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Placement Handbook

Overview of Contents

For general information on the Doctorate in Clinical Psychology please see our programme website.

This handbook is for Psychologists in Clinical Training and Clinical Supervisors. It contains information relating to Clinical Placements for the University of Leeds Clinical Psychology Training

The main aim is to give a general introduction to the University of Leeds Postgraduate Programme in Clinical Psychology and to provide some information, resources and ideas about organising a placement and the process of supervision.

The handbook is an amalgamation of documents from the Leeds Programme, professional guidelines and resources. The versions contained within are the most up-to-date at September 2020. We also endeavor to post updated and new documents on our Extranet site as soon as they become available. Many thanks to the members of the Placement Sub-Committee for their support and comments on various aspects of the Handbook. It may seem a rather lengthy document at first but the aim is to provide a source of reference for supervisors to be able to "dip into" when necessary.

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Section 1 - Key Placement Guidelines

This includes a brief introduction to all clinical placements (Section 1b) and information regarding the development of core competencies and the provision of clinical experience (section 1c).

Section 2 –Planning and Reviewing Supervision and Placements

This section focuses on aspects of becoming a supervisor for the first time and engaging in supervision on the part of the trainee. The structure is as follows:

2a. Preparing for a Placement, comprising:
- *Contracting in Supervision*
- *Induction Pack for Trainees*
- *Observation form*
- *Use of 'live' supervision and recordings in supervision*

2b. Standard Placement Meetings

2c. Criteria for Passing and Failing placements

2d Quality Standards on Clinical Placements, including raising concerns about placements

2e. The Presentation of Clinical Material during Training, including guidelines for Placement Presentations and Consent Form

Section 3 - Additional Information for Placements

This section includes Additional Information for Placements, including:

3a. Service Evaluation Project (SEP) Time in Year 2

3b. Additional notes for year 3 placements

3c. Leadership and clinical placements

3d. Supervising others whilst training

3e. Leeds supervisor training register

3f. Out of region placements

3g. CORENet Protocol

3h. Clinical Skills Observation

Service User and Carer (SUC) Time on Placement

Section 4 – Resources for Supervision on Placement

The fourth section focuses on resources for supervisors and supervisees including a self-assessment questionnaire for supervisors and an up to date and comprehensive reading list.

Section 5 - Guidance from our Regulator, our Professional Body and regional and local policies

A number of professional guidelines from different sources which inform our work are included in section six. These include guidelines for supervision from the BPS and HCPC. They are included here as they detail the standards that are expected of trainees. If concerns regarding practice are raised then reference to HCPC and BPS standards is appropriate.

Section 6 – Placement documentation

As always we are constantly evolving as a Programme particularly in light of the new HCPC/BPS approval and accreditation processes. We will endeavour to keep you up to date with any major changes and, as ever, are interested to hear your views on this handbook and on any other aspect of the Programme. Any feedback would be gratefully appreciated and if we can help in any way please do not hesitate to contact us.

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September 2020
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Section 1

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Key placement Guidelines

A brief introduction to all clinical placements (Section 1b)

Section 1b:

General Placement Guidelines (1)

These Guidelines should be read in conjunction with the BPS Criteria for the Assessment of Postgraduate Training Courses in Clinical Psychology, HCPC Standards of Education and Training and Standards of Proficiency, and the BPS Guidelines on Clinical Supervision. The Guidelines that follow here are in addition to or an elaboration of these documents.

1. **The Status of the Psychologist in Clinical Training**

    - Participants on the Doctoral Programme in Clinical Psychology have traditionally been called a variety of professional titles. In an attempt to aid clarification it is suggested that the title 'Psychologist in Clinical Training' (PICT) be used.

    - The Learning and Development Agreement between the North Local Education and Training Board (LETB), the University of Leeds (and other Higher Education Institutions) and NHS Trusts provides detailed guidance regarding the responsibilities of each party. This Agreement negates the need for honorary contracts or any Disclosure and Barring Service (DBS) or Occupational Health checks, supplementary to those made by the Trust that employs all Psychologists in Clinical Training (the Leeds Teaching Hospitals NHS Trust)

    - All letters and reports written by Psychologists in Clinical Training should be read, and co-signed by supervisors.

2. **Setting up the Placement, Reviewing and Assessment of Placement**

- Psychologists in Clinical Training are actively encouraged to contact their supervisors prior to the start of the placement. There should be an opportunity to meet or discuss over the phone the range of experience, and the opportunities to develop core competencies that can be provided, and the expectations of both psychologist and supervisor.

- Prior to the Placement Planning Meeting, it is expected that a written contract should be completed by the PICT and supervisor detailing the clinical and professional work to be undertaken, and how the development of core competencies will be addressed. This can be found within the 10 core competency sections in the Placement Assessment Form (PAF).

- The Placement Planning Meeting takes place at the University between the PICT and his/her clinical tutor to discuss this contract, and any immediate concerns or queries.

- Midway through the placement, the clinical tutor will visit the placement and meet with both PICT and supervisor for a formal scheduled mid-placement review. This review should involve separate meetings with both the PICT and supervisor as well as a final joint session. The content and aim of this review is set out in the BPS Accreditation documentation.

- At the end of the placement the PICT and supervisor complete the relevant assessment and feedback forms within the PAF. This is reviewed with the clinical tutor at the end of placement meeting, usually at the University. A continuation document regarding strengths and needs to be taken forward to the next placement is also completed.

- The PICT also collects information to inform the completion of sections of CORE-NET and the Logbook .

- If any problems arise on placement, we advise that the Clinical Tutor should be contacted immediately; we would always encourage that this is discussed with the trainee first, if at all possible.

3. Clinical Supervision

- The BPS Guidelines state that there should be a minimum of one hour formal, scheduled supervision per week, but also that there should be time for other informal discussion giving a total contact time of at least 3 hours per week. (N.B. the *minimum* is 1 hour formal supervision and it is expected that 90 minutes may be made available either as standard or at least in the early weeks of a placement)

- The Guidelines also underline that there should be adequate time on placement for clinically relevant reading, and emphasise the crucial role supervisors have in contributing to strong theory-practice links.

- The value of observation of the psychologist's clinical work is essential to provide direct evaluation of and feedback on developing skills. It is expected that the PICT will have an opportunity to both observe their supervisor and be observed either directly (i.e., 'live' or a two-way mirror) or indirectly (e.g., audio or videotaping) on a number of occasions.

4. Client Contact

- The exact amount of client contact will depend on the setting within which the PICT is working and the type of work he/she is undertaking. In an adult psychological therapy context we would expect 6-8 long-term clients. This figure may be higher, e.g., if the PICT is engaging in mainly assessment work or may be lower, e.g., if the PICT is engaged in systemic or process-orientated work. This may also depend on how much the PICT is involved in other clinical psychology roles, e.g. consultation, teaching, supervision, etc. In advising an appropriate work / caseload for a trainee we would suggest a number of factors in relation to the past experience of the trainee are considered. These include:

  - previous experience of clinical work

  - previous experience of clinical area

  - mode of therapy / type of work

  - confidence

  - competence

  - level of risk and complexity

- It is up to the supervisor to assess the above with the trainee to determine an appropriate work /caseload for each individual trainee they supervise within their placement context.

5. Personal and Professional Development

- The personal and Professional Development course which forms part of the taught syllabus covers major professional issues and current legislation. Supervisors can greatly add to this by helping the psychologist consider issues as they arise in clinical work, e.g., informed consent, confidentiality, and in recognising the working of, and application of relevant legislation.

- Supervisors should ensure that PICTs have immediate knowledge of local departmental and Trust/organisation policies and procedures, and any other local agency or multi-agency policies and procedures.

- Supervisors should also enable PICTs to utilise all opportunities to observe and work with other professionals.

6. Academic/Research Requirements

- A list of the various assessments, examinations, and research commitments of the Doctoral Programme are available on the Programme website. For each of the four clinical placements within the first two years, the PICT is required to produce a Reflection on Clinical Practice at the End of Placement Meeting. In Year 1, a Systematic Case Study (SCS) must be completed on placement. In Year 2, a Service Evaluation Project (SEP) must be completed (this is commissioned and may not take place on an allocated placement). Manuals for the SCS and SEP are included on the Programme Extranet in research manuals. In Year 3, an essay based on therapeutic work on placement must be completed.

7. Supervision, Support, and Personal Therapy

- It is recognised that various aspects of clinical work, and professional relationships will trigger personal reactions. Developing self-care strategies is regarded by the Doctoral Programme as a core clinical competency. Supervisors can play a crucial role in helping this development by encouraging PICTs to recognise such personal stress and distress, verbalise and 'talk through' the various components, and utilise tested or new strategies in order to maintain personal health and professional competence.

- In the course of this process it may become apparent that a PICT may need to seek out additional help or support to manage a personal issue or difficulty. Whilst supervisors can offer suggestions and advice (if asked) on how this help can be accessed, supervisors are not expected to offer supervisees personal therapy or counselling.

Clinical Psychology training by many supervisors and Departments in our Region. We endeavour to offer in return as much support, information, and training opportunities as we can. We remain very grateful for the central input from supervisors.

Please do not hesitate to contact one of the clinical tutors or any member of the Programme staff if you have a query, request or comment at any time.

Information regarding the development of core competencies and the provision of clinical experience (section 1c)

Section 1c:
General Placement Guidelines (2)

The Leeds Clinical Psychology Training Programme has developed in line with the latest BPS accreditation criteria and the approval framework of the Health and Care Professions Council. Emphasis is placed on the development of generic core clinical competencies on placement alongside clinical experience. There are a number of key clinical experiences that it is expected a Psychologist in Clinical Training (PICT) will have, that are monitored by the PICT's entries into the CORE-NET system. It is also expected that the PICT will have the opportunities to develop a number of key clinical competencies; these are recorded in the Placement Assessment Form for each placement. Historically it has been understood that certain 'specialities' will provide certain experiences. However, the Core Competencies approach provides greater flexibility regarding the provision of this experience and the emphasis is more on the development of clinical competencies. In addition, trainees now need to provide evidence of competence in CBT plus one other model by the end of three years of training, recorded in the Therapy Competency Logbook.

This approach underlines the importance of the contracting process between PICT and supervisor, where the essential elements of the placement can be negotiated, both in terms of experience to be gained and competencies to be developed.

Over the course of the three years the PICT is expected to have gained experience in the following areas:

A. Clinical Experience

1.Breadth and Diversity of Presentation

Experience of working with clients with the following range of presentations:

- Acute
- Enduring
- Mild
- Severe
- Organic
- Psychosocial
- Coping / adaptation
- Problem amelioration
- Challenging behaviour
- Communication difficulties

2.Developmental Period / Age Range

Experience of working with clients with the following range of ages:

- Infancy / Pre-school
- Child
- Adolescent
- Adult
- Older Adult

3.Intellectual Functioning

Experience of working with clients with a varied intellectual functioning:

- Average
- Mild / specific cognitive deficits
- Moderate / severe cognitive deficits

4.Service Delivery Systems

Experience of working within the following service delivery systems:

- Inpatient
- Residential / Supported
- Secondary
- Primary care
- Other

5.Levels of Intervention

Experience of working within the following levels of intervention:

- Individual
- Family
- Couple
- Group
- Organisational
- Via carer

6.Modes of Work

Experience of working within the following modes:

- Direct
- Indirect – staff / carers / schools
- Multi-disciplinary
- Other

7.Psychological Model / Framework

Experience of working within a variety of psychological frameworks/ models, two of which much be evidenced within a specific competency framework *(See section 7c)*

8.Psychometrics

Experience of delivering a range of psychometric assessments with clients of all developmental stages

B. Clinical Competencies

Utilising the above experiences and over the course of the three years the PICT is also expected to have had the opportunities on placement to develop the following core competencies:

Section 1: PERSONAL AND PROFESSIONAL DEVELOPMENT (1-5)

The PICT should be able to:

- Demonstrate professional attitudes and behaviour (reliable, responsible and open to learn; exhibiting an ethical framework for all aspects of the work; ensuring informed consent underpins all contacts)
- Manage an appropriate case and workload (demonstrates increasing autonomy in taking responsibility for this; is able to prioritise; recognises limits of own competence and requests assistance when in difficulty)
- Recognise and understand inherent power imbalances and how these may be minimised; understand the impact of one's own value base upon clinical practice
- Work effectively with difference, diversity and social inequalities in individuals' lives
- Develop resilience; including a continuous commitment to develop self knowledge and self awareness; the capacity to recognize and act accordingly when own fitness to practice is compromised, with good awareness of boundary issues.

Section 2: SUPERVISION (6-9)

The PICT should be able to:

- Prepare and engage in the supervisory process (develop a shared understanding of the roles of both supervisor and supervisee; asking for/provision of relevant literature; giving and receiving of feedback and constructive criticism; ability to engage in collaborative discussion)
- Demonstrate increasing ability to discuss both content and process within clinical work
- Utilise supervision to discuss support issues and needs with a clear awareness of the boundaries between supervision and personal therapy (i.e. that the supervisor cannot and should not act in the role of personal therapist)
- Develop the skills to provide supervision at an appropriate level within own sphere of competence (including contracting, discussion of boundaries, confidentiality and power, supervision models and feedback methods, power)

Section 3: THERAPEUTIC ENGAGEMENT AND WORKING ALLIANCES (10-14)
The PICT should be able to:

- Facilitate therapeutic engagement and a secure base, demonstrating empathy, curiosity and a respectful attitude with clients, carers, colleagues and services
- Facilitate mutual understanding using accessible language; demonstrate knowledge and application of anti-oppressive practice
- Show an awareness of structure, boundary and termination issues and application in practice
- Exhibit skills in managing challenging situations with service users, carers, teams and services
- Demonstrate an increasing understanding and ability to increase sphere of influence through engagement with different levels of organisational systems (service users, teams, external agencies and organisations)

Section 4: PSYCHOLOGICAL ASSESSMENT (15-18)
The PICT should be able to:

- Conduct assessment interviews (including taking a detailed history); select appropriate further assessment procedures (including observation, or gathering information from others)
- Administer and interpret psychometric assessments; understand key elements of psychometric theory and appropriate utilisation of this knowledge (i.e. awareness of limitations / ethical implications) in conjunction with a good working relationship
- Administer and interpret idiosyncratic assessments (with awareness of social context and organisational structure)
- Conduct appropriate risk assessment and use this to guide practice

Section 5: PSYCHOLOGICAL FORMULATION (19-22)
The PICT should be able to:

- Develop collaborative psychological formulations informed by theory and evidence about relevant individual, systemic, social, political, cultural and biological factors, in a way that helps clients better understand their experience

- Construct formulations a) within an explicit theoretical model; b) utilising theoretical frameworks with an integrative, multi-model, perspective as appropriate and adapted to circumstance and context; reformulate as required
- Ensure that formulations are communicated in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality
- Lead on the implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services.

Section 6: PSYCHOLOGICAL INTERVENTIONS (23-28)

The PICT should be able to:

- Demonstrate knowledge of the empirical basis of treatments/interventions and practice guidance frameworks such as NICE and SIGN; critically appraise relevant literature, including an understanding of social approaches to intervention (e.g. community, critical, social constructionist perspectives)
- Make theory - practice links; demonstrate the ability to utilise multi-model interventions, adapting interventions to individual needs
- Conduct interventions a) related to secondary prevention and the promotion of health and well-being; b) in a way which promotes recovery of personal and social functioning as informed by service user values and goals.
- Have an awareness of the biopsychosocial model and the impact and relevance of psychopharmacological and other multidisciplinary interventions
- Intervene systemically with carers and professionals e.g. implementation of care plans
- Demonstrate an awareness of the limitations of psychological interventions, assess when further intervention may not be appropriate and communicate this sensitively

Section 7: EVALUATION AND RESEARCH (29-33)

The PICT should be able to:

- Utilise and interpret appropriate individual measures to evaluate outcome (e.g. sessional and outcome measures; please refer to data included in use of CORE-NET)
- Utilise, comply and contribute to departmental evaluation and auditing procedures
- Demonstrate the capacity to evaluate processes and outcomes at the organisational and systemic levels, as well as the individual level
- Demonstrate an awareness of outcomes frameworks in wider use within national healthcare systems and an understanding of clinical governance principles
- Conduct research (SCS or SEP) in respectful collaboration with stakeholders and within ethical and governance frameworks (e.g. BPS, HCPC, universities)

Section 8: COMMUNICATION (34-38)

The PICT should be able to:

- Give clear and concise verbal and written reports of work undertaken in a timely manner
- Develop their own individual style of communication and confidence in this

- Adapt their style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication
- Understand the process of communicating effectively through interpreters and having an awareness of the limitations
- Understand the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

Section 9: TEACHING AND TRAINING (39-40)

The PICT should be able to:

- Prepare and deliver teaching and training flexibly, in a way which takes into account the needs and goals of the audience (e.g. appropriate use of language, use of interactive methods, provision of handouts and facilitative training materials)
- Monitor and evaluate effectiveness though self-appraisal and structured feedback mechanisms

Section 10: ORGANISATIONAL AND SYSTEMIC INFLUENCE AND LEADERSHIP (41-45)

The PICT should be able to:

- Demonstrate an awareness of the legislative and national planning contexts for service delivery and clinical practice and an understanding of the organisation in which the placement is based
- Work with service users and carers to facilitate their involvement in service planning and delivery
- Indirectly influence service delivery through working effectively in multidisciplinary and cross-professional teams and consultancy
- Demonstrate leadership qualities e.g. being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams
- Recognise malpractice or unethical practice in systems and organisations and know how to respond to this; be familiar with 'whistleblowing' policies and issues.

Section 2

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Planning and Reviewing Supervision and Placements

2a. Preparing for a Placement, comprising:
- Contracting in Supervision
- Induction Pack for Trainees
- Observation form
- Use of 'live' supervision and recordings in supervision

Section 2a: Becoming a Supervisor and Preparing for a Placement

Allocation

Tutors make every effort to confirm well in advance of the beginning of placements the details regarding trainee-supervisor arrangements. We ask for details of available placements in the spring and early summer before the subsequent academic year (i.e. in May before the placements start in October). At this point we may ask for the availability of placements for the whole year but recognise that circumstances change and we repeat the request in the winter preceding the April-September placements. We aim to confirm the allocation of trainees to placements six weeks before the start of the placement. Unfortunately, this cannot always be the case when placements are in short supply and sometimes last minute arrangements have to be made. We do aim to be in regular contact to keep supervisors up-to-date with the arrangements. You should normally be aware some time in advance that a trainee will be placed with you and the preparation you are able to engage in may make a big difference to how the placement goes.

Training

The Leeds Postgraduate Programme in Clinical Psychology offers a four day Introduction to Supervision Programme, in conjunction with the University of Hull and the University of Sheffield, which you should attend before commencing supervision.

The Programme also offers advanced supervisory workshops so it may be important to consider your own training/skills and whether it would be beneficial for you to attend one of these events. These are advertised on the Yorkshire Psychologists' Post Qualification Training website and mailing list (contact Sarah Snowden to join this hssssno@leeds.ac.uk).

Preparing for Placement

The Programme provides a number of guidelines incorporated within this Handbook which will also help you plan the placement.

Trainees are encouraged to contact their supervisors before the start of the placement to discuss any initial plans and also to make their supervisor aware of their previous experience. It is a very useful part of placement planning to consider the trainee's previous experience in depth

The trainee will arrive on their second and all subsequent placements with a "Continuation Sheet" from their previous placement in their PAF. This document is completed with the previous placement supervisor and outlines both the trainee's strengths and areas for future development.

Trainees also keep a self-appraisal record of their clinical competencies in their PAF. This should provide an invaluable resource in terms of both the experience the trainee has had and the development of their clinical competencies. Detailed information on the documentation trainees will use is provided in section 6 of this Handbook.

Placement Induction

As the placement approaches it is extremely helpful to review your caseload and to plan a suitable caseload for the trainee otherwise valuable time may be lost at the start of a placement. Also, it can be useful to begin planning and preparing colleagues for the trainee's contact with them. It is helpful to have a clear period of induction for the trainee and also to put together some information regarding services, personnel, etc. There is a staggered start to placement 1 which should be used for induction and planning related tasks.

There is usually a lot of basic information to convey to trainees at the beginning of the placement. You might like to make a checklist to remind yourself of these issues to go through with the trainee. They might include the use of diaries, secretarial support, security arrangements, tea/coffee and lunch arrangements, resources, file and record keeping, data collection arrangements, etc.

There is a model induction pack for trainees included at the end of this document.

Observation

A key part of the role of the clinical supervisor is to observe the work of the psychologist in clinical training. In order to help both supervisor and supervisee get the most from

this process we have designed a form for use in giving feedback on this observation. This is included at the end of this document. We now have minimum standards for observation on each placement.

The vast majority of placements involve a high degree of satisfaction on the part of both Trainee and Supervisor; however problems do occur and therefore you can access guidance in the Handbook section 2c Criteria for Passing and Criteria for Failing Clinical Placements (focussed on concerns about the trainee) and section 2d Quality and Clinical Placements (focussed on concerns about the learning environment including supervision).

If you have any queries regarding preparing for the placement, please do not hesitate to contact a Programme staff member.

Contracting

It also important (and can help in in avoiding future difficulties) that the trainee and supervisor should be as clear as possible about their expectations of the placement and each other.

You may want to consider a number of issues including:

- Mode of supervision
- Level of independence
- Material on which the trainee will be assessed and how this will be conducted (including the ways in which you will have access to their work)
- Range of personal and professional issues to be discussed
- How areas of concern will be raised and managed

Agreements on these matters can be recorded in the placement contracting area on each of the sections of the pages relating to the ten competencies within the Placement Assessment Form (PAF). Some supervisors like to have a separate contract for supervision within which there can be a greater level of detail about what can be expected from both supervisor and supervisee.

A suggested structure for this more detailed contract can be found later in this document.

The Placement Assessment Form includes a section on 'Contracting' for each of the ten Competency Areas within which priorities and agreements can be identified and recorded. The purpose of this document is to highlight a number of areas that you might like to consider when planning and reviewing supervision arrangements. This is supplementary to the PAF and is optional (but may be included in the PAF). It has been produced in response to requests from psychologists in clinical training and supervisors.

Please consider the following and record agreements where necessary – it may be more practical to type into the electronic version of this document available via extranet.

Practicalities

· Time, Frequency and Duration of Supervision

· Other opportunities for contact between Supervisor and Supervisee

· Availability of other supervisors (in the absence of named placement supervisors)

· Caseload/workload: type, size and range

· What can be included in supervision? (e.g. direct client contact, reflections, discussions regarding theory/models, modelling and role play, team issues, service development issues)

· How will theory-practice links be supported (e.g. reading, observations of supervisor?)

· What access to work will there be (e.g. direct observation, joint work, audio and video recordings)? How will these be used in supervision?

· In the case of having two or more supervisors – how will communication between parties be managed?

Process issues in Supervision

· Will supervision be based on a particular model (of supervision or of therapy)?

· What expectations are there regarding supervision (e.g. level of detail, level of autonomy, implicit rules of working, what you value or dislike in supervision?)

· How might previous experiences of supervision impact on this relationship?

· How will feedback be sought and how will it be given (including constructive challenge)?

· How will ruptures be managed (including contact with Clinical Tutors)?

· What confidentiality boundaries are there, and how will they be managed?

· How will personal issues (including transference and counter-transference) be dealt with in supervision?

· What are the impacts of the developmental stage and learning style of the Supervisee and of the interpersonal styles of both Supervisor and Supervisee?

· How and when will issues of evaluation be dealt with?

· When will these arrangements be reviewed?

Induction Pack for Trainees

It is suggested that Supervisors might like to have the information below available for psychologists in clinical training (PICTS) prior to the start of the clinical placement.

Some of this information will need to be communicated to the trainee prior to the start of placement, particularly if it has not been possible to arrange a visit before the start date.

- The full contact address(es) of the supervisor/department/service including phone/fax/e-mail.
- A map or details of how to find the placement and a rough approximation of how long the journey will take from the University.
- The service/team structure including names of all staff and areas of responsibility and interests.
- An outline of the Supervisor's areas of responsibility and interest and theoretical/therapeutic models followed.
- Details of the settings, locations that the placement may cover, e.g., working from a departmental base, primary care setting, other outlying clinics.
- Information on resources available on placement, e.g. access to computing facilities, postgraduate and departmental libraries.
- Information re availability of refreshments (tea, coffee, etc.) and lunch possibilities (canteen, local shops, etc.).
- A broad outline of the clinical opportunities available on placement.
- Details of the induction programme arranged or the proposed outline of the weeks of placement, in particular coving the duration of any staggered start to the placement.
- A brief reading list, e.g., key texts, articles, papers.
- The time the PICT is expected to arrive on the first day and the location of this first meeting.

Observation on Clinical Placement

You will find the Observation on Clinical Placement Optional Form for Feedback on extranet under placement paperwork/documents to complete

Use of 'Live' Supervision and Recordings

We actively encourage the use of methods that enables direct experience of a trainees work, such as 'live' methods in which supervisor and supervisee work in each others

presence and the use of recordings which allow a detailed analysis of what happened in the session. This is increasingly important with the introduction of the new accreditation criteria; not only for facilitation of recording of trainees achieving therapy competencies in their chosen models, but also for assessment of development of the common factors in therapy. The following offers guidance to the above but we recommend that you follow your local Clinical Governance arrangements and IT/Confidentiality/Security protocols

It would be hard to imagine training in many practical skills (e.g. plumbing, surgery, art, cookery, bricklaying) being undertaken without a significant proportion of the trainee's work being seen by the supervisor and that of the supervisor being demonstrated to the trainee. Factors which work against this in applied psychology are the issues of confidentiality, the time needed to review and study recordings, the experience of intrusiveness, the planning and preparation involved in ensuring familiarity with the technology, and fears of being 'found out'.

The use of recording and 'live' supervision, adds to the complexity of the supervision process with the need to agree ways of using the material supportively and as an aid to skill development. Advantages include the option to review the interpersonal processes taking place between the psychologist and client, to focus on particular areas of trainee development, to benefit from a different perspective on the work, and for the supervisor to listen to or see as well as hear about the work.

A number of issues need to be considered when using recordings with clients. These include:

· Issues of consent:

In order to use recording with clients, written consent is required. Consent forms may be constructed to suit the clinical situation, but benefit by providing an explanation to clients of how recording will be useful to them – for example, by allowing therapists to devote their full attention to the client with the need for extensive note-taking and allowing them to collaborate with an experienced colleague. The recording may also be offered to clients as a means for them to review their own work between sessions. In addition, consent forms need to include an explanation of the safeguards provided by the worker for the use of the recorded material. There may need to be separate sections by which the client can consent to the recording being used for the purposes of the therapy, and for its purposes of the therapy, and for its use in teaching and/or research. If more than one client is seen at a time as in family therapy or couple work, each participant may be required to give consent to recording.

· Introducing recording and consent to clients:

The introduction to the session will need to incorporate an explanation of the use of the recording and the safeguards of the material, which can be expected by the client. The

introduction benefits from being assured, clearly describing the use of the recording but not inducing undue anxiety. It may benefit from being written down, learned and rehearsed. A common approach is to state that the session will be recorded, the consent form will be offered for signature later in the session, and that the recording be wiped immediately at the end of the session if consent is withheld. This helps to minimise the length of the introduction and the interruption of the engagement process.

· Security of recordings:

With the range of technology available, it is important to be clear about how recorded material will be stored and destroyed. A decision can be taken as to how long the recording will be kept. It is helpful to clarify with the Trust that the recording should not be regarded as part of the case-notes, which are subject to regulations governing the length of time for which they must be held. Some departments have introduced restricted access to recordings and a requirement that they do not leave the premises.

USE OF RECORDINGS IN SUPERVISION

· Negotiating the review process

Once it has been agreed to use recordings in supervision, negotiation between the supervisor and trainee might address issues of control of the use of recording, the focus of the supervision and the roles of the supervisor and trainee. Some methods for using recordings (e.g. Interpersonal Process Recall) leave the control of the recording entirely in the hands of the recaller (supervisee) who can choose to stop the recording at any point for a structured discussion during which the supervisor acts as an enquirer. Similarly, the focus of a particular supervision session can be negotiated such that it is chosen exclusively by the trainee. The role of the supervisor can be defined, for example, as an enquirer, commenter, giver of critical feedback, maker of suggestions, etc. Early in using recordings it may seem more comfortable for the trainee to be responsible for choices about these issues, with supervisor acting as facilitators, providing, within their competence, what is asked of them.

· Review of a complete session

The review of a complete session in supervision is a time-consuming process. Several minutes can be spent in processing a few seconds of a recording. It does offer the advantages of being able to follow the whole of the session, beginning, middle and end, looking at continuity and the development of the therapeutic process. This might be helpful in selecting overriding themes in the work or in trainee development, but unlikely to be feasible in more than a few cases over

the course of training. Agreement would need to be reached as to whether the trainee and supervisor listen to the recording together or separately.

· Review of selected extracts of audio / video-recording:

Various approaches are possible to the selection of extracts of recordings for supervision. The trainee might listen to the tape in advance or on the basis of

recollection of the session with the client, select particular sections to ascertain the supervisor's opinion of the meaning of the interaction with the client, what might have been done in response to developments in the session, an opinion of a specific skill or technique and so on. The supervisor might do the same. Alternatively, sections may be selected at random for discussion or with a view to identifying some development made by the trainee, which may be compared with an earlier extract from work with the same client.

· Interpersonal Process Recall

This is a method of the use of recordings in a variety of contexts, which include supervision, developed by Norman Kagan in the USA. The method may be used for the review of recordings of any conversation with single or multiple recallers who took part in the reviewed conversation. Key elements of the method include the control of the tape remaining with the recaller throughout, the recall being facilitated by the 'Enquirer' who asks particular types of questions about the experience of the recaller at the time the interaction was taking place. It assumes that a great deal was taking place in the interpersonal process, which can later be explored by the recaller, providing an opportunity for the development of ideas about the meaning and course of the interaction. The role of enquirer is complex and requires a sustained focus on helping recallers to develop their own understanding and ideas, rather than the intrusion of any ideas that the enquirer might have about the interpersonal process that was taking place.

Use of a range of media for supervision offers many advantages over the more usual preference for reported work. It creates a context of openness about the work in which what can initially seem a very scary threat to one's professional self comes to be experienced as a sharing of responsibility for clinical outcome with exciting opportunities to share ideas an try out new approaches in an atmosphere of trust. Clinical psychologists have historically not been trained in the use of such methods of supervision, and not surprisingly, statements that mutual observation should be widespread in clinical training are not always reflected widely in practice.

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2b. Standard Placement Meetings

1. Placement Planning Meeting (PPM)

This meeting takes place at the university two to three weeks after the start of the clinical placement. It involves the Psychologist in Clinical Training (PICT) and their allocated Clinical Tutor. Clinical Supervisor(s) are not usually required to attend these meetings.

The aims of the PPM are as follows:

· To review and discuss the Development of Competencies and experience as detailed in Placement Assessment Form (as well as other supporting documents detailed on the checklist below).

· To review the Placement Plan that has been drawn up by the PICT and Clinical Supervisor.

· To check that previously identified gaps in experience or demonstrated clinical competence have been considered and included where possible. From placement 2 onwards, particular consideration will be given to the 'Continuation of Competency Development' document. (This document is completed with the previous placement supervisor and outlines both the trainee's strengths and areas for future development.)

· To talk with the PICT about perceptions, thoughts and feelings regarding the start of the placement and the emerging supervisory relationship.

· For the PICT to present a written paragraph describing reflections on personal development (PPD) undertaken in the previous months and proposing personal development aims for the months to come. The PPD summary paragraph does not need to be retained by the clinical tutor and should be returned to the PICT following the meeting, who can then include it in their Personal Development Journal.

Thus the PICT needs to bring to this meeting:

· The Placement Assessment Form for the current placement

· A written PPD summary paragraph

At the close of this meeting the Clinical Tutor will complete and sign the relevant part of the Placement Assessment Form.

This meeting usually lasts between 45 minutes to one hour.

2. Mid Placement Visit (MPV)

This visit involves the Programme allocated Clinical Tutor visiting the clinical placement. The Clinical Tutor will meet with the PICT and Clinical Supervisor separately and then together. The visit should take place between 10 and 14 weeks into the placement for Years One and Two and between 22 and 26 weeks for Year Three.

The relevant sections of the Placement Assessment Form must be completed by the Clinical Supervisor and PICT prior to this visit.

The usual format for the MPV is as follows:

Meeting with PICT

The Clinical Tutor first meets with the PICT on his/her own for approximately one hour.

This session should involve (in no set order and this is not necessarily an exhaustive list):

- general discussion of the opportunities offered by the placement;

- detailed consideration of the clinical experiences undertaken and the clinical skills/competencies being developed;

- discussion around professional behaviour and professional issues;

- consideration of the progress and process of the supervisory relationship;

- the capacity of the PICT to be reflective;

- reading and talking through the MPV section entries in the Placement Assessment Form;

- discussion of any difficulties encountered and thoughts and plans for the second half of the placement;

The PICT will then be invited to present and discuss a written paragraph describing reflections on personal development learning achieved in the past months and the personal development aims for the following months. This discussion of Personal Development gains and aims does not have to be part of the subsequent discussion with the Supervisor and what can be shared with the Supervisor should be agreed at this point.

The Tutor will take notes of this discussion for feedback to the Supervisor.

Meeting with Supervisor

The Clinical Tutor meets with the Supervisor on his/her own for approximately 30-45 minutes. (This may be longer if some difficulties have been raised prior to the MPV or through discussion with the PICT.)

The Tutor may begin by summarising what has been discussed with the trainee and then invite responses from the Supervisor and further comment. The aims are to establish the Supervisor's thoughts, observations, understanding of the PICT's progress, aptitude, developing competencies, professionalism and

potential gaps in experience as well as any skill/competency deficits. The Tutor and Supervisor will also discuss, from the Supervisor's perspective, what tasks/shifts in

emphasis need to be considered to maximise learning opportunities for the second half of the placement.

Again the Tutor will take notes regarding this discussion in order to provide feedback to the PICT and to revisit at the End of Placement Visit.

Joint Meeting

The PICT is then invited to join the Supervisor and Clinical Tutor for a three-way meeting usually lasting 20-30 minutes.

The Tutor may begin by summarising what has been discussed in the session with the Supervisor and then invite comment from the PICT, thus ensuring that all information has been shared with all parties. General discussion then ensues and thoughts, plans and aims for the remainder of the placement are agreed.

The Tutor will again take notes from this discussion to be revisited at the End of Placement visit. Finally, the Clinical Tutor completes and signs the relevant sections in the Placement Assessment Form confirming that the MPV has been conducted and plans for the remainder of the placement discussed and detailed.

A MPV will usually take 2hrs to 2hrs 30 mins.

Actual or potential problems identified

Should any problems, difficulties, concerns be raised at this visit (or previously notified), then a written plan of remedial action including detailed criteria that need to be met for successful completion of the placement should be agreed and signed by all. It may be appropriate in these circumstances to arrange a further meeting(s) to review progress prior to the End of Placement Visit. (See section 2c Criteria for Passing and Failing Clinical Placements for more information.)

3. End of Placement Visit (EPV)

This meeting should take place as close as possible to the actual end of the placement.

If no particular problems or concerns have been identified at the MPV, then the usual format for this visit is a three-way meeting, i.e. no separate meetings unless requested by either the PICT or Supervisor. The Tutor invites and facilitates discussion concerning the second half of the placement inviting comment on all sections of the Placement Assessment Form from both Supervisor and PICT.

Documents required at this meeting:

· The relevant sections of the Placement Assessment Form (completed by the Clinical Supervisor and PICT prior to the EPV).

· Continuation of Competency development document (completed by the Clinical Supervisor and PICT prior to the EPV).

· The PICT should also produce a summary from CORE-NET (see section 7 of the Handbook).

· Therapy Competency Logbook

· Observation of practice on placement form.

· Audit of clinical placements form (completed by the PICT).

If actual or potential problems and concerns had been raised at the MPV, then these problems and concerns would be specifically addressed again at this stage (in almost all circumstances, additional conversations and meeting(s) will have taken place between MPV and EPV) ensuring that the ensuing decisions regarding the summative pass or fail are an accurate reflection of clinical experience and skill acquisition in the second half of the placement.

At the end of this discussion, the summative pass or fail is recommended.

Following this the PICT presents the Reflection on Clinical Practice

Reflection on Clinical Practice

The Reflection on Clinical Practice will be based on some aspect of the experience gained on placement and can involve a whole host of presentation styles! For further information on Reflections on Clinical Practice please refer to the PPD handbook.

This presentation and following three-way discussion would normally take approximately 20 minutes.

CPD requirements At the final EPV in Year 3 the PICT is not required to present a reflection on clinical practice. In its place the Tutor, Supervisor and PICT have a discussion exploring the PICT's overall personal and professional development over the course and what priorities there may be post-qualification. The KSF appraisal meeting at the university at the end of the third year will focus on the professional development aspects of CPD.

Finally, the Clinical Tutor fills in the relevant sections of the Placement Assessment Form and takes away the completed Form, to be held at the Programme base.

The EPV usually takes around 60 minutes.

2c. Criteria for Passing and Failing placements

1. Introduction

The main aims of the Programme are to help psychologists in clinical training (PICTs) develop their competence as clinical psychologists. Placement experience is an essential part of this process, and for the most part this experience is one that is rewarding for both PICTs and their supervisors. For the supervisor, one of the rewards of supervision is to see the PICT develop growing confidence and competence as the placement progresses. The supervisor rightly sees his or her main function as helping this process along through modelling, feedback, asking questions, encouragement, and continuing discussion of practical and theoretical issues.

2. Factors related to successful placements

1. Several factors have been shown to be associated with successful and enjoyable placements. These are centred on the relationship between supervisor and supervisee, the clarity regarding the expectations of each party, their motivations and prior experiences and the nature, quality and timing of feedback.

2. This suggests that a focus on both content (what will be learned on placement) and process (how the learning will take place) is desirable, and that time spent on establishing open and direct communication early in the placement is likely to be associated with a successful experience.

3. Potential Problems

1. The supervisor feels threatened/defensive about his/her work being scrutinised by another. There is a contingent fear of being 'found out'.

2. The PICT feels threatened/defensive and responds on a possible continuum from apparent excessive dependency to feeling that he/she has to know everything.

3. The PICT fears 'getting it wrong' and does not see failure as providing a greater opportunity for learning than 'getting it right'.

4. One party has heard a rumour about the other on the 'grapevine' and adopts an attitude based on expectations rather than exploring any concerns explicitly with the other.

5. The PICT is not interested in the particular speciality and approaches the placement with an attitude of 'getting through it' rather than as offering many learning opportunities.

6. There is a clash of expectations with one party expecting a particular model and focus of supervision and supervisory role, which differs significantly from that of the other.

7. Criticism is perceived as of the person rather than the work undertaken and this is not discussed.

These represent a few instances of issues that can hinder the development of successful training relationships. It is suggested that these be discussed both at

the beginning of the placement and reviewed as the placement progresses. The Clinical Tutors are available as facilitators for the establishment of training relationships throughout the placement, and they welcome being called on should difficult issues prove hard to resolve between the supervisor and PICT.

4. Monitoring and evaluating clinical placements

The Programme has developed a number of ways in which clinical skills and competencies can be identified, monitored and encouraged. These include:

1. Placement guidelines, which are included in this Handbook as follows:

o Section 1b. General Placement Guidelines 1 (a brief introduction to all clinical placements)

o Section 1c. Placement Guidelines 2 (information regarding the development of core competencies and the provision of clinical experience)

o Section 3. Additional Information for Placements (e.g. out of region placements, additional notes for final year placements)

2. The Placement Assessment Form (PAF). This includes a summary of the aims and objectives of the particular placement, and takes into account previous experience in terms of identified strengths and areas for development. The PAF also includes descriptions of competencies that need to be demonstrated under ten different headings.

3. A system of monitoring and evaluation of developing clinical skills and competencies that allocates one clinical tutor to a trainee throughout their training. This ensures a continuous and consistent overview of skill and competency gain. Trainee / tutor pairings will only be changed in circumstances of a tutor's absence from work (e.g. due to sickness or maternity leave).

4. A system of monitoring and evaluation of clinical competencies that includes: a meeting involving the Clinical tutor and PICT two to four weeks after the start of the placement to review aims and objectives and two subsequent placement meetings involving the clinical supervisor, the clinical tutor and the PICT. (See Placement Handbook section 2b "Standard Placement Meetings").

These mechanisms ensure that procedures are in place on each placement to see that appropriate individualised learning objectives are identified for each PICT, and that their progress to achieving these aims is systematically monitored during the course of the placement. Feedback on the professional performance of the trainee will primarily be formative in nature, acknowledging strengths and noting priorities for future competency development. However, clinical supervisors also play a crucial gate-keeping

role for the profession and must make a summative pass/fail judgement about the adequacy of the trainee's performance. On occasion they may need to register their level of concern about

some aspect of the trainee's professional conduct by recommending that the placement be failed.

The supervisor should normally recommend to the examiners that a PICT passes a placement unless in the supervisor's view the PICT has:

(a) Shown serious, persistent failings in one of the ten competency areas covered by the Placement Assessment Form.

OR

(b) Failed to demonstrate an acceptable general level of competence (bearing in mind the PICT's stage of training).

OR

(c) Failed to complete sufficient work, as set out in the Placement Plan (Aims and Objectives), or otherwise agreed at the mid-placement visit, for his or her general level of competence to be assessed.

OR

(d) Has been suspended from the Programme due to either University or NHS disciplinary proceedings arising from a case of serious professional misconduct.

5. Failing a clinical placement

i. Assessing the Potential for Failure of a Clinical Placement

A number of factors are important to take into consideration in relation to this decision:

· The psychologist in clinical training may not be performing to the best of his/her ability because of temporary problems, for example, personal circumstances that intrude on an individual's ability to be physically, emotionally or psychologically present.

· Individuals may describe, define, or interpret criteria in different ways, so that a consensus is difficult reach, e.g. differences of opinion on what constitutes an appropriate caseload, or a detailed enough letter to a referrer.

· Opinions about the unacceptability of behaviours may vary and the relative severity of behaviours may be difficult to agree on.

The training course requires supervisors and PICTs to be as alert as possible to any potential difficulties, disagreements, personal and professional problems that may result in failure of a clinical placement. There is also a requirement that either or both parties be proactive in involving the PICT's clinical tutor in such situations as soon as is appropriate.

The degree and severity of professional and/or personal behaviour that is regarded as unacceptable should be documented, as well as any perceived resistance to change.

The overall aim is that the Clinical Tutor, Supervisor and PICT make sense of what is occurring, and take whatever steps are necessary to try and resolve the situation. If this is not possible, then a recommendation that the placement is failed will be made.

ii. Procedures and Processes Involved in the Decision to Fail a Clinical Placement

The HCPC and the BPS require an explicit and public statement on the procedure to be followed in the event of a placement being failed. The quality of those in clinical training and their supervisors is such that most placements are passed. However, this also creates a problem in that there may be a lack of familiarity with the decision-making and procedures involved in failing a placement. There is also probably no task harder or more unpalatable for a supervisor than to fail a PICT after having worked hard to help her or him overcome difficulties. For those in clinical training being recommended for a failed placement is also likely to be a difficult and painful experience. Thus for everyone involved the issue is likely to engender a good deal of anxiety. For all these reasons there is a need for detailed guidelines on the subject designed for those infrequent occasions when they are needed.

The following procedures should be followed:

a. Any area of concern should be recorded as a matter of course throughout the placement. As soon as either the supervisor or PICT has concerns that the placement may be failed, these issues should be openly discussed. The relevant Clinical Tutor should be informed immediately of any such discussions. (In the case of the prolonged

absence of the assigned Clinical Tutor, one of the other Clinical Tutors or any other member of the Programme Core Staff Team should be contacted.)

It may be that a phone call is all that is necessary if the discussion between Supervisor and PICT has dispelled concerns and strategies for monitoring subsequent progress are in place. It is more likely that the Clinical Tutor should be invited to a three-way meeting (which can involve initial meetings with Supervisor and PICT separately) that can address the concerns, and plan strategies for tackling difficulties and monitoring progress.

A written summary of all discussions and subsequent action plans will be completed by the Clinical Tutor, signed by all parties (Clinical Tutor, Supervisor and PICT) and held at the Programme base. b. In the case that these discussions have not been able to successfully address the concern raised, then further additional meetings between Supervisor, PICT and Clinical Tutor may need to be scheduled.

A written summary of all discussions and subsequent action plans will be completed by the Clinical Tutor, signed by all parties and held at the Programme base. c. If concerns regarding the possibility of failure of a clinical placement have been raised prior to the Mid-Placement Visit, then these concerns should be revisited at the Mid-Placement Visit. If concerns persist, then part of the three-way meeting should address these concerns and put in place a specific plan of action that clearly outlines the tasks that need to be completed and the criteria for successful completion that would result in a 'pass' recommendation. Further meetings prior to the End of Placement Visit may be scheduled. A written summary of all discussions and subsequent action plans will be completed by the Clinical Tutor, signed by all parties and held at the Programme base. d. If concerns regarding the possibility of failure of a clinical placement are raised post Mid-Placement Visit, then these concerns should be immediately communicated to the Clinical Tutor. An urgent meeting should be arranged involving the Supervisor, PICT and Clinical Tutor. As above, a considered plan of action needs to be agreed with clear criteria that need to be met for successful completion of the placement. Additional meetings may need to be scheduled.

A written summary of all discussions and subsequent action plans will be completed by the Clinical Tutor, signed by all parties and held at the Programme base. e. If the Supervisor recommends a failure of clinical placement at the End of Placement Visit this needs to be documented in full by the Clinical Tutor. The views and opinions of both Supervisor and PICT need to be recorded, along with all attempts that have been made to rectify the situation. Both the Supervisor and the PICT are invited to provide a written account of the placement and the difficulties encountered, as well as any other information that they wish to be taken into account. The Clinical Tutor will then take all this information to the Examinations Board. In the situations where the trainee has two supervisors who disagree about a recommendation of placement failure, the Examinations Board will take into account all the information presented to it and come to a decision based on this evidence. f. The Examinations Board will make a decision on whether or not to uphold the Supervisor’s recommendation for failure of clinical placement. Whatever decision has been reached, the External Examiner’s opinion will be sought prior to the final decision of the Board. g. The decision of the Examinations

Board will be communicated to both the Supervisor and the PICT by the Clinical Tutor. Rights and routes of appeal will also be communicated.

iii. Criteria for Failure of a Clinical Placement What follows are illustrative examples of behaviour that could lead to failure of a clinical placement.

These are linked to each of the ten competencies in the Placement Assessment Form. Depending on the degree, severity, and/or frequency of occurrence, action required by the supervisor could be a telephone call to the Clinical Tutor to discuss the situation, a request for an early placement visit, or a request for an immediate placement visit.

Examples

Personal and Professional Development The PICT demonstrates a prejudicial attitude towards a client group or group of colleagues. He/she is unreliable, irresponsible, and lacks a conscientious approach. He/she gives little or no importance to confidentiality or obtaining informed consent. He/she demonstrates an inability to prioritise or manage an appropriate caseload. He/she is unable to recognise when a task is beyond his/her capacity. He/she does not show sufficient consideration and awareness of inherent power imbalances.

Supervision The PICT consistently fails to attend supervision sessions. He/she is unwilling to discuss clinical work or allow direct or indirect observation. He/she demonstrates extreme defensiveness or rigid adherence to one theoretical model. He/she seems unable to consider that personal attitudes are directing formulations of clinical work. He/she behaves in an oppressive way towards his/her supervisor. He/she is unable to effectively use constructive criticism and feedback. He/she is unable to discuss both content and process issues in supervision appropriately.

Therapeutic Engagement and Working Alliances

A PICT demonstrates significant difficulties in engaging with clients, families/carers or colleagues in a way that indicates a major problem in recognising, acknowledging, understanding and/or being aware of the psychological state of another. He/she has inappropriate contact with a client or family/carer. He/she is unable to demonstrate an awareness of the importance of boundary and termination issues. He/she is unable to demonstrate an ability to engage successfully with different levels of organisational systems (e.g. service users, teams, external agencies).

Psychological Assessment

The PICT shows a significant lack of development in fundamental assessment skills such that relevant information is not obtained and/or procedures are not followed. He/she is unable to adequately select, administer and interpret assessments. He/she does not demonstrate an awareness of the importance of risk assessment and/or appropriate skills in this area.

Psychological Formulation

The PICT is unable to synthesise information in order to use formulations to inform interventions. Theoretical knowledge and theory practice links are absent

and/or the socio-political context is not considered. The original formulation is upheld despite contrary evidence. He/she is not able communicate formulations in accessible, culturally sensitive and non-discriminatory language.

Psychological Interventions

The PICT is unable to adapt intervention models to individual needs. He/she is unable to demonstrate knowledge of the relevant theoretical basis and practice guidance frameworks underpinning interventions. He/she is not able to adapt interventions appropriately to individual needs. He/she is unable to consider service users' values and goals when designing interventions. He/she is unable to demonstrate an awareness and understanding of social approaches to intervention (e.g. community, critical, social constructionist perspectives). He / she is unable to demonstrate an awareness and understanding of the impact and relevance of psychopharmacological and other multidisciplinary interventions. He / she is not able to demonstrate an awareness of the limitations of psychological interventions and assess when further intervention may not be appropriate.

Evaluation and Research

The PICT does not adhere to Departmental auditing procedures or any individual evaluative measures without explanation. He/she does not demonstrate the capacity to evaluate processes and outcomes at the individual, organisational and systemic levels. He/she does not conduct research projects in respectful collaboration with stakeholders and within appropriate ethical and governance frameworks (e.g. BPS, HCPC, University regulations).

Communication

The PICT does not adapt their style of communication in response to different levels of cognitive ability, sensory acuity and linguistic fluency. Oral and/or written reports of clinical work are consistently poorly structured, incomplete, imprecise or ill formulated. The PICT is consistently late in submitting work.

Teaching and Training

The PICT refuses to take on a teaching/training role without explanation. He/she takes on a teaching/training role but does not ascertain the objectives or needs of the audience. There is little evidence of preparation for the teaching session and /or no attempt to evaluate the session through self-appraisal or structured feedback mechanisms.

Organisational and Systemic Influence and Leadership

The PICT cannot demonstrate an understanding of the organisational context in which they are working (philosophy, routes of communication, roles and functions) including

the legislative and national planning contexts for service delivery and clinical practice. He/she devalues, dismisses or denigrates the experience of service users, families and carers in service planning and delivery. He / she is unable to demonstrate appropriate leadership qualities, e.g. being aware of and working with interpersonal processes, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices. He/she does not recognise the

importance of recognising and responding to unethical practice in systems and organisations (including 'whistleblowing' policies and issues). He/she does not consider or value the contribution of other professionals. He/she is unable to recognise, tolerate or accept difference in opinion. He/she is unable to recognise when to seek an opinion from/involve other staff.

6. Consequences of failing a placement

(i) Failure on two placements will lead to termination of the PICT's registration on the Programme. This will lead to the termination of the contract of employment. (ii) Following a placement failure in any of the first three placements, the PICT will be required to undertake a subsequent placement with the aim of showing evidence for the development of competency within the raised area of concern. In the event of a failure on the fourth placement the PICT will be required to undergo a subsequent placement in their third year, which will have implications for choice and duration of the elective placement. In the event of the final year elective placement being failed, the PICT will be required to undertake another appropriate placement (which could be done in a shorter time e.g. 4 months). In this instance, the University would support a request for an extension to the contract of employment whilst the placement was undertaken. If this final placement is also failed, then the PICT will have failed the Programme and will not be eligible for registration with the HCPC as a Clinical Psychologist. (iii) In the event of serious professional misconduct (as defined in the BPS Guidelines on Professional Practice of Clinical Psychology) the Chair of the Examiners may require the immediate suspension of the PICT's registration with the University following consultation with the Clinical Tutor. The relevant disciplinary proceedings of the PICT's employer would be set in motion. (iv) As a consequence of (ii) above and the PICT's contract of employment being terminated and the PICT being excluded from the Course, the usual University/NHS appeals procedures would be available to the PICT.

2d Quality Standards on Clinical Placements, including raising concerns about placements

The following are the Standards that are monitored through the Audit of Clinical Placements process. They have been grouped according to competency areas. The audit

form is available at the end of the placement assessment form for trainees to fill in. The appropriate standards have been added to this version in bold so that supervisors can see what is expected in relation to the different areas.

There is also an expectation that all Trusts and therefore all placements will be adhering to the Equality Act (2010).

We have also included a further section at the end of this document regarding raising concerns about the quality of clinical placements.

Supervision

· How regular has supervision been [frequency]?

o The Programme expects that supervision will be a minimum of once per week

· How long is each supervision session [average]?

o 1 hour is an absolute minimum, 90 minutes is the expected average (particularly years 1-2)

· Were there 'cover arrangements' when your named supervisor was not available?

o It is expected that such arrangements will be made and that other clinical psychologists will take responsibility in their colleagues absence; where appropriate senior clinicians from other professions may provide guidance (e.g. in situations of high risk) if agreed with the named supervisor

· How many supervision sessions were missed or cancelled [and not rearranged]?

o It is expected that all missed or cancelled sessions will be re-arranged

· How was your work sampled (e.g. directly/audio or video recording)?

o Work must be sampled – supervisors and trainees can negotiate the most appropriate means in order to address leaning outcomes. All observation should be with the consent of any clients/families/carers.

· How did you sample the work of your supervisor?

o It is expected that trainees will have opportunities to sample a variety of their supervisor's work

· Did you have an adequate and appropriate clinical case-load?

o It is expected that trainees will be neither under occupied nor over occupied

· How well supported were you within supervision?

o This is a qualitative/subjective judgement

· How well supported were you by the department/service as a whole?

o This is a qualitative/subjective judgement

Communication

Was there a planned induction process (including, but not limited to, orientation to bases, introductions to teams, admin processes, timely access to computer systems and associated training; induction to records systems, local fire safety procedures, lone working/safe working policies and other appropriate guidance)?

o It is expected that there will be a planned induction process

· Did you have access to computer?

o It is expected that there will be access to appropriate computing facilities

· Was there secretarial support for typing and sending reports?

· And did you use this support?

Research and Evaluation

· Did you have access to library facilities?

o It is expected that trainees will have access to library facilities whenever they are provided by Trust in which their placement is taking place

· Did you gain awareness or have involvement in research activities in the service? (Includes audit and evaluation activities)

· Awareness (please give details:

· Involvement (please give details):

Service delivery

· Were there opportunities to develop skills in collaborative working with other professionals?

· Were there opportunities for joint working with other professionals?

o It is expected that, where supervisors work in teams, trainees will have access to work with clinicians from other professions

· Were there opportunities to gain organisational awareness e.g. Trust policies, professional issues, service system?

o It is expected that trainees will be aware of all relevant policies etc

Teaching

· Were there teaching or training opportunities on placement?

Personal and professional development

· Was consideration given to working with difference and diversity?

· What opportunities to work with these issues were there?

Basic Physical Requirements:

· Did you have access to a desk?

· Did you have use of appropriate clinical space in which to see clients?

· Did you have lockable storage for confidential material?

· Did you have safe space for personal belongings?

o It is expected that each of the above will be provided

· Were there any actual or potential problems with access to buildings, facilities or equipment?

o Any non compliance to Equality Act provisions should be reported to the programme directly

RAISING CONCERNS ABOUT THE QUALITY OF CLINICAL PLACEMENTS

The question is frequently asked by trainees - "What happens with respect to information about perceived bad practice in supervision which is given by trainees to Clinical Tutors?"

This document represents an attempt to clarify the current approach of the Clinical Tutors to this sensitive issue. It is important to remember that the vast majority of placements are satisfactory and many outstandingly positive for both supervisors and trainees.

The approach of the Clinical Tutors is to prioritise a good training experience for all trainees. This is consistent with a good supervisory experience for supervisors and dependent on a range of factors including the interpersonal and the contextual.

(Please read this document in conjunction with Placement Handbook section 2c – Criteria for Passing and Failing Placements)

Context

In order to enhance learning opportunities for both supervisor and trainee, a context of openness and trust is generally beneficial. The evaluative component of the supervisor-trainee relationship can induce anxiety and fear of negative evaluation in both parties. One role of the Clinical Tutor is therefore to try to facilitate the construction of an open and trusting relationship. The approach in the first instance is one of prevention rather than restitution of difficulties. They attempt this during placement visits by asking questions regarding the process of supervision, with a view to opening up those areas in which people may experience difficulties (e.g. conflicting expectations of supervision), so that they become topics which may be talked about. A further approach is to encourage 'live' and 'recorded' work, i.e. each party openly showing the other their work, and suggest approaches to feedback and criticism whereby the trainee or supervisor stays in control of this, e.g. by inviting feedback on a particular topic or theme, by self-reflection and critique and by the use of specific methodology, e.g. Interpersonal Process Recall.

It may be noted that the evaluative element of the supervisory relationship affects both the supervisor and trainee and this can lead to reluctance by both parties to be usefully critical. This is supported in the research literature, which suggests that supervisors generally find giving negative feedback very difficult. Although research data may not be available, trainees' experience suggests that it may also be difficult for trainees to give negative feedback to supervisors. Supervisors and trainees may both fear for their reputation in the profession. Trainees fear that they will fail a placement and may concentrate on presenting a façade of competence rather than adopting an open approach to learning. Thus there can be a general reluctance to comment critically by either party.

The first placement in training can be particularly important for trainees, as this will expose previously unrecognised expectations which may be unrealistically high. There may be a tendency to seek the 'perfect' placement and a failure to recognise the skills and responsibility of the trainee in constructing a satisfactory experience. The possibility of learning from imperfect placements is frequently overlooked. There is diversity of approach in the profession, and expectations of supervision may differ markedly between supervisor and trainee. This inherent tension may be explored and agreements negotiated at the instigation of either supervisor, trainee or both. Clinical Tutors have a role in helping trainees develop realistic expectations of placements,

whilst ensuring quality of placements is not compromised beyond professional standards.

The role of the Clinical Tutors is to facilitate quality of training and this involves offering support and development opportunities to both trainees and supervisors. They are therefore non-aligned with either party in the event of any difficulties arising. The Clinical Tutors recognise that much sensitive information comes their way and they try to deal with this confidentially and sensitively. Supervisors and trainees also recognise the need for careful handling of the communication of their experiences on placement and when asked by other trainees are appropriately circumspect, not wanting to colour too much the view of a trainee about to start a placement with a supervisor they have known. Some information is, however, transmitted between different parties in the training process, leading to the development of supervisor 'reputations'. In this regard it is just as difficult being a trainee having a 'bad' experience with a highly-regarded supervisor as being a trainee having a 'good' experience with a poorly-regarded supervisor. Reputations do change over time and it is possible for reputations both to fall from grace and to be resurrected.

Given these issues, the approach of the Clinical Tutors is first and foremost as 'placement-nurturers' rather than 'placement-police'. This may lead to a view that nothing is done about reported poor supervisory practice rather than what actually happens – what is done is kept confidential. Confidentiality makes it more possible for supervisors and trainees to be open with the Clinical Tutors about any difficulties they are experiencing. However, in the event of serious difficulties, the tutors will take the lead.

Action Taken

In the event of a trainee complaining about or being worried about what is happening on placement and bringing this to the Clinical Tutors, a variety of approaches and decisions are taken. The approach depends upon:-

• What the trainee wants the Clinical Tutor to do.

• Whether the difficulty is disclosed during or at the end of a placement.

• The seriousness of the matter.

• Whether the matter concerns the actions of the supervisor with regard to the trainee or to the supervisor's clients.

• Whether the difficulty seems to be specific to a particular placement or whether similar difficulties have been experienced by more than one trainee.

• To what extent the difficulty is to do with what is happening in a psychology department at a particular time. This can include interpersonal difficulties between members of a department in which the trainee becomes triangulated, or arise from pressures upon the department as a whole, e.g. workload issues related to the contracting process.

• Whether the difficulty is of the kind where supervisory practice may be regarded as adequate, as opposed to potentially destructive and harmful. To borrow a phrase, 'good enough' supervision is the aspiration. The impact of the contexts in which placements take place cannot be underestimated. There are numerous pressures on supervisors from which trainees may be either protected or to which they may be exposed. These can lead them to negatively evaluate placements. Trainees may inadvertently find themselves the communication conduit for people who are struggling with each other, the non-threatening ears for disaffected staff, or evoke feelings related to the training experience of the supervisor. Trainees need to consider these contextual factors in the light of psychological frameworks, and in so doing develop an internal supervisor which will enhance their future practice in the profession. The Clinical Tutors try to help trainees to stand back and take a reflective rather than emotionally reactive stance in such instances. This may include helping trainees to develop an explicit understanding of wider organisational issues on placement. It may also reduce the experience that some trainees have had of feeling personally responsible for difficult relationships on placements, that in retrospect they have come to see as a product of organisational dynamics.

• What may be happening for the trainee more generally. Sometimes, as with supervisors, life events or a trainee's more general experience of training may colour attitudes to placements and supervision. The Clinical Tutors take a broad view in trying to understand and help clarify the issues. An approach encompassing such a broad perspective is generally seen as more helpful than locating the blame in a single party.

The following approaches are adopted:

1. The trainee discusses the matter with the Clinical Tutor (it is helpful if concerns can be put in writing, but this is not essential) and together they explore how the trainee might handle the difficulty. Further meetings may be agreed.

2. As a result of this discussion, the Clinical Tutor may meet with the trainee and supervisor together for additional placement visits as required.

3. The Clinical Tutor may subsequently meet with the supervisor to explore how to deal with the particular aspects of the practice, either for the

remainder of the placement or with regard to future placements. Supervisors as well as trainees find difficulties in placement painful and often want to work on their supervisory practice.

The majority of difficulties are resolved to a greater or lesser degree by these approaches. In some cases the difficulties are more severe and lead to the following:

1. The placement is terminated early. As this is a 'public' action, trainees and supervisors often prefer other outcomes. Such action is most likely where the relationship has broken down beyond reconstruction.

2. It is agreed with the supervisor that he or she will not supervise for the Course under the circumstances in which the level of difficulty has proved untenable. Where this is

the case, this is explicitly discussed with the supervisor, and reasons given so that supervisors should not be left wondering why they are not being invited to provide placements. This is the case irrespective of placement shortages. Should such a supervisor wish to supervise in the future, a discussion can be initiated with the Clinical Tutors and agreement reached as to what would need to be different in order for the placement to work.

3. In instances where the difficulties arise from wider departmental issues, the Clinical Tutors make whatever interventions are possible for a 'neutral' party. However, this may be limited as the Clinical Tutors do not have an official brief to help departments 'troubleshoot' in regard to such matters. The Clinical Tutors do, however, encourage trainees to respond to such issues, not only at the level of the effects on the person but also as a professional psychologist, using psychological theory to take a more detached view. In our experience, all departments experience phases of development in which staff are under stress and it will be crucial for trainees to learn to manage this effectively.

4. It should be noted that there are many reasons why particular clinical psychologists are not involved in supervising placements, for example the nature of the specialism, availability of suitable accommodation, conflict with other roles, the need for a 'rest' etc. Assumptions made about this are almost certainly unhelpful.

In taking these latter approaches, it can take time for the Clinical Tutors to accumulate sufficient data to be sure of the appropriate action and they do not usually choose to act precipitately. There is a distinction between supervisory experiences that are difficult but can be useful and those that are difficult and unacceptable.

It is recognised that documentation of agreements and interventions is important in ensuring clarity between the parties involved. Where agreements and interventions affect an ongoing relationship between a supervisee and a supervisor these will be put in writing to both parties. This may follow a Mid

Placement Visit or other meeting between Tutor, Supervisor and Supervisee where actions are agreed with the intent to improve or manage a situation that has given cause for concern. Agreements made between Tutors (on behalf of the Clinical Psychology Training Programme) and a Supervisor regarding the ongoing use of a placement (including decisions not to use it) will be put in writing following discussion. This is correspondence between the Programme and the Supervisor, it will be confidential between those parties and decisions regarding the use of placements will not be communicated to previous supervisees or other potential supervisees. Copies of all correspondence regarding placements will be held in an appropriate place at the programme base.

The success of placements or otherwise is strongly related to the interpersonal relationship between supervisor and trainee. Preparation for placements for both trainees and supervisors is important in the development of a relationship which facilitates learning. Clinical Tutors contribute to the process of preparation through timetabled sessions with trainees, and supervisor training events on making the most of placements. In scientist-practitioner tradition, this draws on the body of research

addressing this topic. The Placements Subcommittee of the Programme Management Committee monitors and evaluates this aspect of training and welcomes ideas and comments.

Acknowledgement: Adapted from an original document from the

University of Sheffield Clinical Psychology Training Programme

2e. The Presentation of Clinical Material during Training, including guidelines for Placement Presentations and Consent Form

The following are guidelines for the assessment of placement material during each year of the Doctorate in Clinical Psychology course.

Year One

End of Placement Visit 1: Presentation of reflection on clinical practice End of Placement Visit 2: Presentation of reflection on clinical practice

Year 2

End of Placement Visit 3: Presentation of reflection on clinical practice End of Placement Visit 4: Presentation of reflection on clinical practice

Placement Presentation to First and Second Years:

Note: it is not permitted for PICTs to use their Systematic Case Study (SCS) for this presentation.

For further information Please see 'Guidelines for Placement Presentations', included at the end of this section

Year 3

Placement Presentations

Reflection on Clinical Practice

At the end of each of the placements in years 1 and 2, PICTs are expected to produce a reflection on clinical practice. This will usually occur at the End of Placement Visit with the supervisor and clinical tutor present.

The purpose of this exercise is to promote systematic reflection on some aspect of the learner's personal and professional development. There is no specified format for this assignment and trainees are invited to use their creative talents to maximise their experiential learning. The feedback given will be formative.

Over the first two years of their training, trainees will include a reflection on clinical practice based around each of the following areas:

- An element of difference or diversity;

- An ethical dilemma;

- A model of supervision.

Trainees can chose which order they address these themes over the two years.

Placement Presentation (Year 2)

During the second year, trainees present a clinical issue at the "Placement Presentation Meeting" which is chaired by a member of the programme team and which trainees from the first and second years are expected to attend. The subject they speak about has to be based on their clinical practice in year 1 or 2 of the course. This can be a more 'traditional' case presentation using a specific aspect of a case (e.g. informed consent to

a psychometric investigation) or on wider issues that relate to many experiences in an area of practice (e.g. working

at a systems level in a learning disability service). Wherever possible a current case should be presented in order that the client/family/system can benefit from this exercise. Trainees are also asked to provide both a formulation and re-formulation of the clinical work they are presenting.

Trainees are encouraged to give consideration to their choice of material so that there is mutual benefit (that the audience learn about the issue/area of practice and are given 'food for thought' and the presenter gains new perspectives on their work). Trainees are also encouraged to find ways of engaging their audience through participatory exercises and in a 'questions and answers' section at the end of the presentation. Through this forum trainees are given an opportunity to develop skills in presenting clinical material to their peers and in the use of appropriate presentation media. As audience members they also develop and practice skills in questioning presenters. Consent must have been sought from the client where appropriate (and justification offered if this is not the case). The person should not be identifiable from the material presented. Feedback is formative currently formative but will become summative for the new intake (2020-2023). A copy of the consent form is included at the end of this document.

Placement Presentation (Year 3)

At the end of Year 3, trainees are expected to present material at a 'Final Placement Presentation' to which all trainees and members of the programme staff are invited. The remit for the presentation is that it addresses issues of theory-practice linking in a particular placement experience. Typically trainees choose a clinical issue from their workload on placement and draw on the therapeutic principles and theoretical perspectives that they have studied in their final year elective module. Examples of therapy-based placement presentations have included psychodynamic formulations, family therapy interventions and process analysis of child-centred play therapy. The programme provides written guidance to help trainees with this assignment and discussion of placement material is an integral part of all elective teaching modules in the final year. The aims of the day are to share practice and dilemmas in therapeutic work and the role of psychological theory and principles in each. Further, it is an opportunity for trainees to gain further experience of presenting to their peers using electronic media and with a specific remit and time constraint. Feedback on this presentation is formative.

Guidelines for Placement Presentations

Introduction

Placement Presentations are a mandatory part of the course. They provide an opportunity for trainees to develop their presentation skills and to benefit from

discussion of clinical work within a peer group setting. Presentations are also attended by members of the staff team. Trainees will receive formative feedback from a staff member and peers. Whilst this is not part of the formal assessment process, this feedback can be used to inform the annual appraisal process.

The aims of the placement presentations are as follows:

· To provide an opportunity to present and share clinical work with other trainees. Specifically to:

o present a clinical formulation embedded within the available evidence-based literature

o facilitate discussion of clinical work, allowing new ideas to be considered for the benefit of service users/carers

o obtain feedback on presentation skills

Procedure

· Ensure that you are aware of the presentation sessions in the timetable and when you are due to present yourself.

· Select a piece of work to be presented. This may be a piece of individual work, family work or may focus on group interventions, staff training or consultation. If in doubt please seek advice from your clinical tutor. The presentation should last 30 minutes, there are up to 10 minutes following this for questions and discussion. Finally 10 minutes are available for feedback at the end of session.

Choosing work to present

The following points may help you to choose work to present:

• The placement presentations are designed as opportunities to practice presenting to others and to share and discuss clinical work. Any piece of work can be suitable. The work does not have to be perfect, with a successful outcome and extensive notes. An early or provisional formulation may be sufficient (although some attempt at a formulation should be presented). An unsuccessful piece of work, or one where a therapist is feeling "blocked", or progress differs from what is expected on the basis of the available evidence base, may be a useful basis for discussion. A "good" presentation is one with opportunities for the presenter and the group to learn mutually from the presentation and inform work in the future. Appropriate self-disclosure and consideration of issues of diversity, ethics and inter-professional issues are encouraged.

• The placement presentation session should be used to explore work other than that in your single case study (SCS). The presentation provides an opportunity to focus in depth on an additional piece of placement work, explore dilemmas, gain ideas and enhance the breadth of training.

• Consent: You have to be able to justify the consent arrangements for your placement presentation. Consent should be obtained and recorded in clinical notes on placement using a consent form. For children, parental consent should be sought unless the child can be deemed as Gillick competent. For adults who lack capacity to consent permission should be sought from people who have significant relationships with this person (please discuss further with your supervisor/clinical tutor). In exceptional situations you may judge with your supervisor that it would be harmful to seek consent – this judgement should be recorded in your supervision notes. Please complete the attached consent form and hand in to the Chair of Placement Presentations for your presentation.

• If you have any further queries about placement presentations, please contact your clinical or academic tutor.

Structure

Presentations should usually be on PowerPoint but other methods of presentation can also be arranged with prior consultation with the office staff and facilitating members of staff. There is not a set structure to the presentations and the following headings can be used as a guide for preparation:

Areas to consider include:

· Reason for selection of this work for presentation and aims.

· Consent and the process of obtaining this (see above).

· Confidentiality – only the minimum necessary information should be presented, avoiding detail that may identify a person or persons.

· Distressing material – many areas of clinical work contain potentially distressing material; it can be helpful to acknowledge this at the start of the presentation.

· Referral - method of referral; referral source; information available.

· Assessment - rationale for selection of assessment procedures; what alternatives were considered but rejected and the rationale for this; the

construction and development of instruments where appropriate, any literature suggesting that they might be effective in answering the assessment questions posed.

· Assessment findings and interpretation. Identification of problem(s) and strengths - major and subsidiary problems; problems not identified upon referral; problem for whom; existing coping strategies; diversity issues?

· Formulation(s) in psychological terms (with reference to the literature and relevant NHS or BPS guidelines). Rationale for future intervention and implications for the client (in terms of risk management or/and treatment choice).

· Intervention options considered - relationship to formulation(s) and to the literature and relevant guidelines.

· Nature of any intervention process; nature of the therapeutic relationship.

· Reformulations and revisions of intervention where appropriate.

· Maintenance - how planned; what follow-up expected; preparation for relapse.

· Evaluation of outcomes - how measured; how effective and in what way; side effects (positive and/or negative); present data to back up your conclusions.

· If the work involves several people, e.g. family, team or system, consider the multiple perspectives involved.

· Any communications back to referral agencies.

· Critical assessment of the work – what might be different in hindsight/future; any alternative formulations or strategies that might have been/could be considered; can/could work have been more effective; how unsuccessful work is accounted for; is/was the choice of outcome measures the best?

· How information was communicated (e.g. letters, reports, verbally) to others (including person/people you worked with, colleagues, referrer, significant others).

· Perspective of the service user(s) on the work carried out.

· Summary of what has been learnt.

All case presentations should include some consideration of relationships and process issues, as well as diversity and inter-professional issues evident in the work.

Please note that it is a course requirement to do a presentation in Year 2, If you are unable to present due to illness, etc. please arrange an alternative presentation slot in consultation with Tom Isherwood or Jan Hughes.

Section 3

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Additional Information for Placements

3a. Service Evaluation Project (SEP) Time in Year 2

Conducting the Service Evaluation Project (SEP) within 2nd Year Clinical Placements: Guidance for Psychologists in Clinical Training and Their Supervisors

There has been some confusion about the time allocated to the SEP in Year 2. This statement from the Clinical and Research Directorates should clarify the situation.

Historically, PICTs were allowed time within the placement to complete their SEP – when teaching blocks, annual leave and Christmas and Easter breaks from teaching were taken into account this equated to 60 hours. This was decided when most trainees conducted their SEPs within the service in which they were currently on placement.

Now, however, all SEPs are commissioned by departments and a PICT may carry out this research during a placement in a different department. A concern that has been raised is that this may sometimes have a detrimental effect on the range of experiences on placement which are open to the PICT, who as a result has a less satisfactory placement experience.

It is important, however, that PICTs are not penalised for carrying out a commissioned project and our principle is still that PICTs should have enough time to complete the SEP. There are some important considerations, however:

· PICTs can request up to 3 hours a week from their Clinical Placements in Year 2 (retaining the maximum allowance of 60 hours)

· SEPs contribute to the development of services across the region and many supervisors have positive experiences of SEPs carried out in their service. Supervisors may have more immediate concerns about the placement experience, however, and time spent on SEPs should always be negotiated with the Supervisor. It would be reasonable for a Supervisor to request information about how the time is being spent and to restrict whether and how this time is taken in order to ensure that competencies can be developed and demonstrated.

· For most SEPs this time could be spread between two placements rather than taken out of one. PICTs can be requested to provide evidence of time taken for SEP activity. Clinical Tutors will ask about these negotiations and plans within the remit of the placement visits.

· In the norm, PICTs are expected to spend SEP time at their placement base so that they are available to colleagues and clients as appropriate. The exception is when the PICT needs to be at a different site in order to collect data or meet with supervisors and the course would support this. Other exceptions must be negotiated with the Supervisor.

· This arrangement is purely for work on the SEP; it is not an entitlement to additional study time and ends when the SEP is completed. Similarly, if the SEP has not been

completed by summer, the expectation is that the trainee will take any additional time needed from their two study days rather than the placement. SEP time should not be requested during July, August and September.

· If there are difficulties on placement which result in a need for time in order that particular competencies can be developed and demonstrated, this will take priority over the requirements of the SEP in the short term. It is expected that Clinical and Research Tutors will be contacted by the trainee if this need arises.

We hope that this represents a fair arrangement. If anyone has any queries or problems, please let us know.

Gary Latchford, Research Director and Jan Hughes, Clinical Director

3b. Additional notes for year 3 placements

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Organising Year 3 Placements

This starts in January of Year 2.

We ask that trainees do not make contact with any supervisors prior to the time-tabled slot in January which is conducted by Jan Hughes (Joint Programme Director).

In this session a number of issues are raised for trainees to consider e.g. gaps in experience/competency, employability etc. and there is time for trainees to discuss these. They are also asked to consider their preliminary ideas about potential supervisors, both in terms of their first preference of supervisor and who would be their second preference.

Sometimes it becomes apparent that there is a particularly popular clinical population. In this scenario the trainees that are interested are identified and asked to meet and work together to consider how all of their needs may be met. Trainees are then encouraged to go and speak to potential supervisors. It is very much stressed that supervisors are busy people and so trainees should only approach those where there is a definite possibility that they might want this placement.

These meetings occur between January and March. In March there is a second time-tabled slot. At this point the expectation is that trainees will have more definite plans. If it becomes clear that trainees have not been able to solve any potential problems in terms of two or more trainees wanting the same supervisor then a process is set up. Jan will work with the supervisor to consider which trainee would gain the most from the placement. Jan and the supervisor will devise an 'application' process often with the trainees having to submit some documentation. A collaborative decision will be agreed between and supervisor and Jan and communicated to the trainees. Those who are unsuccessful will need to consider their second preference, which should already be in place.

Trainees are expected to be clear with supervisors whether or not a supervisor is first or second preference for a third year placement. Please email Jan before the last Friday in April clearly stating first and second preference of supervisor. By doing this you are also confirming that these supervisors are aware that you are putting their names forward. It is expected that all placements are confirmed very soon after all preferences have been stated, and the paperwork will be sent out to supervisors and trainees in May. Trainees should inform any second preference supervisors if they are not taking up a placement with them.

Placement Structure

Trainees are on placement for two days per week from the third week in October until the thesis submission in the middle of May. Following this the placement extends to four days per week.It is expected that trainees will complete these additional two days within their existing placement. In exceptional circumstances trainees can request to start a new placement for two days week

from May – September. This must be in agreement with the trainee's clinical tutor. A clear rationale for this must be provided in writing to Jan who will consider this request and liaise with the trainee, tutor and supervisor to ensure this is in everybody's best interest. The teaching day for third year trainees is Thursday and it is negotiable which other days in the week are clinical and which are research.

Research Time Flexibility

Through negotiation with their supervisor, trainees can have 4 additional days on placement between mid October and the end of December, and have 4 additional research days between the beginning of January and the thesis hand-in date in mid May. You need to decide whether this would be helpful to you and then follow this process outlined below.

· Negotiate flexibility with your supervisor, bearing in mind the needs of the service. This should be done as soon as possible.

· Be clear with your supervisor which days will be additional on placement in the first 2.5 months and which will be lost from placement in the next 4.5 months.

· The research days gained (and therefore placement days lost) should not be used in conjunction with annual leave, so there is no possibility of an extended period of time away from clinical work (no more than 3 weeks)

· These research days are communicated to your clinical tutor and discussed and reviewed at placement meetings

Clinical Aims

The third year of training offers the opportunity to gain substantial clinical experience within the final year of training. The Programme suggests the following guidelines be used when planning Year 3 placements (in addition to the General Placement Guidelines 1 and Placement Guidelines 2).

1. Clinical Experience and Core Competencies

The flexibility of the final year should be used to both fill gaps in both earlier trainee clinical experience (e.g., limited opportunities for group work, insufficient exposure to particular clinical problems or populations) and developing competencies (e.g., supervision in a particular psychotherapeutic method, becoming familiar with the consultancy role, delivering supervision). The details in the clinical log should enable the trainee and clinical tutor to organise a suitable placement and identify suitable priorities.

2. Longer Term Therapeutic work

Opportunities should be found for longer-term therapeutic work lasting at least six months and longer where available and appropriate. Trainees should take responsibility for complex and challenging cases provided adequate support and

supervision exist. Questions of achievable treatment goals, discharge criteria and problems of termination should be highlighted in supervision. These opportunities should focus on ensuring that the trainee meets the competencies for their second chosen model of therapy.

3. Time Management Skills

It is reasonable that Year 3 trainees should take on a case load that will encourage the development of time-management skills. In anticipation of the pressures and expectations faced by newly qualified clinical psychologists, supervisors should aim to promote competence in effective self-organisation.

4. Leadership and Organisational Issues

At a time when the NHS culture is in a dramatic state of flux, opportunities to inform trainees about organisational issues and increase their political and business awareness should be grasped. Publications such as New Ways of Working for Applied Psychologists ('NWW'; BPS, 2007) and the Clinical Psychology Leadership Development Framework (BPS, 2010) promote a number of roles for psychologists including a clear emphasis on skills in leadership. Psychologists in clinical training should be aware of these roles through their development on placement and the third year of training is an opportunity to further explore their capacity to lead. Through everyday interactions or through discrete projects trainees are encouraged to examine how they influence others and provide leadership. The following points are also consistent with developments suggested in NWW.

5. Working with Other Professionals

Much of a qualified psychologist's endeavour depends for its success on the quality of working relationships created with members of other disciplines. Opportunities for collaborative projects with other professions including both teamwork and consultancy activity, should be incorporated in Year 3 plans.

6. Consultation and Supervision

Psychologists in clinical training may well be asked for support or advice by colleagues and other professionals whilst on placement, and this is certainly something that will happen quickly post qualification. NWW documents detail a number of distinctions between consultation (often brief, time-limited, spontaneous or reactive in nature) and supervision (typically an ongoing relationship with clear delineation of roles). These are skills which it is appropriate to continue to develop in the third year. There is now a requirement within the BPS that trainees demonstrate their

ability to deliver supervision and so this needs to be considered creatively within the third year. There are often opportunities to work with other professionals (e.g. health care or support workers) or others in training. Where this is not possible opportunities for peer supervision with other trainees can be organised. Trainees have also provided one-off sessions of case supervision to their supervisors as a way of gaining experience

in this role. Supervisors retain clinical responsibility for all the placement related work of the psychologist in clinical training.

7. Presentational Skills

Psychologists are increasingly expected to publicise the results of their efforts in forms beyond the traditional reply to referral letter or spoken feedback to colleagues. Proficient presentational skills are therefore a professional asset we would wish to promote in the third year.

A number of guides have been produced that relate to specific areas of competence development; these aim to develop practice and skills in areas such as leadership and supervision (of others). They can be found in Section 3 of the Placement Handbook.

Clinical Tutor Team (Jan Hughes, Tom Isherwood, Tracey Smith, Fiona Thorne)

3c. Leadership and clinical placements

Since 2010, Leeds Clinical Psychology Training Programme has been encouraging PICTs to think about and document their experiences of leadership skills development using a specifically designed form. With the advent of the new accreditation criteria, 'Leadership' has now been included as a core competency. This document outlines areas for discussion in supporting the development of these skills.

Background

Leadership skills have been identified as a key contribution that Clinical Psychologists can make to teams and services. This is emphasised in ***New Ways of Working for Applied Psychologists in Health and Social Care – Organising, Managing, and Leading Psychological Services*** **(British Psychological Society, 2007)** where it is recommended that *"Pre-qualification Doctoral programmes should include the development of leadership and team-working competencies".* There is recognition that leadership is a concept that relates to all clinical psychology grades and areas of practice (not just senior and specialist roles).

Scope

There will be different opportunities for learning in different placement contexts; for the purposes of this area of competency development 'leadership' should be defined broadly to include all work where the Psychologist seeks to influence, persuade, direct, negotiate, facilitate of 'lead' in areas of their practice. There is a distinction to be made between indirect and direct client work. These skills can be found in direct work with clients; however, some therapeutic traditions seek to guard against undue influence, power and direction in direct work (most notably in person centred traditions). The focus of this area of competency development is indirect work (i.e. with other professionals, team members, care staff, systems, agencies and organisations). That said there are interesting parallels/comparisons to be drawn between styles required for client work and those required to influence teams and systems.

Some attempts to influence will be subtle (most communications could be cast as an attempt to depict or assert a particular (psychological) perspective); letters and phone calls might provide opportunities to consider leadership and influence as well as more obvious examples such as training or multidisciplinary case conferences. Trainees can reflect on: the language used in attempts to change a view or situation; their decision to speak/not speak at particular points; what they are trying to achieve in discussions with/reports to others and how they can be effective in doing so; apprehension and inhibition and their alternatives.

Developmental Perspective

As with other areas of competency development it is appropriate to expect clear shifts in awareness and skills over the course of training rather than prescribe specific levels of attainment. The following are suggested:

Year One

- Some limited awareness own impact on others and the system
- Identification of opportunities (taken or otherwise) to influence/lead others
- Observation and reflection on leadership by others

Year Two

- Increased awareness of own impact on others and the system (esp. teams)
- Ability to identify barriers to influence/leadership and ways to address these (scenario discussion)
- Ability to gather and use feedback on contributions to work in teams

Year Three

- Awareness of own strengths and needs in leading/influencing others and systems
- Ability to identify and reflect on political and organisation context of situations in which one is seeking to influence/lead
- Ability to lead on specific areas within practice (discrete projects or initiatives)

You may find it useful to refer to the following:

- *New Ways of Working for Applied Psychologists in Health and Social Care – Organising, Managing, and Leading Psychological Services (British Psychological Society, 2007)* *http://www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/ppb-activities/new_ways_of_working_for_applied_psychologists.cfm* for an overview of literature and commentary on its application to clinical psychology including links to tools such as the Personal Leadership Profile which may prove an aid to reflection and development
- See also the *Clinical Psychology Leadership Development Framework (BPS. 2010)* available through the BPS website

3d. Supervising others whilst training

Guidance on Opportunities, Development and Limits

Supervision of others is an activity undertaken by the majority of clinical psychologists as part of their post qualification practice; indeed it can be a core part of clinical work. New Ways of Working (BPS, 2007) encouraged the development of this and surveys of recent graduates from clinical training programmes in the region indicated that clinical psychologists were undertaking supervision of others within the first few months post qualification.

There are few training courses in supervision post qualification. Trusts have made developments in recent years, but these are often focussed on nurses supervising nurses, and the Introductory Supervisor Workshops remain the most substantial local opportunity. Therefore the development of skills that will support the supervision of others whilst in training is a responsible and proactive step. This is reflected in the emphasis within the new competency framework (please see Section 2)

Psychologists in clinical training might not feel confident to undertake supervision of others, and supervisors of them (who retain responsibility for the trainee's work) might not be certain of what to expect. The following are intended to guide the development of competence. They are developed from an Advanced Supervisor Workshop in Burnsall, February 2010.

Opportunities

These are not intended to map directly onto the three years of training although the 'advanced skill development opportunities' might only be expected in the final year.

Beginning

· Reflections on what works for the trainee in supervision (as a potential model for what their own supervision of others might look like)

· Reflection on own skills in understanding processes such as supervision

· Reflection on helpful and unhelpful experiences and how these might affect processes in supervision

· Contribution to peer group supervision in a team

· Reflection on the parallels and differences between supervision and direct therapeutic work

· Increased knowledge of models of supervision (reading about it and applying it to own supervision i.e. receiving supervision).

Intermediate

· Research supervision (or supervision of audit/evaluation work) to assistant psychologists or other professionals

· Observation of the supervisor supervising someone else/group supervision

· Opportunities for 'consultation'/brief or 'one-off' supervision of an aspect of a case for another professional

· Recognition of the informal roles that PICTs take on when asked about a case by others, how they have conversations with colleagues that are similar to supervision, reflections on what they do when invited to comment on another's work/possible developments of that work

· Peer group supervision (recorded to aid reflection on process) with attention to models of/frameworks for supervision.

Advanced/Later developments

· Joint work with supervisor in a group setting

· 2 trainees on same placement supervising each other with supervisor observing the process

· Live' supervision of an assistant psychologist (supervisor present to support learning and reflection by the trainee)

· Supervisee supervising the supervisor on a case

· Trainee supervising other MDT members regarding a particular therapy modality

· Running a supervision group for health care support workers

· Trainee supervising assistant psychologists or other professionals 1:1.

Anticipated development

· A key early development was to understand the process and the trainees need in that process. Initially there might only be reflections, hypothetical discussions regarding the process of supervision, what is expected of supervisors, what positions you can be drawn into.

· A subsequent development can be to apply theory to formulate the supervision process; this could include discussions of parallel process (where the process, emotional content and relationship in direct therapy work have parallels with the process of supervision) and how examining responses to talking in supervision can inform direct work. Other cognitive and systemic models also have applications

· Understanding the needs of others for development, being able to acknowledge and use what they do know and where you can add to develop their practice (often without using the word supervision).

· Recognising that the development of others (colleagues) is a role that they have the capacity to undertake and that they have skills and models to aid this (especially knowledge of learning styles, skills development, the zone of proximal development). Learning how to facilitate reflective

practice in others, individually or in groups, formally or informally, directly/ explicitly or indirectly/implicitly.

Limits

· Before undertaking any supervisory activity a person needs to understand the process as a supervisee first (therefore the emphasis on reflection and observation in the early stages above)

· There is a need to appreciate what practice might be like/common in other professions and what psychology might add (and what psychologists cannot/will not do).

· Any formal supervision of others needs to be negotiated and documented fully in the placement contract; however there is recognition that 'supervision-like' conversations can happen unexpectedly/spontaneously and that these cannot be planned for.

· Supervisor might have to have a good relationship with the potential supervisee

· Recognising that there might be an experience gap (that supervisees might have more years of experience in a setting than their supervisors) and how to work with this – this can be true post-qualification

· The supervisor retains clinical responsibility, and as with other clinical work, will need access to supervisory work both to ensure good practice and to aid feedback and support reflection.

Clinical Tutors have a responsibility to oversee negotiations of work undertaken as part of placements. We will review and comment on what is planned at Placement Planning Meetings and reassess at the subsequent Mid and End of Placement Meetings; however we can be called upon to discuss, comment or clarify in the intervening periods.

Clinical Psychology Training Programme - University of Leeds

Contracting in Supervision

The Placement Assessment Form includes a section on 'Contracting' for each of the 10 Competency Areas within which priorities and agreements can be identified and recorded. The purpose of this document is to highlight a number of areas that you might like to consider when planning and reviewing supervision arrangements. This is supplementary to the PAF and is optional (but may be included in the PAF if preferred).

It has been produced in response to requests from psychologists in clinical training and supervisor

3e. Leeds supervisor training register

Supervision Register for Clinical Psychologists providing Clinical Placements for the University of Leeds Clinical Psychology Training Programme

In order to maintain our responsibilities to ensure good quality supervision for Psychologists in Clinical Training we are required by the Health and Care Professions Council (HCPC) to maintain a register of supervisors. HCPC and the Learning Development Agreement between the Yorkshire and the local Education and Training Board (North), Higher Education Institutions and NHS Trusts provide guidance from which the following standards are drawn (described below).

Supervisor Training

- *Basic requirements:*
  - Attendance on Introductory Supervisor Programme
  - Commitment to ongoing supervisory training
  - Commitment to Continuous Professional Development
  - All supervisors must be registered with their regulatory body (HCPC for all practitioner psychologists)
  - Attendance at least one Advanced Supervisor Training event every 5 years
- *Recommendations:*
  - Developing supervisory resources and methods seen as a priority, e.g. the establishment of a designated coordinator of supervision

We will seek to maintain an accurate and up to date register which includes details of:

- HCPC registration (and any registration with other professional bodies as appropriate)
- Date when last placement was provided
- Dates of introductory supervisor training (ISW)
- Dates of attendance at advanced supervisor training (ASW)
- Location and specialty details to aid searching of the list
- An email address in order that any updates can be sought

We will add details automatically if supervisors attend one of the workshops organised by the three Yorkshire and the Humber Training Courses (provided by the universities of Sheffield, Hull and Leeds). We will also ask for updates regarding any other supervision-related training courses that have been attended.

"Grand-Parenting Route"

We are aware of a small number of very experienced supervisors currently on our register whose supervision training and experience pre-dates current arrangements for supervisor training and who may therefore appear ineligible according to these criteria to continue supervising without first undertaking an approved Introductory Supervisor Training Workshop. We wish to retain the services of these very experienced supervisors. We therefore include provision for experienced and established supervisors to maintain their registration with providing they meet our "experienced and established supervisors' criteria". We will assess the training and experience in such circumstances on a case by case basis, using the criteria adopted by the BPS in their old "grand-parenting route" to entry on their "Register of Applied Psychology Practice Supervisors" (now closed). Experienced and established supervisors wishing to maintain their eligibility to

supervise on the programme will need to attest to their delivery of supervision as the primary supervisor for a period of at least 12 months or 30 hours in the five years immediately preceding the date of the application.

Supervision Training Learning Outcomes: Understanding and Application

1. Have knowledge of the context (including professional, ethical and legal) within which supervision is provided and an understanding of the inherent responsibility.

2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, including protecting time), confidentiality, accountability.

3. Have knowledge of developmental models of learning which may have an impact on supervision.

4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.

5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.

6. Have skills and experience in developing and maintaining a supervisory alliance.

7. Have knowledge of the structure of supervised professional experience including assessment procedures at different levels of qualification up to Chartered Status level, and the changing expectations regarding the supervisor's role.

8. Have skills and experience in contracting and negotiating with supervisees.

9. Have an understanding of the transferability of professional skills into supervision and the similarities and differences.

10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating supervisees.

11. Have skills and experience in the art of constructive criticism, on-going positive feedback and critical feedback where necessary.

12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).

13. Have skills and experience of using a range of supervisory approaches and methods.

14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.

15. Have an understanding of the issues around difference and diversity in supervision.

16. Have an awareness of the ongoing development of supervisory skills and the need for further reflection/supervision training.

17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

3f. Out of region placements

The Programme is based in Leeds and placements are provided throughout the Region and more specifically West Yorkshire for most Supervised Clinical Practice). It is expected that trainees will be placed in local Departments for the duration of their training. There are a number of exceptional circumstances when this may not be the case, as follows:
1. The trainee requires experience/expertise that is **not available** locally for the third year elective placement.
2. There is a shortage of placements within a specialist area and the Programme requests placements from another Region (this would usually only apply in the third year of training).
3. The trainee requests placements out of Region for personal circumstances.
In the latter case, the following should be considered:
1. The reason should involve a **change** in personal circumstances, which could not have been foreseen when starting the Programme.
1.
2. The personal circumstances should be of a nature that would mean discontinuing the Programme if out of region placements could not be found.

3. Any placement out of Region involves a significant increase in workload for: clinical tutors in terms of organisation and travelling; the local course who will often have limited placement resources; local supervisors who have to become familiar with different documentation and assessment procedures. There is also a need to ensure the quality of training for all trainees on the Programme and to consider individual developmental needs. It therefore involves a complex series of negotiations with the local Course and clinical supervisor(s), with no guarantees these negotiations will be successful.

Procedure

1. Please note: You must not approach any supervisors out of region without explicit agreement from the Clinical Director (CD). This an important national agreement that all programmes follow.
2. Discuss reasons for the request and possible options with clinical tutor.
3. Apply to CD
4. There must be no concerns across any element of the programme (clinical competency development, academic, research and professional record).
5. CD negotiates with local programme.
6. Supervisor, local programme, and clinical director are in agreement and governance arrangements in place.

Other local options must be considered as an alternative plan because out of region placements can never be guaranteed.

3g. CORENet Protocol

Training in using the CoreNet system

It is useful to view the video guide (https://vimeo.com/channels/420792/videos) prior to using the system. There are 16 short videos which will take approximately one hour and 10 minutes if watched back to back. This is an open access resource and does not require any login details. This resource can be shared with your clinical supervisors.

Detailed instructions on using CORENet are available from the Corenet website (https://corenet3.coreims.co.uk/yorkshire/TrainingModule/login.aspx?ReturnUrl=%2fyorkshire%2ftrainingmodule%2fhome.aspx) . This site is access restricted and requires a CORE Net login. There is also a link on the VLE.

Logging in and setting up clients

- https://corenet3.coreims.co.uk/yorkshire/home.aspx
- All clients seen should be put on the CORENet system even if they are not using the measures in the system, or indeed any outcome measures. N.B. THIS RULE APPLIES EVEN WHEN A CLIENT HAS NOT GIVEN CONSENT FOR THEIR FEEDBACK DATA TO BE STORED ON CORE NET.

IMPORTANT!

The CORENet system automatically generates a client ID code. However, it can be difficult to work with client data when using these codes. We suggest you use a coded system which consists of:

- A number to identify the placement (where 1 is the placement number) - so 1BHYFOJM
- Add 7 letters (where two of which are client initials). You can decide a consistent pattern – so in this example positions 6 and 7 are the actual initials – the others are decoys/different each time) – so 1BHYFOJM

Assessment Form (AF)

- All sections of the AF should be completed as fully as possible. If any information is not available, the therapist needs to seek this from the client where reasonable to do so.

End Form (EF)

- If a client fails to attend their final appointment or if therapy continues after a placement ends you still need to complete an EF.

- If a client is seen but either has not been accepted for therapy, or has subsequently not returned to start therapy an EF must still be completed

- Once you have completed your work with a client, collect your final outcome measure from them, fill in your EF and **'close' their case**.

- It is important to remember to close the case. If you don't close your cases promptly, then the work you have done will not be reflected in audits carried out by the service. If you are able to get into the habit of closing your cases promptly and spend time reflecting while doing so, then you have a final chance to learn from the journey you have made with each client.

- Trainees should be reminded to review their case load and ensure all cases are fully completed and closed when necessary at Placement visits.

Made a mistake?

- If you have entered a client by mistake you can change the status to "created in error"
- If you have closed a case without having fully completed a AF or EF, you can filter by status to find the case in 'closed' cases and add data to the forms as you would normally

FAQ's	
Questions	Answers
I haven't been able to use CORE Net on my first placement in child health as the measures that have been appropriate are not on the system	All clients seen should be put on the CORE Net system even if they are not using the measures in the system (The trainee can still do a AF and EF)
I didn't have any patient contact till after my Placement visit and a large portion of those were assessment clients only. With the exception of one client, who again hasn't filled in measures on the system, I am unable to fill this in	The trainee can enter the client, and complete an AF even if there is only an assessment carried out. The trainee should still enter the case even if measures are not put in.
I have seen someone for several sessions of neuro testing, so did not complete measures for this as improved well-being was not the aim of the work. Just to confirm: is this okay?	All clients should be entered into CORE Net regardless of the focus of the work

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Creating summary data for placement visits

The summary of the data you get out of CORENet is rather large and unwieldly so you will need to copy this data into an excel summary file which has been created by the Hull course:

1. Log in to CORE-Net
2. On the 'Manage' menu, choose 'Reports'
3. Click on "Click here to choose report"
4. Click on the "+" sign next to Extracts
5. Click on "All Client Data 1"
6. Select any filters you may want to use e.g. placement number
7. Click on "View Report" You should now see a list of your clients
8. To begin exporting this data, click on the  icon and choose Excel.
9. Select all of the data by clicking the green arrow in the top left corner (see below). Copy this

10. Open the CORE Net excel summary file and go to the "All client data 1" tab
11. Click on the green arrow in the top left corner (like above) and paste the data in to the "All client data 1" page
12. Repeat steps 5-11 selecting "All client data 2" in both CORE Net and on the excel tab
13. The portfolio summary tab will display a summary of your placement

NB Please ensure that excel client summary files for your MPV's and EPV's from CORENet are stored on your M:drive and deleted once you have had your placement meeting. Data must not be stored on any local hard drives (e.g. c: drives).

If you have any queries, please email c.n.dowzer@leeds.ac.uk.

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3h. Clinical Skills Observation

Observation of Clinical Skills Exercise 2020
Clinical Psychology Training Programme
University of Leeds

Competence in psychological therapeutic work is a core activity for clinical psychologists and this exercise is intended to inform those in training, their tutor and their placement supervisor(s) of strengths and of any development needs in relation to beginning therapeutic work. Whereas in the second and subsequent placements, trainees take forward areas for development based on their activity in the placement, before the start of their first placement this is clearly impossible. The main aim of this exercise is to inform the planning of observation on placement, giving trainees, their tutors and supervisors an early indication of developmental needs or of strengths in a particular area.

This exercise comprises a 30 minute role play and subsequent feedback, reflection and discussion. The focus is on general therapeutic clinical skills rather than those that are associated with a specific model or population. The demands of the task are intended to simulate those of an initial assessment session. The feedback is **formative** (focussed on development) rather than summative (pass or fail).

On the day those in training will receive verbal feedback immediately after the role play from their simulated patient, who will also provide written feedback before the end of the day. The role play will be recorded. Trainees review the session and complete their own self-appraisal form in advance of a feedback and discussion session with their tutors. The feedback from tutors is based on a framework which is in use on a number of training programmes. It has a number of dimensions such as 'structure', 'understanding and reflection', 'rapport' and 'exploration'. Following the discussion a summary of feedback from all parties will be compiled by the tutors and sent to the trainee (usually within a week). This is for the trainee to take into placement in order to develop placement plans with their supervisor and it is expected that they will feed back those discussions into the PPM.

There is an expectation that supervisor and trainee will observe each other's work on placement. This exercise does not replace or reduce the need for supervisors to see and hear their trainees 'in action' on placement; rather the intention is to inform this process.

How to use the feedback if concerns are identified

On placement: The person in training should meet their supervisor to plan how any concerns will be addressed. The clinical tutor will discuss the feedback with the trainee and with their supervisor in advance of this meeting. The meeting to plan how to address concerns can involve the clinical tutor at the request of either of the other two parties.

At University: It is expected that the Placement Planning Meeting (in the last week in November) will involve the placement supervisor, unless there is prior agreement between them and the clinical tutor that this is not needed.

Subsequent meetings can be arranged as required and these can take place at the university or on placement, or if all parties are confident that the concerns have been addressed then the next meeting will be the Mid Placement Visit.

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Clinical Skills Feedback Form

Name of trainee:

Simulated Patient:Date:

Feedback:

Comments and recommendations:

Actions required, if any:
Completed by:
Clinical tutor: Academic tutor:

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Extending Direct Observations
Year 3 Mid-Placement Visit (MPV)

Building on the Minimum Standards for Observation and the Observation of Clinical Skills, the aim is to have an opportunity for feedback on observations in each of the three years of training. In Year 1, the Observation of Clinical Skills Day is well established and takes place in the initial teaching block. Plans for year 2 are still in development. The Placements Subcommittee agreed that it was important to recognise diversity of needs and increasing autonomy in Year 3 of training. A number of different options were identified for achieving this and integrating into the third year MPV was felt to be most useful.

Aims

As there is no reflective case presentation in the third year of training, the aim is to incorporate a reflective component into the third year MPV, which includes live material (audio- or video-recording). The MPV will provide a forum for the clinical tutor, supervisor and trainee to review and reflect together upon an audio or video-recording of the trainee engaged in a piece of clinical work. We would like this recording to be approximately 10 minutes long.

Choosing the Focus

Planning for this will begin at the Placement Planning Meeting (PPM). The idea is that this is linked with a competency from the PAF. Options can include: a piece of therapeutic work, team-working, consultation, supervision of others. Ideally this will link with the trainee's aims for their development in their final year of training.

To maximise the learning from this we are most interested in hearing reflections about process, rather than a focus on specific content. It could also link with areas for development from previous continuation documents and / or be an area that the trainee would like additional reflection on. We are interested in hearing about work that has been challenging, yet offered specific learning opportunities for the trainee's development. It could be a piece of work that has gone particularly well or that has posed a specific dilemma, for example.

Potential questions to think about:
Why have you chosen this?
What went well?
What was the specific dilemma / challenge that you had / have?
How have you been trying to make sense of this?
What has been the impact on yourself?
What have you learnt?
What next for your learning?

The hope is that trainees can share some of their reflections about their learning illustrated with a real example. As with other reflections on clinical practice, the aim is that this is developmental and formative for the trainee's learning.

Process

The third year MPV will be extended by 30 minutes, meaning the overall time allowance for this meeting is approximately 2 hours 30 minutes. The plan is that the audio- or video-recording will be listened to or watched after the individual meetings, at the point when the trainee, supervisor(s) and clinical tutor join together for the three-way meeting. It is anticipated that the recording will form part of the review of competency development, as the aim is that the recording chosen links with a competency from the PAF. It is up to the trainee how they would like to share the piece of work ie:

- Listen to the recording all the way through then share your reflections on it
- Pre-decide specific points to stop the recording and share reflections
- Use interpersonal process recall in the recording review and share reflections on process and learning in the moment.

The recording may help to facilitate agreeing of specific aims for the remainder of placement / training.

Consent

We would expect you to follow the usual procedures for consent regarding presenting clinical material. Please discuss and agree with your supervisor what needs to be agreed in terms of consent and / or speak with your clinical tutor.

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Minimum Standards for Observation on Placement

All trainees have to be observed either directly or indirectly by their clinical supervisors whilst on placement. However, on occasion, a trainee may complete their placement without having any form of direct observation. Through discussion with supervisors locally, it has been agreed that a minimum standard needs to be agreed for trainee observation on placement. This is consistent with other models of training.
A **minimum standard for observation** has been agreed for each placement:
a)one direct live observation by the supervisor of the trainee completing a piece of clinical work eg. one therapy session. This can be individual therapy but could also include: a consultation, MDT work, training, teaching etc. (See: 3k(i) Clinical Observation Form and 3k(ii) Observation on Clinical Placement, for optional forms to support this).
b)one indirect (audio or video-recording) to be reviewed per placement during supervision. Again, this does not have to be individual therapy and the supplementary forms described above may be useful.
c)at least one opportunity to be offered to the trainee to observe the supervisor directly and/or indirectly, ideally early on in the placement.
It is acknowledged that on occasion, perhaps on specific placements, this would be more difficult to complete –if this arises on the placement you offer, we would encourage you to discuss with the trainee's clinical tutor in the first instance.

You will find the 360 feedback questionnaire in the placement paperwork section on extranet

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Service User and Carer (SUC) Time on Placement

All trainees have a half day early on in placement that is dedicated to SUC involvement. The aim of this is for trainees to investigate what potential opportunities there are to link in with community/third sector organisations and /or SUC involvement projects on their placements.

We hope this half day is seen as an opportunity – both to think about what may already be happening, but also to have conversations that influence and encourage services to think about lived experience and community engagement. We recognise that different services are engaged with thinking about engagement / involvement work at different levels.

Trainees should use this time to ascertain what is happening both:

a. in their service in relation to service users and carers being involved in the service
b. in relation to links with third sector organisations / charities etc eg Recovery Colleges, MIND etc

We ask that trainees consider:

1. whether there are any specific projects relevant to the placement aims that they could become involved in.
2. If there is nothing in existence either internally or externally – are there links that you can begin to make that would be beneficial for service users and the broader community?

The minimum requirement for this is that trainees have conversations during their half day to find out about what is happening on their placement. Ideally this then leads to a longer piece of work throughout the placement eg forging links with external agencies, looking at teaching opportunities etc.

Some examples of Service User and Carer Involvement whilst on Placement:

- some trainees have established, joined or co-facilitated SUC reference groups;
- become involved in specific projects eg. re-designing a waiting room with those who use it; gaining feedback on developing a service by organising a focus group;
- co-facilitated a group with an ex-service user in a third sector organisation eg a group for asylum seekers and refugees.
- Worked into a third sector housing organisation

Please speak to your Clinical Tutor if you have questions about this.

Section 4
Resources for Supervision on Placement

Within this section there is some information regarding particular supervisory resources:

We offer a range of CPD for our supervisors. Introductory and advanced supervisor workshops (ISW and ASW) take place in collaboration with the Universities of Sheffield and Hull. ISW take place over a nine month period with an associated portfolio of assessments. Completion of this makes supervisors eligible to apply for the Register of Applied Psychology Supervisors in the BPS. ASW are one-off events open to all potential supervisors. All presentations and supporting documents for the training can be accessed via the extranet, on the Supervisor page. If you would like any further information on any of our workshops please contact one of the Clinical Tutor team.

It is worth also considering the other resources that are available to you as a supervisor. First and foremost, the Programme staff see supervision as a collaborative exercise between the psychologist in clinical training, supervisor and placement tutor. If there are any queries or concerns about an individual trainee, it is always possible to contact the placement tutor. It may be appropriate to contact one of the four clinical tutors if you have more general queries on 0113 3432732.

Another important 'resource' to consider, in terms of getting possible guidance or support is that of colleagues. There may be other clinicians in your area or even further afield who would be willing to discuss the process of supervision or possibly engage in a peer supervision group. It may be possible to also get support from your own manager or clinical supervisor. Although not all that common, supervision for supervisors is an option we would encourage you to pursue.

In further areas of this section:

- A reference list with some introductory reading and more detailed references

- The Supervisory Relationship Questionnaire (both the short and long version). This is a 'measure' initially developed by Marina Palermo and Helen Beinart based on investigations of what constituted a productive supervisory relationship from the point of view of the trainee. This is currently best used as a structured examination of supervision by the trainee and should be used as a tool to aid discussion.

- The Leeds Alliance in Supervision Scale developed by Nigel Wainwright.

Other resources (often developed from our supervisor training ventures) will be added to this section as they become available.

Please bear in mind any Programme staff member would be happy to discuss any questions you may have, so please do not hesitate to contact us.

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The Clinical Tutor Team
Contact number: 0113 3432732

Supervision References

The following books are helpful sources of ideas.

Carroll, M. (2014). 2nd Edn. Effective Supervision for the Helping Professions. SAGE Publications Ltd.

Fleming, I., & Steen, L. (2011). Supervision and Clinical Psychology. Theory. Practice and Perspectives. London: Routledge. Second edition

- *Written by clinical psychologists for clinical psychologists.*

Hawkins, P., & Shohet, R. (2012). 4th Edn. Supervision in the Helping Professions. (Supervision in Context). Milton Keynes: Open University Press.

- *British publication aimed at multi-disciplinary readership. Cheap and readable. Provides a good model of supervision.*

Hughes, J. (2011). Practical Aspects of Supervisions. Chapter 11 in Fleming, I., & Steen, L. (2011). Supervision and Clinical Psychology. Theory. Practice and Perspectives. London: Routledge. Second edition

Milne, D. (2009) Evidence-based Clinical Supervision: Principles and Practice (Paperback) London: BPS/Blackwell

Scaife, J. (2014). Supervision in Clinical Practice: A Practitioners Guide. London: Routledge

- *An excellent updated version of Joyce's 2009 book with excellent chapters on contracting, group supervision and the use of audio and video recordings in supervision (amongst many others). Also includes a very accessible guide to models used in supervision*

Shohet, R. (2010). Passionate Supervision. Jessica Kingsley Publishers.

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THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ)

Developed by Marina Palomo (supervised by Helen Beinart) © 2010
The British Psychological Society

THE SHORT SUPERVISORY RELATIONSHIP QUESTIONNAIRE (S-SRQ)

Leeds Alliance in Supervision Scale (LASS)

Notes on use

The Leeds Alliance in Supervision Scale (LASS) was developed as a sessional measure of the supervisory alliance.

The LASS is based upon a number of research measures designed to tap the supervisory alliance, and a number of alliance theories that underpin these measures.

The LASS should be completed **at the end** of each supervision session, in the last 10 minutes. Completion of the LASS provides an opportunity for the supervisee to provide feedback on how they felt about the supervisory working alliance in that session. This feedback can then be used as a discussion point, allowing an open discussion about how the supervisee and supervisor feel about the supervisory alliance.

Completion of the LASS in each supervision session also allows for changes in the alliance to be monitored and discussed by both supervisee and supervisor.

The aim of the LASS is to promote open feedback and discussion about the supervisory alliance so that it can be fostered and used as an effective component of clinical supervision.

If the LASS is to be used to track change over several supervision sessions, care must be taken to ensure that the lines used in the Visual Analogue Scales are always 10cm long.

Leeds Alliance in Supervision Scale (LASS)

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Section 5
Guidance from our Regulator, our Professional Body and regional and local policies

BPS Criteria for the Assessment of Postgraduate Training Courses in Clinical Psychology

BPS Guidelines on Clinical Supervision

HCPC Standards of Education and Training and Standards of Proficiency,

HCPC standards-of-proficiency/practitioner-psychologists

HCPC standards-of-conduct-performance-and-ethics

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Section 6

Placement Documentation

A Guide to Placement Documentation

(i) Overview

If you have any further questions, please contact Tracey Smith (t.e.smith@leeds.ac.uk) or any of the Clinical tutor team.

Documentation includes (please see Section 7):

- Placement Assessment Form (PAF)
- Self-Appraisal Form
- CORE-NET
- Therapy Competency Logbook
- Placement Experience Record
- Curriculum Vitae (CV)

Trainees will need to demonstrate competence in CBT plus one other model of therapy at least across their three years of training. This will need to be evidenced through the monitoring of competencies within individual therapies through the logbook.
We are encouraging trainees to use electronic versions of the documentation and submission at end of placement needs to be electronic.

(ii) Step-by-Step Guide to Placement Paperwork

The following checklist is at the front of the PAF and explains what is needed for each of the placement meetings. The following sections explain in detail what is needed and how to complete each of the elements. It is anticipated that computers / tablets will be available at each of the placement visits wherever possible. If this is not possible then alternative arrangements to complete all relevant paperwork will have to be made (see below).

Placement Planning Meeting – PPM

- PPD Review (reflections on personal and professional development since last meeting)

- Self Appraisal of Competencies

- Negotiate CORE-NET and Therapy Competency Logbook completion with supervisor

- Placement plan (found in the PAF) agreed with supervisor following discussion between Supervisor and Psychologist in Clinical Training. Please note – not every competency needs to be worked towards on every placement).

- Discuss Service User and Carer time on placement

Mid Placement Visit – MPV

- PPD Review (reflections on personal and professional development since last meeting)
- MPV sections of the Placement Assessment Form completed (following discussion between Supervisor and Psychologist in Clinical Training)
- Summary at Mid Placement to be completed by Supervisor and Psychologist in Clinical Training
- 'MPV' summary document from CORE-NET to be inserted into PAF
- Update relevant information for Therapy Competency Logbook
- Prepare initial thoughts about next placement (placements 1-4)

End of placement Visit – EPV

- Supervisor and trainee complete summary statements for each competency
- Supervisor completes EPV summary
- 'EPV' summary from CORE –NET inserted into PAF
- Completion of Therapy Competency Logbook in relation to current placement
- Complete the Continuation of Competency Development document with your supervisor(s)
- Prepare 'Reflection on Clinical Practice' presentation and commentary (or in year 3 prepare a final Reflective Paragraph on *Personal* Development)
- Update Placement Experience Record
- Complete Audit of Clinical Placements Form at the back of the PAF

Placement Planning Meeting – PPM

- PPD Review – this is a summary reflecting on trainees personal and professional learning and progression and developmental needs at this point of placement

- Self Appraisal of Competencies (See section 7c(vii)) – This is to be completed at the end of trainees last placement / beginning of new placement with their *current* appraisal of competencies

- Negotiate CORE-NET and Therapy Competency Logbook completion with supervisor – most supervisors are now familiar with trainees' use of CORE-NET but it is important to discuss this in early meetings to ascertain Trust policy and procedures and ensure that supervisors know what the expectation is of you and them. In these early discussions it would be useful to highlight the expectation that you will discuss use of measures in supervision to further inform your work with clients

- Placement plan agreed with supervisor following discussion between Supervisor and Psychologist in Clinical Training. This is to be completed electronically as the PAF then acts as a working document that can be emailed between supervisors, tutors and trainees.

  There may also be discussion about which models of therapy the trainee is specifically going to be thinking about on this placement.

- Service User and Carer involvement opportunities are identified both within the NHS Trust but with a focus on community / third sector organisations. The time could be spent forging links with / exploring opportunities for community engagement

Mid Placement Visit – MPV

- PPD Review – this is a summary reflecting on trainees personal and professional learning and progression and developmental needs at this point of placement

- Summary at Mid Placement to be completed by Supervisor and Psychologist in Clinical Training – a summary of work completed to date and how this has gone / is going to be completed by both supervisor and trainee in the PAF prior to the meeting.

- MPV sections of the Placement Assessment Form completed (following discussion between Supervisor and Psychologist in Clinical Training) - This is to be completed electronically as the PAF then acts as a working document that can be emailed between supervisors, tutors and trainees.

- 'MPV' summary document from CORE-NET to be inserted into the PAF – look on the VLE for a video which gives instructions of how to do this. In addition, print off any summary graphs from client work obtained through sessional and outcome measures

- Update relevant information for Therapy Competency Logbook – through discussion together, trainee and supervisor to review the logbook and agree any specific therapy competencies that have been achieved and observed (either directly or through review of audio material) by the supervisor at this point in placement. During the first placement at least, there is an expectation that the clinical observation form will be used at least once.

- Prepare initial thoughts about next placement (placements 1-4) – for discussion with your clinical tutor at the MPV

- The summary of agreements from MPV will either be typed into the form during the meeting or recorded by hand and typed up at a later date.
  Trainees then save the PAF electronically.

End of placement Visit – EPV

- Review Summary of Recommendations from MPV

- Summary statements to be completed. Supervisors to recommend a Pass, Pass with recommendations or Fail

- 'EPV' summary from CORE -NET to be inserted into the PAF – look on the VLE for a video which gives instructions of how to do this. In addition, print off any summary graphs from client work obtained through sessional and outcome measures.

- Completion of Therapy Competency Logbook - through discussion between trainee and supervisor to review the logbook and agree any specific therapy competencies that have been achieved and observed (either directly or through review of audio material) by the supervisor throughout the placement.

- Complete the Continuation of Competency Development document with your supervisor(s) – Supervisor(s and trainees to discuss trainees areas of strength and areas for development prior to EPV

- Trainees then collate PAF and Therapy Competency Logbook and email to Sarah Snowden hssssno@leeds.ac.uk copying their supervisors and clinical tutors in. This 'signs off' the placement paperwork.

Prepare 'Reflection on Clinical Practice' presentation and commentary to be written in PAF (or in year 3 prepare a final Reflective Paragraph on *Personal* Development). Over

the first two years of their training, trainees will include a reflection on clinical practice based around each of the following areas:

- An element of difference or diversity;
- An ethical dilemma;
- A model of supervision.
- A 'wildcard'.

Trainees can chose which order they address these themes over the two years.

Please ensure that the following are also completed:

- Update Placement Experience Record
- Update Curriculum Vitae (CV)
- Complete Audit of Clinical Placements Form at the back of the PAF prior to EPV.

https://dclinpsych.leeds.ac.uk/clinical-supervisors/

Under the placement paperwork tab you will find the following:

1 The above guide to placement documentation
2 Placement Assessment form
3 Therapy Competency Logbook
4 Therapy Competency Logbook Guidance -FAQ's
5 Placement Experience Record
6 CORENet protocol
7 Developmental Guide to Core Competencies
8 Supervision contract
9 Clinical Observation form
10 Observation on Clinical Placement – optional form
11 360 feedback questionnaire
12 Supervisor Relationship Questionnaire Long and Short versions