of coursework and not in the appendices.

A formulation may either draw principally on a single psychological model or may refer to a number of models or theories. Where a single theory or model is used, a discussion as to why this particular approach to the clinical problem was adopted, together with some comment on which alternative models were considered and why they were not adopted should be included. It is important that, when making a formulation, the full range of information available about the client is utilised. The basis of the formulation is the nature of the clinical problem/issues, with a focus on how the person describes their experience, and how issues are inter-related, rather than attempting to fit the client to a particular model or diagnostic entity. Trainees should exercise care in the use of any diagnostic information and be mindful of the meaning of any diagnosis to the individual. Where such information is used there should be careful exposition of the reasoning for this and consideration of its utility in the context of the work. Finally, the formulation should lead directly to proposals and recommendations regarding interventions or other work in relation to the client. It should include a consideration of whether or not the proposed work is suitable for the client as you understand them at this stage of the work.

Evidence Based Practice.
This should comprise a brief consideration of any clinical guidelines (e.g. NICE, BPS, APA, NIMHE), major systematic review (e.g. Cochrane library) or service protocols (e.g. guidelines which consider to idiosyncratic local need or diversity) which relate to the client group, presenting problems and/or intervention(s) chosen below. Relevant guidelines should be identified, together with a concise summary of its recommendations. Trainees are not necessarily expected to follow such advice but must show awareness of the recommendation. Where the intervention chosen either falls outside the existing guidelines or is not supported by an evidence base, some comment is required. If an evidence base is not available for a particular presenting problem, consider whether evidence can be derived from elsewhere.

Intervention
This should comprise an account of therapeutic work or other intervention, giving a description of the process, the therapeutic relationship and the nature of any general problems encountered. It is not necessary to summarise every session and what happened within it. However, trainees do need to outline the major themes underlying the work undertaken, how this proceeded, how the client received it and how the work was terminated. Trainees’ ideas about the work may change as it progresses, necessitating a reformulation and possible changes in intervention. This might include noticing repeating patterns or cycles of interaction, the effects of being with the client on you, your impact on the client and observations about the relationship. Assessment, formulation and intervention may be viewed as a cyclical process with one aspect informing another and it would be appropriate to modify the format to reflect this. If trainees write about work in which the intervention was trialled or ended prematurely they must reflect on possible reasons for, and impact of, this. When all or part of the intervention takes place in a system or organization this should be described in this section.

Outcome
Evaluation of outcome at the end of intervention, together with any follow-up information, should be included. If the work is ongoing this section should include evaluation of the work so far and the likely course of future work. This may include subjective accounts (from the trainee, the client and/or others) that may be informal or collected more systematically (e.g.
through diaries). It is expected that at least one outcome measurement tool (e.g. a validated self-report questionnaire) should be used at least twice during the intervention (baseline and follow-up). Weekly routine outcome monitoring is advisable. Trainees are able to flexibly select outcome measures that are appropriate for the presenting problem (e.g. problem-specific or more global measures of distress, wellbeing or functioning) and the context within which the work is being conducted (e.g. client-reported, or parent / carer-reported measures). Trainees might consider whether reliable and clinically significant change has been demonstrated. Outcome measures may be supplemented with a measure of the alliance, helpfulness, process or session impact where appropriate. In exceptional circumstances when routine outcome monitoring is not appropriate, the rationale for not measuring outcomes should be explicitly justified in the case study. Trainees are expected to objectively evaluate the outcome of their work. However, the work does not have to have been ‘successful’ if trainees can illustrate what they have learnt from this.

Critique
This should comprise a critical review of your work, including suggestions as to how it might have been handled differently. Some comments relating outcome to original formulation should be given, together with an appraisal of possible alternative formulations. Attempts should be made to relate the presenting issues and subsequent work to the relevant clinical literature and some key references should be cited. Some reference should be made to the choice of theoretical model or models. You might want to consider in retrospect whether the approach was suitable for the client and consider what other approaches may have achieved.

Personal and Professional Development and Diversity
There should be consideration given to what the trainee has learnt about themself at work. This might include feelings they experienced in the work and how they responded to these, what personal qualities they brought to the work and whether these were a help or a hindrance, and the impact on the work of any current or past life events or experiences. It is important to recognise how the trainee’s own unique and personal narrative and background informs their perception of, and clinical work with, people. For example if the trainee grew up in a predominately patriarchal household, they may view male clients differently to female clients. The role of supervision and how this contributed to their understanding of the work could also be commented on.

Trainees are encouraged to consider and explore diversity issues (for example, age, gender, (dis)ability, sexuality, race, culture, beliefs, power, socio-economic status) in all aspects of their clinical and academic work.

With regard to clinical practice reports studies, diversity issues must be explicitly considered. Trainees need to demonstrate an awareness and understanding of how similarities and differences between themselves and their clients impact on the work, the issues associated with privilege, and the impact of the power they hold within the therapeutic relationship. It may also be important to consider issues of diversity between themselves and their supervisor.

Focus of Clinical Practice Reports
The information provided above is intended as guidance for all clinical practice reports. In addition, each report must place particular emphasis on a different area. Approximately 1000 words of the assignment should be devoted to the particular area of emphasis. It is usual for the focus to be addressed in a separate section, but alternatively it could be integrated throughout the report. Each report will address one of the four areas. The details of the different areas of emphasis are as follows:

Process
Particular attention should be paid to the process of the clinical work. This should include interpersonal processes and their impact on the work. Where appropriate the processes involving the contextual organisation around the client should also be considered. The trainee may also want to consider processes which link to the stage of the work – forming a therapeutic relationship, engagement in the work, processes around endings, etc. It is an expectation that recording will be carried out with some clients, with their consent, in order to ensure that this requirement can be
fulfilled. An appendix should be dedicated to edited transcripts or summaries of audio or video recorded material, which illustrate the issues referred to. Please note that the full text of sessions is not required, only edited extracts.

Supervision

The role of supervision should be explored in some detail. Trainees will need to keep a supervision log or diary recording the main themes discussed in supervision, the learning that took place and how this affected the client work. Trainees could consider what kind of supervision was developed in response to the demands of a particular piece of work e.g. information giving, space for reflection and containment (and whether this changed over the course of the work); or whether the model of intervention used was reflected in the nature of the supervision. Illustrative extracts from the supervision diary should be appended to the main text as an appendix. Trainees may consider drawing on a specific model of supervision.

Personal and professional development

The focus here is on learning about oneself at work using illustrative examples from a learning and development log. Selected extracts from this log should be provided in an appendix. It may be helpful to think about whether or how the work has been challenging, for example by considering some of the issues around providing psychological help in a context of social injustice / disadvantage, and how managing that process can be a key element in working with some clients/client groups and can be personally challenging (e.g. in raising prejudices or challenging familiar narratives).

Inter-professional learning

This focus includes work with other professionals. It should consider factors leading to the success or otherwise of the joint work and reflections on how differences in terms of roles, underlying philosophies or models, etc, were integrated/reconciled. Other professionals are defined as any other staff groups including support workers but excluding psychology assistants. Inter-professional learning could take place via: speaking with staff from other disciplines; shadowing other professionals; visiting services other than clinical psychology to understand the context of the client’s involvement in mental health, social care, voluntary or private sector services; joint team work, including therapeutic work; joint seminars or clinical reviews. The emphasis should be on both the trainee’s learning from others and what the trainee brought to the understanding of others. Trainee awareness and response to systemic processes should also be considered under this focus.

The title page should clearly indicate which of these areas is being addressed. Please note that all clinical practice reports should explore these issues to some extent. However, each assignment provides an opportunity to discuss one area in more depth.

Awareness of Ethical Issues

Consideration of the ethical issues involved in the work should be described and discussed at relevant points in the report. Examples may include: the decision to exclude or include family members, the making of home visits in circumstances where the client is not clearly the person requesting help (e.g. where help has been requested by a carer or family), and how this might impact on the client/work, consideration of who is the client (e.g. the referrer, the client or the client's family), issues of confidentiality, consent for the work, potentially aversive or coercive procedures, etc.

In order that formal letter or report writing can be assessed, copies of letters or reports written to professional colleagues should be appended.

Consent

The process of attempting to obtain consent for assessment and/or therapeutic work should be described early in the clinical practice report. It is likely that this will be affected by the approach adopted in the particular service, age and capacity of clients to give consent. Approaches taken to ensure either that the client is giving informed consent or that issues around duty of care have been considered in relation to clients who are unable to give informed consent should be included.

Consent for the work to be written up as a clinical practice report should normally be sought from the client and this process should be documented in the report. Trainees may wish to consider routinely
informing clients that they may have the work written up as a clinical practice report at the commencement of therapy.

**Joint work**

There are constraints on the submission of some kinds of joint work because of the problems it raises in evaluating trainees' personal contribution. A distinction is made between (a) joint work for which the trainee took the primary responsibility and (b) joint work in which the candidate shared equal responsibility with another professional. There is no restriction on the number of pieces of joint work of type (a) that can be submitted. However, only *one* instance of joint work of type (b) may be included. Work undertaken jointly with another trainee clinical psychologist or in which the trainee took a subsidiary role should not normally be submitted unless responsibility can clearly be identified with one trainee. Similarly, clinical work where the trainee has undertaken solely follow-on work that had been instigated by a previous (trainee) clinical psychologist cannot normally be submitted. In all cases of joint work it should be made clear which procedures were carried out by the trainee and which by a co-worker, though trainees will be expected to take responsibility for the whole of that which is submitted. In such circumstances, trainees should ensure that they have discussed the work with their clinical tutor.

**Retention of information**

In the case of failed coursework presentation of alternative work completed on the same placement will normally be required. While continuing on the programme trainees must retain access to all relevant process/supervision information until coursework from a placement is formally passed. This must be carried out within specific trust guidance. It is the trainee’s responsibility to ensure the process for this.
Research Handbook

Please consult MOLE for the research timetable, additional guidance and relevant forms.

The research process is supported by teaching timetabled throughout the three years of training and overseen by the Director of Research Training with the support of the Research Support Secretary (RSS).

Throughout any research project trainees are advised to keep in regular (e.g. at least six weekly) contact with your research supervisors with records of all meetings to be recorded on the PATS (personal and academic tutoring system) university system.

Trainees should also systematically plan their research and placement time between April of the second year and May of the third year (i.e. from placements 3, 4, 5, and 6) in liaison with placement and research supervisors. The arrangements, which must fulfil the required breakdown of days, must be signed off by each supervisor and the clinical tutor before or at the commencement of each placement. Additional research days are available to facilitate write up and in some cases analysis but these days must be agreed with placement supervisors, clinical tutors, and the research supervisor (see the form available on MOLE). In the event that a new proposal or substantive revision is required it is not possible for trainees to take additional research days and the time required to undertake additional research work must come from the remaining research days and the standard study days available to trainees.

Procedure for approval and implementation of Research Projects
Trainees are normally expected to complete their research in areas linked with the research subgroups within the CPU and/or specific NHS priorities where there is strong NHS supervisory support. Trainees may also conduct research under the supervision of other psychologists within the department, where the proposed project is of relevance to clinical psychology. Academic staff expertise and interests along with the availability of local NHS interests are made explicit during staff research presentations and in an annually revised booklet (February/March of the first year). In addition, staff interests can be viewed at any point via the CPU/Department website.

During March and April of the first year trainees are actively encouraged to approach academic supervisors to discuss potential projects. However, trainees may informally discuss projects/areas of interest earlier than this in the first semester.

In late April or early May of the first year, trainees are required to submit via the Research Support Secretary a request for supervisor form indicating a first and second choice of supervisor. Blank forms are available on MOLE. The form needs to be signed by their first and second choice of University supervisor, confirming they have met with the trainee. A supervisor’s signature does not guarantee that this supervisor will be allocated to you (see below).

The requests for supervisor/s are discussed within a meeting of the academic staff and the actual allocation of supervisor is decided upon in this meeting. The allocation process will take existing workloads into account. Whilst every attempt is made to assign supervisors according to trainee choice, choice is not guaranteed. In reality most trainees will get either their first or second choice of supervisor. Trainees will be informed of their allocated supervisor towards the end of the second semester. It may be that a small number of trainees will at this time be advised to approach specific members of the academic team in order to put in a new request for supervisor.

There are trainee research presentation slots towards the end of the first semester. These provide an opportunity to present an outline of the proposed study and to seek feedback from peers and the presentation facilitator (who will usually be academic members of staff). These presentations also provide an opportunity for further developing presentational skills, although the emphasis is on finalising preparation to submit a research protocol for academic review.
In July of the first year trainees are required to submit an electronic copy of a full-project proposal for review. This enables the viability and quality of the research, together with cost to be assessed. Four research days are available to take usually during the second placement. Timing of these days must be negotiated and agreed with the placement supervisor in advance of them being taken and approved by a member of the clinical tutoring team and the research supervisor. If at a subsequent time a new research protocol is required the trainee will not normally be able to take additional research days and the time required to prepare a new protocol must be taken from general study time. It is important to work collaboratively with your supervisor(s) and approach them with draft versions of the proposal for comment. The full proposal should be of sufficient detail to enable independent reviewers to decide upon (a) the practicality and (b) the adequacy and appropriateness of the design and intended procedures. Guidelines on preparing a protocol can be found on MOLE.

During September trainees will attend a protocol review meeting with the lead internal reviewer. The research proposal will be subject to independent scientific review by two members of academic staff, as well as a statistical expert (Dave Saxon) in the case of quantitative research, and a qualitative expert (Andrew Thompson) for qualitative research. The trainee’s supervisor(s) are also invited to the meeting. The trainee should notify their supervisors of the date as early as possible to facilitate this. Following the review detailed feedback is provided and trainees are required to make any necessary alterations to their proposal. Trainees will be advised of the deadline for resubmission, which will usually be in November at the start of the second year. However, trainees are encouraged to submit ahead of this deadline to facilitate early engagement with the ethics and governance processes. Protocols will be re-reviewed by either one or both reviewers (depending on the level of changes required). Further alterations maybe necessary prior to the release of a formal approval letter from the Director of Research Training allowing you to proceed with seeking ethical and governance approvals.

An electronic copy of the final version of the approved proposal should be provided to the Research Support Secretary.

All research undertaken by University students must be registered with the University’s Research Services. The Research Support Secretary will automatically do this for trainee research following internal approval of the proposal.

Appropriate ethical and governance approvals must be sought, including any required R+D approvals (see below), as well as confirmation of governance sponsorship, prior to the work commencing. If the project is a University sponsored clinical trial there is an additional process prior to commencement of the project (guidance is available on the research pages of MOLE and in teaching). Proof of application for ethical approval should be lodged with the Research Support Secretary and evidence of this should be provided by December during the early part of year two.

Research taking place within the NHS requires R+D approval and registration by the participating Trusts. The internal approval process of the programme meets the national criteria for peer review of research proposals for the purpose of research governance and therefore we have arranged that projects successfully approved can apply for exemption from further scientific review at local NHS sites. Trainees are advised that they will still need to apply for R+D approval from the NHS site as this involves consideration of other areas as well as scientific review.

The University will normally indemnify all projects and act as research sponsor. In some cases the participating NHS Trust may prefer to act as the sponsor. If you are conducting a clinical trial sponsored by the University (e.g. developing/testing self-help etc.) you will be required to undertake some additional approvals prior to commencing your research, as well as following some additional monitoring processes (see the research pages of MOLE for advice).

All research undertaken within the NHS or by NHS employees is liable to be audited to ensure that governance and ethical procedures have been adhered to. To enable audit, all projects are required to maintain an ongoing research site file (guidance available on MOLE), which must
normally be kept for a maximum of five years following completion of the research. The site file should contain amongst other things a research contract (detailing who is involved and their obligations), any letters relating to internal review, ethical review etc., consent forms and data. Teaching is provided on establishing and maintaining a site file. The site file should normally be submitted to the RSO within 2 weeks of submission of the thesis.

Further information regarding all timings and deadlines relating to the research process can be found on the research timetable (see MOLE). Please note that having an approved proposal, as well as submitting evidence of applying for appropriate ethical approval to the Research Support Secretary, are requirements for continuation into the third year of the programme and must be achieved by the end of the second year of training.

Any amendments to the protocol post scientific approval must be reported to the Research Support Secretary and a copy of the amended documents provided, as these may need to be re-reviewed internally. Copies of ethics and R+D approvals for amendments must also be provided to the Research Support Secretary.

The University uses an electronic system for recording all supervision meetings and it is the Trainees responsibility to complete this form following all supervision meetings. Supervisors can also make entries on the system. Trainees are encouraged to discuss any problems with their research early on with their supervisors. Trainees may also seek additional advice from Andrew Thompson, Director of Research Training. A formal review of progress should be conducted between the University Supervisor and NHS Supervisor and Trainee in November of the third year. At this time supervisors will audit the site file and review the costings, consent forms, and ethical conduct in relation to the study, as well as looking at the raw data collected. There is a report form relating to this audit and a copy of this must be lodged with the RSS by the end of November. Trainees are also required to prepare a formal protocol outlining the proposed literature review and to get this signed off by their supervisor who must notify the Research Support Secretary. Trainees are strongly encouraged to register the thesis literature review protocol on a review database such as PROSPERO.

For University Sponsored clinical trials, there are additional monitoring requirements (see MOLE for further information)

Research funding
A research budget Research funding (of up to £600) is available where necessary to assist the conduct of high quality research. All potential expenses must be justified and specified in advance within the protocol. If additional funding is required trainees should liaise closely with their supervisor/s who may be able to assist if possible in seeking funding in the from external bodies and other sources (charities, research collaborators; NHS Trusts). Alternatively the scope of the proposed project may need to be revised.

The deadline for submission of the thesis is the last working day of May in the final year. Three copies of the thesis or two copies of the thesis together with an electronic copy on CD must be submitted to Research Services (see guidelines http://www.sheffield.ac.uk/rs/code). The same version without appendices must be submitted via Turnitin by this date. (Further guidelines on the preparation of the thesis are provided on MOLE). An Access to Thesis form should be completed that indicates that there will be an embargo on electronic access to the thesis for the maximum period. All outstanding claims for expenses should also normally be submitted at this time.

The trainee must retain all raw data until any recommendation to Faculty for completion is made. Electronic datasets/transcripts must be submitted with the rest of the site file, within 2 weeks of thesis submission. Trainees should upload any data to their individual folder on the DClin Research Server, instructions can be obtained for the Research Support Secretary. This data should be submitted in a meaningful format (see guidelines on MOLE).

The thesis will be formally examined by a Viva in July.
Outcome of the thesis Examination

Oral Examinations

Following completion and submission of all coursework including the thesis within the designated registration period, candidates will be examined orally by the External Examiner and the Internal Examiner. A brief report completed by the supervisor regarding origins of the work, degree of independence and difficulties encountered is submitted with the thesis.

Examination Outcome

Outcome of examination for the research thesis are as follows:

Pass without amendment

Pass with minor corrections to the satisfaction of the examiners. The Board of examiners may require minor revisions to specified sections to strengthen some of the areas of weakness or provide clarification. The revisions will need to be carried out within 3 months.

Pass with major corrections to the satisfaction of the examiners. The Board of examiners may require major revisions to specified sections such as re-writing sections, correcting calculations or clarifying arguments. The revisions will need to be carried out within 6 months.

Resubmission. In this case the thesis has not been deemed to pass and the trainee is required to complete further work or modify their thesis in order to resolve any difficulties identified by the examiners. The same internal and external examiners will review the thesis. The resubmission may be requested with or without a further viva at the discretion of the examiners. The resubmission should be completed within 12 months.

For more detailed information regarding the outcome of thesis after oral examinations please refer to Research Services: Code of Practice for Research Degree Programmes 2018-19, page 48 Available at: https://www.sheffield.ac.uk/rs/code

Dissemination Log

Trainees should then start to work on dissemination in collaboration with their supervisor/s. A log detailing required and actual dissemination activity and future dissemination plans is required to be submitted usually within one month of the Viva having taken place (see guidance on MOLE).

Study completion process

Following Viva, the site file must be submitted to the Research Support Secretary this entails a short meeting with the Research Support Secretary to ensure all required documentation is within the file. Trainees should arrange this individually with RSS. The research should also be signed off with ethics and governance committees upon completion (see guidance on completion of Site File on MOLE).

Please note that submission of the site file and dissemination plan is a requirement for completion of the Programme.

Once the thesis has been approved by examiners an electronic Library copy should be submitted to the White Rose Server and copied to the Research Support Secretary for uploading to MOLE (see instructions on MOLE), and a copy lodged with the supervisors. It is recommended that this version should be embargoed via the library Access to Thesis form. The electronic copy must be an edited version to exclude anything that has copyright. Where such material is removed a note should appear in the thesis. Please note that an award cannot be made until the Library copies of the thesis (bound and electronic) have been submitted.

Bound copies of the final thesis should be offered to the participating service and feedback to participants and/or service/s should then be arranged (and confirmation that this has happened is required in the dissemination log). Feedback will usually be via a brief report or presentation. The Trainee will normally need to bear the cost of any publication/dissemination activity.

There is an expectation that the work will be published and disseminated at appropriate conferences and within appropriate service contexts and trainees should work on this during the final summer
months. A schedule for pursuing publication should be agreed with the supervisors (and attached to the dissemination log. A copy of this is available on MOLE).

**Late submissions**
The deadline for the research thesis is the **last working day of May**. An extension to this deadline is granted only in extenuating circumstances (e.g. significant illness of at least seven days and requiring a doctor’s certificate), and then only after consultation with the Chair of the Board of Examiners and provision of documentary supporting evidence. This extension would normally be for no longer than 2 weeks.

The next deadline for submission will be the last working day in November in the same year and these will be formally examined by viva in January of the following year. Trainees who fail to submit on time need to consider the implications of late submission. These might concern difficulties in being employed as a qualified clinical psychologist within the first year following training, attendance at a later examination board and the payment of a continuation of registration fee. Trainees are, therefore, strongly discouraged from late submission for those reasons, together with the additional administrative work for the Programme which arises from late submissions. A policy document concerning employment issues is available from the Unit Administrator.

**Claiming research expenses**
It is the trainee’s responsibility to estimate total research costs for their main research project and to have these costs approved by their research supervisor at the University. Items of expenditure to be costed may include: transcription, copyrighted questionnaires, travel and mileage (excluding that to and from a trainee’s usual NHS base), photocopying, essential tests and equipment, consumables (large quantities of stationery, audio tapes, etc.), postage.

A detailed costing of the research must be submitted as part of the research proposal, on an approved form, which is provided on MOLE.

Detailed guidelines on how to cost a proposal are provided on MOLE. Please follow these guidelines carefully. If you have any queries regarding the guidelines please contact the Research Support Secretary.

Expenditure will be recorded throughout the project, and it is the trainee’s responsibility to ensure that these costs are not exceeded. **Expenses incurred over the agreed amount will be the responsibility of the trainee and will not be reimbursed.**

Please remember that research costs can only be claimed with respect to your main research project. Costs incurred for service evaluation projects etc. cannot be met by the University. However, if a Unit or Trust is the direct beneficiary of any research project that you are engaged in, it would be appropriate to seek some support (e.g. postage, stationery, photocopying, printing etc.) from the NHS unit involved. Please discuss this with your relevant clinical or liaison research supervisor.
Guidelines for preparation of the research thesis

The thesis is required to contain original work. It will involve an investigation with human participants and is of clinical relevance. The findings should contribute to the knowledge base of clinical psychology and there should be evidence of the exercise of independent critical power. Both parts of the thesis should be of a sufficient quality suitable for publication in peer-reviewed journal following style modification. The thesis should be prepared in accordance with APA format. In preparing the thesis, Trainees are advised to look at previous theses and to look at examples of similar reviews and studies within the extant literature base.

Formatting
The thesis should be on good quality A4 paper leaving a 40mm margin at the binding edge and at least 20mm at the other margins. All pages should be presented throughout in font size not less than 12 and double-spaced and double-sided. The text should be numbered (Arabic) from the literature review onwards and use lower case Roman numerals prior to the review. Theses over the word count will not be accepted.

Candidates must ensure that the work is appropriately anonymised throughout so that no participant can be easily identified.

The thesis is in a portfolio style and will consist of 3 sections:

1. a self contained LITERATURE REVIEW written in the style of the British Journal of Clinical Psychology (BJCP) but with additional word allowance for full reporting of the work completed. The word count for the review is 8,000 words excluding references and tables (reasonable titles and footnotes associated with tables are also excluded from the word count).

2. A self contained RESEARCH REPORT in the style of BJCP but with additional word allowance for full reporting of the work completed, together with a detailed presentation of results and in depth discussion, consideration of methodological limitations, need for future research and clinical implications. The word count for the empirical paper is 8,000 words excluding references and tables (reasonable titles and footnotes associated with tables are also excluded from the word count).

3. APPENDICES must include proof that ethical approval was gained and may also include other supplementary information. The letter(s) of approval from the relevant ethics committee(s) and information sheets provided to participants would normally be included. Copies of any scales utilised must also be included (at least in the examiners copies). In all cases of qualitative research clear trails of evidence should also usually be included (i.e. there should be worked examples of the analysis showing extended sections of data). Other supplementary information might also be included (e.g. outlines of interventions tested, additional quantitative analyses etc.). The thesis should largely be able to be examined without the need for the appendices to be read in detail. There is not a word limit for the appendices, however they should be put together with economy in mind and only include useful supplementary material.

The maximum total length for the whole thesis is 16,000 words excluding tables, references and appendices.

There should be no duplication or cross-referencing of pages or sections between the literature review and the research report.
Layout, this should be presented as follows:

a) Title page for whole thesis
   This should contain a succinct and accurate title that reflects both parts of the thesis.

b) Access to Thesis form

c) Declaration page that the work has not been submitted for any other degree or to any other institution

d) Structure and Word Counts page
   Word counts must be given separately for the literature review and empirical study. The total word count must be given a) without references and tables and b) with references and tables. The word count for the appendices is not required.

e) Lay summary/Abstract
   A 500 word unstructured lay summary covering both parts of the thesis. This should be targeted towards a specific audience (e.g. collaborating service, research participants, charity that provided the predominant support for the work, or a general academic audience). This summary may serve as a sufficient report for sharing the findings of the thesis with non-academic partners.

f) Acknowledgements
   Research supervisors should be acknowledged. Collaborators and others who have provided substantive assistance may also be acknowledged. Acknowledgements should be brief and appropriate for viewing by a public audience.

g) List of Contents
   This should include page numbers
Section 1  Literature Review

This should conform precisely to the format of the British Journal of Clinical Psychology (BJCP), including provision of a separate abstract. The specific word count for the review is 8,000 words excluding references and tables. BJCP is 5,000 words and the extended word count is provided to allow space for additional description of the methodological approach used within the review. A structured abstract in the style and word count of BJCP is required and this should also include additional bulleted statements as required by BJCP.

The purpose of the literature review is to provide a clearly structured, contemporary, focused, critical review of the scientific literature surrounding the research work to be undertaken. It should be assess the state of knowledge in a particular area, identify key important theoretical and empirical questions still to be answered and make recommendations about how these could be addressed by further research. Clinical implications of current knowledge status should also receive comment. A variety of different review methods may be used and trainees are required to be specific about the approach used with their supervisors before conducting the review. This should involve the preparation of a literature review protocol that requires review by the supervisory team. Confirmation that a literature review protocol has been prepared is required as part of the audit of the research process described earlier. Trainees are strongly encouraged to register the literature review protocol on a recognized review database such as PROSPERO.

The literature review should relate to the issues associated with the research conducted in the second part of the thesis. However, it should also be a stand-alone piece of work and may cover an area wider than the focus of the empirical study reported in part two of the thesis.

Regardless of the type of review conducted there is an expectation that the review include a description of the aims and search strategy methods. This must include information on the databases used and how papers were selected for inclusion. The review must demonstrate critical appraisal of identified papers. The use of quality appraisal criteria is encouraged and where used should be clearly reported. It is usually of more value to integrate the critique as studies are considered rather than present a generic critique at the end of the review. The use of tables to systematically summarise information on papers is strongly encouraged. Such tables should be presented within the main body of the review with the exception of tables used for data extraction, which might in some circumstances be included as an appendix. The literature review should culminate with a clear assessment of the current state of knowledge on the basis of the evidence and a discussion of issues that still need addressing. This is likely to include your own research question. The review should also where possible draw conclusions or make recommendations relevant to clinical practice.
Section 2 Research Report

This should confirm precisely to the BJCP format including inclusion of a separate abstract. The word count for the empirical paper is 8,000 words excluding references and tables. BJCP is 5,000 words and the extended word count is provided to allow space for additional description of the methodological approach used and to provide space for detailed reporting of results.

This should include:

Title
A succinct and accurate title for the research report

Abstract
A structured abstract in the style and word count of BJCP. This should also include additional bulleted statements as required by BJCP.

Introduction
This should be a concise (approximately 2,000 words) exposition of the background to and rationale for the research. Whilst inevitably there will be some overlap with the literature review candidates should ensure précising rather than duplication with the literature review is practised. This should include (a) a clear justification for the study in terms of the gap in, or critique of the current literature and (b) a clear rationale for the methodology selected. It should conclude with a detailed exposition of the research question and clear aims and hypotheses.

Method
This should include details of participants, procedures including ethical safeguarding, selection and nature of measures (actual copies to be included as part of the appendices) and description of the analytic approach. The rationale for the sample size for all types of design should be clearly made. For qualitative studies the method of data collection must also be detailed and the full semi-structured interview schedule might be included in the method (or alternatively where the schedule is extremely long it might be placed in an appendix). Quality control or procedures put in place to ensure validity should be clearly described here. Where appropriate there might be a section that also contains a consideration of reflexivity.

Results
This should explain clearly how hypotheses have been tested or the research questions addressed. A clear logical thread to the process of analysis should be present. Findings from analyses should be appropriately reported. Descriptive statistics that would be of value in comparison with other samples can be included if appropriate or might be included in an appendix. The results should focus upon the specific questions asked. Qualitative studies should provide a sufficient number and range of excerpts from the data so as to support the suppositions made, however there should also be an appropriate amount of commentary provided and presentation of lengthy excerpts of raw data should be avoided.

Discussion
The findings should be systematically discussed in terms of their strength, potential meanings, their theoretical and clinical implications and their limitations including a methodological critique.

Conclusions
A short paragraph maybe inserted summarising the main findings and stating the contribution of the study.

References
Presented in accordance with APA format.
Section 3  Appendices

Each section may have an Appendix containing supplementary material. This may include:

i) Additional literature review data extraction tables (these should be included after the literature review and will not be counted towards the word count). Summary tables that are essential to the utility of the review should be included in the review itself. It is not expected that supplementary tables will be routinely appended and the use of appendices in the literature must only be used where it clearly shows evidence of the method used in the review over and above what can be explained within the text.

ii) If the thesis involves any degree of collaboration with another trainee or research project (i.e. joint collection of data or harvesting of data from an existing study etc.), then an appendix describing the relationship between the thesis and the other work is required. The emphasis of this will be on clarifying that the thesis is sufficiently independent to warrant the award of a Doctorate (see notes on preparing a protocol on MOLE)

iii) Proof of ethical approval/s (these should always be included after the study - Copies of all letter(s) of approval from the ethics/governance committee(s) should be appended)

iv) Information sheets, blank consent forms, measures and materials
   - Exemplar copies of measures used or long interview schedules
   - Copies of recruitment materials such as posters/tweets etc.
   - Blank copy of consent form
   - Copies of information sheet/s
   - Copies of interventions used (e.g. self-help materials etc.)
   - Evidence of audit process (qualitative studies only)
   - Evidence of reflexivity process (qualitative studies only)

Where work or additional analyses have been completed which are not included in the research report these maybe included with a brief explanation within the appendix. Candidates should ensure that descriptive statistics of their major variables are available at some point within the thesis. Please note that actual details of statistical workings should not normally be included at any point in a thesis.

In the case of qualitative studies it is appropriate to include a brief worked example to demonstrate the qualitative analysis conducted and to demonstrate the quality of the data collected.

Any queries about thesis guidelines should be directed to Dr Andrew Thompson, Director of Research Training

Submission
You are required to submit to Research Services two formally bound copies using the University crest, as well as an electronic copy which should be provided on a CD before 4 pm on the deadline date (Further details on submission process are available on MOLE). Thesis should be appropriately titled with a title that reflects both parts of the work. The University Print Service provides a binding service. You are recommended to book early to ensure availability. All trainees are advised to consult with their supervisor closely during the preparation and submission of the thesis. Following completion Trainees are required to ensure that either a copy of the thesis or an appropriate synopsis is lodged in the appropriate NHS setting in which the research was conducted, and that an additional bound copy of the thesis is provided directly to the supervisor. Data and site files are also to be submitted (see MOLE for guidance).
Appendices

1. Programme of Dates
2. PTC Terms of Reference
3. Policy of taking leave during teaching
4. Health and Safety Policy
5. Useful Names and Addresses
6. Entry Agreement
7. University guidance on unfair means
8. Writing tips for SAQs
9. Guidance on preparing coursework and the thesis so that it is in APA format
10. Regulations for the degree of Doctor of Clinical Psychology
11. Programme Specification
12. Acronyms
### Appendix 1

**Doctor of Clinical Psychology - University of Sheffield**

**PROGRAMME OF DATES 2018 - 19**

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<td></td>
</tr>
<tr>
<td>13</td>
<td>Uni Vacation</td>
<td>17 Dec 18 Placement Continues Bank hols 25&lt;sup&gt;th&lt;/sup&gt; &amp; 26&lt;sup&gt;th&lt;/sup&gt; Dec</td>
<td>Placement Continues Bank hols 25&lt;sup&gt;th&lt;/sup&gt; &amp; 26&lt;sup&gt;th&lt;/sup&gt; Dec</td>
<td>Placement Continues Bank hols 25&lt;sup&gt;th&lt;/sup&gt; &amp; 26&lt;sup&gt;th&lt;/sup&gt; Dec</td>
</tr>
<tr>
<td>14</td>
<td>Uni Vacation</td>
<td>24 Dec 18 Placement Continues</td>
<td>Placement Continues</td>
<td>Placement Continues</td>
</tr>
<tr>
<td>15</td>
<td>Uni Vacation</td>
<td>31 Dec 19 Placement Continues Bank Hol 1&lt;sup&gt;st&lt;/sup&gt; Jan</td>
<td>Placement Continues Bank Hol 1&lt;sup&gt;st&lt;/sup&gt; Jan</td>
<td>Placement Continues Bank Hol 1&lt;sup&gt;st&lt;/sup&gt; Jan</td>
</tr>
<tr>
<td>16</td>
<td>Uni Vacation</td>
<td>7 Jan 19 Placement Continues</td>
<td>Placement Continues</td>
<td>Placement Continues</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td>14 Jan 19 Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>21 Jan 19 Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday</td>
</tr>
</tbody>
</table>

* Study day alternate weeks - see full timetable for details

**Pre-placement planning visit to take place during this period - to be agreed between supervisor and trainee.**
<table>
<thead>
<tr>
<th>Week</th>
<th>Monday</th>
<th>FIRST YEAR</th>
<th>SECOND YEAR</th>
<th>THIRD YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>28 Jan 19</td>
<td>Teaching Mon or Mon/Tues* SAQ1 deadline</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>20</td>
<td>4 Feb 19</td>
<td>Teaching Mon or Mon/Tues* OCSAs Mon 4th Feb</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday Shared Teaching Leeds Fri</td>
</tr>
<tr>
<td>21</td>
<td>11 Feb 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>22</td>
<td>18 Feb 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td></td>
<td>Half term</td>
<td>25 Feb 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
</tr>
<tr>
<td>24</td>
<td>4 Mar 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday &amp; Tuesday</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>25</td>
<td>11 Mar 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday Shared teaching Leeds Fri</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>26</td>
<td>Selection Tue &amp; Wed</td>
<td>18 Mar 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
</tr>
<tr>
<td>27</td>
<td>Selection Mon &amp; Tue</td>
<td>25 Mar 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
</tr>
<tr>
<td>28</td>
<td>Easter hols</td>
<td>1 Apr 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
</tr>
<tr>
<td>29</td>
<td>Easter hols</td>
<td>8 Apr 19</td>
<td>Teaching Mon or Mon/Tues* Placement 1 ends Fri 12th Apr (73 days)</td>
<td>Placement 3 ends Fri 12th Apr (76 days)</td>
</tr>
<tr>
<td>30</td>
<td>Easter Friday bank Hol</td>
<td>15 Apr 19</td>
<td>Study **</td>
<td>Study** Study Placement 5 ends Fri 19th Apr (88 days)</td>
</tr>
<tr>
<td>31</td>
<td>Easter Monday bank hol</td>
<td>22 Apr 19</td>
<td>MINIBLOCK Tue - Fri ACP1 &amp; CS1 deadline Tue 23rd Apr</td>
<td>MINIBLOCK Tue - Fri ACP2, CS3 &amp; SAQ3 deadline Weds 24th Apr</td>
</tr>
<tr>
<td>32</td>
<td>29 Apr 19</td>
<td>MINIBLOCK Mon - Thurs</td>
<td>Teaching Monday Placement 4 starts Weds 1st May</td>
<td>Teaching Tuesday</td>
</tr>
<tr>
<td>33</td>
<td>Bank Hol</td>
<td>6 May 19</td>
<td>Teaching Tuesday Placement 2 starts Wed 8th May</td>
<td>Teaching Tuesday</td>
</tr>
</tbody>
</table>

** Pre-placement planning visit to take place during this period - to be agreed between supervisor and trainee. Full details of placement/research/study time to be individually planned.
†Selection Dates: Tue 19th, Wed 20th, Mon 25th & Tue 26th March
First and Second year trainees are requested to help with Selection for half a day over this period.
**Doctor of Clinical Psychology - University of Sheffield**  
**PROGRAMME OF DATES 2018 – 2019**

<table>
<thead>
<tr>
<th>Week</th>
<th>Monday</th>
<th>FIRST YEAR</th>
<th>SECOND YEAR</th>
<th>THIRD YEAR</th>
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<tr>
<td>34</td>
<td>13 May 19</td>
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<td>Teaching Tuesday</td>
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<tr>
<td>35</td>
<td>20 May 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Study – pre thesis***</td>
</tr>
<tr>
<td></td>
<td>Half term</td>
<td>Bank hol</td>
<td>Teaching Tuesday</td>
<td>Study – pre thesis***</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Thesis submission deadline</td>
<td>Monday 31st May</td>
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<tr>
<td>36</td>
<td>27 May 19</td>
<td>Teaching Tuesday</td>
<td>Teaching Tuesday</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>3 Jun 19</td>
<td>Teaching Mon or Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday***</td>
</tr>
<tr>
<td>38</td>
<td>10 Jun 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Teaching Monday</td>
<td>Teaching Tuesday***</td>
</tr>
<tr>
<td>39</td>
<td>17 Jun 19</td>
<td>Teaching Mon or Mon/Tues*</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>40</td>
<td>24 Jun 19</td>
<td>Placement continues Shared teaching Thu</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Joint Course Conference Fri</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28th June</td>
</tr>
<tr>
<td>41</td>
<td>1 Jul 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
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<tr>
<td>42</td>
<td>8 Jul 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>43</td>
<td>15 Jul 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>44</td>
<td>22 Jul 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>45</td>
<td>29 Jul 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>46</td>
<td>5 Aug 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>47</td>
<td>12 Aug 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>48</td>
<td>19 Aug 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>49</td>
<td>26 Aug 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td></td>
<td>Bank Hol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>2 Sep 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td>51</td>
<td>9 Sep 19</td>
<td>Placement continues</td>
<td>Placement continues</td>
<td>Placement continues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Placement 4 ends</td>
<td>Placement 4 ends</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fri 13th Sept (72 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>16 Sep 19</td>
<td>Placement 2 ends</td>
<td>Study time</td>
<td>Placement continues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fri 20th Sept (73 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>23 Sep 19</td>
<td>New semester</td>
<td>New semester</td>
<td>Placement 6 ends</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Weds 25th Sept (83 days)</td>
</tr>
</tbody>
</table>

***Study days pre-thesis deadline weeks 35 & 36 taken from weeks 37 & 38, 4 days placement per week from week 38

n.b. Dates of External Board and VIVAs in 2019 are Monday 8th and Tuesday 9th July

***** Please ensure you are available on both days*****

**NB Contract for 2016 intake ends on Weds 25th Sept 2019**
Semester recommences Monday 23rd September 2019
Please note: Placement days above have not excluded Bank holidays. There are the following number in each placement:

- Placement 1 – 3 bank holidays – Christmas & Boxing Day, and New Years Eve
- Placement 2 – 2 bank holidays – 1 x May & 1 x August
- Placement 3 – 3 bank holidays – Christmas & Boxing Day and New Years Eve
- Placement 4 – 3 bank holidays – 2 x May & 1 x August
- Placement 5 – 4 bank holidays – Christmas & Boxing Day, New Years Eve and Easter Fri
- Placement 6 – 4 bank holidays– Easter Monday, 2 x May & 1 x August
Appendix 2

Programme Training Committee

Terms of Reference

The Programme Training Committee is responsible for the long-term strategic planning and management of the Doctor of Clinical Psychology at the University of Sheffield. Its purpose is to provide a forum in which stakeholders associated with the Programme meet to plan, implement and review all aspects of Programme policy. The detailed implementation of the Programme policy is devolved via a sub-committee structure, which is directly accountable to the Committee. The latter also includes regular meetings of the Programme Team.

The primary functions of the Committee are:

i To promote and review a coherent Programme philosophy.

ii To oversee the academic curriculum and maintain high academic standards appropriate to professional training.

iii To monitor the provision of clinical placements and to ensure that high standards of clinical experience and supervision are achieved.

iv To ensure that trainees' needs for personal and professional development are met by the Programme.

v To formulate and overview the methods of assessment of academic and professional performance as required by the formal examination regulations of the Programme.

vi To monitor the organisation and function of other courses delivered within the CPU including the Certificate in Low Intensity Psychological Interventions, the Diploma in High Intensity Psychological Interventions and the Certificate in Clinical Supervision by Distance Learning.

vii To monitor the selection of trainees to the Programme.

viii To promote good practice in clinical psychology throughout the Region via the support of applicable research and continuing professional development.

ix To disseminate information and actively seek the views and involvement of all relevant stakeholders (University, local Psychology Services, Supervisors, Service Users, and Yorkshire and The Local Education and Training Board).

x To liaise with and advise the Clinical Tutors, and the relevant SHSC Personnel Officer, on aspects related to the employment of trainees, the provision of placements and the promotion of good supervisory practice.

xi To liaise with appropriate Regional bodies associated with the profession and its training (e.g. Division of Clinical Psychology, (DCP), Special Interest Groups, and the Regional Training Advisory Group (RTAG)).

xii To monitor the quality of the Programme and to prepare an annual review, together with necessary documentation associated with Contracting and/or Accreditation.
To liaise and collaborate closely with the Doctor of Clinical Psychology programmes at Leeds and Hull, and continue where appropriate our links with Leicester and Nottingham/Lincoln Universities.

To review these 'Terms of Reference' regularly and to make any such changes thought appropriate by the Committee.

**Membership of the PTC**

**Chair:** Unit Director or nominee

**Secretary:** Unit Administrator

**University staff:**
- Head of the Department of Psychology or nominee
- Full, part-time and honorary lecturers
- Unit Administrator

**Clinical tutoring:** Director of Clinical Practice & Clinical Tutors

Supervisors drawn from the following localities:

- Barnsley, Nottinghamshire, Doncaster, Derbyshire, Lincolnshire, Sheffield/Rotherham
- And where possible across the following specialties:
  - Adult Mental Health, Learning Disabilities, Child, Older Adults,
  - Health Psychology, Forensic

**Trainee representatives** (or nominee)
- i) 1st year
- ii) 2nd year
- iii) 3rd year

**Certificate and Diploma in Psychological Interventions**
- i) Programme Director
- ii) Teaching staff
- iii) Trainee representative from each Programme

**Representative from the Yorkshire and the Humber commissioners**

Any of the above may be invited to a particular PTC or co-opted onto the Committee. Similarly, they can request to place a specific item of business concerning the Programme on the agenda of the committee and attend the relevant meeting.

August 2017
Appendix 3

PROGRAMME POLICY ON TAKING HOLIDAY LEAVE DURING ACADEMIC TEACHING TIME

Background and purpose of policy

Taking annual leave during teaching time is, as a general principle, not supported and will not be authorised by members of the Programme team. The Programme recognises, however, that on rare occasions trainees may need to take annual leave during an academic semester. For example, trainees may need to take annual leave that coincides with a school holiday, to fit in with partners’ holidays, or some religious observances.

A policy has been developed by trainees, which enables the Programme team to respond to and acknowledge circumstances where trainees would have reasonable requests for taking holiday during teaching time. This policy and the implementation of the system is administered and monitored by trainees. The policy is reviewed on a regular basis and any modifications are agreed at the Programme Training Committee.

General Principles

i) Trainees may take no more than two teaching days as holiday leave during any one academic year.

Leave may not be taken during the following periods:

- Semester one (up to Christmas) of the first year
- All teaching miniblocks
- Examination Boards
- Vivas
- If a trainee is due to give a case or research presentation they must arrange to swap this session.

However, in certain circumstances (e.g. religious observances) this may be acceptable. Any requests for leave during these times should be discussed in the first instance with the clinical tutor.

ii) Normally only two trainees are permitted to be absent from teaching because of holiday leave at any one time. Some degree of co-operation and a rota system must be arranged between trainees in individual year groups.

The system is organised and monitored by trainees and should involve the minimum of office administration. Trainees are responsible for making sure that they are acting within the policy.

iii) It would be at the discretion of the Programme team to refuse holiday leave during teaching time if the core learning experience was threatened.

iv) Trainees have a responsibility to acquaint themselves with any teaching missed (e.g. by discussion with peer(s), reading presentation/handouts, looking for relevant material on MOLE etc.)

v) Any holiday leave taken during teaching time should not be taken without prior discussion with an appropriate Programme team member. It should not be assumed by trainees that the granting of such leave is automatic. Rather, trainees should continue to prioritise their teaching experience.
vi) Trainees have individual responsibility and obligation to contact speakers affected by such leave to explain/apologise for intended absence.

vii) Each person within a year group will be responsible for alerting other year group members of intended leave during teaching time. A form is available on which all year group members should sign their assent and it should be remembered that official approval is co-dependent on group assent. The group should not sign consent without first having ascertained that no more than one or possibly two trainees are requesting annual leave on that date. However, group assent should not be taken as a guarantee of staff approval.

viii) In addition to requesting leave during teaching time, the general procedure for gaining approval for annual leave must be followed with approval being sought from the clinical tutor.

Procedure for application

The following procedure must be followed if you wish to apply for leave during teaching time.

i) A signed form should be obtained indicating that all year group trainees agree to you taking leave during teaching time. See Appendix A.

ii) The signed form and the standard leave form must be submitted to the Clinical Tutor (via Jacquie Howard). Do not make final arrangements prior to gaining written approval from your clinical tutor.

iii) The trainee should contact all speakers who will be teaching on day(s) they will be absent. Trainees should also inform the Programme Administrator of their intended absence.

iv) Attendance and absenteesism during teaching time should be monitored by individual year groups. Each year group has a named elected representative who is responsible for monitoring attendance and providing feedback when required.

Monitoring and Regulation Process

This policy is reviewed regularly at the Programme Training Committee. In addition, trainee attendance and sickness are routinely monitored in Internal Examination Boards.
Appendix 4

University of Sheffield, Department of Psychology PGR Health and Safety

Induction Training
All research students are required to undertake a Health and Safety Induction online which gives you an introduction to Health and Safety Policy and Procedures in the University. This is in addition to you undertaking Fire Training, Display Screen Equipment (DSE) training and where applicable Out of Hours Training. Please go to the link below and follow the instructions. https://hs.shef.ac.uk/

Safety Procedures
By Law, everyone has a safety responsibility, so it is up to you to familiarise yourself with the University Health and Safety Policy issued to all students, and Departmental H&S policy which can be found on the psychology website (https://www.sheffield.ac.uk/psychology/info_for_staff_and_research_students/health_and_safety_summary), to read and understand all the safety notices in the Department, know the locations of fire extinguishers and first-aid boxes (one on each floor), and know how to contact the Control Room in an emergency.

Fire Training - You must complete online fire safety training annually, which is accessed at: https://hs.shef.ac.uk/

Fire Procedures - All rooms are fitted with smoke detectors but it is still important for you to remember what to do in the event of a real fire. If you discover a fire you must alert others by one or all of the following:

- Breaking an Emergency Point to sound the alarm bells (there are 2 on each floor situated by the doors which lead onto the stairs at each end of the corridors).
- By contacting the University Control Room on extension 4444, who will summon the Fire Service.
- Shouting 'fire'.
- Only tackle a fire with the appropriate extinguisher if you are entirely sure that it is safe to do so. If you leave a fire burning or hear the continuous alarm bells evacuate the building.
- Remember to leave by the nearest exit (not via the lifts) and to shut all doors behind you.
- Get away from the building, especially windows and doors, in case of explosion.
- Assemble at your evacuation point (USport field for Mushroom Lane Annexe, The Concourse for the neuroscience labs at Alfred Denny, The Cathedral green space for Cathedral Court building) until you are given the all-clear.

Fire evacuation drills are held throughout the University during the third and fourth weeks of the Autumn Semester. The fire alarms are also tested weekly on Tuesdays at 11.30am; but no action is required.

Accident Procedures
In the event of an illness or injury where medical attention is required, arrangements should be made for the injured person to be sent directly to hospital by ringing the Control Room on 4444, who will summon an ambulance. Where possible, a qualified first aider/appointed person should be enlisted to
take charge of the situation and/or give appropriate treatment, until the person receives medical help. The department’s current first aiders are Sharon Keighley and Josh Swift. If neither are available please contact control who will request first aid from a member of security team who are all first aid trained.

**Reporting Accidents**
If there has been an accident then a report form must be completed as soon as is practicable. This is available online: [https://docs.google.com/a/sheffield.ac.uk/spreadsheet/viewform?formkey=dExPZDVwQjhER1ZiN0lpRHlzWEVInFE6MQ#gid=0](https://docs.google.com/a/sheffield.ac.uk/spreadsheet/viewform?formkey=dExPZDVwQjhER1ZiN0lpRHlzWEVInFE6MQ#gid=0)

If a member of the first aid team attends and first aid is given the first aider must complete a first aid form, found at: [https://docs.google.com/a/sheffield.ac.uk/spreadsheet/viewform?formkey=dFVqa1owa25mNlNpcjNXpHY21IM0E6MQ#gid=0](https://docs.google.com/a/sheffield.ac.uk/spreadsheet/viewform?formkey=dFVqa1owa25mNlNpcjNXpHY21IM0E6MQ#gid=0)

**Display Screen Equipment Guidance (DSE)**
All postgraduates are required to be trained to complete the DSE training to be able to set up their workstation correctly for their use and so minimise risk to the user. Online training can be found at: [https://hs.shef.ac.uk/](https://hs.shef.ac.uk/)

If after undertaking training you have concerns regarding your workstation set up or you are experiencing discomfort with your working position please contact Josh Swift, (j.swift@sheffield.ac.uk) who is the Display Screen Assessor for the Department.

**Study Outside Normal Hours**
Normal working hours in the Department of Psychology are from 8.00 am to 6.00 pm Monday to Friday. The different buildings which Psychology occupy operate slightly different main entrance door closure times and information about these times should be sort from the admin team. PGRs who wish to work outside normal hours must first successfully complete online fire safety and out of hours training.

**Out of Hours Training** – The online training can be found at: [https://hs.shef.ac.uk/](https://hs.shef.ac.uk/) and you must have in date Fire awareness training. Once you have passed both training sessions please inform Sharon Keighley s.keighley@sheffield.ac.uk for an application form to have your Ucard activated.

Everyone intending to stay in the building after 6.00pm, or coming in out-of-hours, must sign the book in the reception/entrance areas of each building and make sure they sign out when they leave. This is so that if there is an emergency, such as a fire, people in the building can be accounted for.

Normally, work out-of-hours should be restricted to library work, computing, writing reports and making non-risk observations. No practical or experimental work should be performed where there is risk of personal accident or injury. There are standard emergency procedures that apply in the building, and you must make sure that you are familiar with these.

**Portable Electrical Equipment**
All portable electrical equipment has to be tested regularly to ensure that it is in a safe condition. If you are bringing your own personal equipment into the department, then you need to contact Andy Ham in the Workshop, Ext: 26542, in order to have it tested before you use it. If you think a piece of departmental equipment is faulty, you should never attempt to modify or repair it yourself, always get expert help.

**General Conduct and Safety**
- Safety signs and devices must be obeyed.
• Fire doors should not be fastened open.
• Smoking is not permitted anywhere in the building, this includes E cigarettes.
Appendix 5

RELEVANT NAMES AND ADDRESSES
Psychology Services

Sheffield
Linda Wilkinson
Director, Psychological Services
Sheffield Health & Social Care NHS Foundation Trust

Fulwood House
Old Fulwood Road
Sheffield  S10 3TH
☎ 0114 271 8528

Sheffield
Johann Labuschagne
Head of Psychological Services
Sheffield Teaching Hospitals NHS Foundation Trust

A Floor, Medical Education Centre
Northern General Hospital
Sheffield  S5 7AU
☎ 0114 271 5495

Sheffield
Lindsay Jacobs
Acting Head of Psychological Services
Sheffield Children’s NHS Foundation Trust
Department of Paediatric Clinical Psychology
1 Northumberland Road
Sheffield  S10 2TH
☎ 0114 226 2344

Barnsley
Nigel Beall
Professional Lead for Psychological Services
South West Yorkshire Partnership NHS FT
11/12 Keresforth Close
Off Broadway
Barnsley  S70 6RS
☎ 01226 645223

Rotherham & Doncaster
Contact person for Clinical Psychology:
Ian Brown
Intensive Communities Therapies Team
Heron Building, Swallownest Court
142A Aughton Road, Swallownest
Rotherham  S26 4TH
☎ 01709 302230

NHS Health Education Yorkshire & the Humber Headquarters
First Floor, Blenheim House
Duncombe Street
Leeds
LS1 4PL
☎ 0113 295 2000
https://yh.hee.nhs.uk

Health and Care Professions Council (HCPC)
Park House
184 Kennington Park Road
London
SE11 4BU
☎ 0207 582 5460
http://www.hcpc-uk.org/

The British Psychological Society (BPS)
St Andrews House
48 Princess Road East
Leicester
LE1 7DR
☎ 0116 254 9568
Email: enquiries@bps.org.uk
http://www.bps.org.uk/

Division Of Clinical Psychology (DCP)

DCP Chair
Esther Cohen-Tovee
The British Psychological Society
St Andrews House
48 Princess Road East
Leicester  LE1 7DR
☎ 0116 252 9529
Email: chair_dcp@bps.org.uk

Yorkshire and Humber DCP
Yorkshire and Humber DCP Chair
Annette Schlosser
Academic Coordinator ClinPsy D Course at
University of Hull
Room 129 Aire Building
University of Hull
Cottingham Road
Hull  HU6 7RX
Email: a.schlosser@hull.ac.uk
University of Leeds – DClinPsychol Programme
Clinical Psychology Training Programme
Leeds Institute of Health Sciences
Level 10, Worsley Building
Clarendon Road
Leeds LS2 9NL
☎ 0113 343 2732
Email: clinical-psychology-training@leeds.ac.uk

University of Nottingham / University of Lincoln DClin Psy Programme
Division of Psychiatry and Applied Psychology
University of Nottingham
YANG Fujia Building, B Floor
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Appendix 6
D Clin Psy Entry Agreement

All psychology trainees who study for a University degree that prepares them to work as a clinical psychologist are directly exposed within their training to aspects of the clinical environment.

It is therefore essential that clinical psychology trainees fulfil the requirements of Health Professions Council outlined in their Standards of Conduct, Performance and Ethics (http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/index.asp) and the British Psychological Society's Code of Ethics and Conduct (http://www.bps.org.uk/the-society/code-of-conduct/code-of-conduct_home.cfm). These apply for clinical psychologists at all levels including trainees and therefore, before accepting the offer of a place to train as a clinical psychologist at the University of Sheffield, we wish you to be aware of their expectations of trainees as regards their professional behaviour.

We ask you to agree to the following, as derived from the HPC/BPS requirements to guide you as you become a competent practitioner. If you have difficulty with any aspects of the following statements, then the Clinical Psychology Unit (CPU) staff will discuss with you how best to resolve the matter.

Please read the following statements and sign to confirm that you understand them and will conform to them:

1. When I meet patients and listen to them I will respect their views, treat them politely and considerately, respect their privacy and dignity and respect their right to refuse to take part in my learning.

2. I will not allow my views about a person’s lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status or perceived economic worth to prejudice my interaction with patients, teachers or colleagues.

3. I will not abuse the trust of a patient or other vulnerable person and I will not enter into an unprofessional relationship with another person in the clinical context, for example, a patient with whom I have come into contact.

4. I will be honest in my dealings with others, including patients, teachers and colleagues. I will also make clear to others that I am a trainee clinical psychologist and not a qualified practitioner. I understand, accept and agree to be bound by the principle of confidentiality of patient records and patient data. I will not discuss patients with other students or others outside of the clinical setting except anonymously. I will respect all clinical and other records of patients.

5. I will maintain appropriate standards of dress, appearance and personal hygiene so as not to disquiet patients, teachers or colleagues.

6. I will expose my face fully to patients, teachers and colleagues in all clinical and teaching settings, and whenever on University, NHS or other sites where I attend for teaching, learning or assessment.

7. I will engage in psychological work with patients of both sexes, irrespective of the gender, culture, beliefs, disability or disease of the patient. Before undertaking any psychological assessment or intervention. I will obtain permission to do so from the patient or appropriate other where this is impossible because of age or competence. I will participate in practising clinical skills with other students, for the purpose of learning skills.
8. I will attend all placements, classes and other teaching sessions as required by the regulations of the DClin Psy programme. I will travel as required to the placements designated.

9. I recognise that successful completion of the programme may require study outside of contracted hours.

10. I will be honest in completing course work for assessment and will never plagiarise material from other sources and submit it as my own work.

11. I will inform the Clinical Psychology Unit if I am arrested, charged, convicted, cautioned, or reprimanded in relation to any offence prior to or during my time as a student.

12. I will communicate effectively and appropriately with patients, supervisors, programme staff and peers in a timely way.

13. I will carefully evaluate and take action to minimise risk to others and myself.

14. I will take responsibility for my own learning and be proactive in finding learning opportunities.

15. I will complete all Occupational Health appointments as required by the DClin Psy programme and provide any authenticated reports of laboratory tests as may be required.

16. I will inform the CPU if there is any significant change to my health that might affect my fitness to practise as a trainee or subsequently as a clinical psychologist.

17. I confirm that I have been truthful in my application to the Clearing House for Clinical Psychology Courses, and that I did not omit any important or relevant information on my application. I understand that if the CPU discovers that I have been untruthful in my application, it reserves the right to withdraw an offer or terminate the course of study.

I confirm that I have read and understood the above statements and will conform to them whilst a trainee clinical psychologist. I also confirm that I have read the Health Professions Council’s document *Standards of conduct, performance and ethics (2009)* and British Psychological Society’s *Code of Ethics and Conduct*.

Name: ..............................................................................................................................................

Signed: ..............................................................................................................................................

Date: ..............................................................................................................................................
Appendix 7

USE OF UNFAIR MEANS IN THE ASSESSMENT PROCESS (non invigilated exams):
ADVICE TO STUDENTS

The University expects its graduates to meet certain criteria relating to good academic practice. (See the University’s Learning, Teaching and Assessment Strategy for a complete list of the characteristics of the Sheffield Graduate) These include:

- being able to carry out independent enquiry and engaging critically with a wide range of evidence;
- demonstrating that you can use and handle information in a professional and ethical way;
- demonstrating that you are fit to practice in your chosen professional field, meeting the requirements of relevant statutory bodies;
- being able to work as a constructive member of a team;
- being able to communicate effectively both orally and in writing.

Throughout your programme of study at the University you will learn how to develop these skills. Your assessed work is the main way in which you demonstrate that you have acquired and can apply these skills and characteristics. Using unfair means in the assessment process is dishonest and means that you cannot demonstrate that you have acquired these essential academic skills.

What constitutes unfair means?
The basic principle underlying the preparation of any piece of academic work is that the work submitted must be your 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 (see definitions below). Rules about these forms of cheating apply to all assessed and non-assessed work.

1. **Plagiarism (either intentional or unintentional)** is the stealing of ideas or work of another person (including experts and fellow or former students) and 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 assignment 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 assignments to other students.

3. **Double submission (or self plagiarism)** is resubmitting previously assessed work on one or more occasions (without proper acknowledgement). This may take the form of copying either the whole assignment or part of it. Normally credit will already have been given for this work.

4. **Collusion** is where two or more people 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. 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.

How can I avoid the use of unfair means?
To avoid using unfair means, any work submitted must be your own and must not include the work of any other person, unless it is properly acknowledged and referenced.
As part of your programme of studies you will learn how to reference sources appropriately in order to avoid plagiarism. This is an essential skill that you will need throughout your University career and beyond. You should follow any guidance on the preparation of assessed work given by the academic department setting the assignment.

You are required to attach a declaration form to all submitted work (including work submitted online), stating that the work submitted is entirely your own work.

If you have any concerns about appropriate academic practices or if you are experiencing any personal difficulties which are affecting your work, you should consult your personal tutor or a member of staff involved with that unit of study.

The following websites provide additional information on referencing appropriately and avoiding unfair means:

The Library provides online information literacy skills tutorials
http://www.librarydevelopment.group.shef.ac.uk/shef-only/research/plagiarism_rsch.html

The Library also has information on reference management software
http://www.librarydevelopment.group.shef.ac.uk/shef-only/research/recordmanagerefs.html

The English Language Teaching Centre operates a Writing Advisory Service through which students can make individual appointments to discuss a piece of writing. This is available for all students, both native and non-native speakers of English.
http://www.shef.ac.uk/eltc/languagesupport/writingadvisory

What happens if I use unfair means?
Any form of unfair means is treated as a serious academic offence and action may be taken under the Discipline Regulations. For a student registered on a professionally accredited programme of study, action may also be taken under the Fitness to Practise Regulations. Where unfair means is found to have been used, the University may impose penalties ranging from awarding a grade of zero for the assignment through to expulsion from the University in extremely serious cases.

Detection of Unfair Means
The University subscribes to a national plagiarism detection service which helps academic staff identify the original source of material submitted by students. This means that academic staff have access to specialist software that searches a database of reference material gathered from professional publications, student essay websites and other work submitted by students. It is also a resource which can help tutors to advise students on ways of improving their referencing techniques. Your work is likely to be submitted to this service.

For further information
(www.shef.ac.uk/ssid/charter/guidance_taught.html)
(www.shef.ac.uk/ssid/procedures/grid.html#discipline) (www.shef.ac.uk/ssid/exams/plagarism)
Appendix 8
Writing tips for your SAQs

The requirements for the SAQs are detailed in the relevant assessment handbook. However, while those requirements are clearly stated, there are some common errors that trainees make in their presentation. When these errors are made, they result in conditional marks or failures of the individual SAQ. This document lists those errors, so that you can avoid making them.

The following is intended to supplement what is in the assessment guidelines, rather than replacing them in any way. You should make sure that what you submit meets the core criteria in the assessment guidelines, as well as avoiding the common errors that are reflected in the suggestions below.

How not to get it wrong
The following reflect things that are sometimes or commonly done poorly by trainees. We advise that you learn from others’ experience, and make sure that you do the following:

• Attend to the guidelines
• When you label an SAQ as an ICP or a CR, make sure that is what you actually do (some trainees have labelled it one way and then done the other type of SAQ). We will mark it as if it were what you have said it is.
• You must complete equal numbers of papers from all sections, and in terms of ICP and CR, you can mix and match these.
• Don’t make typographical errors (spelling, format, punctuation) or grammatical errors. Use your spell checker, grammar checker, etc.
• Put your references/bibliography in APA format (this is not an area where approximation will do – use the APA guidelines)
• Include the personal viewpoint where it is asked for (‘What have I learned based on my knowledge or experience’, rather than ‘What could be learned by the average clinician’)
• Include and balance both good and weak points of the paper concerned (most papers can be critiqued and praised)
• Make your own critique (don’t just list bits from the ‘Limitations’ section that the authors already provided)
• Make sure that you note any substantive limitations of the paper
• Don’t critique the paper on the basis of something that is actually dealt with in the paper (e.g., ‘There was no control group’ when there was one)
• Don’t copy material wholesale or with minor modifications from the paper that you are critiquing (it will look like plagiarism when you submit it)
Appendix 9
Guidance on preparing coursework and the thesis so that it is in APA format

All academic clinical projects, case studies, and the thesis are required to be presented in accordance with the style of the American Psychological Association’s Publication Manual (APA), except that English rather than US English spelling should be used. This will enable you to write in an international accepted style commensurate with the requirements of the majority of psychological journals. There are copies of the latest edition (6th) of the APA manual in the resource library - there are some significant changes to referencing style of this edition in comparison to earlier editions. This includes use of Digital Object Identifier numbers known as doi and the use of eclipses for seven or more authors in the end list.

We would urge you to look at the manual so that you can become familiar with what is expected with regards to not only submission of coursework but also dissemination of psychological knowledge.

Failure to comply with the required style will result in a conditional mark being awarded for coursework and resubmission. This results in further administrative burden for staff as well as for trainees. Style deviations within the thesis will require correction and also produces additional work for all involved. Therefore, please familiarise yourself with the APA format.

Some additional tips

In addition to the manual itself, you may find the following useful:

To help you the library has links to a range of referencing styles at http://www.sheffield.ac.uk/library/useful/refs.html.

Specific information on APA style can be found at the association's website at http://www.apastyle.org/.

Within this site there is a really useful APA tutorial available at http://flash1r.apa.org/apastyle/basics/index.htm - please look at this

Also guidance on general format is available at http://www.psych.uw.edu/psych.php#c
And http://owl.english.purdue.edu/owl/resource/560/01/

Wikipedia has the following entry of interest http://en.wikipedia.org/wiki/APA_style

Reference

Appendix 10
(extract from University Calendar – Programme Regulations)
http://www.shef.ac.uk/calendar/regs

PSYR09 REGULATIONS FOR THE
DEGREE OF DOCTOR OF CLINICAL
PSYCHOLOGY (DClinPsy)
This programme of study is non-modular.
A. For candidates without professional qualifications in
Clinical Psychology (PSYR09 (Full-Time))
1. A person may be admitted as a candidate who is a recognised
graduate in Psychology and is eligible for the Graduate Basis
for Chartered Membership (GBC) of the British Psychological
Society. Except with the permission of the Faculty it shall be a
condition of registration that a candidate is to be an employee
of the National Health Service or of an employer deemed to
be equivalent.
2. A candidate shall undertake
(a) prescribed coursework, including academic clinical projects,
case studies, and short-answer questions
(b) supervised practice in Clinical Psychology on placement
(c) a thesis.
3. The examination shall consist of
(a) academic clinical projects
(b) short-answer questions
(c) case studies
(d) observed clinical skills assessment
(e) assessment of clinical competence on placement
(f) a thesis
(g) an oral examination on all aspects of submitted work.
4. The programme of study shall be pursued for three years by a
full-time candidate. A single extension to registration of one
year is the maximum permitted. Supervised practice in
Clinical Psychology on placement shall be for a period of at
least two days per week throughout the programme of study.
5. A candidate shall pursue a programme of research in
accordance with the General Regulations for Higher Degrees,
and shall present a thesis in accordance with those
Regulations.
6. A candidate who fails in any part of the examination may be
permitted to retake that part of the examination on one
occasion only.
7. A candidate who contravenes the Standards of conduct,
performance and ethics of the Health and Care Professions Council or
the Code of Conduct for Psychologists or the Guidelines for
Professional Practice of Clinical Psychology 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 Practise or the
General Regulations as to the Discipline of Students.
8. No aegrotat awards can be made from this programme.
Appendix 11
Programme Specification
A statement of the knowledge, understanding and skills that underpin a
taught programme of study leading to an award from
The University of Sheffield

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</tr>
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<td>7</td>
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<tr>
<td>8</td>
<td>Faculty</td>
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<td>9</td>
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<td>10</td>
<td>Other Departments involved in teaching the programme</td>
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<td>Mode(s) of Attendance</td>
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<td>Duration of the Programme</td>
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<td>13</td>
<td>Accrediting Professional or Statutory Body</td>
<td>Health and Care Professions Council, British Psychological Society</td>
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<td>14</td>
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15. Background to the programme and subject area

The main purpose of the programme is to train graduate psychologists to doctoral level to enable them to become chartered and practitioner clinical psychologists who can meet the future client and organisational needs of the National Health Service (NHS). The programme was established in 1991 and currently has full approval by the Health and Care Professions Council (HCPC) and the British Psychological Society (BPS). The programme is organised by the University of Sheffield in partnership with Psychology service managers throughout Yorkshire and The Humber and the northern region of the East Midlands. The training contract is held by Health Education in Yorkshire and The Humber. The Sheffield Health and Social Care Trust currently employ trainees on the programme.

Further information can be accessed via the Clinical Psychology Unit website (www.sheffield.ac.uk/clinicalpsychology)

16. Programme aims

The overall aim of the programme is to provide the training, at doctoral level, which is necessary for graduate psychologists, to be able to apply for registration with the Health and Care Professions Council (HCPC) as practitioner clinical psychologists and to apply to register with the British Psychological Society (BPS) as Chartered Clinical Psychologists. In keeping with the mission and aims of the University the programme aims to provide this training within a national centre of excellence for both professional training and clinical research. In addition, the programme will seek to be responsive to the local and national needs of the NHS.

Its aims are therefore for trainees to have:

1. The skills, knowledge and values to work within the legal and ethical boundaries as required by HCPC, the BPS and current legislation, and to act in the best interests of service users at all times.

2. The skills, knowledge and values to integrate psychological theory with practice in both academic and clinical work.
3. The skills, knowledge and values to develop evidence based practice.

4. The skills, knowledge and values to respect, and so far as is possible uphold, the rights, dignity, values and autonomy of every service user.

5. The skills, knowledge and values to work in partnership with other professionals, support staff, service users and their relatives and carers; to develop working alliances and understand the dynamics present in relationships, with clients, including individuals, carers, and/or services (e.g. team working), to carry out psychological assessment; to develop a formulation based on psychological theories and knowledge; to carry out psychological interventions; and to evaluate their work and the risks and these implications.

6. The skills, knowledge and values to communicate information, advice, instruction and professional opinion effectively with clients, referrers and others, orally, electronically and in writing throughout the care of the service user and be able to move between and use appropriate forms of communication (e.g. taking into account age, physical ability and learning ability).

7. The skills, knowledge and values to work effectively and in a non-discriminatory manner with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives.

8. The understanding of the importance of confidentiality, related governance, and the limits to this.

9. The skills and knowledge to be able to obtain informed consent, exercising a professional duty of care, which includes the recognition of situations where it is necessary to share information to safeguard service users or the wider public.

10. The skills, knowledge and values to work effectively with systems relevant to clients, including for example multi-disciplinary teams, statutory and voluntary services, self-help and advocacy groups, user-led systems, and other elements of the wider community, and working with other mental health professionals.

11. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare including planning, designing and delivering teaching and training, supporting the learning of others in the application of psychological skills and knowledge.

12. The skills, knowledge and values to conduct research and evaluation that enables the profession to develop its knowledge base, to monitor and improve the effectiveness of its work, to monitor and improve services.

13. The skills in managing personal learning agenda and self-care, and in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems

14. The understanding of the obligation to maintain fitness to practise, which will include maintenance of high standards of personal and professional conduct, personal health, continuing professional development, and management of the impact of their practice.

15. The understanding of complex ethical and legal issues of any form of dual relationships and the power imbalance between practitioners and clients and how these can be managed appropriately.

16. To understand how to practise as an autonomous professional and exercise professional judgement and responsibility, and work at a level appropriate to training with the knowledge of the limits of one’s own practice and when to seek advice or refer to another professional.

17. Programme learning outcomes

The DClin Psy programme learning outcomes cover the standards set by HCPC and the BPS that demonstrate competence required for trainees to be able to work as clinical psychologists in the NHS. These standards provide frameworks for knowledge and understanding and skills required for the profession; during their learning process, trainees are also expected to gain generic and transferable academic and research skills at doctoral level.

By the end of the programme trainees will have knowledge and understanding of:

| K1 | Contemporary theory in clinical psychology and related fields, including knowledge of health, disease, disorder and dysfunction, theories and evidence concerning psychological development and psychological difficulties across the lifespan and their assessment and remediation, and how biological, sociological and circumstantial or life-event related factors impinge on psychological processes to affect psychological wellbeing. |
| K2 | The evidence base related to health care and the promotion of physical and psychological wellbeing. |
| K3 | A range of models of assessment, formulation and intervention designed for individual clients, carers and service systems and the relationship between these processes. Methods for planning and evaluating |
assessments, treatments, and interventions based on a scientist practitioner and reflective practitioner model, including the involvement of service users and carers in such evaluations.

**K4** Specialist client group knowledge across the profession of clinical psychology in a range of settings and services.

**K5** Psychological models relating to a range of presentations including acute to enduring and mild to severe presentations, problems with biological or neuropsychological conditions, and problems with mainly psychosocial factors such as problems with coping, adaptation and resilience to adverse circumstances and life events.

**K6** Psychological models related to clients from a range of cultural and social backgrounds, of all ages, across a range of intellectual ability, with significant levels of challenging behaviour, with developmental learning difficulties and cognitive impairment, with communication difficulties, with substance misuse problems and with physical health problems.

**K7** Psychological models related to working with individual clients, couples, families, carers, groups and at the organisational and community level and in a variety of settings including in-patient or other residential facilities with high-dependency needs, secondary health care and community or primary care.

**K8** The impact of difference and diversity on people’s lives, psychological wellbeing or behaviour, and its implications for working practices.

**K9** The organisation and management structures within the NHS and other relevant health care and voluntary service settings, including current policies on health care planning, delivery and resourcing and the role of other professions and stakeholders in health and social care.

**K10** Change and transition processes at the individual, group and organisational level.

**K11** Leadership theories and models and their application to service-delivery and clinical practice, including evaluation and response to organisational and service delivery changes and the provision of consultation.

**K12** Social approaches, such as those informed by community, critical and social constructivist perspectives.

**K13** The impact of psychopharmaceutical and other clinical interventions on psychological work with clients.

**K14** Advanced knowledge of quantitative and qualitative clinical research and service evaluation methods.

**K15** Ethical issues related to research and the management of complex clinical cases.

**K16** The importance of participation in training, supervision and mentoring for continuing professional development

**K17** Supervisory methods and processes, in the role of supervisee and supervisor.

**K18** Consultancy models and the contribution of consultancy to practice.

**K19** A professional and ethical value base including that set out in the HCPC Standards of conduct, performance and ethics and the BPS Code of Ethics and Conduct, the BPS Division of Clinical Psychology (DCP) statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.

**K20** Establishing and maintaining a safe practice environment that minimises risks to service users and others, including awareness of applicable health and safety legislation and workplace policies and procedures.

**K21** Professional principles and how these are expressed and translated into action through a number of different approaches to practice, and how to modify approaches to meet the needs of an individual, groups or community.

**K22** Professional competence relating to personal and professional development and awareness of the clinical, professional and social context within which the work is undertaken.

**K23** The profession of Clinical Psychology, including its history and the evolution of healthcare systems in the UK

**K24** Malpractice or unethical practice in systems and organisations and how to respond to this, including familiarity with ‘whistleblowing’ policies and issues.

**Skills and other attributes: Transferable skills. By the end of the programme, students will have the:***

**S1** Skills to gather appropriate information, and to generalise and synthesise prior knowledge and experience in order to apply them in different settings and novel situations.

**S2** Skills to evaluate the applicability of scientific literature for clinical practice.
| S3 | Skills to apply scientific theory, models and evidence to clinical problems and data; to be able to demonstrate a logical and systematic approach to problem solving. |
| S4 | Skills to reflect on their own clinical practice and scientific understanding and to be able to change their practice as needed to take account of new developments. |
| S5 | Skills to adapt communication to a variety of audiences and using a variety of methods, including the use of IT and other modes of communication. |

**Skills and other attributes: Subject Specific Skills. By the end of the programme, students will have the:**

| S6 | Clinical and research skills to work effectively as a reflective practitioner and scientist practitioner; to be able to use research, reasoning and problem solving skills to determine appropriate action; to be able to engage in evidence based practice, and evaluate practice systematically. |
| S7 | Psychological assessment skills including: undertaking and recording a thorough, sensitive and detailed assessment, developing and maintaining effective working relationships and appropriate use of a range of assessment methods, techniques and equipments. These methods should include competence in the use of standardised tests (formal assessment procedures), systematic interviewing procedures and other structured procedures and conducting appropriate risk assessment. The methods should be appropriate to the service user or carer, environment and the type of intervention likely to be required. Skills also include the ability to assess social context and organisational characteristics. |
| S8 | Psychological formulation skills including: integration of assessment information, psychological models and evidence (including interpersonal, societal, cultural and biological factors) and clients’ perspectives; use of formulation to plan interventions; and revising formulations where appropriate; use of formulation to facilitate understanding with clients and other professionals; understanding the need to implement interventions and care-plans in partnership with clients, other professionals and carers; being able to critically evaluate risks and their implications. |
| S9 | Psychological intervention skills (or the ability to undertake or arrange investigations as appropriate) including: the ability, on the basis of psychological formulation, to implement psychological therapy or other interventions to the presenting problem and to the psychological and social circumstances of the client; working collaboratively with individuals, couples, families, groups, carers, or services; working directly and indirectly; working in more than one recognised psychological intervention model; recognising when (further) intervention is inappropriate or unlikely to be helpful. |
| S10 | Evaluation skills (monitoring and reviewing the ongoing effectiveness of planned activity and modifying it accordingly): to be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care; to be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user; to recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes; to be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately; recognise the value of case conferences and other such reviews. |
| S11 | The ability to communicate effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of audiences. To be aware of the characteristics and consequences of both verbal and non-verbal communication and how this can be affected by culture, age, ethnicity, gender, sexuality, religious beliefs and socio-economic status. To understand explicit and implicit communications in a practitioner - service user relationship. |
| S12 | Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, including those who experience difficulties related to anxiety, mood, adjustment to adverse circumstances or life events, eating, psychosis and use of substances, and those with somatoform, psychosexual, developmental, personality, forensic cognitive and neurological presentations. |
| S13 | Ability to integrate and implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological therapy. This will include cognitive-behaviour therapy and at least one other evidence-based approach. |
| S14 | Skills to teach to a variety of audiences and support the learning of others in the application of psychological skills, knowledge, practices and procedures. |
| S15 | Ability, through supervision, to reflect on practice and making appropriate use of feedback received. |
| S16 | Skills to make informed judgements on complex issues in specialist fields, often in the absence of complete information. |
### Skills and other attributes: Research and Audit Skills. By the end of the programme, students will have:

| S24 | The ability to understand and use applicable techniques for research and academic enquiry, including qualitative and quantitative approaches. |
| S25 | The ability to conduct service evaluation and small N research and to use appropriately to develop clinical practice and the skills to consider and apply appropriate levels of service user and public involvement in research. |
| S26 | Ability to conceptualise, design, develop and conduct independent, original applied research of a quality to satisfy peer review and extend the forefront of the discipline. |
| S27 | Understand research ethics and be able to apply them. |
| S28 | Understanding of the need and value of undertaking clinical research and development post-qualification including skills in the dissemination of research and audit findings to both peer and public audiences. |
| S29 | Skills to evaluate the effectiveness, acceptability and other broader impacts of interventions or service structures and auditing clinical effectiveness. |
| S30 | Skills to critically appraise academic and research literature and to recognise the value of research to the critical evaluation of practice, including an understanding of statistical and clinical significance. |

### Skills and other attributes: Personal and Professional Skills. By the end of the programme, students will have:

| S31 | Developed an ethical and professional value base. |
| S32 | The skills to manage effectively issues of difference and diversity within clinical practice. |
| S33 | The ability to manage effectively their own personal learning needs. |
| S34 | The ability to understand the value of reflexivity and reflection on practice and the need to record the outcome of such reflection. |
| S35 | The ability to develop the skills to manage the impact of clinical practice and seek appropriate support when necessary, with good awareness of boundary issues. |
| S36 | An understanding of the inherent power imbalance between practitioners and clients and how abuse of this can be minimised. |
| S37 | The skills to work collaboratively and constructively with colleagues and service users. |
| S38 | An understanding of the impact of one's own value base on clinical practice. |
| S39 | Monitoring and maintaining the health, safety and security of self and others. |
| S40 | Developed leadership qualities. |

### Skills and other attributes: Service Delivery Skills. By the end of the programme, students will have:

| S41 | Ability to work with users and carers to facilitate their involvement in service planning and delivery. |
| S42 | Understanding of the need to maintain the safety of both service users and those involved in their care. |
### S43
Understanding of the principles and processes of quality assurance, and engage in quality assurance programmes where appropriate; to be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures; to be able to maintain an effective audit trail and work towards continual improvement.

### S44
Ability to provide supervision at an appropriate level within their own sphere of competence.

### S45
Ability to conduct consultancy.

### S46
Ability to work effectively with formal service systems and procedures.

### S47
The skills to work effectively as part of a multidisciplinary team and to understand mental health and other legislation and the role of the psychologist.

### 18. Teaching, learning and assessment

**Development of the learning outcomes is promoted through the following teaching and learning methods:**

The programme has four main methods of teaching and learning: academic programme, clinical placements, research training and personal and professional development. Throughout the programme there is an emphasis on the integration of theoretical and clinical knowledge.

The academic programme is delivered through a variety of methods: formal lectures, skills based workshops, seminars, case workshops. These methods are supported through academic tutorials and guided reading. Trainees present their own cases, which facilitates theoretical-practice links. Trainees are allocated a Personal Tutor whose role is to assist in the learning process and provide support throughout training. Yearly review meetings are held between the trainee, their Personal Tutor and their Clinical Tutor to clarify each trainee’s individual progress through all aspects of the programme and to clarify future training objectives. There is a budget for trainees to apply to attend clinical workshops/conferences to develop identified training needs or interests.

Clinical skills are developed on clinical placements where trainees are involved in supervised clinical work, supported by teaching from the academic programme. On placement they will observe others, be observed and tape their clinical work for supervision. Supervisors on clinical placement will offer additional relevant guided reading. Clinical tutors provide support and planning for each trainee for each placement’s learning aims and objectives.

Research training is gained through formal teaching and practical sessions, workshops, seminars, research presentations, and the supervision of research projects. Research and statistical support are available to trainees. All projects have to meet either the NHS Research Governance or University Research Governance standards depending on the focus of the study. All projects have to receive ethical review (either University or NHS as appropriate).

Personal and professional development is promoted through specific teaching sessions, a “buddy” system, personal tutors and Balint-type and reflective practitioner groups. Each trainee is also allocated a mentor, a clinical psychologist, who provides an opportunity to discuss personal and professional issues arising out of training, in confidence outside of the programme.

**Opportunities to demonstrate achievement of the learning outcomes are provided through the following assessment methods:**

The assessments provide trainees with formative as well as summative learning. The assessed coursework includes:

- Short Answer Questions
- Observed Clinical Skills Assessment (OCSA)
- Clinical Practice Reports
- Academic Clinical Project 1: Literature Review
- Academic Clinical Project 2: Single Case Study
- Academic Clinical Project 3: Service Evaluation Project
- Research Thesis

Clinical placements are assessed through clinical supervisors’ Assessment of Clinical Competence.

Knowledge and Understanding (K1 – K24) are assessed via:
• Short Answer Questions
• Academic Clinical Projects
• Research Thesis
• Clinical Practice Reports
• Assessment of Clinical Competence.

Transferable Skills (S1 – S5) are assessed via:
• Academic Clinical Projects
• Research Thesis
• Clinical Practice Reports
• Short Answer Questions

Subject Specific Skills (S6– S23) are assessed via:
• Clinical Practice Reports
• OCSAs
• Assessment of Clinical Competence.

Research and Audit Skills (S24 – S30) are assessed via:
• Academic Clinical Projects
• Research Thesis
• Short Answer Questions

Personal and Professional Skills (S31 – S40) are assessed via:
• Clinical Practice Reports
• OCSAs
• Assessment of Clinical Competence.

Service Delivery Skills (S41 – S47) are assessed via:
• Assessment of Clinical Competence.
• Clinical Practice Reports

19. Reference points

The learning outcomes have been developed to reflect the following points of reference:

Subject Benchmark Statements
http://www.qaa.ac.uk/AssuringStandardsAndQuality/subject-guidance/Pages/Subject-benchmark-statements.aspx


University Strategic Plan
http://www.sheffield.ac.uk/ourplan

Learning and Teaching Strategy (2011-16)
http://www.shef.ac.uk/lets/strategy/lts11_16

Health and Care Professions Council (see http://hcpc-uk.org)
Standards of Education and Training
Standards of Proficiency
Guidance on Conduct and Ethics

British Psychological Society (see http://www.bps.org.uk/index.cfm):
Code of Ethics and Conduct;
Code of Human Research Ethics;
Division of Clinical Psychology Statement of Core Purpose and Philosophy;
20. Programme structure and regulations

The programme is a partnership between the University and clinical psychologists working within Yorkshire and the Humber. Accordingly staff associated with the programme are members of the Department of Psychology, including the clinical tutor team, clinical supervisors throughout Yorkshire and the Humber and the northern region of the East Midlands and members from other departments of the University. The structure of the 3-year programme comprises teaching blocks, day release teaching, clinical placements and private study time. This structure enables theory-practice links to be maintained throughout the programme. During the first year there is an introductory teaching block of three weeks.

This is followed by two five-month clinical placements separated by a two week mini-block. When on placement trainees attend the university for teaching, for between one and three days during semester time. The second year consists of two five-month clinical placements, the first introduced by a three-week teaching mini-block, and the second by a one-week teaching mini-block. During semester time, year two trainees attend teaching sessions in the university one day per week. In the third year trainees attend one teaching block at the beginning of the year and then two five-month clinical placements. Year three trainees attend teaching sessions in the university one day per week during the semester times. Private study days and research days are provided throughout the programme.

Academic

The curriculum is designed to reflect a developmental progression from working individually with clients (Year 1) to working with systems, families and groups (Year 2) to specialist and organisational level work (Year 3). This progression is reflected throughout the teaching, which is grouped into themes. There are four themes that run through all three years and are designed to cover the learning outcomes. The first theme comprises knowledge and understanding of Psychological Models, Theories and Evidence Base; and the second theme Clinical skills. These two themes each occupy about 30% of the teaching time, and primarily cover the learning outcomes ‘Knowledge and understanding’ and ‘Subject specific skills’. The teaching in these themes includes psychological assessments, formulations and interventions across a wide span of client groups and a variety of therapeutic approaches. The third and fourth themes cover Research skills and Professional & Ethical Skills and each occupy about 20% of the teaching time. These themes cover the learning outcomes ‘Transferable skills’ and ‘Personal and professional skills’. Throughout the teaching programme the integration of theory with practice is encouraged, and there are opportunities for trainees to reflect on their own practice and understanding. The remaining time in the curriculum is reserved for essential employee and academic support, including NHS trust mandatory training; introduction to professional bodies; and academic support (e.g. personal tutor).

Clinical Experience

Clinical placements and the academic programme are designed to link with each other wherever possible. In line with the academic programme, trainees work with clients across the lifespan, and with carers and service systems. In the first year placement experience is focused on work with individuals, often for adults within Adult Mental Health services, Older Adults, Health and Medical and Psychosis and Recovery services. In the second year placement experience focuses on direct work and working with carers and staff often in services for children, adolescents and families, and people with learning disabilities. In year three optional placements are available, although this is dependent on the training requirements of each trainee. Trainees complete six approximately 5-month placements over the three years of the programme. Over the programme each trainee will gain experience across a range of service settings, including primary care, community, residential and day services and with clients presenting a wide variety of problems, who have a range of abilities, including communication problems. There is a wide range of placements available, including psychosis and recovery, primary care, psychotherapy, neuropsychology, addictions, medical psychology, forensic work, adult mental health services, child and adolescent mental health services, older adult mental health services, people with learning disabilities services. Clinical supervisors work in the service setting of the trainees’ placements, and are usually qualified clinical psychologists with at least two years’ experience. During each placement clinical tutors will discuss the placement aims and activities and review progress mid-way through the placement. At the end of the placement the trainee and clinical supervisor meet to discuss their respective feedback forms, including the supervisor’s Assessment of Clinical Competence.

Research

Research teaching is provided throughout the three years of the programme. This teaching is supplemented by the experience gained by trainees in conducting and submitting four pieces of research related work: a literature review; a single case study; a service evaluation project; and a research thesis. Specific teaching on all of these
pieces of work is offered through workshops, group tasks, interactive teaching and personal supervision. Topics for the research thesis are based on the available expertise within the department and usually also developed in collaboration with NHS colleagues. A research supervisor, from the academic staff group and usually an additional supervisor from the NHS, are allocated to each trainee in their second year. The personal tutor is available to assist trainees with any concerns about their coursework in general and will alongside

Detailed information about the structure of programmes, regulations concerning assessment and progression and descriptions of individual modules are published in the University Calendar available on-line at http://www.shef.ac.uk/govern/calendar/regs.html.

21. Student development over the course of study

Throughout the programme there are various assessed pieces of coursework that must be submitted, plus assessments at the end of each placement: Assessment of Clinical Competence 1 to 6 (ACC1-6). The assessed coursework includes: Short Answer Questions 1 to 4 (SAQ1-4); Case Studies 1 to 4 (CS1-4); Observed Clinical Skills Assessment (OSCA); Academic Clinical Project 1 (Literature Review; ACP1); Academic Clinical Project 2 (Single Case Study; ACP2); Academic Clinical Project 3 (Service Evaluation Project; ACP3); and Research Thesis. To qualify for the D Clin Psy trainees must pass all pieces of coursework and Assessments of Clinical Competence. The following assessments must be passed to progress to the next year or graduate:

For the full-time programme:
- Year 1: SAQ1; ACP1; CS1; OSCA; ACC1 and ACC2.
- Year 2: SAQ2 and SAQ3; ACP2; CS2 and CS3; ACC3 and ACC4.
- Year 3: SAQ4, ACP3, CS4, ACC5 and ACC6, Research Thesis.

22. Criteria for admission to the programme

Admission criteria can be found on the departmental website: www.sheffield.ac.uk/clinicalpsychology/programmes/doctor/entry

23. Additional information

This specification represents a concise statement about the main features of the programme and should be considered alongside other sources of information provided by the teaching department(s) and the University. In addition to programme specific information, further information about studying at The University of Sheffield can be accessed via our Student Services web site at http://www.shef.ac.uk/ssid.
### Appendix 12

## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Assessment of Clinical Competence</td>
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<tr>
<td>ACP</td>
<td>Academic Clinical Project</td>
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<tr>
<td>BPS</td>
<td>British Psychological Society</td>
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<tr>
<td>CAT</td>
<td>Cognitive Analytic Therapy</td>
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<tr>
<td>CLRN</td>
<td>Comprehensive Local Research Networks</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>CPF</td>
<td>Clinical Psychology Forum</td>
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<td>CPPAB</td>
<td>Collaborative Placement Planning and Allocation Board</td>
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<td>CPSC</td>
<td>Clinical Practice Sub-committee</td>
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<td>CPSR</td>
<td>Centre for Psychological Services Research</td>
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<td>CPU</td>
<td>Clinical Psychology Unit</td>
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<td>CS</td>
<td>Case Study</td>
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<td>CSC</td>
<td>Curriculum Sub-committee</td>
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<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<td>CSUH</td>
<td>Central Sheffield University Hospitals</td>
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<td>CTCP</td>
<td>Committee on Training in Clinical Psychology</td>
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<td>DClin Psy</td>
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<td>DCP</td>
<td>Division of Clinical Psychology</td>
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<td>DDA</td>
<td>Disability Discrimination Act</td>
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<td>EEB</td>
<td>External Exam Board</td>
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<td>HCPC</td>
<td>Health and Care Professions Council</td>
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<td>HEYH</td>
<td>Health Education Yorkshire and the Humber</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>IEB</td>
<td>Internal Exam Board</td>
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<td>IET</td>
<td>Independent Evaluation of Teaching</td>
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<td>PWP</td>
<td>Psychological Wellbeing Practitioner</td>
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<td>RDaSH</td>
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<td>REF</td>
<td>Research Excellence Framework</td>
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<td>RP</td>
<td>Reflective Practitioner</td>
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<td>RSC</td>
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<td>RTAG</td>
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<td>RTP</td>
<td>Research Training Programme</td>
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<td>SAQ</td>
<td>Short Answer Questions</td>
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<td>SCH</td>
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<td>ScHARR</td>
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<td>SETs</td>
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<td>STH</td>
<td>Sheffield Teaching Hospitals</td>
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<tr>
<td>TUPE</td>
<td>Transfer of Undertakings (Protection of Employment) Regulations</td>
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