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Information & Contacts

All of the Information you need to organise placements is in this handbook which is also saved on Moodle for Students and RHUL website for supervisors.

Contact the Clinical Tutor Team dclinpsy@rhul.ac.uk / 01784 443851:

Dr Kate Theodore – Clinical Director & Deputy Course Director
Mrs Michelle Watson - Student & Course Administration Officer
Ms Jennifer Lutley - Senior Student & Course Administration Officer

Details of supervisor workshops for those supervising Clinical Psychology trainees in the North Thames region are available on our website.

Supervisors and trainees should adhere to professional practice guidance from the HCPC and BPS in relation to all aspects of clinical practice and supervision.

The following BPS additional guidance for clinical psychology practice and supervision is also available:

- BPS Guidelines on clinical supervision
- BPS Code of Ethics and Conduct
- BPS Generic Professional Practice Guidelines
- HCPC Standards of Conduct, Ethics and Performance
- HCPC Guidance on Conduct and Ethics for Students
- HCPC Standards of Proficiency for Practitioner Psychologists
- HCPC Standards of Education and Training

Line Management

All training places are commissioned by Health Education England and are required to adhere to their Practice Placement Standards. Trainees are employed full-time by Camden & Islington NHS Foundation Trust and are full-time registered students at Royal Holloway, University of London. They have completed all employment and DBS checks with the Trust. Their line manager at Royal Holloway is Professor Helen Pote, Course Director. Camden and Islington NHS Foundation Trust and Royal Holloway hold a Placement Agreement with all placement trusts and organisations to ensure that trainees are able to work within services without the need for an honorary contract (see Contractual Agreements on the website).

Whilst on placement supervisors act as proxy line managers and are responsible for monitoring trainee attendances, absences, performance, conduct and fitness to practise. Trainees are expected to conform to placement Trust policies, BPS and HCPC codes of professional conduct and ethics listed above.
Trainees should inform their supervisors and the Course should any absences, concerns or complaints arise on placement. Supervisors must inform the Course immediately should any supervision, conduct, complaints or fitness to practise issues arise on placement. If supervision arrangements need to change, then supervisors should also inform the course as soon as possible.

Camden and Islington NHS Foundation Trust provide trainees with an employment induction which should fulfil all of the mandatory training trainees need prior to going on placement, namely Fire, Manual Handling, Infection Control, Equality & Diversity, Safeguarding Adults & Children Level 2 and Conflict Resolution. Some Trusts may require a separate Trust induction. Annual mandatory training will be completed by trainees and they are required to keep a record of this to show to placement supervisors.

At the start of placement all supervisors must provide an induction to Local Trust Health and Safety policies, safeguarding and clinical risk management procedures (including home visit/lone working policies where applicable), Information Governance procedures, systems for recording in clinical notes and systems for making room bookings. Trainees are expected to conform to all Local Trust policies.

Clinical Supervisors are also expected to monitor within placement travel and sign trainee’s monthly travel expenses, which will be countersigned by the Course.

**Supervision**

Supervisors and Trainees are expected to conform to BPS and HCPC supervision guidelines.

The Course recommends 1.5 hours of formal supervision per week. The BPS guidelines on clinical supervision state that “there must be a formal scheduled supervision meeting each week that must be of at least an hour’s duration... total contact between the trainee(s) and Supervisor(s) must be at least 3 hours a week, and will need to be considerably longer than this at the beginning of training.”

Trainees have one named supervisor, but may conduct specific pieces of clinical work with additional supervisor(s) who can be from other professional disciplines. Opportunities for joint working with the supervisor, and for the trainee to observe experienced clinicians and be observed working with clients are deemed essential. Trainees and supervisors are requested to keep a written record of the main discussion and action points from supervision and observations.

Plans for supervision cover in the event of unexpected absence, holidays, illness etc. must be in place and Trainees and Supervisors must inform the course immediately of any significant changes to supervision arrangements.

**Placement days**

Trainees will be on placement for an average of 2.5 days per week. This varies from 2-5 days per week according to their stage of training. Trainees are expected to be on placement for a minimum of two days per week at all times unless they are on annual leave.
During term-time academic days are fixed, so trainees are not available for placement on those days. During the rest of the week, trainees may be on placement or conducting research.

<table>
<thead>
<tr>
<th>1st years</th>
<th>Fixed Academic days</th>
<th>Placement Days Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd years</td>
<td>Mon, Tues,</td>
<td>Weds, Thurs, Fridays</td>
</tr>
<tr>
<td>3rd years</td>
<td>Thurs, Fri</td>
<td>Mon, Tues, Wed</td>
</tr>
<tr>
<td></td>
<td>Weds (autumn term only)</td>
<td>All days possible (except Weds in the autumn term)</td>
</tr>
</tbody>
</table>

A placement planning grid to assist you and the trainee in allocating placement, study, research and annual leave days is provided. The number of days for each activity is clearly specified, but the particular days of the week for each activity are not specified, to allow for variation based on the needs of the trainee, the supervisor and the service. See example below.

<table>
<thead>
<tr>
<th>Week Date</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-Oct-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Oct-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-Nov-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-Nov-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-Nov-17</td>
<td>A</td>
<td>A</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>28-Nov-17</td>
<td>A</td>
<td>A</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5-Dec-17</td>
<td>A</td>
<td>A</td>
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<tr>
<td>12-Dec-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19-Dec-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26-Dec-17</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-Jan-18</td>
<td></td>
<td>A</td>
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<td></td>
<td></td>
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<tr>
<td>9-Jan-18</td>
<td>A</td>
<td>A</td>
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<td></td>
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<tr>
<td>16-Jan-18</td>
<td>A</td>
<td>A</td>
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<tr>
<td>23-Jan-18</td>
<td>A</td>
<td>A</td>
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<td></td>
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<tr>
<td>30-Jan-18</td>
<td>A</td>
<td>A</td>
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<tr>
<td>6-Feb-18</td>
<td>A</td>
<td>A</td>
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<td></td>
<td></td>
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<tr>
<td>13-Feb-18</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>20-Feb-18</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27-Feb-18</td>
<td>A</td>
<td>A</td>
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<td></td>
<td></td>
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<tr>
<td>6-Mar-18</td>
<td>A</td>
<td>A</td>
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<td></td>
<td></td>
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<tr>
<td>13-Mar-18</td>
<td>A</td>
<td>A</td>
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<tr>
<td>20-Mar-18</td>
<td>A</td>
<td>A</td>
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<tr>
<td>27-Mar-18</td>
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<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-Apr-18</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-Apr-18</td>
<td>A</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Caseload
Trainees usually carry eight substantive pieces of clinical work at any one time. This caseload will obviously be tailored to the specific placement needs as well as the trainees’ developmental needs and learning outcomes. It will combine direct and indirect clinical work. Caseloads should be planned early, preferably before the start of placement, to ensure that trainees start to see clients within the first few weeks of placement and build up to a full caseload and range of clinical activities in the first 6 weeks.

Study
Trainees should have one half day per five placement days for clinical placement study. This can be taken at home or at the placement depending on service needs.

Additional Exam study leave of approximately 2 weeks is normally taken in June or early July of the first year of training. The spread of study (block or occasional days) should be agreed with the supervisor and be in line with service demands.

The Service-Related Research Project is completed during one placement - 13 days are set aside for this project over the course of training.
**Annual Leave**
Most trainees will have 27 days of annual leave. This must be negotiated with the supervisor in advance and taken in each placement block. Due to course requirements annual leave cannot be carried over between 6 month placements. With supervisor and Course agreement 5 days of annual leave can be carried over to the second 6 months of a 12 month placement.

**Observations, Competence Monitoring and Placement Documentation**
Trainee’s clinical targets agreed at the end of the previous placement will be provided to the new supervisor by the trainee and should be included in the placement contract.

Trainees clinical practice must be **observed at least 3 times** during each 6 month placement. This should include ‘live’ observation of their clinical assessment and intervention skills. Recordings of sessions may also be used to supplement this.

Two formal ratings of competences using standard competence rating scales completed based on these observations must be completed every 6 months.

To monitor the experience and competence of the trainee, trainees and supervisors will be expected to complete the following and trainees submit documents to Moodle. All documents are available on Moodle and our website:

1. **Placement Contract** - Completed 2-4 weeks after placement start date.
2. **Placement Evaluation Form – (PEF)** - Completed at the middle of placement and updated at the end of placement.
3. **Mid-placement review meeting (MPR)** - Between weeks 8-12 of placement a member of the course staff will visit the trainee and supervisor to evaluate and record progress. PEF report of the meeting is submitted 2 weeks after the MPR window.
4. **End of placement review meeting (EPR)** - Final evaluation meeting usually conducted between trainee and supervisor in the final week of placement. PEF report of the meeting submitted 2 weeks after the end of Placement with signed ACE Log.
5. **Three observations of trainee practice and two formal ratings of competences** based on these observations must be completed every 6 months. Tools for observation are available from Royal Holloway. Results are reported in the PEF.
6. **ACE Log** - electronic record of clinical experience and competences will be prepared for review at MPR and EPR. A signed copy is submitted with EPR documentation. Client permission is required for data to be recorded on the ACE system.

**Trainee Support**
Support to trainees will be offered through supervision and by the Course. Supervisors should be aware that Trainees have a Personal Tutor - a member of the Course staff who will support and monitor the trainee’s personal-professional development. Other support is also provided by the Course including a facilitated Reflective Practice Group, access to an Independent Personal Advisors, Student Counselling Services and Candi NHS Foundation Trust Occupational Health Services. If trainees or supervisors are concerned about a trainee’s welfare they should inform a member of course staff immediately.
 Placement Documentation Deadlines:

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Completed by</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start of Placement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract</td>
<td>Trainee &amp; Supervisor</td>
<td>Trainee submits to Moodle 2-4 weeks after start of placement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MPR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE Log</td>
<td>Trainee</td>
<td>Trainee emails to MPR visitor 1 week prior to the MPR</td>
</tr>
<tr>
<td>Placement Evaluation Form</td>
<td>Trainee &amp; Supervisor, MPR Visitor</td>
<td>Draft completed and emailed to MPR visitor 1 week prior to the MPR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MPR visitor completes within 2 weeks of MPR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trainee submits signed form to Moodle 2 weeks after MPR window</td>
</tr>
<tr>
<td><strong>EPR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACE Log</td>
<td>Trainee</td>
<td>Trainee submits form and ACE Log to Moodle 2 weeks after the end of placement.</td>
</tr>
<tr>
<td>Placement Evaluation Form</td>
<td>Trainee &amp; Supervisor</td>
<td></td>
</tr>
</tbody>
</table>

*Note that for first years on one year placements, there must be 2 EPRs: one at the end of the first six months and one at the end of the year.*
This section covers the placement allocation process across the three North Thames DClinPsy courses. In addition, guidance on trainee induction, orientation, and activity organisation is covered.

**Placement allocation**
All Royal Holloway DClinPsy trainees undertake placement in North Thames. Placements in North Thames are shared between Royal Holloway and the other two Courses at University College London and the University of East London. Placements are sourced and allocated collaboratively between these three Courses.

At Royal Holloway the Clinical Sub-Committee oversees and assesses the appropriateness of placement allocations made by the Course.

Several hundred psychologists and mental health professionals working in the North Thames part of the London Region provide placements. Supervisor details are stored securely on a shared electronic database. If a Supervisor wishes to record any changes to their contact details, please contact Michelle Watson at dclinpsy@rhul.ac.uk

Placement planning is conducted jointly by the three Courses to ensure fairness of distribution; a single tutor from one of the three Courses takes responsibility for organising placements for each speciality.

<table>
<thead>
<tr>
<th>Course</th>
<th>Placements responsible for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Holloway</td>
<td>People with Learning Disabilities</td>
</tr>
<tr>
<td></td>
<td>Health</td>
</tr>
<tr>
<td></td>
<td>Neuropsychology</td>
</tr>
<tr>
<td></td>
<td>Forensic</td>
</tr>
<tr>
<td>University College London</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td></td>
<td>Long Term Needs</td>
</tr>
<tr>
<td></td>
<td>Specialist Adult</td>
</tr>
<tr>
<td>University of East London</td>
<td>Child (core and specialist)</td>
</tr>
<tr>
<td></td>
<td>Older Adults</td>
</tr>
</tbody>
</table>

Placements commence in October and April each year. Placements are sourced by emailing supervisors 4 months before the placement is due to start. Trainees are allocated to placements in February and July and supervisors informed of their allocated trainee about 6-8 weeks before placements commence. Trainees are informed of their placement allocation about 4 weeks before and asked to contact supervisors to arrange a placement visit in order to confirm placement suitability and arrange practicalities for the placement. The course will confirm placement arrangements in writing. Trainees will provide a brief CV to supervisors.
Trainees are closely matched to placement requirements provided by supervisors. However, given the limited number of placements available, exact matching of trainee to individual placement needs is not always possible. Supervisors should contact the Course immediately if they feel that an allocated trainee is not suitable for their clinical placement.

In order to ensure co-ordinated management of the placement resources across the region, it is important that neither trainees nor supervisors make independent arrangements regarding placements. Doing so is disruptive to the allocation process. It has a negative impact on our working relationships with other supervisors and courses. It also causes anxiety amongst trainees.

Most placements are within the NHS and the course aims to prepare Clinical Psychology trainees for working within the NHS when qualified. However, a small number of placements are within charities and the private sector, many of whom are providing NHS services for complex clients. The supervision follows usual employment, BPS, HCPC and HEE requirements. Trainees working within private placements are not entitled to earn additional funds in addition to their full-time NHS contract.

**Induction and Orientation**

Supervisors should inform their line manager and colleagues that a trainee will be working in the service and discuss implications.

At the pre-placement meeting or initial supervision meeting it is important to discuss the trainee’s previous experience, their needs and interests and the opportunities provided by the placement. Trainees will provide a brief CV. Supervisors should provide any necessary placement required reading.

At the start of placement all supervisors must provide an induction to Local Trust Health and Safety policies, safeguarding and clinical risk management procedures (including home visit/lone working policies where applicable), and information governance procedures. They must also ensure an induction is provide to systems for recording in clinical notes, making room bookings, and make the trainee aware of any required attendance at local meetings. Trainees will be expected to conform to all Local Trust policies. Some supervisors develop an induction pack of placement information to ensure trainees are provided with everything they need to know in order to function effectively in the service.

Caseloads should be planned early, preferably before the start of placement, to ensure that trainees start to see clients within the first few weeks of placement and build up to a full caseload and range of clinical activities (at least 8 pieces of ongoing clinical work) in the first 6 weeks. Supervisors should plan an orientation to local services and staff. This doesn’t all have to happen immediately and trainees can take some responsibility in setting up visits and meetings. This should include orientation to the:

- **Professional role** of the clinical psychologist within the placement setting, including consideration of how this fits into the multi-disciplinary team where appropriate.
- **Trust** or employing organisation. Providing a ‘who’s who’ of local managers, local agencies, abbreviations used in meetings (PCT’s, MHA, AMHP, etc.), plus orientation to other systems with which the service works if appropriate, including service user and carer organisations.
- **Functioning of the team**, such as membership, roles, usual working practices, and attendance times etc. Small details such as how to pay for tea and coffee should also be included.

It is usually helpful to move through clear phases of induction to independent clinical work. For
example, a) trainee watches supervisor; b) trainee and supervisor work together; c) supervisor
watches trainee. The issue of independent working should be discussed in supervision; there is a
delicate balance between restricting a trainee's opportunity to learn and develop and allowing
premature (and, therefore, probably unstable) autonomy.

The risk assessment and management procedures need to be considered carefully as the trainee
progresses to more independent working. Supervisors need to be sure that trainees are aware of
and have the ability to follow, risk management procedures before trainees begin to work
independently.

**Time on placement**
The trainee will be on placement for an average of 2.5 days per week. This varies from 2-5 days per
week according to their stage of training. Trainees are expected to be on placement for a minimum
of two days per week at all times unless they are on annual leave. See Guidance on attendance and
annual leave (Moodle/Website).

A placement planning grid is provided to assist the supervisor and the trainee in allocating
placement, study, research and annual leave days. The number of days for each activity is clearly
specified but the particular days of the week is left flexible to fit with the needs of the trainee, the
supervisor and the service.

During term-time, academic days are fixed so trainees are not available for placement on those
days. During the rest of the week, trainees may be on placement or conducting research.

<table>
<thead>
<tr>
<th>Academic days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st years</td>
</tr>
<tr>
<td>Mon, Tues,</td>
</tr>
<tr>
<td>2nd years</td>
</tr>
<tr>
<td>Thurs, Fri</td>
</tr>
<tr>
<td>3rd years</td>
</tr>
<tr>
<td>Weds (first term only)</td>
</tr>
</tbody>
</table>

An example planning grid will be provided with the initial allocation letter. The planning grid consists
of two elements:

- a calendar for the weeks of the placement with the academic teaching days mapped in
- a table detailing the exact number of days to be allocated to other activities such as research and
  study.

Supervisors should ensure that they agree the plan for the allocation of days with trainees at the start
of the placement. This will include the scheduling of study days and annual leave. Planning should be
based around a number of key guidelines, including:
• Trainees are expected to be on placement for a minimum of two days a week at all times unless they are on annual leave.

• Any academic, study or research days must be taken in such a pattern so as to ensure that there are always two days per week on placement. It must not be taken in blocks unless this is specifically requested by the supervisor and agreed by the Course.

• Exam study leave (in the first year) may be taken as a block or spread across the placement as agreed with the supervisor and to be in line with service demands.

• Clinical Study time: One half day per five placement days is allocated to the trainee for clinical study. This time is set aside for reading material relating to their clinical work. Study time may be taken either weekly or fortnightly as agreed between supervisor and trainee, however it cannot be accumulated beyond one day in any 10 placement days and it may not be accrued for use as a longer study break. Trainees may spend study time at the placement base or elsewhere according to the needs of the service and agreed with the supervisor

• Academic Study time: Academic study is taken outside of placement time, and is scheduled on College days. Trainees may very occasionally also need to attend College for meetings on study days.

• Service-Related Research Project: This is expected to be carried out on placement. 13 days are set aside for this project over the course of training. Trainees often complete this project in their first year of training.

• Thesis Research days: Thesis project days are allocated from the end of the first year and throughout the 2nd and 3rd years of the Course. The specific days taken for thesis research are left flexible to fit with placement and research demands.

Research on Placement
As part of the Course, trainees are required to complete a service related research project (SRRP detailed in the Research Handbook). The SRRP is designed to ensure that trainees have the experience of conducting small-scale research related to quality improvement. The SRRP should demonstrate that the following learning outcomes have been achieved:

• Capability of identifying, small-scale, locally-driven, service-oriented research questions reflective of local service needs;

• Competence in research skills, including refining research questions, demonstrating an understanding of ethical issues, choosing appropriate methods and analyses, reporting outcomes;

• Working collaboratively with others (e.g. service users, other colleagues);

• Awareness of the relevant legislative and national planning context of service delivery and clinical practice;

• Ability to facilitate appropriate service user involvement in relevant aspects of the project, e.g. development of project rationale, selection of measures, dissemination of findings, etc.

• Understanding change processes in service delivery systems;

• Ability to present the results using appropriate scientific style;

• Ability to communicate service-related evaluation results to relevant individuals within a service in a manner that provides sufficient basis to enable decisions relating to the service to
be made.

Examples of suitable topics might include an evaluation of a group, analysis of data routinely collected by the service, a small-scale survey, or a small piece of qualitative research. To ensure that the project is viable and has a clear research design, trainees are asked to provide a very short research proposal (maximum 1 page) which they will submit by email to the Course research tutor for approval before embarking on the project. Trainees are encouraged to complete their SRRP early on in training, usually in the first year, but it is recognised that opportunities for research may not exist on every placement.

Travel to placement
Guidance for claiming back travel to and from placement are outlined in the Procedure for Making Travel Claims (Moodle/Website).
This section covers trainee and supervisor responsibilities. This includes information about responsibilities around line management, professional standards, as well as the support structures available to trainees. Guidance on clinical risk management, confidentiality and consent, record keeping and non-discriminatory practice are also covered.

**Employment & Line Management**

Trainees are employed full-time by Camden & Islington NHS Foundation Trust and are full-time registered students at Royal Holloway, University of London. Their line manager at Royal Holloway is Professor Helen Pote, Deputy Course Director.

Since 2010, Camden and Islington NHS Foundation Trust and Royal Holloway hold a Placement Agreement with all placement trusts to ensure that trainees are able to work within services without the need for an honorary contract.

Whilst on placement, supervisors act as proxy line managers and are responsible for monitoring trainee attendances, absences, performance conduct and fitness to practise. Trainees are expected to conform to BPS and HCPC codes of conduct. Trainees should inform their supervisors and the Course should any absences, concerns or complaints arise on placement. Supervisors must inform the Course immediately should any supervision, conduct, complaints or fitness to practice issues arise on placement. If there needs to be any change to supervision arrangements the trainee and supervisor should also inform the Course as soon as possible using dclinpsy@rhul.ac.uk

Camden and Islington NHS Foundation Trust complete all employment and DBS checks. They provide trainees with an employment induction which should fulfil all of the mandatory training trainees need prior to going on placement, namely Fire, Loads, Infection Control, Equality & Diversity, Safeguarding Adults & Children Level 2 and Conflict Resolution. Some Trusts may require a separate Trust induction, which should be arranged by the placement supervisor.

At the start of placement all Supervisors must provide an induction to Local Trust Health and Safety policies and procedures (including home visit policies where applicable), Information Governance procedures and systems for recording in patient’s notes and making room bookings. Trainees will be expected to conform to all Local Trust policies.all relevant local service policies as discussed above.

Clinical Supervisors are also expected to monitor travel within placement, and sign the trainee’s monthly travel expenses if applicable. This will be submitted to the course by the trainee and countersigned by Course staff.

Guidance for claiming back travel to and from placement are outlined in the Procedure for Making Travel Claims (Moodle/Website).

**Fitness to Practice**

The Course recognises that the training process is intensive and stressful. It is important that trainees understand the importance of maintaining their own health, and that they are able to manage the physical, psychological and emotional impact of the Course. Awareness and maintenance of one’s fitness to practice as a clinician is an important part of a trainee’s personal-
professional development and a HCPC professional standard. Fitness to practice is defined by HCPC as having the skills, knowledge, character and health to practice the profession safely and effectively. These are clearly detailed in the HCPC Standards of Conduct, Ethics and Performance (2016).

If trainees have any concerns that they are suffering significant stress which is impacting on their functioning or clinical work, or any concerns about their fitness to practice, they should notify their supervisor and a member of Course staff (usually their Clinical or Personal Tutor) as soon as possible. This notification will be considered as a sign of positive professional behaviour and the supervisor/course staff will work with the trainee to develop a plan of action. This will include identifying additional sources of support.

Similarly, if supervisors have concerns about a trainee’s stress levels, clinical functioning or fitness to practice on placement they should contact the Clinical Tutor Team as soon as possible. This would usually (but not always) be done in collaboration with the trainee. Supervisors who have significant concerns about a trainee’s functioning, should act in the best interests of service users and contact the Course even if the trainee does not feel this course of action is necessary.

RHUL has Fitness to Practice procedures for courses that lead to a professional qualification in a health care discipline (Moodle/Website). These procedures are designed to be implemented when there are issues relating to suitability to practice that may not be picked up by normal assessment procedures.

The Course also has a Protocol for Confidentiality and the Sharing of Information about trainees, (Moodle/Website) which outlines the principles and procedures around management of information about personal circumstances of trainees.

Support
In addition to the usual support offered on placement by supervisors, trainees are offered personal-professional support throughout their training which may help them monitor and maintain their fitness to practise. In addition to support from supervisors, Trainees have a Personal Tutor - a member of the Course staff who will support and monitor the trainee’s personal-professional development. Trainees are expected to meet with them once a term. Other support options are also available including facilitated reflective practice groups, diversity reflective practice groups, access to an independent personal advisors, student wellbeing services and Candi NHS Foundation Trust Occupational Health Services (PAM). If trainees or supervisors are concerned about a trainee’s welfare they should inform a member of course staff immediately.

Professional Standards
Introduction
Trainees and Supervisors are expected to conform to BPS and HCPC codes of professional conduct and ethics and adhere to their supervision guidelines. The following section details some key points from the policies below which are most relevant to placements but should be read in conjunction with the professional practice guidelines, Camden & Islington NHS Foundation Trust employee policies and local placement Trust policies. Details of current policies from professional bodies can be found in the Policies folder on Moodle.
• British Psychological Society (2008) Record Keeping: Guidance on Good Practice
• British Psychological Society (2017) Professional Practice Guidelines
• BPS (2012) e -Professionalism Guidance on the use of social media by clinical psychologists
• BPS Supplementary guidance on the use of social media
• BPS (2014) DCP Guidelines on clinical supervision
• BPS (2019) Standards for the accreditation of Doctoral courses in clinical psychology
  • BPS Forensic Faculty (2006) Occasional Briefing Paper No 4 Risk Assessment and Management
• Data Protection Act (2018)
• General Data Protection Regulation (2018)
• Health & Care Professions Council (2016) Guidance on Conduct and Ethics for Students.
  London: HCPC.
• Health & Care Professions Council (2016) Standards of Conduct, Performance & Ethics.
  London: HCPC.
• HCPC Standards of Education and Training (2017)
• Mental Capacity Act 2005: Code of Practice (2007)

These documents are introduced to trainees during their induction teaching block in the first year of training and they are required to familiarise themselves with them.

Trainees have a dual role as employees of the NHS and postgraduate students of the College. They are therefore bound by the Contracts of Employment and Conditions of Service of the Employer as well as by College rules and regulations. Additionally, trainees while on placement are bound by any conditions in operation in the placement or imposed by the organisation providing the placement. Supervisors should make sure that trainees are informed of these local policies during the induction to placement.

Trainees must always use the term Trainee Clinical Psychologist when introducing themselves to clients.

Any concerns about a trainee’s professional practice or conduct on placement should be immediately referred to the trainees’ Line Manager - Helen Pote, Clinical Director / Deputy Course Director (email: dclinpsy@rhul.ac.uk).

Where a trainee fails to meet the expected standards of general behaviour or professional standards, then the normal disciplinary procedures will be followed:
  • College procedures related to student conduct are available on the RHUL website.
  • As employees of C&I Mental Health Foundation Trust, trainees are also subject to Trust disciplinary procedures.
Managing risk

The management of risk is covered in a number of different forums throughout training. This includes: formal teaching in the first-year induction (clinical skills teaching; adult assessment and formulation; C&I mandatory training such as safeguarding adults and children and lectures on suicide and anger management). Within these lectures trainees are signposted to the relevant BPS and HCPC documents on managing clinical risks.

- Forensic Faculty (2006) Occasional Briefing Paper No 4 Risk Assessment and Management
- Health & Care Professions Council (2016) Standards of Conduct, Performance & Ethics. London: HCPC.

At the start of the placement, trainees must discuss risk management in supervision and become familiar with local placement Trust policies regarding risk management including any lone working guidelines, where relevant.

Clinical risk issues should be discussed with the supervisor as soon as possible and procedures for contacting the supervisor in emergencies and recording risk should be agreed and documented in the Placement Contract.

There are specific placements that require more intense and localised training before the trainee is able to start the placement (such as Broadmoor High Secure Hospital, the Medium Secure Hospital settings, and Feltham Young Offender’s Institute). Trainees are required to complete specific risk management training as part of the Trust induction for these placements.

Ending of Clinical Work

The Course expectation is that all trainee involvement with and responsibility for their clients on any given placement ends with the end of that placement. This includes the completion of all reports and records before the end of the placement. Variation of this practice would be highly unusual and must be based on a specific clinical need and negotiated specifically with the Course staff to ensure that all clinical and indemnity, employment, supervision and training issues have been considered.

Client Confidentiality and Consent

Gaining consent for assessment and treatment from clients, and addressing the boundaries of confidentiality are essential to ensure a good therapeutic relationship, that is both safe and effective. The Course discusses these issues with trainees during the induction block and Trainees’ initial ability to discuss issues of confidentiality and consent is assessed by the Course by the clinical interview pass-out before they commence their first placement.

Trainees should familiarise themselves with local Trust guidelines on confidentiality and consent and use these to inform their work. Supervisors should check that the trainee’s performance in this regard is appropriate to the specific placement setting and local Trust guidelines.

Trainees should discuss and adapt the following guidelines with supervisors at the beginning of their placements in order that they are appropriate for the local context.
Consent

You need to gain informed consent for your clinical work, including explaining and getting consent for additional, particular aspects of being a trainee (e.g., how information is recorded and its use for educational purposes). Details are outlined below about the principles and requirements of consent for trainee clinical psychologists, written versus verbal consent, and consent given by others when the client lacks capacity to consent.

The following guidance is based on principles outlined by the HCPC and BPS, including the following:

- HCPC (2016) Guidance on Conduct and Ethics for Students
- BPS (2017) Practice Guidelines

Informed Consent to be seen by a Trainee Clinical Psychologist

Informed consent is when someone has all the information they need, in a format they can understand, to make a decision about whether or not they want to give their permission to have a particular intervention or assessment. Client consent to be seen by a trainee clinical psychologist should be sought at the first contact. Consent however is an ongoing process, and consent should be revisited at key points during any therapeutic relationship.

When clients are offered the option of seeing a trainee clinical psychologist, information should be provided to them about what seeing a trainee is likely to involve. This will usually include, for example, that the trainee will be regularly supervised, the nature of the trainee’s training and experience, the length of time that the trainee will be available, what may happen when the trainee’s placement comes to an end, any audio recording that may be planned, that the work may be written up for academic purposes, and that the client may be asked to comment on the trainee’s performance (see RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form, standard and easy read versions, on Moodle). Clients have the option of consenting to specific elements of this, for example, they may consent to being seen by a trainee and to having anonymised information included on the ACE log, but not consent to having anonymous information included in a case report or to audio recording.

In clinical practice trainees should do the following as a minimum (except in emergencies):

- Make sure that before you carry out any assessment or intervention, the service user is aware that you are a trainee;
- Make sure that the service user has given their permission for the assessment or intervention to be carried out by a trainee;
- Explain the assessment or intervention that you are planning to carry out;
- Explain the risks associated with any assessment or intervention, before you carry it out;
- Follow guidance and policies on consent from RHUL, your placement Trust and your employer (Camden & Islington NHS Foundation Trust).

Adapted from HCPC Guidance

Being a trainee entails additional educational requirements to consent. Trainees are required to explain the purpose of collecting and storing anonymised data for training requirements, what data is collected and how it is stored.
Written Consent

Wherever possible, we advise trainees that best practice to ensure a clear and transparent consent process is to use a written consent form. The RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form (standard and easy read versions) is available for this purpose on Moodle. The form covers all aspects of consent relevant to being seen by a trainee but clients have the option of selecting among the options.

These forms may require further adaptation for specific clinical settings or to meet individual clients’ needs. When clients have signed a consent form to being seen by a trainee clinical psychologist, this signed form should be stored at placement / on the client’s clinical notes (in accordance with guidance from the service / placement supervisors) for a minimum of 1 year.

In some clinical settings, seeking consent to use information for various purposes related to training may be a more complex or staggered process. Therefore, these processes will need to be reviewed with individual supervisors and placements, and to help inform these discussions with supervisors, we have set out below some additional information and guidance for specific situations, where it may not be possible or appropriate to use the standard DClinPsy consent form.

When written consent is not possible but verbal consent is possible

Where it is not possible to use a written consent form (e.g., the client is not willing or able to use written consent), trainees must still ensure they seek informed verbal consent from clients to be seen by a trainee, and what this will involve. The information on the written consent form should be explained and consent (or not) noted in each case. Where only verbal consent is gained, the nature and extent of the consent given should be recorded in the client’s clinical notes (in accordance with guidance from the service / placement supervisors).

There follows some specific guidance around the different areas clients may (or may not) consent to when being seen by a trainee clinical psychologist. These areas are covered by the RHUL written consent form, but further detail is provided for clarity where written consent is not possible.

Consent for anonymous information to be stored on ACE

Trainees are required to explain the purpose of collecting anonymised data in terms of training requirements, what data is collected and how it is stored. Trainees are required to gain client’s consent to hold their data in this way.

Where written consent is not possible using the RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form, verbal consent from clients is also acceptable for ACE. The following is a suggestion as to how this requirement may be verbally explained to clients. This sort of statement should be used when gaining verbal consent from clients to store their data on ACE, and can also be used when introducing the written consent form:

‘My University requires me to keep an anonymous electronic record of the work I do in the NHS to monitor my progress. I would like to store some information about you and the work we do in this way. As you will know, we work according to strict NHS confidentiality requirements. Apart from my supervisor and me, the only other person who may look at this information is my University Tutor who is a qualified clinical psychologist who works or does research, in or for the NHS. He / she is also bound by strict NHS confidentiality requirements and will not be able to link the computer record to you. I need your permission to store the information on the computer. At the end of my training, the record will be archived for 3 years then deleted from the computer.’
A record of the written consent or verbal consent gained should be noted on the client’s clinical records. Trainees should also indicate on the client’s anonymised ACE record whether the individual client has consented to being seen by a trainee and to having information recorded on ACE.

As with other electronic client records such as RIO, ACE records fall under the Data Protection Act and clients can request a copy of the information that is held about them in this way.

**Consent for Reports of Clinical Activity or Case Presentations**

A client may have consented to a trainee’s work with them being presented in written or oral form for educational purposes by indicating such consent on the relevant section of the RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form. Such consent allows a trainee to write up their work with this client for a Report of Clinical Activity or present the work as a Case Presentation.

Verbal consent from clients is also acceptable but only where written consent is not possible. The following is a suggestion as to how this requirement may be verbally explained to clients, either when introducing the written consent form or where written consent is not possible to obtain:

“As part of the University training requirements, I may prepare a confidential, anonymous report on the work we have done. I need your permission to do this should I want to prepare such a report. You are completely free to say no and this will not in any way affect our work or the services you will get.”

This sort of statement may also be used to clarify with a client who gives written consent but you are unsure whether they have fully understood what they have agreed to.

The trainee must report, on the front sheet of all work submitted for academic purposes, how the process of consent was addressed as outlined in the following wording.

‘The subject of this report, or a responsible carer, was informed in advance and did not object to their anonymised personal and other details relating to the work undertaken potentially being included in a report produced for training purposes.’

**Consent for Audio or Video Recording of Clinical Work**

We recommend that trainees should have gained written and signed consent from service users to make audio/video recordings of any clinical work as indicated on the RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form (standard and easy read versions) already referred to.

Gaining client consent to record clinical work should entail providing information around the uses to which recordings may be put, that they will be stored securely (following Trust / Service protocols) and when they will be deleted.

Trainees should take particular care when recording any clinical sessions, adhering to the following BPS Practice Guidelines on recording:

- Express consent should be obtained by trainees before audio or video recording of psychological sessions takes place. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made.
• Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes.
• If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.
• The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Clients who may lack capacity to consent to be seen by a trainee clinical psychologist

The Mental Capacity Act came into force in 2005, providing a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It covers people with dementia, learning/intellectual disabilities, acquired brain injury and some mental health problems. The Act sets out clear principles and steps for assessing whether a person lacks capacity to take a particular decision at a particular time. No-one can be labelled ‘incapable’ as a result of a particular medical condition or diagnosis. Guidance on the Act has been provided in the Mental Capacity Act Code of Practice.

For people without the capacity to give informed consent to be seen by a trainee clinical psychologist, those responsible for their care in accordance with professional guidelines and local Trust policies, will need to make a decision regarding whether it is in the individual’s Best Interests to be seen by the trainee clinical psychologist.

It is important that the Programme is able to assess the full range of work conducted by trainees as part of their training, which may include psychological input conducted in the Best Interests of clients deemed to lack capacity to consent to being seen by a trainee. This ensures that all work conducted during Clinical Psychology training has the potential to be submitted to the same processes of academic rigour. Therefore, if a trainee wishes to write a Report of Clinical Activity or present a Case Presentation for a piece of work conducted in the Best Interests of a client who lacked capacity, those professionals / others who contributed to the Best Interests decision making and / or those in the network who may have been involved in the psychological intervention, should be consulted in terms of whether they agree for the work to be written up for academic assessment.

Similarly, agreement for the trainee to record on ACE information regarding their work with a client who lacks capacity to consent, should be sought from those professionals / others who contributed to the Best Interests decision making and / or those in the network involved in the psychological assessment or intervention.

Further details regarding the process and ethical considerations around consent to assessment or intervention should be explicitly discussed in Reports of Clinical Activity for cases where the capacity to consent might be an issue (e.g., anyone under the age of 16, people with learning/intellectual or other disabilities, and generally clients who may not have the capacity to consent).

Confidentiality and anonymity obligations during training

Trainees must ensure that they consider and respect clients’ dignity in all written and spoken communications about their clinical work. It is important for trainees to consider whether their clients would feel respected if they were to read or hear any of the information being shared about them.
BPS guidance is clear that no academic / training documents (including training case reports or case presentations, published reports / articles) should identify clients to which they relate, even by means for example of initials, service name or date of appointment, as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record, subject to relevant data protection legislation.

Trainees should ensure they make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures, and papers which are anonymised and are part of the trainee’s academic learning, and belong to the trainee and are subject to the training provider’s policies and procedures.

Trainees and Course Staff are bound at all times, including periods in College, by the rules, expectations and practices relating to confidentiality in the NHS. The requirements of confidentiality also apply to interactions among trainees and between Course Staff and trainees, except when the consequences of not breaking confidentiality may lead to serious harm. For instance, clients should not be discussed in any public place in the Department or College. Any discussions with other trainees or with Course staff must be regarded as consultations and may only occur in circumstances that enable strict confidentiality to be maintained.

Trainees must ensure that client and carer confidentiality is protected in all work submitted for university requirements. The HCPC ‘Guidance on conduct and ethics for students’ states that students should remove anything that could be used to identify a service user from academic reports (HCPC, 2016).

For the purposes of Case presentations and Reports of Clinical Activity (RCA) submitted as part of the Course, all material must be anonymised. All identifying features such as names, addresses, hospital numbers and any other recognisable details must be changed or deleted. Trainees must not use the client’s own name or initials when referring to him or her in any communications, verbal or written. The client’s personal details should be restricted to the minimum required for describing the intervention.

When using computers in the Psychology Department, or at home, or any place other than the NHS Department responsible for the patient it is essential that all material be fully anonymised. False names, addresses and dates of birth must be used. Computer systems in the Department are not protected from intrusion, in the same way that systems in the NHS might be. Hence special precautions need to be taken to ensure confidentiality.

To further protect the confidentiality of clinical information all written information relating to any aspect of Course work should be stored on the encrypted memory stick that will be issued to each trainee at the start of the Course. This memory stick is the property of the Course and will be returned at the end of training, when all information on it will be erased. The memory stick is the responsibility of the trainee and if lost, the trainee will be required to purchase an equivalent to replace it.

The requirements of the Data Protection Act (2018) apply to the Clinical Doctorate.

Everyone responsible for using personal data has to follow strict rules called ‘data protection principles’. They must make sure the information is:

- used fairly, lawfully and transparently
- used for specified, explicit purposes
- used in a way that is adequate, relevant and limited to only what is necessary
Trainees must adhere to the Trust guidelines where they are on placement regarding use of audio-recording equipment. In general, clinical work should be recorded using digital recorders or ‘dictaphones’ designed for this purpose, unless the placement service endorses the use of another type of device. Personal mobile phones should never be used for the audio-recording of clinical work.

The Course adopts the position that no material relating to patients may be taken from NHS Departments. Nor may such material be brought into the Department or stored on the College or Department computer systems. Evidence that a trainee has done so will be treated as a breach of confidentiality and responded to accordingly.

Breaches of confidentiality involving trainees while in the Department will be regarded as a disciplinary matter and will be formally reported to the employing authority, which may institute whatever actions they deem appropriate.

Trainees should be familiar with BPS guidance regarding electronic health records and specific issues regarding managing confidentiality when using electronic records (see section on Record keeping).

**Record keeping**

During the induction trainees are introduced to HCPC and BPS publications that include guidance on good practice for case notes and electronic health records.

- HCPC Expectations for Record Keeping set out in standards of Conduct, Performance & Ethics and Standards of Proficiency

Trainees are required to familiarise themselves with these publications and the local Trust policies regarding record keeping. The BPS cautions that as the pace of change with regard to record keeping is rapid, professionals must ensure that they update their understanding from general guidelines by paying attention to the prevailing legal, DoH, and Trust policies.

**Guidance for trainees and supervisors:**

- A record in an NHS context is defined as “anything which contains information (in any media) which has been created or gathered as a result of any aspects of the work of NHS employees” (HSC 1999/53, Appendix A, para 5.1 – taken from DCP Record Keeping: Guidance on Good Practice, 2008).
- Ownership of the clinical records belongs to the Trust where the trainee is on placement. It is important for trainees to clarify with supervisors what the service’s procedures for notes and documentation are.
- Trainees should keep appropriate and timely records for all clinical contacts. Trainees should ensure that all records are clear, accurate, written up promptly (on the same day or
The day after) and handled in accordance with applicable legislation, protocols and guidelines.

- Written records are now rarely used in the NHS, but in some cases trainees might be asked to complete them (e.g. in case of electronic system outages). If asked, trainees should follow the basic principles of good written records: use the paper provided by the organisation; write in black ink; don’t leave spaces between lines/entries; sign and date alterations; record date and time of session, attendees, location, key points discussed, actions and outcomes; write your name and sign and date entries.

- Supervisors are not required to validate all clinical record entries completed by the trainee, unless this is the policy of the placement Trust. It will be essential for supervisors to audit trainee notes from time to time to ensure that they are adhering to good practice guidelines in their record keeping.

- Trainees should familiarise themselves with electronic health record systems used by the Trust and undertake the required Trust training to use these systems reliably. Trainees should be familiar with BPS guidelines on electronic health records.

- Activity recording of the amount of clinical contacts should be completed by the trainee if this is a Trust requirement.

- Trainees should contribute to team records and they have a professional responsibility to inform other professionals involved in the care of the client about their involvement.

- Sharing of records should be restricted to a need to know basis, but absolute confidentiality of records cannot be assured. Trainees should be aware of the circumstances by which records may be requested for legal and clinical purposes.

- Trainees should normally obtain consent from clients for the disclosure of any records, restricting the scope of disclosure of records for professional purposes.

- Trainees should make sure they inform clients at the first contact about what records will be kept in relation to their care. This includes the ACE record.

- Trainees and supervisors are requested to keep a record of the main discussion and action points from supervision. The DCP recommends that the supervision record should include: copies of contracts; date and duration of each supervision session; a supervision log book with minimal notes on the content of supervision, decisions reached and actions agreed; and a written record of reviews of supervision (e.g. MPR).

- Where appropriate discussion and decisions from supervision should also be reported in the clinical record. This is particularly relevant if risk issues have been discussed.

- Trainees and supervisors should be aware that from a legal standpoint anything that identifies the client forms part of their record and could be called upon as part of the usual clinical record for legal purposes. In practice some supervision reflections and notes to aid the trainees learning are often kept in an anonymised form.

- Letters, reports and notes in clinical records must be signed appropriately. Accepted terminology is to be used. The British Psychological Society requires the following: “Trainee Clinical Psychologist working under the supervision of…. (name of supervisor)”. Supervisors share clinical responsibility for the work undertaken by the trainee, and so the usual practice is for supervisors to countersign trainees’ letters and reports. Trainees should check with supervisors what is the expected practice within the Trust that they are working in, e.g. whether supervisors also need to countersign entries into clinical notes. Letters should be sent out in a timely fashion.

- Every case would usually have a brief case ending / closure report prepared by the trainee and given to the supervisor at the end of their involvement, identifying who is responsible for any further work and follow-up. Normally, responsibility is assumed to remain with the supervisor.

NHS Departments will be aware that trainees present anonymised accounts of work carried out on placement to clinical seminars including fellow trainees and members of staff. These discussions are
not supervision of the clinical case but are intended to enhance the learning of the trainees. They do not need to be recorded in the clinical records. Any suggestions relating to assessment or treatment made on these occasions, if relevant, are required are to be discussed with the supervisor before any action is taken by a trainee and documented in the clinical records.

Anonymised reports of clinical activity on clients approved by supervisors are submitted for purposes of assessment by Course staff as part of the evaluation of the clinical competence of trainees. These are part of the requirement for the Doctorate but are bound and stored separately and kept securely by the Course. Trainees are required to show these reports to their supervisors and seek written approval that they are a true representation of the clinical work undertaken on the placement. Clients should give written or verbal consent for the trainee to complete this form of clinical report as detailed in the preceding discussion on consent.

The Department has a Test Library and additional resources which trainees are able to borrow for educational purposes, using a booking system. Other equipment, such as stopwatches, tape recorders etc., can also be borrowed from the Department. These materials are covered by the same arrangements and regulations as test materials. Test material, record sheets and other equipment may not be used for clinical purposes in the NHS or kept as part of the clinical record.

**Non-discriminatory practice and service user and carer involvement**

The Course is committed to ensuring trainees practice in a culturally sensitive and non-discriminatory manner. Trainees should familiarise themselves with professional and placement guidelines regarding non-discriminatory practice.

Key to developing a non-discriminatory approach is ensuring service user and carer involvement in all aspects of the Course. The Course aims to help trainees:

- work in partnership with service users and carers,
- understand the various needs, beliefs and world views held by service users and carers,
- become practitioners who can use the views and skills of service users to promote positive change.

Trainees’ development in line with these aims is monitored and reviewed through the MPR and EPR assessment process, and through their Developmental Reviews.

More guidance from the course on Service user and carer involvement on the Course can be found in the Moodle/Website.

**Guidance on the use of Social media**

When using social media and networking sites trainees and supervisors need to be aware of issues relating to clinical boundaries and professional presentation. Guidance from the BPS and DCP regarding responsible use of social media in clinical psychology is available (BPS, 2012. See Moodle/Website). Trainees are advised to review their own social media in relation to these guidelines at the start of the Course.

- BPS Supplementary guidance on the use of social media

Guidelines on client confidentiality and consent should also be applied to any social media communications.
COURSE REQUIREMENTS FOR PLACEMENTS

This section covers the requirements on placement with regards to supervision, caseload and nature of the work trainees are expected to undertake on placement.

Supervision

The HCPC and BPS Guidelines on supervision provide a summary of the main essential components of good quality supervision and the course expects that supervisors will follow these guidelines.

- BPS Additional guidance for clinical psychology training courses: Guidelines on clinical supervision
- CORE Supervision Framework.
- BPS (2014) DCP Guidelines on clinical supervision

Amount

The course recommends 1½ hours per week of formal supervision. Naturally, the type and amount of supervision needed will depend partly upon the stage of training and partly on the needs of the trainee.

The BPS requires that there be “a formal scheduled supervision meeting each week that must be of at least an hour’s duration... The total contact between the trainee(s) and Supervisor(s) must be at least 3 hours a week, and will need to be considerably longer than this at the beginning of training”. Additionally it is anticipated there will be contact at other times for joint work or observation.

Eligibility

Trainees will normally have one named main supervisor who will be a qualified Clinical Psychologist, with at least 2 years of post-qualification clinical experience, as recommended by the BPS. All supervisors should be HCPC registered. Whilst BPS guidance on supervision highlights that trainees may be supervised by professionals other than Clinical Psychologists, the Course stipulates that over the course of training, the majority of a trainee’s supervision will be provided by appropriately qualified Clinical Psychologists.

Where the supervisor is not an appropriately qualified Clinical Psychologist, but has qualification in and experience of psychological practice (e.g. Counselling Psychologists or high intensity IAPT practitioners) the Course will consider their eligibility on an individual basis. When initially supervising trainees from the Course these supervisors may be required to have their supervision overseen by an appropriately qualified Clinical Psychologist. The Clinical Psychologist will also sign off the placement documentation (Contract & Placement Evaluation Form at MPR/EPR). If the Course determine that quality standards for placements and supervision are met the supervisor may not require additional support for future placements.
Trainees may also conduct specific pieces of clinical work with additional supervisor(s) who can be from other professional disciplines. Where discrete pieces of trainees’ clinical work are supervised by a professional from a non-psychologically trained profession (e.g. Occupational Therapist or Social Worker), an appropriately qualified Clinical Psychologist will always bear primary responsibility for overseeing this supervision.

Additionally, it is expected that all supervisors will understand the context of Clinical Psychology training. Supervisors’ workshops provided by the North Thames Courses can support all supervisors to develop this understanding. As the profession becomes more specialised, it is often difficult for one supervisor to provide the full range of experiences needed. Increasingly placements are created on a modular basis, with one named supervisor taking a lead role in structuring the placement, monitoring the trainees’ development, and co-ordinating with other supervisors. Details are in the Moodle/Website.

Responsibilities
Trainees and Supervisors should inform the course as soon as possible of any changes to supervision arrangements or concerns about trainee fitness to practice. Supervisors should plan supervision cover in the event of unexpected absence, holidays, illness etc and document these arrangements in the Clinical contract. The Course should be informed of alternative supervision arrangements if they are required.

Supervisors should ensure that they know what a trainee is doing – as they will share responsibility for their actions. Supervisors should be aware that trainees are employed by Camden & Islington NHS Foundation Trust and their line manager is the Course Director, Prof. Andy MacLeod. Supervisors should make expectations clear about attendance and time management e.g. leave, illness, absence, required meetings.

Supervision should be an open process. Opportunities for the trainee to observe experienced clinicians and to be observed working with clients are deemed as essential components of supervision. Joint work is also important, particularly in the early stages of the placement, and joint work also provides opportunities for mutual observations.

Supervision should enable trainees and supervisors a forum for monitoring the trainee’s fitness to practice. It is well recognised that various aspects of clinical work can give rise to personal stress or distress. Trainees also need personal support and to be invited in supervision, in an appropriately professional way, to discuss any stressors or personal feelings which may arise in connection with their clinical work. If in the course of this process, it becomes apparent that a trainee may need to seek out additional help or support to manage a personal issue, supervisors are not expected to provide personal therapy or counselling. Indeed, this is seen as inappropriate. It would be reasonable, however, for supervisors to provide advice on accessing the necessary help.

Supervision standards
Supervision should pay close attention to the professional, procedural and legal frameworks within which the clinical work takes place. Supervisors should provide a clear induction to these contexts early on in supervision and ensure understanding and adherence to the University and Trust policies and procedures. Specifically, how clients will be told about confidentiality, consent to being seen by
a trainee, procedures for checking and countersigning letters, risk procedures and guidelines relevant to the placement context.

Trainees and supervisors are requested to keep a record of the main discussion and action points from supervision in a supervision log.

The quality of the supervision will depend upon many factors, but the relationship between the supervisor and the trainee is clearly of central importance. These are some of the factors, which enhance supervision quality:

- Regular supervision should be conducted in scheduled, weekly and uninterrupted sessions.
- Supervision must occur on premises at which the placement is arranged.
- Trainees and supervisors should discuss supervision experiences and styles to negotiate a working agreement for supervision sessions.
- Trainees and supervisors need to be prepared to discuss personal issues as they arise and are relevant to the trainee’s clinical practice.
- Tolerance on both sides, of differences in style and theoretical orientation.
- Empathy for the trainee on the part of the supervisor and a willingness to give positive as well as negative feedback.
- Openness on the part of the trainee to hear and learn from constructive criticism.
- Mutual observation and joint work.
- Supervisor should facilitate theory-practice links, will give reading material and then discuss it, in relation to the casework and service.
- Supervisors and trainees should shape the content of supervision together and plan supervision sessions. An agenda would:
  - Be broader than ‘what happened in the last session?’
  - Encourage thought about the cycle of competence: Assessment / Formulation / Intervention / Evaluation.
  - Vary learning methods e.g. presentation of formulations, discussion of case material, reading of clinical papers, role plays, video-taping and feedback.

Supervisors may also find it helpful to refer to the CORE Supervision Competences Framework commissioned by the Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland. This is centrally a pan-theoretical outline of supervision competences, though model specific (e.g. systemic) competences for supervision are also detailed. The framework is in the Moodle/Website.

**Joint Supervision**

In cases where there is more than one supervisor involved in a trainee's placement, a primary supervisor would usually be identified who will take responsibility for the planning and co-ordination of the trainee’s placement, supervision and assessment and for liaison with Course staff (BPS, Guidelines on Clinical Supervision). Where there is more than one supervisor, supervision time is commonly more than 1.5 hours in total per week.

In some cases the supervision will be equally shared between supervisors with each assuming responsibility for separate sections of the placement. In these situations one supervisor should assume responsibility for overall management of the placement with regard to ensuring training
needs are met and other line management issues are satisfactory (e.g. attendance, workload across the whole placement experience).

We recommend regular communication (minimum monthly) between the two supervisors regarding the trainee; this helps trainees to feel supported and contained and monitors the joint caseload effectively.

Where there is a primary supervisor they should take responsibility for completing the relevant placement forms (Contract and Placement Evaluation Form - MPR/EPR see the Moodle/Website) and deciding upon the ratings of competences but the other supervisor will contribute, either through discussion and checking the form or through adding separate comments on the form. In equally shared supervision it is advisable that supervisors meet to discuss their feedback and come to an agreed rating for each competence. If this is not possible differences of opinion should be noted on the Placement Evaluation form and discussed with the Mid-placement visitor. Both supervisors should attend the MPR and EPR meeting and have discussed their feedback with the trainee prior to the meeting.

Joint supervision, where trainees meet in pairs or groups with a supervisor to discuss clinical work, is often highly valued by the trainees, but care should be taken to ensure that trainees do get the individual attention they need.

**Supervisor Training**

Supervisors need access to enough information and educational resources to support the supervision process. To this end every year there are regular training workshops undertaken for supervisors.

All workshops are free of charge to supervisors. They are run jointly with the Tutors from RHUL, UCL and UEL. These workshops are held online or in London at the Royal Holloway base at 11 Bedford Square WC1, UCL and at UEL. Further details can be obtained on the course website or from Michelle Watson, Student & Course Administration Officer (Clinical Psychology) on 01784 414388.

The new Supervisor Workshop is a two-day workshop and is run three times a year (February, June and September). It is a requirement for all those new to clinical psychology supervision an offers an opportunity to learn what the task involves, consider course requirements and develop their supervision skills. Presentations detailing Course structures and requirements are followed by opportunities to practice implementing supervision skills using videos and role-play. All new supervisors are required to attend this workshop before taking a trainee.

Together the two-day workshop for new supervisors and the one day advanced supervisor workshop form the core training for supervisors. This training is accredited by the BPS in order that completion of these 3 days will enable supervisors to enrol in the BPS Register of Applied Psychology Practice Supervisors. This is designed to recognise chartered psychologists’ special expertise in supervision. The register is open to all eligible chartered psychologists, irrespective of their training background. Please see BPS website for more details.

**Caseload**

Placement experience makes up half of the clinical psychology training and is the main opportunity for trainees to develop their clinical skills and link theory to practice. The learning opportunities,
support and supervision provided on placement are key for trainees in developing their clinical confidence and achieving their learning goals.

Though the learning outcomes of the placement are generally defined in terms of attainment of competences, having sufficient clinical experience to develop skills and broaden knowledge is essential for the development of a competent and clinically confident trainee.

Supervisors should plan an introduction to clinical work at a pace negotiated with the trainee, but make sure that this is not too slow. The range and amount of cases on the clinical caseload should be planned and monitored carefully by supervisors. The planning should take into account the usual rate of drop-out/no-shows in order that the caseload does not take too long to establish. Supervision should enable a regular review of the caseload.

**As a general guideline trainees usually carry eight substantive pieces of clinical work at any one time.** This caseload will obviously be tailored to the specific placement needs and the trainee’s developmental needs and learning outcomes. Trainees should usually be seeing clients within the first few weeks of placement and should be building up to a full caseload and range of clinical activities in the first 6 weeks.

Defining what constitutes a substantive piece of clinical work is somewhat context dependent. The nature and content of the clinical activities will vary, reflecting the work on offer in the placement. Calculation of workload will not be based solely on client contacts, so trainee may not always have 8 clients on their caseload. Substantive pieces of clinical work may include a range of clinical activities. Some examples would be:

- a therapy session with an individual
- a therapy session with an established group
- an assessment session with an individual
- an assessment clinic in which the trainee is an active participant
- a team meeting in which the trainee is an active participant
- conducting the service-related research project
- conducting a teaching session for staff

Direct clinical work is usually expected to form the core of most placements, particularly in early placements, so that trainees can begin to acquire assessment and therapy skills. Trainees should have a range of clinical experience. See earlier section on expected caseload. No one placement can be expected to provide comprehensive coverage and supervisors should not feel burdened by trying to find types of cases which they would not normally treat themselves. However, when selecting cases, it may be useful to consider the categories below and to aim for variety.

- Cases from across the age range (life stages are more important than chronological age);
- Problems of varying severity and duration;
- A range of presenting problems;
- More than one therapeutic approach – including cognitive behaviour therapy;
- Exposure to more than one different level of intervention e.g. individual, couple, family, carers/staff, group.

Trainees must complete clinical work by the end of the placement and no clinical cases can be carried over into another placement. However, if the trainee is working within the same Trust for the
subsequent placement and there is an exceptional reason why a case must be carried over then the trainee/supervisor must discuss this with the course before considering any follow up work.

Variations on the expected workload
In some settings the pattern of service delivery might mean that trainees undertake fewer “pieces” of work. Examples might be where:

- each client contact requires a lot of contact time (for example, intensive assessments prefaced by liaison with other professionals, followed by feedback to the client and by further liaison)
- there is a model of intensive supervision associated with each case

Upper limits to the expected workload
There is no formal upper limit, because there are settings where the work is composed of multiple high-volume, low intensity contacts. However, it is assumed that trainees and supervisors will negotiate workloads and ensure that these are not inappropriately high.

Meetings
Trainees often attend meetings. Where their role is as an active member of the meeting, actively contributing to clinical decision-making in relation to their own and other cases, this can constitute a ‘piece’ of work. However, if their role is closer to an observer, or they are not expected to contribute, then it does not usually count.

Preparation for clinical activities
Some pieces of work require considerable advance preparation, and this should be recognised. However, it is important to consider whether this preparatory work is always associated with the activity, or whether it creates a temporary increase in the workload. For example, setting up a therapeutic group often involves assessing a large number of clients, but once it is running a group usually constitutes a single piece of work.

Indirect Work
As well as direct clinical work, it is expected that trainees will develop competence in working indirectly and in consultation over the course of training. Indirect ways of working will be more the focus of the work on some placements than others.

Service user involvement
It is also essential to support the trainee’s understanding of how the service works collaboratively and constructively with service users and carers, to facilitate their involvement in service planning and delivery, within the therapeutic relationship and beyond. More information about the Course’s involvement with service users and carers can be found in the Moodle/Website.
Multi-disciplinary team work

Developing a sense of the functioning of the unit or system within which they are working, will be helpful both for the trainees' understanding of the placement and their knowledge of the functioning of the health service. It is also helpful to support the trainee’s understanding of how the service works collaboratively and constructively with service users and carers, to facilitate their involvement in service planning and delivery, within the therapeutic relationship and beyond.

Some discussion of team working, leadership and management issues will be helpful in deriving a context for the treatments offered, and this will be particularly important where work is done in a multidisciplinary team.

Teaching and presentation of clinical work

Suitable opportunities to teach others should be explored on all placements. These may or may not occur in the first placement, but all trainees should present a piece of work to people other than their supervisor at least once (e.g. department case discussion, multidisciplinary case review, etc.).

There is also specific course guidance on developing leadership competencies (Moodle/Website) for trainees at all stages of training.

Observations of Practice

The trainee must have the opportunity to observe the supervisor working clinically and the supervisor must observe the trainee working clinically, before the Mid Placement Review. Most trainees need to begin by observing their supervisors, before moving progressively to more independent work. It is usually helpful to move through clear phases of (a) trainee watches supervisor (b) trainee and supervisor work together (c) supervisor watches trainee. The issue of independence should be a part of supervision; there is a delicate balance between restricting a trainee's opportunity to learn and develop and allowing premature (and, therefore, probably unstable) autonomy. The risk assessment and management procedures need to be considered carefully as the trainee progresses to more independent working. Supervisors need to be sure that trainees are aware of and have the ability to follow, risk management procedures before trainees begin to work independently.

The Course requires that for observation and competence assessment:

- The trainee is able to observe the supervisor at least 3 times.
- Trainees clinical practice must be observed at least 3 times during each 6 month placement. This should include ‘live’ observation of their clinical assessment and intervention skills. Recordings of sessions may also be used to supplement this.
- Two formal ratings of competences using standard competence rating scales completed based on these observations must be completed every 6 months. (e.g. Cognitive Therapy Scale Revised, Systemic Practice Scale)
- For observations both ways, at least one of these observations should be ‘live’ (which could also be conducted through joint clinical work between supervisor and trainee) and other observations of trainee or supervisor may use recorded material (audio or audio-visual recording).
Supervisor Observation and Live Assessment of Competence
Trainees are also required to ensure they and their supervisors both rate live (or recorded) therapy sessions using standardised competence rating scales. A range of different measures have made available by the Course, depending on the placement or therapeutic model used. There is a requirement for rating scales to be completed on at least two sessions per 6-month placement, with at least one of these having been rated by each Mid Placement Review.

The feedback is formative, and the completed competence rating scales do not need to be returned to the Course. However, it is expected that the trainee and supervisor discuss their respective ratings in supervision, to reflect on trainee strengths and areas for development, and that it is recorded on the Placement Evaluation Form at both MPR and EPR the number and type of standardised competence rating scales used on the placement.

Client feedback on competence
All trainees must obtain feedback about their clinical work from their service users and/or carers using Client Feedback Questionnaires (See Moodle/Website)

The feedback is entirely formative, and is intended to aid trainees’ collaborative working with clients and their own reflective practice to develop their skills further. It is therefore helpful to seek feedback from a range of clients, and include those for whom sessions may not have gone so well. The purpose is to aid reflective practice, and not for RHUL to assess the trainee’s work.

Feedback forms do not need to be completed at the end of therapy sessions, and may be useful earlier in the therapy process, however trainees should consider the fact that it may easier for service users to be honest when therapy has finished as opposed to the middle of therapy sessions. In using the feedback for reflective practice, trainees should also consider issues such as ‘power imbalance’, and a ‘need to please’, which may influence the way service users complete questionnaires.

RHUL do not ask for the forms to be submitted, but ask supervisors to sign MPR and EPR forms to state whether the completed feedback forms have been discussed in supervision (Section B, Part 7 of the form).
COMPETENCE EVALUATION

This section covers the process of evaluation on placement. These include the Placement contract, the recording system for clinical work (ACE) and MPR and EPR processes. There is also specific guidance with regards to specific competencies required for completion of training.

Introduction
Responsibility for monitoring the achievement of clinical competence and experience is shared between trainees, supervisors and the course staff. A number of monitoring mechanisms within and across placements are used to determine experience gained and the progress and achievement of clinical competence. These include the ACE clinical log system, the Placement Contract, the MPR Placement Evaluation Form, the EPR Placement Evaluation Form and the Placement Information Form. These documents are used carefully in individual meetings with trainees to help the course and trainees ensure they will achieve all of the required competences by the end of the 3 year training period. The individual meetings held with trainees include Supervision, MPR and EPR meetings, Mid Training Competency Reviews, Personal Tutor meetings and Developmental Reviews.

Clinical competences must be demonstrated across a range of clinical settings. Trainees will be required to complete 3 years of training placements, spread over a variety of 6 to 12 month placements. Each trainee will follow an individual placement plan. Usually this consists of an initial 12 months in adult settings, followed by two six month placements in child, learning disability, older adult, neuropsychology or health settings. The final year of placements is much more varied between trainees, depending on their areas of interest and the competences already achieved.

Competencies are outlined in detail in the Competency Based Training Guidance (Moodle/Website).

Ultimately it is the trainee’s clinical tutor who holds responsibility for monitoring their clinical competence and ensuring that the professional standards and competences are achieved across the 3 years of training. To ensure their clinical competence is monitored effectively trainees are required to:

- Complete for each placement and submit to Moodle assigned:
  - Placement Contract,
  - MPR Placement Evaluation Form
  - EPR Placement Evaluation Form
  - ACE Log at end of placement
- Review and raise outstanding competence targets with new supervisors.
- Keep their ACE clinical log, which is their record of clinical experience and competences, up to date.
- Update the Placement Information Sheet before each placement allocation.
- Gather feedback from clients using the client feedback questionnaires.
**Placement Documentation Deadlines:**

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<tr>
<th>Documentation</th>
<th>Completed by</th>
<th>Deadline</th>
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<tr>
<td>Start of Placement</td>
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<tr>
<td>Contract</td>
<td>Trainee &amp; Supervisor</td>
<td>Trainee submits to Moodle 2-4 weeks after start of placement</td>
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<td>MPR</td>
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<tr>
<td>ACE Log</td>
<td>Trainee</td>
<td>Trainee emails to MPR visitor 1 week prior to the MPR</td>
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<tr>
<td>Placement Evaluation Form</td>
<td>Trainee &amp; Supervisor</td>
<td>Draft completed and emailed to MPR visitor 1 week prior to the MPR</td>
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<td>MPR Visitor</td>
<td>MPR visitor completes within 2 weeks of MPR</td>
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<td>Trainee submits signed form to Moodle 2 weeks after MPR window</td>
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<td>EPR</td>
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<tr>
<td>ACE Log</td>
<td>Trainee</td>
<td>Trainee submits form and ACE Log to Moodle 2 weeks after the end of placement.</td>
</tr>
<tr>
<td>Placement Evaluation Form</td>
<td>Trainee &amp; Supervisor</td>
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*Note for first years on one year placements there needs to be 2 EPRs; one at the end of the first six months and one at the end of the year.*
Placement Contract & Placement Evaluation Form (PEF)
Placement Contracts outline the learning outcomes for each placement. That is, they outline the areas of competence a trainee will need to achieve in order to pass the placement. The placement contract will also identify the clinical experience to be gained to facilitate the achievement of those clinical skills. Placement Contracts are required for each 6 month placement. If the placement is of 12 months duration the contract will be reviewed and updated at the 6 month stage after the EPR.

The Course list of specific competences (see below) should be used to inform the Contract content. A signed copy of the Placement Contract needs to be submitted to Moodle 2-4 weeks after placement start date. Placement Contract can be found in the Moodle/Website.

MPR and EPR Placement Evaluation Forms (PEF) are tools for monitoring the placement experience and evaluating the achievement of clinical and professional competencies. The Placement Evaluation Forms were developed using the BPS competence framework and the HCPC professional standards. The PEF is a detailed form but once it has been completed at MPR it simply needs updating at EPR.

Placement Evaluation Form for MPR and EPR can be found in the Moodle/Website.

Audit of Clinical Experience - ACE
Trainees must keep a log of their clinical experience. Completion of the log is a course requirement. It enables the tutors and the Course assessors to check that enough work of sufficient variety is being undertaken, and it is helpful as a basis for planning future placements. The log also contributes to trainees’ annual reviews and the detailed planning of placement contracts as trainees arrive on subsequent placements. It can identify areas where the trainee is experienced and where there are gaps in training.

The Audit of Clinical Experience (ACE) is an Internet-based facility developed at Royal Holloway that allows Trainees on NHS placements to log anonymised details of their clients in a special database. In addition to storing the details, ACE allows data editing and the production of a variety of reports and graphical data that can be used in summarising client characteristics and activities within and across placements. The Basic Report provides a summary of clinical presentations and outcome, and is used in the placement meetings.

Trainees are required to explain the purpose of collecting this data in terms of training requirements, what data is collected and how it is stored. Trainees are required to gain client’s consent to hold their data in this way. The following is a suggestion as to how this requirement may be explained to clients. As with other electronic client records such as RIO, ACE records fall under the Data Protection Act and clients can request a copy of the information that is held about them in this way.

‘My University requires me to keep an anonymous electronic record of the work I do in the NHS to monitor my progress. I would like to store some information about you and the work we do in this way. As you will know, we work according to strict NHS confidentiality requirements. Apart from my supervisor and me, my University Tutor is the only other person who may look at this information is my University Tutor who is a qualified clinical psychologist who works or does research, in or for the NHS. He / she is also bound by strict NHS confidentiality requirements and will not be able to link the
computer record to you. I need your permission to store the information on the computer. At the end of my training, the record will be kept for 3 years and then deleted from the computer.’

ACE BASIC REPORTS (LOG) need to be submitted at MPR and EPR for Review. A validated copy by the supervisor is submitted at EPR

For further information, please refer to the Short Guide to ACE (see Moodle/Website)

Security
ACE uses a physically and electronically secure server (computer) based at Royal Holloway to record, store and process the information. Details held on the system are anonymised and encrypted (stored in a high security code) to NHS standards of confidentiality, and in accordance with client rights under the Data Protection Act. Rules regarding the sharing of information, embodied in the Caldicott principles, have also been met (following consultation with the Caldicott Guardian of the NHS Information Authority). The encryption level used is the same as used by most banks in their internet operations. The system has also received the approval from Heads of Psychology Services in North Thames. The entire file of information relating to a particular cohort will be deleted when all have completed the Course.

Users of the system are required to comply with the confidentiality requirements and the procedures implemented to maintain the rights of clients, the confidentiality of the data and the security of the system.

Trainees require supervisor permission to use the system, as well as consent from clients themselves. Supervisors who need to reassure themselves further about the use of the system can request a copy of a joint statement from the NHSIA Caldicott Guardian and the Course. This statement is not intended in any way limit decisions regarding the use of ACE, which may be made by placement supervisors, or ultimately, by Caldicott Guardians in local Trusts. If there are any queries or issues about ACE and its use, please contact the relevant year tutor.

A demonstration of the system can be arranged by trainees at the request of the supervisor on the understanding that all information relating to the site and its content are confidential. The Course is happy to consider any issues and suggestions for improvement made by trainees, supervisors and service managers.

The MPR & EPR process
The MPR and EPR are important aspects of the placement experience. They are both an opportunity for trainees to provide constructive feedback and reassure, and a formal evaluation of the placement experience and trainee’s competence. It is an opportunity for the placement to be evaluated in relation to its learning outcomes. The process is usually a helpful one for trainees and supervisors as a chance to reflect and set targets for future development.

To ensure continuity of monitoring / placement evaluation and to minimise paperwork for supervisors and trainees, the MPR and EPR have been designed to have a very similar format and documentation. The documentation is available in the Moodle/Website.

Points to Remember in Making Evaluations, Giving and Receiving Feedback:
• Both parties should be aware that feedback is a two-way process.

• All ratings of competence are evaluations of performance appropriate for the current stage of training.

• Both supervisors and trainees must try to set aside personal feelings, either negative or positive, when making evaluations.

• Quantitative ratings must be clear, half ratings for example between acceptable and unsatisfactory are not permissible.

• Qualitative feedback is essential both for the trainee and supervisor. Please operationalise your feedback and give concrete examples where you can, and note which areas of clinical activity you have been able to observe directly. This is particularly important for ratings “Acceptable” and lower.

• Feedback needs to be detailed, constructive and designed to facilitate change. Evaluations should usually be based around objective factors.

• Feedback about clinical performance should combine information about areas of strength and areas for development and should ideally be communicated in the context of a good, supportive supervisory relationship. The better this relationship is, the more likely that feedback will be listened to and subsequently acted upon.

• Supervisors and trainees should raise doubts about supervision, performance or competence as early in the placement as possible. They should raise these formally at the time of the MPR or they may even wish to talk to the Clinical Tutor / Mid Placement Visitor, in advance of the MPR. It is bad practice to “spring” new information at the time of the EPR.

• If supervisors or trainees are in any doubt about how to give feedback or what to say, they should contact the individual responsible for the trainee’s Mid-placement visit or Clinical Tutor for help as soon as possible.

• If, at any stage, the supervisor judges the trainee’s performance to be on the borderline of failure, then he/she must inform the Clinical Tutor or Mid-placement Visitor as soon as possible. The trainee should be told and be given the opportunity to discuss the problems.

• Situations where the feedback is entirely negative should be avoided. Wholly negative feedback of a trainee’s performance is unlikely to facilitate the development of a range of effective therapeutic skills. However, if a supervisor is seriously unhappy with a trainee’s performance, the supervisor needs to regard themselves as under an obligation to the profession to indicate this.

• Supervisors and trainees should be familiar with the guidelines on passing and failing placements and procedures to deal with dissatisfaction about outcomes including grievances.
MPR

The MPR consists first of completion of the MPR Placement Evaluation Form (see Moodle/Website) by the supervisor or trainee. Trainees and supervisors need to prepare, independently or conjointly, their ratings on the Placement Evaluation Form as the visitor will also use this as a basis for the MPR visit discussion. Specific recommendations for developing these areas should be suggested. This is followed by an MPR visit by the Course MPR Visitor to support the trainee and the supervisor in evaluating the placement to date and to set targets for the remainder of the placement. We expect that supervisors and trainees have had an opportunity to discuss their feedback before the MPR meeting.

This Placement Evaluation Form should be emailed to the MPR visitor no later than one week before the MPR visit.

It is the trainee’s responsibility to liaise with their supervisor and MPR visitor and co-ordinate a convenient time to meet. The Course placement administrator should be notified of a date as soon as possible once this is arranged. Ideally, the date of the MPR should be included in the placement contract.

MPR should take place between the 8th and 12th week of the placement. However, if the MPR cannot be in the middle of the placement, an early review is preferable to a later one.

Preparation for the Visit

At the MPR, all parties will need to have a copy of:

- Placement Evaluation Form
- Placement Contract
- Audit of Clinical Experience (ACE) - MPR BASIC REPORT

Trainees should provide hard and/or electronic copies of these to the MPR visitor, plus a map and directions for the visit venue at least ONE WEEK in advance of the meeting.

If trainees or supervisors have any serious concerns about the placement which they feel are going to be difficult to raise at the preparation meeting or at the MPR, they should notify their MPR visitor as soon as possible before the meeting to discuss the best way to address these concerns.

During the visit

The visitor first meets independently with the trainee, then with the supervisor and finally jointly with both trainee and supervisor to discuss the Placement evaluation form.

After the visit

Any additional comments arising from the meeting will be added to the MPR Placement Evaluation Form. The visitor will also complete the MPR Summary front sheet: summarising their impressions of the placement experience and trainee competence. The MPR Placement Evaluation Form will then be forwarded to the trainee within 2 weeks of the MPR.

Changes to supervisor and trainee comments will only be accepted if they are corrections of facts
reported at the meeting, and can only be made by or in agreement with the person who made the comment. Any other comments that trainees or supervisors wish to provide will be added as an addendum to the report.

A signed copy of the MPR Report should be submitted by the trainee to Moodle by 2 weeks after the MPR window.
EPR
The End of Placement Review is the time when feedback about the clinical skills and competences of the trainee and the quality of the placement are collected formally. The placement is evaluated in relation to its learning outcomes. In an ideal world the EPR should contain no surprises; ideally the trainee will know about his/her strengths and weaknesses and the supervisor will know the good and bad points about the placement.

EPR Process

- Trainees and supervisors should set a date and time to meet and discuss their end of placement feedback and sign the appropriate forms for completion of the placement.
- Supervisors and trainees should prepare their comments on the EPR Placement Evaluation Form BEFORE they meet so that both can give open and honest feedback without fear of this affecting the other’s evaluation of their competence.
- A member of Course staff does not usually attend the EPR meeting. However, the trainee, the supervisor or the Course may request that this happens (See below for Facilitated EPR).

Completion of the EPR Documentation

Trainees and supervisors complete the EPR Placement Evaluation Form, including a review of the targets set at the MPR. The placement grade is awarded – Pass/Fail/Refer to Tutor (see following section).

Trainees need to submit a signed:

- End of Placement Evaluation Form
- Audit of Clinical Experience (ACE) - BASIC REPORT

EPR Targets are routinely passed onto the next placement supervisor. These targets are usually agreed towards the end of placement by the trainee and the supervisor and written on the form.

A member of course staff will routinely review the appropriateness of these targets and consider any amendments/additions required to support competence development. The targets are then forwarded to the next supervisor for inclusion in the placement contract.

A signed copy of the EPR Report should be submitted by the trainee to Moodle 2 weeks after the end of placement date. Late submissions may lead to placement failure and the trainee should contact dclinpsy if there are serious reasons why a late submission is likely.

Facilitated EPR

Although a member of Course staff does not routinely attend the EPR meeting, there may be circumstances where this is requested in advance by the trainee, the supervisor or the Course staff. This usually occurs in circumstances where:
• Any party has concerns about giving or receiving feedback.

• There are concerns that the placement may be awarded a fail or refer to tutor grade, specific targets have been set for the placement which would benefit from review by the course staff.

• Learning targets from a previous failed or referred placement are being monitored by the Course.

If it is the case that a member of Course staff (such as Clinical Tutor or MPR Visitor) does attend to facilitate the EPR meeting, this should follow the structure of a Mid-Placement Review meeting. As with MPR, all documentation should be sent to the EPR visitor one week before the EPR date.

It is usual following a facilitated EPR (whether this is a failed placement or not) for agreed targets to be forwarded to the next placement supervisor along with the full end of placement documentation. The course team will liaise with the next placement supervisor to ensure there is clarity in the learning targets and supervision capacity to support the student in meeting these targets.

A signed copy of the EPR Report and a supervisor validated/signed ACE Basic Report should be submitted by the trainee to Moodle by 2 weeks after the end of placement date.

Placement visitor
All trainees are allocated a member of the Course Staff or an Associate Clinical Tutor. This individual remains, wherever possible, as the trainee's MPR visitor for the duration of the trainee's time on the Course. This arrangement enables the member of staff to monitor the placement experiences of the trainee for the duration of the Course and to provide supervisors with relevant background information or details of special requirements.

One year placements
Placement Documentation varies slightly from the normal procedures of one year placement.

Contracts: One year contracts should be based on the usual placement contract, but they will need to be adapted to include arrangements for phasing of different aspects of clinical experience. The contract should be formally reviewed and developed after 6 months of the placement, usually at or soon after the first EPR.

MPR: For one year placements there will be two MPRs (months 3 and 9) with Placement Evaluation Forms completed each time. Any serious problems arising on placement should be raised with the trainee’s placement visitor. If serious problems emerge early in the placement, and after discussion with all parties the placement visitor considers it appropriate, it may be possible to convert the placement into a six-month placement.

EPR: For first year one year placements there needs to be an EPR and Placement Evaluation Forms at the end of the first 6 months, and at the end of the year. Only one EPR and PEF is required for third year, one year placements.

Mid Training Competency Review
Approximately 18 months into training trainees meet individually with the clinical tutors to validate
the clinical competences they have achieved so far and consider future learning needs, training and employment aspirations. This information is used to develop a placement plan for achieving the outstanding competences over the remainder of the course and support trainees towards their desired NHS employment.

Following the submission of information about competencies by the trainee the Clinical Tutors will meet to determine any competence targets which must be met in the remainder of training. Trainees are formally written to after this meeting with an outline of their outstanding competences and the plan to the achieve these. Trainees will be expected to regularly provide information and updates to Clinical Tutors in the monitoring of competences achieved.

**Specific Competence standards**

Trainees are expected to demonstrate clinical competence with a range of client groups. It is impossible for trainees to complete placements with all clinical client groups. For example, trainees may not complete placements in older adult or learning disability contexts. For this reason, the course pays particular attention to how competence will be demonstrated across the lifespan and with clients with developmental or acquired disabilities. The competences and experience gained across client groups is specifically monitored using the PEF, ACE and the competency review meetings. Clinical tutors are responsible for assessing clinical competencies achieved and trainees must ensure the PEFs and ACE are completed in a timely manner to enable evaluation of competences.

Course guidance for development of specific clinical competences in the following areas has been developed in conjunction with members of the Course Clinical Sub-Committee and in consultation to guidance from the CORE frameworks and BPS DCP faculty guidance. Details of basic and advanced competencies in each area can be found in the Moodle/Website:

1. Cognitive Behavioural Therapies
2. Systemic
3. Psychodynamic
4. Children/Adolescents
5. Neuropsychology
6. Older Adults
7. Learning/Intellectual Disabilities
8. Physical Health Conditions
9. Forensic
10. Leadership
11. Psychosis and Bipolar Disorder
12. Cultural

**Leadership Competencies**

Trainees may develop knowledge and skills on placement which contributes to their development as effective leaders. Trainees and supervisors are sometimes concerned that encouraging trainees to take on leadership roles will be too premature or go beyond the competences of trainees.

The BPS and the course take the view that newly qualified clinical psychologists should undertake leadership and service development roles early on in their career, so undertaking these responsibilities under supervision whilst training is essential in ensuring clinical psychologists
become effective leader in the future. The updated BPS Accreditation Criteria (2014) also places a greater emphasis on skills of indirect influence and leadership in bringing psychological mindedness to services. Further guidance on developing leadership competencies is available in the Moodle/Website.
At the end of each placement the supervisor will grade the placement. Two grades are available – Pass and Fail. If it is impossible for a supervisor to determine the placement as a pass or fail a Refer to Tutor decision will be awarded. All gradings take into account the stage of training of the trainee and are a recommendation to the Course Executive and Board of Examiners who will consider the grade in the context of any extenuating circumstances.

Though most placements are passed without concern sometimes a fail grade (or Refer to Tutor) is warranted due to: lack of opportunity to achieve competencies; or failure to achieve competences despite opportunity; or, (very rarely) failure due to misconduct. The specific criteria is as follows.

**Criteria for Fail grading:**

Trainees can be failed on a placement for a number of reasons including, but not restricted to:

- Failure to reach minimally acceptable levels of core competence, despite repeated supervisor attempts to address this shortfall through teaching and practice.
- Failure to reach minimally acceptable levels of core competence related to impairment that cannot be sufficiently resolved despite reasonable adjustments being in place where appropriate.
- Persistent unprofessional practice.
- Single examples of unprofessional or unethical practice, if of sufficient seriousness. Examples that might constitute placement failure might include serious lack of sensitivity to clients and/or colleagues; professional misconduct; failure to complete a sufficient amount of work, etc.

**Refer to Tutor**

In certain circumstances the supervisor may be in doubt as to whether the performance on placement warrants a Fail grade. There will still be serious concerns about performance on placement, professional behaviour or lack of opportunity to achieve competences but the supervisor is unsure if this meets the criteria for a fail at this stage of training. For example, failure to achieve the required number of observations on placement may result in a Refer to Tutor grade. In these circumstances the supervisor awards a Refer to Tutor grade, which in practical terms is referring the failure decision to the Course Executive.

**Procedure for Fail grading or Refer to Tutor**

Any concerns about potential placement failure should be raised as early as possible in the placement, and if at all possible should be discussed explicitly with the trainee and Course staff at the Mid Placement Review. Objectives will be set and operationalised clearly for the remainder of placement to maximise the opportunities for the trainee to pass the placement. Where there is potential for a placement fail or ‘refer to tutor’, usually the End of Placement Review will be facilitated by Course tutor.

If a Refer to Tutor or placement Fail grade is recommended by supervisor(s) at the end of the placement, this recommendation will be considered at the Course Executive who will make the decision on whether outcome of placement is a pass or fail. Course regulations require trainees to pass six 6-month placements. Therefore if a placement is deemed a fail, the placement will need
to be re-taken with specific targets agreed for future placement(s) and shared with future supervisor(s). Targets from subsequent placements will be reviewed at Clinical Tutor Meetings for agreement of outstanding competences met and those to be continued forward to future placements. Decisions will be ratified at the Course Exam Board.
From time to time there will be concerns about the quality of the placement opportunities or supervision offered. The course take these concerns seriously and endeavours to address all concerns in order to continually develop placement and supervision quality. The North London Courses have developed a protocol for dealing with these concerns and auditing placement quality. This protocol is outlined in the Protocol for Managing Placement Concerns (see Moodle/Website)

Trainees and supervisors have a professional responsibility to inform the course of any concerns about the quality of supervision or placement. However, Trainees are often concerned about the impact that raising concerns about supervision quality will have on the evaluation of their clinical competence. The course is fully aware of the power dynamics within the supervision relationship and clinical tutor staff are used to dealing with any concerns raised sensitively and in collaboration with the trainee. Experience teaches us that the earlier concerns are raised the more effectively they can be dealt with, and to this end, trainees are strongly encouraged to raise any concerns with one of the clinical tutor team as soon as possible.

This guidance has been compiled in response to a number of national events and documents, including the publication of the Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, and Flynn (2012) Winterbourne View Hospital Serious Case Review.

Serious incidents on Placement
If any trainee has concerns, having witnessed what they feel to be poor practice or having experienced a serious untoward incident, they should speak to their placement supervisor first if possible, as well as to a member of Course staff such as their year Clinical Tutor. The role of the Course staff is to support trainees in our shared commitment to maintaining safe, effective and compassionate practice.

Suspension or Removal from Placement
A situation may arise where there is a need for immediate suspension of a trainee from training or a trainee’s removal from placement. For example, if a trainee becomes a danger to themselves or behaves in such a way as to constitute a danger to clients., If a situation like this arises, course staff will take whatever action is necessary, in close liaison with the College Registry, the employer and the placement. The case will then be reviewed by the Course Executive, and the Course & Clinical Directors will then liaise with the College and the employer.

Guidance on specific procedures for suspending registration is given in the Code of Practice for the Academic Welfare of Postgraduate Students, copies of which will have been given to trainees and which is also available from the following website:

    http://www.rhul.ac.uk/Registry/academic_regulations/
Duty of Candour and Serious Incidents on Placement
This duty of candour should be considered in line with Trust incident reporting procedures and appropriate apologies should be offered by staff to patients. Trainees should discuss these procedures and responsibilities with their supervisors. Useful guidance is available from the NHS Litigation Authority.

The NPSA recognises that first priority of the organisation is to meet the needs of affected individuals, then re-establish a safe environment, followed by information provision and staff involvement. Depending on the seriousness of the event first notification to senior staff must happen as quickly as possible, ideally within hours. Once a 'root cause analysis' has been undertaken, then an action plan should be drawn up which leads to learning and avoidance of a repeat occurrence.

The NHS Trust in which the trainee is on placement will have their own policies for reporting serious incidents, and trainees must be aware of and follow such policies in the first instance. This is likely to involve following the incident reporting procedures specific to the NHS Trust or other organisation where they are on placement. However, trainees should also report any serious incident that occurs to their clinical tutor or other Course staff member; the trainee’s line manager can then follow up with Camden & Islington NHS Foundation Trust as the trainee’s employer.

Witnessing poor practice on placements
Serious untoward incidents are rare. However, and there may also be times when trainees on placement may witness what they perceive to be poor practice or practice they believe to be below an expected standard, while not reaching the level a serious incident. This may include unprofessional behaviour or unsafe systems of work. The University has an obligation to follow this up effectively.

The general guidance for trainees is to raise concerns initially directly with the person involved wherever if feels possible to do so, then their supervisor, and then a clinical tutor or other Course staff team member.

The Course is very aware of the challenges facing all clinicians in raising ethical issues or issues of poor practice witnessed in the workplace. However, the situation may be particularly difficult for trainees given the complex power dynamics they experience as learners within complex settings. This can mean that trainees are reluctant to raise issues of concern when they occur, for fear of the implications for their training or career. However, issues that are raised a long time after the incident occurred may be more difficult to act upon. Trainees are therefore encouraged to act rapidly on any concerns they have.

Workers who make a disclosure in the public interest (or ‘whistleblow’) are protected by law, and therefore can do so without losing their job or being victimised as a result of what they have uncovered. If a trainee feels they have an issue they wish to report, they should discuss this with their clinical tutor or other Course staff team member.

The Course is available to support trainees in raising and discussing and addressing concerns. The Course is committed to promoting cultures of compassion, mutual respect, and valued diversity for patients, carers and staff.

The UCL, UEL and Royal Holloway Courses have developed a Protocol for Managing Placement Concerns (Moodle/Website)
Grievances and Complaints

Grievances concern real or perceived causes for complaint about staff or trainees. An individual or a group with a common complaint may raise a grievance. Examples could include trainees who feel that they have been unfairly treated by a placement supervisor or a member of Course. Supervisors or clients may also have complaints they wish to raise with the Course about staff conduct.

Grievances should first be raised with the relevant member of staff if possible, or, if that is not possible, with another member of Course Staff. Grievances about Course staff can be raised with the Course Director. Grievances about the Course Director may be taken up with the Head of the Psychology Department. Because grievances may concern matters of employment practice, or behaviour that is the subject of professional codes of conduct (HCPC/BPS) the procedures to follow may vary. Trainees and Supervisors should familiarise themselves with the relevant professional and local guidance related to professional behaviour and complaints. If a client raises a complaint regarding a trainee, the Course should be informed and the trainee’s employer will also be notified via the trainee’s line manager.