The British Psychological Society

Promoting excellence in psychology

Standards for the accreditation of Doctoral programmes in clinical psychology

January 2019

The British Psychological Society

Partnership & Accreditation

www.bps.org.uk/partnership

Contents

Introduction

The British Psychological Society ('the Society') is the learned and professional body, incorporated by Royal Charter, for psychology in the United Kingdom. The key objective of the Society is 'to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge'. The purpose of the Society's accreditation process is to further that objective.

What is accreditation?

Accreditation through Partnership is the process by which the British Psychological Society works with education providers to ensure quality standards in education and training are met by all programmes on an ongoing basis. Our approach to accreditation is based on partnership rather than policing, and we emphasise working collaboratively with programme providers through open, constructive dialogue that allows for exploration, development and quality enhancement.

Benefits of accreditation

Delivering a programme that meets the standards required for accreditation is a significant commitment, and there are many reasons why Society accreditation is worth your investment of time and money:

- It is a highly regarded marker of quality that prospective students and employers value.
- It enhances the marketability of your programmes.
- It gives your graduates a route to Society membership, an integral part of students' development as psychologists, or as part of the wider psychological workforce.
- It is a high quality benchmarking process aimed at getting the best out of programmes.
- It provides an opportunity for you and your students to influence the society and its support for education providers and students.
- Together we have a powerful voice in raising the profile of psychology and psychological practice in the UK and internationally.

Our standards

In 2017, the Society's Partnership and Accreditation Committee (PAC) and its constituent Education and Training Committees reviewed the overarching programme standards, with the aim of providing greater clarity and more effective signposting to other relevant guidance in a way that is helpful to programmes when they articulate their work.

Our standards are intended to be interpreted and applied flexibly, in a way that enables programmes to develop distinctive identities that make the most of particular strengths shared by their staff team, or those that are reflected in the strategic priorities of their department or university. During partnership visits, the questions that visiting teams will ask will be designed specifically to give education providers every opportunity to confirm their achievement of the standards.

Our standards are organised around eight overarching standards, as follows:
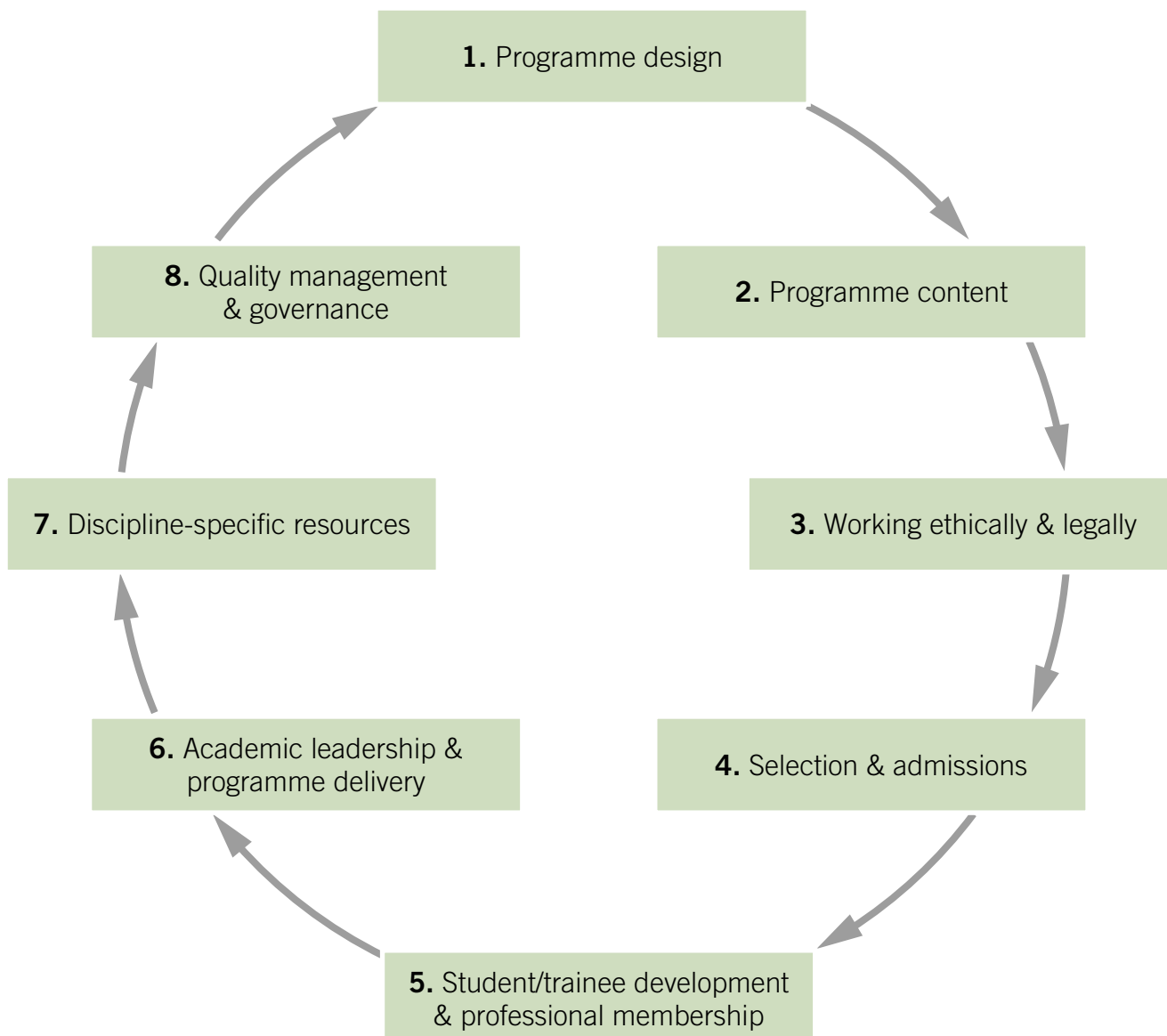
The standards have been derived following extensive consultation between the Society and education providers, and must be achieved by all accredited programmes. Each overarching standard is followed by a rationale for its inclusion, together with guidance and signposting of other relevant resources.

This document

This document sets out the accreditation standards for the accreditation of programmes in clinical psychology. The standards came into operation on 1 October 2017.

If you are submitting a new programme for accreditation, or are preparing for an accreditation visit or review, you should read these standards in conjunction with the relevant process handbook. All handbooks can be downloaded from **www.bps.org.uk/accreditationdownloads**.

Accredited Doctoral programmes meet the requirements for Chartered membership of the Society (CPsychol) and full membership of the Division of Clinical Psychology. Such programmes will seek to prepare trainees for professional practice as a clinical psychologist. Practitioner psychologists are statutorily regulated by the Health and Care Professions Council (HCPC), and it is a legal requirement that anyone who wishes to practise using a title protected by the Health

Professions Order 2001 is on the HCPC's Register. Programmes will also, therefore, need to seek approval from the HCPC.

Preface

The statements in this document form a policy statement by the Society on what accredited programmes should achieve. Programmes should also note the following:

1. The aim of this document is to specify the standards that programmes should achieve. It is not the Society's intention to reduce the diversity between programmes or impair their flexibility to respond to local and changing circumstances. Related to this, the standards often reference indicative, rather than prescriptive, criteria to facilitate this. It is important to emphasise that while the Society expects that the required standards are met, a key emphasis in this document is that wherever possible, the Society does not wish to be prescriptive in how these standards are achieved.

2. Accredited programmes will also need to be approved by the Health and Care Professions Council (HCPC). The HCPC's role is to assure threshold levels of quality, by ensuring that graduates of approved programmes meet the Standards of Proficiency. The Society's accreditation process is designed to work beyond those quality thresholds by promoting quality enhancement.

3. In reading this document, it is essential to recognise that although the various aspects of working as a competent clinical psychologist are described separately, it is the combination and integration of these components that are particularly important. This is true for both the required outcomes of training and for the process of training.

4. In meeting the requirements of a professional training in clinical psychology, programmes should be sufficiently flexible in content and structure to adapt readily to current and future needs and to the emergence of new knowledge in clinical psychology and related fields. They should also play a major part in the identification of such needs and the development of innovative practices. Programmes should refer to the standards and guidelines which are identified and revised from time to time by the Division of Clinical Psychology's Faculties for guidance in relation to the knowledge and skills required for work with specific populations and groups.

5. Programmes will need to work collaboratively with relevant external stakeholders and especially commissioners to identify and negotiate any particular skill sets they may wish to prioritise, and how the standards outlined in this document might best be implemented locally.

6. Education providers may offer two or more programmes in the same branch of applied psychology, and these will be considered as separate programmes.

7. The current accreditation standards have been informed by a number of contemporaneous guidelines and strategy documents. These have included Divisional and Society guidance in relation to knowledge and skills required for work with a wide range of specific populations, the leadership development framework, the Good Practice Guidelines series including those related to formulation, psychological health and wellbeing, connecting communities, codes of conduct and ethical guidelines for practice and research, and working in teams (**www.bpsshop.org.uk**). These guidelines are free to Divisional members.

8. In addition to Society guidelines, these accreditation standards have been informed by:

- Evidence-based practice guidelines such as those as disseminated in NICE/SIGN guidelines on what works for whom (**www.nice.org.uk**; **www.sign.ac.uk**). The Society notes, however, that this guidance is designed to inform, not replace, clinical decision making and such guidance should not be applied in any formulaic fashion – especially pertinent when dealing with the complexity and co-morbidity for which training needs to prepare clinical psychologists. The Society recognises that programmes may wish to be informed by other knowledge bases when developing their curricula – especially where guidelines such as NICE have not been sufficiently developed for given populations or services (e.g. interventions with people with intellectual disability).

- National strategies and policy initiatives related to psychological health and wellbeing. Specific examples are not referenced as rapid change is a feature herein. However, current themes, across the four nations, relate to an increased emphasis on mental health, psychological wellbeing, the talking therapies, improving access, redesign of services, stepped care interventions, diversification of healthcare providers, secondary prevention, psychological interventions in physical healthcare etc. This list is not exhaustive but reflects the contemporaneous influences which have informed the standards review.

Acknowledgements

In preparing the current review of our accreditation standards the Committee for Training in Clinical Psychology was mindful that current standards represent an evolution of such over a great many decades. The values, ethos and tenets which underpin our standards reflect the foresight, intellectual rigour, work and commitment to the profession of clinical psychology of a great many people from our community both current and historical. At this juncture we wish to pay particular tribute to three directors of training programmes who had started this most recent process with us – Malcolm Adams, Andrew Cuthbertson and Mark Rapley. We will remember and thank them for their wisdom, vision and creativity.

The core training of a clinical psychologist: Statement of intent

Clinical psychology is a postgraduate, doctoral, three year training programme which promotes transferable knowledge and competencies relevant to working across a very wide range of health and social care programmes and presentations. These include, for example, services for children, adults, older adults, families, people with developmental and intellectual disability, mild–severe mental health difficulties, physical health presentations, chronic conditions, forensic services, and other groups and presentations which may have been included in a specific training pathway. This is in contrast to multiple, often sub-doctoral, programmes which prepare graduates for work with only circumscribed groups, presentations or models of therapy. As well as safeguarding and improving quality of service provision, the cost-efficiency for commissioning of training is evident.

Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and wellbeing, minimise exclusion and inequalities and enable service users to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure.

The evidence base tells us that different interventions work for different presentations and groups. It also tells us about the central importance of non-specific therapist factors in outcomes. Moreover, service users often present with complex and co-morbid presentations which range from psychological interventions to complex presentations and the specifics of service user contexts. A defining feature of the clinical psychologist is the capacity to draw from, and utilise, different models of therapy, and evidence based interventions, as appropriate to the needs and choices of the service user. The clinical psychologist is not a uni-modal therapist, although by the end of training specific competencies will be professionally accredited by the Society through programme accreditation, within cognitive-behaviour (and one other) model of psychological intervention (which will vary, depending on the training pathway pursued). Many will develop further particular expertise in specific therapies.

The evidence base highlights the relevance of psychological processes, support and interventions across a great many healthcare presentations. Clinical psychologists are trained not just to deliver interventions, but to also promote psychological mindedness and skills in other health, educational and social care providers.

Clinical psychologists as reflective scientist practitioners

Clinical psychology is one of the applications of psychological science to help address human problems. Clinical psychologists have been trained not only to be critical consumers of research, and ever emerging knowledge bases, but to contribute to this knowledge base through research, with relevant skills benchmarked at doctoral level. Clinical psychology has a prominent history of developing, evaluating and refining psychological interventions which are often then promulgated across the skill base of other professions and practitioners.

Complementing this capacity to draw critically from the evidence base to inform their work, clinical psychologists embrace an ethos of practice-based evidence. A critical evaluative stance pervades practice which includes utilising an outcomes framework, informed by wellbeing and recovery principles, as well as the values and goals of the service user. Clinical psychologists will often lead on developing systems of practice-based evidence within services.

Reflective practice is also promoted through an effective use of supervision and collaboration with service users and other colleagues in setting goals and monitoring progress. Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development.

Clinical psychology in practice

Clinical psychologists work with individuals, couples, families and groups and at the organisational and community level. They work in specialist and generic services which increasingly are accessed by groups historically considered as 'specialist'. They work across a diversity of health and social care providers (e.g. NHS, social care, third sector and independent providers and education) and in a variety of settings including in-patient and community, primary, secondary and tertiary care and with all age groups and presentations as noted above.

Overview of the accreditation standards

The standards outlined in this document highlight the training requirements necessary for enabling the graduate clinical psychologist to practice as described in this statement of intent. Whilst the Standards of Proficiency, regulated by the HCPC, assure quality thresholds for safe practice, the accreditation standards outlined here are designed to promote quality enhancement.

Graduates of accredited programmes who have attained these enhanced standards will be eligible for Chartered status through full divisional membership of the Division of Clinical Psychology.

The key features of the accreditation standards include:

- Emphasis on overarching competencies to deliver tailored, multi-modal and often complex, psychological interventions across a range of ages, presentation configurations and service delivery systems and which are informed by knowledge and skills from across formal psychological therapies and other evidence bases.

- Increased credibility that specific knowledge and skills sets, which contribute to the above, have been obtained through transparent benchmarking of work against competence frameworks adapted and appropriate to the age, presentation or specialism to which they are applied.

- Delivering a curriculum which is contemporaneous, relevant to current healthcare exigencies and informed by the evidence base and social contexts.

- Incorporating systematic approaches to in vivo assessment to further quality assure competence development.

- Deepening collaborative practices with service users and carers (including in ways informed by DCP good practice guidance on the involvement of service users and carers in clinical psychology training).

- Greater emphasis on skills of indirect influence and leadership in bringing psychological mindedness to services.

Programme standard 1: Programme design

The design of the programme must ensure that successful achievement of the required learning outcomes is marked by the conferment of an award at the appropriate academic level.

1.1 Credits and level of award: Doctoral programmes seeking accreditation against the requirements for Chartered membership of the Society (CPsychol) must comprise 540 credits, and must result in the award of a level 8 qualification (level 12 in Scotland).

1.2 Duration and location of studies:

1.2.1 For postgraduate professional training programmes in psychology, the **total** period of study must be no less than three years full-time (or the equivalent part-time).

1.2.2 The Society does not stipulate a maximum study period within which an accredited programme must be completed.

1.2.3 Up to one third of the total credits of an accredited UK programme may be undertaken outside of the UK. Where a greater proportion is undertaken abroad, we consider this to be a separate programme requiring separate accreditation.

1.3 Award nomenclature: The education provider must ensure that the title of any award accurately reflects the level of trainees' achievements, represents appropriately the nature and field(s) of study undertaken and is not misleading, either to potential employers or to the general public.

1.4 Assessment requirements:

1.4.1 Programmes must have in place an assessment strategy that maps clearly on to programme and module learning outcomes, incorporates a wide range of formative and summative assessments, and which reflects trainees' development of knowledge and skills as they progress through their studies. Each of the competencies specified in Programme Standard 2, below, must be assessed at the appropriate level.

1.4.2 Accredited postgraduate programmes must stipulate a minimum pass mark of 50 per cent for all modules that contribute to the accredited award where quantified marking is employed. No compensation across modules is permissible.

1.4.3 Programmes must have a clear set of published regulations relating to assessment which are readily accessible and understood by applicants, trainees, staff, supervisors and internal and external examiners. The criteria for passing or failing the programme must be explicit, together with any fall-back awards criteria. These regulations and assessment criteria must relate clearly to the programme's learning outcomes.

1.4.4 Assessment practices should be fair, valid, reliable and appropriate to the level of the award being offered. Assessment should be undertaken only by appropriately qualified staff, who have been adequately trained and briefed, and given regular opportunities to enhance their expertise as assessors.

1.4.5 Programmes should have effective systems in place in order to quality assure, ratify or mediate assessment decisions. This typically involves systems of internal moderation, external examiner review of standards and failure decisions and an exam board which can oversee and, where appropriate, make decisions on pass/fail recommendations.

1.4.6 Programmes must provide written guidelines on criteria for failure in the assessment of all components of the programme. The criteria must be clearly related to the programme's required learning outcomes. In general, the whole period of training should comprise work that is of an acceptable standard. If a trainee has failed an assessment of competence, but been allowed to continue in training, then there must be a clear mechanism for extending the period of training, if necessary, to ensure that there is an opportunity for acceptable standards of practice to be reached and for core competencies to be acquired.

1.4.7 Assessments must give appropriate weighting to professional competence. The Programme Director(s) must take responsibility for ensuring that there are adequate procedures to ensure that trainees who are incompetent or whose behaviour is unethical do not obtain a qualification in clinical psychology. There must also be mechanisms to ensure that such trainees should be identified as early as possible in the programme, and are not allowed to continue if remedial action is ineffective. These procedures should, as far as possible, be consistent across those used by the university and trainees' employers.

1.4.8 Education providers should have in place policies and procedures to deal thoroughly, fairly and expeditiously with problems which arise in the assessment of trainees. Programmes must have an explicit appeals procedure, consistent with university and employers' procedures, for considering formal appeals from trainees who fail to satisfy the examiners. Trainees should be made aware of the process they should follow if they wish to pursue an appeal at the beginning of the programme.

1.4.9 Mechanisms should exist to consider the relevance of extenuating circumstances with respect to decisions about student progression. However, these should not compromise assessment decisions regarding attainment of learning outcomes.

1.5 Inclusive assessment:

1.5.1 Education providers should have inclusive assessment strategies in place that anticipate the diverse needs and abilities of students.

1.5.2 Where reasonable adjustments need to be made for disabled students, these should apply to the process of assessment, and not to the competencies being assessed.

1.6 Assessment procedures:

1.6.1 Education providers should ensure that detailed and up to date records on trainee progress and achievement are kept. Throughout a programme of study, trainees should receive prompt and helpful feedback about their performance in relation to assessment criteria so that they can appropriately direct their subsequent learning activities.

1.6.2 Programmes should use a range of assessment methods, formative and summative, as appropriate to assessing the learning outcomes related to academic knowledge, clinical practice, research competencies and personal and professional development.

1.6.3 In addition to methods of assessment of clinical skills which are based on how the trainee disseminates their work orally and in writing, systematic assessment tools must be in place for evaluating trainees' clinical competencies in vivo. This means that, as part of the assessment of trainees' competence, they should be observed,

and the outcome of that observation should contribute to the overall assessment process – either discretely or as part of a larger assessment unit (e.g. placement ratings). Programmes may choose observational assessment tools or protocols that are most appropriate for their context. How these are applied may also vary and some possible examples of application are provided below:

- supervisor or programme staff observation and assessment of clinical practice (e.g. psychometric and other approaches to assessment, intervention);
- supervisor or programme staff observation of simulations related to the above (e.g. role plays involving service users, colleagues or actors);
- supervisor or programme staff assessment of recordings of practice (audio or video) and/or transcriptions of the same.
- supervisor or programme staff observation and assessment of non-therapy skills (e.g. performance in multidisciplinary team, presentations, training).

1.6.4 In addition to observation and assessment by supervisors or programme staff, programmes are also encouraged to work with service user and carer colleagues to design ways in which their feedback may be incorporated into the assessment process.

Rationale for inclusion

The Society has clear expectations about teaching, learning and assessment on accredited programmes, and the provisions that should be built into the design of those programmes to ensure quality. The standards outlined above will ensure that those seeking entry to specific grades of Society membership on the basis of having completed an accredited programme have met the stipulations set out in the Society's *Royal Charter, Statutes and Rules*.

Guidance and signposting

- Part A of the UK Quality Code addresses Setting and Maintaining Academic Standards, and signposts relevant qualifications and credit frameworks, as well as guidance on the characteristics of different qualifications. Providers may also find it helpful to refer to a further five chapters from Part B of the Quality Code (**www.qaa.ac.uk**):
  - Chapter B1: Programme Design, Development and Approval
  - Chapter B3: Learning and Teaching
  - Chapter B6: Assessment of Students and the Recognition of Prior Learning
  - Chapter B9: Academic Appeals and Student Complaints
  - Chapter B11: Research Degrees
- The Health and Care Professions Council sets out its requirements around programme design and delivery and assessment in its Standards of Education and Training (SETs 4 and 6; **www.hcpc-uk.org/education**). Information on the threshold level of qualification for entry to the HCPC Register is provided in SET 1.
- The Society's standards require that all accredited stage one MSc and Doctoral programmes stipulate a minimum 50 per cent pass mark for all modules that contribute to the accredited award. Some providers operate a standard 40 per cent pass mark for their postgraduate programmes; accredited programmes will need to seek variation from

the provider's standard regulations in order to meet this requirement. Graduates who do not achieve the necessary 50 per cent pass mark for all modules contributing to the accredited degree should receive an alternative award to enable them to be distinguished from those who have achieved the expected standard.

- The Equality Challenge Unit has produced guidance on Managing Reasonable Adjustments in Higher Education, which providers may find helpful (**www.ecu.ac.uk**).

- The Society's accreditation standards make provision for trainees to undertake some study or placement time abroad as part of their programme (up to one third of the total credits of the accredited programme). Study abroad opportunities may not be available for all trainees, and arrangements will vary across different providers. Where study abroad opportunities are available, the UK provider must ensure that the study abroad being undertaken allows trainees to cover all of the required curriculum and competencies appropriately by the time they have completed their programme (though not necessarily in the same way as others on their cohort), and that this learning will effectively support their progression. More detailed information is available in our guide to studying abroad on an accredited programme, which can be downloaded from **www.bps.org.uk/internationalaccreditation**.

- Where more than one third of the total credits for the programme are undertaken outside of the UK, the Society considers this to be a separate programme requiring separate accreditation. Information regarding the Society's international accreditation process can be found at **www.bps.org.uk/internationalaccreditation**.

- The Society does not specify a maximum study period for an accredited programme. It is expected that individual education providers will have in place regulations governing the maximum permissible period of time that may elapse from initial enrolment to completion, regardless of individual circumstances, to ensure the currency of their knowledge, their competence, and the award conferred upon them.

Programme standard 2: Programme content (learning, research and practice)

The programme must reflect contemporary learning, research and practice in psychology.

2.1 Programme content requirements

2.1.1 Clinical psychology programmes will vary in the emphases they place on work with particular clinical groups, therapeutic modalities, curriculum content, non-therapy skills, training methods etc. This is healthy and promotes diversity and richness within the profession. It ensures programmes can be responsive to regional and national priorities, opens up opportunities for some programmes to coordinate and complement their efforts and offers prospective applicants choice of programmes which best suit their own preferences, learning style and goals. Similarly, trainee clinical psychologists within programmes may follow a range of training pathways depending on practice placement experiences, research undertaken, optional modules chosen etc. Thus whilst all graduates will demonstrate core standards of proficiency, with transferability demonstrated across the range of clients and services as specified below, some variation in individual strengths and competencies will be both inevitable and desirable.

This context means that whilst the BPS will accredit programmes as meeting the standards required for their graduates to be eligible for Chartered status, it will be incumbent on programmes to validate the specific portfolio of skills and competencies of graduates in a way which is transparent to employers and commissioners of services. Whilst programmes are free to develop their own portfolio format, examples of how this might look are contained in Appendix 1. These examples should be seen as indicative, rather than prescriptive.

2.1.2 Overarching goals, outcomes, ethos and values for all programmes include the following:

By the end of their programme, trainees will have:

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological wellbeing through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.

2. The skills, knowledge and values to develop *working alliances* with clients, including individuals, carers and/or services, in order to carry out *psychological assessment*, develop a *formulation* based on psychological theories and knowledge, carry out *psychological interventions*, *evaluate* their work and *communicate* effectively with clients, referrers and others, orally, electronically and in writing.

3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.

4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact

of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.

5. Clinical and research skills that demonstrate work with clients and systems based on a *reflective scientist-practitioner* model that incorporates a cycle of assessment, formulation, intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.

6. The skills, knowledge and values to work effectively with *systems* relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.

7. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare. This includes leadership skills and competencies in *consultancy*, *supervision*, *teaching* and *training*, working collaboratively and *influencing psychological mindedness* and *practices of teams*.

8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.

9. A professional and ethical value base, including that set out in the BPS *Code of Ethics and Conduct*, the *DCP statement of the Core Purpose and Philosophy* of the profession and the *DCP Professional Practice Guidelines*.

10. High level skills in managing a *personal learning agenda* and self-care, in *critical reflection* and *self-awareness* that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues.

2.1.3 NINE core competencies are defined as follows:

1. **Generalisable meta-competencies**

    a. Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.

    b. Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations.

    c. Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.

    d. Being familiar with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision-making without being formulaic in application.

    e. Complementing evidence-based practice with an ethos of practice-based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

    f. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

    g. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.

    h. Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.

    i. Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity, and working as a reflective practitioner within ethical and professional practice frameworks.

2. Psychological assessment

    a. Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.

    b. Ability to choose, use and interpret a broad range of assessment methods appropriate:

- to the client and service delivery system in which the assessment takes place; and
- to the type of intervention which is likely to be required.

    c. Assessment procedures in which competence is demonstrated will include:

- performance based psychometric measures (e.g. of cognition and development);
- self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours);
- systematic interviewing procedures;
- other structured methods of assessment (e.g. observation, or gathering information from others); and
- assessment of social context and organisations.

    d. Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.

    e. Conducting appropriate risk assessment and using this to guide practice.

3. Psychological formulation

    a. Using assessment to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors.

b. Constructing formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.

c. Constructing formulations utilising theoretical frameworks with an integrative, multimodel, perspective as appropriate and adapted to circumstance and context.

d. Developing a formulation through a shared understanding of its personal meaning with the client(s) and/or team in a way which helps the client better understand their experience.

e. Capacity to develop a formulation collaboratively with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

f. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

g. Ensuring that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

h. Using formulations to guide appropriate interventions if appropriate.

i. Reflecting on and revising formulations in the light of ongoing feedback and intervention.

j. Leading on the implementation of formulation in services and utilising formulation to enhance teamwork, multi-professional communication and psychological mindedness in services.

4. Psychological intervention

a. On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with:

- individuals
- couples, families or groups
- services/organisations

b. Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

c. Ability to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological interventions, of which one must be cognitive-behaviour therapy. Model-specific therapeutic skills must be evidenced against

a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.

d. In addition, however, the ability to utilise multi-model interventions, as appropriate to the complexity and/or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.

e. Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and wellbeing.

f. Conducting interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals.

g. Having an awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.

h. Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives.

i. Implementing interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

j. Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to clients and carers.

5. Evaluation

a. Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).

b. Devising innovate evaluative procedures where appropriate.

c. Capacity to utilise supervision effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.

d. Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.

e. Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.

f. Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

6. Research

a. Being a critical and effective consumer, interpreter and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

b. Conceptualising, designing and conducting independent, original and translational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and merit publication including: identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis (both quantitative and qualitative), reporting outcomes and identifying appropriate pathways for dissemination.

c. Understanding the need and value of undertaking translational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.

d. The capacity to conduct service evaluation, small N, pilot and feasibility studies and other research which is consistent with the values of both evidence-based practice and practice-based evidence.

e. Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups etc.) and within the ethical and governance frameworks of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

7. Personal and professional skills and values

a. Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.

b. Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.

c. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices.

d. Understanding the impact of one's own value base upon clinical practice.

e. Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.

f. Capacity to adapt to, and comply with, the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

g. Managing own personal learning needs and developing strategies for meeting these. Using supervision to reflect on practice, and making appropriate use of feedback received.

h. Developing strategies to handle the emotional and physical impact of practice and seeking appropriate support when necessary, with good awareness of boundary issues.

i. Developing resilience but also the capacity to recognise when own fitness to practice is compromised and take steps to manage this risk as appropriate.

j. Working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

8. Communication and teaching

a. Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

b. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

c. Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

d. Understanding of the supervision process for both supervisee and supervisor roles.

e. Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

f. Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof.

g. Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

9. Organisational and systemic influence and leadership

a. Awareness of the legislative and national planning contexts for service delivery and clinical practice.

b. Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.

c. Providing supervision at an appropriate level within own sphere of competence.

d. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.

e. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as 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.

f. Working with users and carers to facilitate their involvement in service planning and delivery.

g. Understanding of change processes in service delivery systems.

h. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.

i. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

2.1.4 The structure of training

1. It is essential that programmes provide a holistic experience of training that enables trainees to develop an integrated set of learning outcomes.

2. Programmes should provide a balanced and developmental set of academic, research and clinical experiences throughout training. The academic component needs to provide an integrated curriculum supporting the clinical and research training. The research training needs to be carefully planned and have sufficient time devoted to it to enable trainees to conduct research at a postgraduate level and to be in a position to contribute to the knowledge base of the profession.

3. Supervised practice needs to be gained across the range of clients, therapy and intervention modalities and settings as outlined below (section 2.4.1). Clinical experience will be gained in service delivery systems that offer a coherent clinical context. This can include settings defined for the purposes of training by one, or a combination of, factor(s) including the population (e.g. child, adult, older people), special needs (e.g. intellectual disability, serious mental health problems, health-related problems, substance abuse), psychological interventions (e.g. model of therapy) or service delivery contexts (e.g. primary, secondary and tertiary care, in-patient, out-patient, community, third sector, leadership, consultancy or inter-professional working).

4. A hallmark and strength of clinical psychology training is that generalisable and transferrable skills and competencies are developed. This is evidenced by demonstration of the core competencies outlined in 2.1.3 above and across the settings outlined in 2.4.1 below. However, it would be impossible to demonstrate these competencies across ALL such settings, and combination of settings, and thus, once again, these are indicative rather than prescriptive. Moreover, programmes generally, and individual trainees specifically, will vary in emphases and strengths. A sufficient range of experience must be attained, however, to evidence this transferability in practice. Thus, the *specific* settings, population and interventions in which competencies have been demonstrated must be monitored and available within a training portfolio (see Appendix 1 for an example of how such a portfolio might look).

5. It is important to recognise that the scope of clinical psychology is so great that initial training provides a foundation for the range of skills and knowledge demonstrated by the profession. Further skills and knowledge will need to be acquired through continuing professional development appropriate to the specific employment pathways taken by newly qualified psychologists.

6. Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the health and social care sectors. These requirements will be shaped in part by national policies and service frameworks, as well as by evidence of recruitment problems in specialties or regions. National standards as set out by the Division of Clinical Psychology's Faculties should guide training patterns for each cohort of trainees and programmes should consult with these and other local stakeholders to ensure that – across the trainee cohort – there is optimum, effective and efficient use of all available placements.

7. Of the total programme time (exclusive of annual leave), at least fifty per cent must be allocated to supervised clinical experience. In addition, at least ten per cent must be available to trainees for self-directed study throughout the programme. Of the remaining time there must be an appropriate balance between research activity and learning and teaching, to ensure that the guidance outlined in sections 2.2 and 2.3 below can be met.

2.2. Teaching and learning:

2.2.1 A clear programme specification must be in place that provides a concise description of the intended learning outcomes of the programme, and which helps trainees to understand the teaching and learning methods that enable the learning outcomes to be achieved, and the assessment methods that enable achievement to be demonstrated with adequate breadth and depth. The programme specification (and any module specifications) must include learning outcomes that reflect the specific programme content requirements outlined above.

2.2.2 Education providers must be able to document the intended programme and module learning outcomes, and the ways in which these are mapped on to the programme content requirements outlined above.

2.2.3 Programmes must have a statement of orientation and values that underlie their programme specification. In addition to articulating learning outcomes and an assessment strategy that reflect the competencies outlined in this handbook, programmes must be able to show how their orientation and values inform their teaching and learning strategy.

2.2.4 Trainees are entitled to expect a learning experience which meets their needs, and which is underpinned by competent, research-informed teaching, and a supportive and enabling learning environment.

2.2.5 Programmes must meet the following specific curriculum requirements:

1. Programmes should have an academic syllabus and a coherent plan for organising and presenting the material to be covered. The academic syllabus and plan will reflect the programme specification and will be designed to help trainees achieve the learning outcomes set out in 2.1 above. The content of curricula should reflect relevant and up to date psychological knowledge and skills, ensuring that contemporary psychological practice and research is promoted. Programmes should be able to demonstrate how the syllabus has been informed by general and specific guidance such as: DCP policy (including Faculty good practice

guidelines); recognised practice guidance such as NICE/SIGN where this exists, and other sources relevant to the practice of clinical psychology and its advancing knowledge base.

2. It is recognised that programmes may legitimately vary in their curricular emphases, taxonomical system and language for defining presentations. Programmes should be mindful of the DCP position statement regarding limitations in 'diagnostic' frameworks and this may inform language and taxonomy. However, to a greater or lesser degree the indicative areas of curriculum content specified in this document, have been informed by commonly used taxonomies as understood not only by the profession, but by service users, carers, commissioners, colleagues and other stakeholders.

3. Indicative content for a clinical psychology curriculum should reflect a broad range of conditions and interventions that includes the following:

   a. A satisfactory introductory programme that addresses practical issues and is geared to familiarising the trainee with skills in engaging clients, working collaboratively, assessment methods, including interviewing, observational techniques and psychometric assessment.

   b. Clinical psychology in context including our history and the evolution of healthcare systems in the UK.

   c. Knowledge and theories related to the psychological needs and problems of a range of client groups across the lifespan and relevant to clinical psychology. In practice this should relate to:

   • common mental health presentations (e.g. anxiety presentations and depression);

   • severe and enduring mental health presentations (e.g. hearing voices, psychosis, complex trauma);

   • physical health presentations and issues related to adjustment and coping across the lifespan;

   • presentations of infancy and childhood (e.g. infant mental health, developmental, social, adjustment to adversity, physical health presentations, looked after children, conduct and mood difficulties);

   • presentations of older adulthood (e.g. related to developmental changes and psychosocial adaptation, losses to cognitive functioning);

   • neurological presentations of adult and childhood;

   • presentations of those with physical and intellectual disability;

   • specialist clinical presentations which could present across the lifespan and in combination with other presentations such as substance misuse, addictive behaviours, eating disorders, personality disorders and forensic presentations.

   In practice trainees will often work with complex and co-morbid presentations and thus will be required to synthesise the relevance of any single presentation knowledge base for transtheoretical application.

   d. Substantial teaching on the theory and practice of psychological assessment methods, including the interpretation of findings and the

formulation of clinical problems. There should be explicit consideration of the relationship between assessment, formulation, intervention and evaluation. This should be in relation to service users across the age range, with the range of presentations and as underpinned by the different therapeutic modalities as specified in 2.4.1 below.

e. Understanding of the theoretical and evidence bases related to commonly used psychometric assessments. Psychometric theory and approaches to understanding assessment findings including statistical and clinical significance should be understood.

f. Substantial coverage of formal systems of psychological interventions and this must include more than one orientation and approach. Content should include the philosophical and theoretical bases of therapies, their practical application to various client groups, and their current empirical status. Consideration should be given to the evidence base of what works for whom and when it is appropriate to draw from different knowledge bases, especially in work with complex and co-morbid presentations.

g. Opportunities for learning about professional and organisational issues. This should include the organisation of health and social care services and the profession, and the work of related professions and agencies. The Society's *Code of Ethics and Conduct* should be covered together with emergent ethical competence frameworks for applied psychology, as well as the impact of major legislative frameworks, statutory regulation, and other significant developments affecting the profession.

h. Issues concerning the influences of society, cultural and other areas of diversity should be integrated throughout the academic programme, demonstrating the relevance to clinical practice. Values related to an ethos of critical community psychology, recovery and wellbeing should inform appropriate aspects of the curriculum.

i. Non-therapy skills such as exerting influence and leadership, critical self-awareness, communication and teaching, models of consultancy, multidisciplinary working and group and organisational processes.

j. Programmes should be responsive to new developments and areas of concern within the profession and aim to incorporate learning opportunities in such areas within the programme as and when appropriate.

4. The plan for delivering the academic syllabus must ensure that trainees receive adequate preparation for their clinical placements and that there are adequate links between the taught material and contemporaneous placements. This will mean that the plan takes account of the likelihood that trainees in the same cohort will be working in different clinical specialties at any one time.

5. Programmes should provide substantial learning opportunities that use a range of educational methods, adapting the style of these to the stage a trainee has reached. In general, methods should be used which require substantial trainee participation.

6. The majority of the learning opportunities should be provided by clinically qualified psychologists. However, service users and carers should inform and participate in the delivery of the curriculum. Teaching by other psychologists and professionals is to be encouraged as is engagement with inter-professional learning.

2.3 Research:

2.3.1 Programmes must have an explicit and written statement of aims and objectives for a programme of research training throughout the programme. This should be developed in discussion with supervisors and should include the aim of encouraging clinical research during placements. Where appropriate, collaborative research should be encouraged.

2.3.2 Programmes should provide sound teaching and training in research methodology. This will include:

- formal teaching of research design and methods including small N designs, pilot and feasibility studies and those methods, both quantitative and qualitative, that are most useful in the conduct of applicable clinical research including service evaluation;

- ethical issues in research;

- statistical analysis including both exploratory and hypothesis testing methods;

- critical appraisal of published research including systematic reviews, and

- supervised research work involving not only a major project but also some smaller scale service related research or research related to professional issues.

The Society has published *Supplementary guidance for research and research methods on Society accredited postgraduate programmes*, and providers must be able to demonstrate how they have taken account of these guidelines in designing, developing and delivering their research methods and project provision.

2.3.3 Trainees must complete at least one formally assessed smaller scale project involving the use of audit, service development, service evaluation or applied research methods related to service delivery or professional issues.

2.3.4 During the programme trainees must undertake an independent research project that requires them to conceptualise, design, carry out and communicate the results of research that is relevant to clinical psychology theory and practice. Research methodologies and traditions are not prescribed and programmes and examiners should take an inclusive approach to acceptable products. However, this research should be at doctoral level, merit publication through a peer–reviewed process and contribute to the knowledge base related to clinical psychology.

2.3.5 All research projects must demonstrate that they conform to the appropriate relevant ethics and governance procedures and to the Society's guidelines on the conduct of research.

2.3.6 Trainees must have access to computer facilities for data analysis and have adequate training in their use, including guidance on data protection and confidentiality.

2.3.7 Each trainee must have a research supervisor who is competent in research supervision. The Programme Director or research coordinator must be

responsible for approving the allocation of research supervisors. Supervisory loads must be monitored and be such that adequate supervision is provided to trainees. There should be a research agreement between supervisor and trainee that covers matters such as a schedule of regular supervision meetings and progress reviews, written feedback on drafts and a timetable for the project.

2.3.8 Great care must be taken to allow trainees to plan and organise their research project in good time, such that there is the opportunity to complete it successfully. Time must be set aside early on in the programme for discussion of the proposed project. Regular monitoring of trainees' progress and the quality of the research must be carried out throughout the programme.

2.3.9 Programmes must be sensitive to the problems that may arise in carrying out applied research. Care must be taken to anticipate common difficulties and take preventative action.

2.3.10 The research curriculum must be designed to promote post-qualification practice that includes research activity through conducting and facilitating research, and applying research to inform practice.

2.4 Supervised practice:

2.4.1 Clinical experience and skills:

Programmes must ensure that trainees gain the following clinical experience and skills:

1. The learning outcomes described above need to be demonstrated with a range of clients and across a range of settings. In keeping with the spirit of these standards, these outcomes are not defined prescriptively, and there are multiple pathways through which these goals may be achieved. The range of service user presentations and settings is outlined below and these experiences should be supported by the curriculum exposure as outlined in 2.2 above to promote the competencies defined in 2.1.3.

2. **Service Users:** A fundamental principle is that trainees work with clients across the lifespan, such that they see a range of service users whose difficulties are representative of problems across all stages of development. These include:

- a wide breadth of presentations – from acute to enduring and from mild to severe;

- problems ranging from those with mainly biological and/or neuropsychological causation to those emanating mainly from psychosocial factors;

- problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions;

- service users with significant levels of challenging behaviour;

- service users across a range of levels of intellectual functioning over a range of ages, specifically to include experience with individuals with developmental intellectual disability and acquired cognitive impairment;

- service users whose disability makes it difficult for them to communicate;

- where service users include carers and families;

- service users from a range of backgrounds reflecting the demographic characteristics of the population. Trainees will need to understand the impact of difference and diversity on people's lives (including sexuality, disability,

ethnicity, culture, faith, cohort differences of age, socio-economic status), and their implications for working practices.

3. **Service delivery systems:** Trainees should have experience of working across a range of healthcare systems and providers. These could be largely within the NHS but may also involve work within third sector, social care, and independent providers encompassing primary and community care, secondary care and in-patient or other residential facilities. The extent to which such placements are used will be dependent on local circumstances.

4. **Modes and type of work:** Trainees should:
   - undertake assessment, formulation and intervention both directly and indirectly (e.g. through staff, carers and consulting with other professionals delivering care and intervention);
   - this work should be underpinned by at least two evidence-based models of formal psychological intervention, one of which must be cognitive-behaviour therapy;
   - however, trainees must be able to work with complexity and co-morbidity and thus draw from knowledge bases across models of therapy, and evidence bases for different interventions and approaches, when appropriate to the needs and choices of the service user;
   - work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;
   - be critical of their own approach, and aware of how to practise in the absence of reliable evidence, as well as being able to contribute from their work to the evidence base.

5. Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken.

6. The national standards as set out by the Division of Clinical Psychology's Faculties should provide reference information for supervised practice commensurate with competence in a given area of work. Based on this reference information programmes will develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. The degree to which programmes privilege particular faculty guidance is one way in which specific programme strengths and identity will emerge.

7. The length of time in a placement, the number of, and the length of time involved with, service users must be sufficient to allow this. An adequate balance of time must be allocated across services and client groups, and optimum use made of available placements, so that the required range of experience across the lifespan may be gained.

8. The programme of supervised clinical experience needs to be planned for each trainee in order to ensure that all trainees will gain required experience. The Programme Director or Clinical coordinator is responsible for monitoring each individual plan and making adjustments as necessary so that any gaps or problems can be identified early and resolved later in training. The main requirement is that over the period of the programme trainees must gain the

range of experience noted above, rather than spending specified lengths of time in particular placements. Flexibility in placement planning is needed to ensure this. Trainees must be fully involved in monitoring their individual plan.

9. Programmes should ensure that within clinical placements trainees have experience of working with other professions, and that the opportunities for inter-professional learning are maximised.

10. Trainees must keep a portfolio of their clinical experience to enable their training plan to be monitored and to evidence the range of presentations, service delivery systems, modes of working etc. in which competencies have been accrued.

11. The portfolio must clearly summarise the experiences and work undertaken within a given placement setting and cumulatively across training. Whilst it is expected that the competencies outlined in section 2.1.3 related to the transferrable skills of assessment, formulation, intervention and evaluation will be integral to most placements, the specific service user presentations, service settings and modes of working will vary and need to be defined and summarised in a readily accessible and transparent way. Whilst a template example is presented in Appendix 1, programmes are encouraged to develop their own portfolio system.

12. In addition, programmes must operationalise their requirements for trainees to demonstrate competence in the two specific models of psychological therapy required (one of which must be cognitive behaviour therapy) in a credible and robust way. The Society recognises that there is no patent on defining these and that individual training programmes and trainees will vary in the breadth and level of competence promoted. However, the Society will accredit programmes in so far as they have operationalised their own minimum standards for individual validation. These should be benchmarked against recognised criteria, where these exist, such as those formulated by the Society's Centre for Outcomes Research and Effectiveness (CORE). However, programmes may adapt these, or indeed use other credible competence frameworks, which best capture the application of CBT and other therapies to specific ages, populations and presentations. A template example of how these might look is presented in Appendix 1.

13. Similar requirements for test competencies should be operationalised as outlined in 2.5.2 below.

2.4.2 Clinical supervision:

Programmes must ensure that trainees' clinical supervision meets the following standards:

1. Programmes must have access to an adequate number of appropriately qualified and experienced placement supervisors.

2. Trainees will have a co-ordinating placement tutor or supervisor who is a qualified clinical psychologist. The identification of a co-ordinating tutor or supervisor is intended to ensure that the trainee participates in supervision with an appropriately qualified psychologist for the majority of their training. The co-ordinating supervisor may be a member of the programme team.

3. In addition, trainees will have clinical or practice supervisors. These supervisors must be appropriately qualified, but may be registered in a different domain of psychology, or be a member of another profession:

    - Psychologists providing supervision to trainees on accredited programmes must be registered with the Health and Care Professions Council.
    - Members of other professions who are providing supervision to trainees on accredited programmes should normally be registered with an appropriate professional or statutory body.

    The nature of supervision provided will depend on the organisational context in which the placement takes place and may range from supervision of specific case work to supervision of the whole placement experience. It is for programmes to ensure that all supervisors, based on their training, experience and CPD, have the appropriate competencies to be offering the particular services in which they are supervising the trainee.

4. All supervisors are expected to have completed training in supervision as recognised by the Society or provided by the education provider.

5. All clinical supervisors must be fully aware of their responsibilities. No placement should be arranged unless the supervisor has indicated her or his willingness to provide full supervision and take responsibility for the trainee. The programme must have written guidelines on clinical supervision, or, alternatively, utilise the Society's guidelines, which are available at **www.bps.org.uk/accreditationdownloads**. The guidelines on supervision must be circulated to all supervisors.

6. A variety of supervisory arrangements is acceptable. These include trainee to supervisor ratios of 1:1 and 2:1 and various forms of team supervision for groups of trainees. The programme must ensure:

    a. that each trainee has a named supervisor who is responsible for the co-ordination of their supervision and who formally assesses the trainee in consultation with the other supervisor(s) involved; and

    b. that individual supervision provides opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as ongoing case work.

7. Supervision in all placements must meet the following standards:

    a. The general aims of the placement should be established prior to or at the very beginning of the placement. These should make explicit reference to these training standards, and the specific competencies that need to be developed must have been mutually agreed in person to ensure that expectations can be clearly set and communicated on all sides.

    b. A written placement contract should be drawn up towards the start of the placement. The contract should outline the amount, frequency and nature of the supervision that will take place as well as any planned interaction between the three parties involved (programme-trainee, placement-trainee, placement-programme) for the purposes of placement monitoring.

c. There must be a formal, scheduled supervision meeting each week that must be of at least an hour's duration. Supervision should normally take place on a face-to-face basis, although education providers may specify within the contract any circumstances under which alternative arrangements may be put in place. The supervision required may differ depending on the stage of development of the trainee and any specific learning needs that may have been identified.

d. The trainee must have an appropriate amount of individual supervision in addition to any group supervision.

e. Total 'contact' time between supervisor(s) and trainee(s) must be at least three hours per week.

f. There must be a formal, interim review of the trainee's progress in the placement, and of the experience provided.

g. Full written feedback should be given on the trainee's performance on placements.

h. The trainee must see and comment on the full report.

i. Trainees must have the opportunity to observe the work of their supervisors; supervisors must observe the work of trainees.

j. Supervisors should be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work.

k. Supervisors should closely monitor and help develop trainees' communications (oral and written) and non-therapy skills as defined above.

8. There must be a formal process whereby the programme team monitors the clinical experience of trainees and the supervision provided, and helps to resolve any problems that may have arisen. This process must be timed such that if there are problems there will be still be time available in the placement to overcome the problems, if this is feasible. The process must include the opportunity for a member of the programme team to hold discussions in private with the trainee and supervisor individually prior to a joint discussion. A written record of the monitoring and any action plan agreed must be held on file.

9. Regular workshops on supervisory skills and other training events for supervisors must be organised by the programme to ensure effective supervision. Supervisors should attend workshops and training events periodically. Programmes must ensure that the training events offered meet the needs of both new supervisors and more experienced colleagues. Suggested learning objectives for introductory supervisor training are provided at **www.bps.org.uk/accreditationdownloads**.

10. Trainees must have the opportunity to provide feedback on the adequacy of placements and supervision, and programmes should ensure that it is possible to change important aspects of placements that are found to be unsatisfactory.

11. Programmes must have a formal, documented audit process for clinical placements and supervision in partnership with Heads of Service and

supervisors. The Programme Board/Training Committee must have mechanisms for considering the outcomes of each audit, and procedures for seeking to overcome any problems that are identified.

2.4.3 Critical evidence-based practice:

1. During the periods when trainees are on clinical placements, supervisors should guide trainees to read relevant literature and use their knowledge of the literature to inform their clinical work, particularly formulation of clinical problems.

2. It is important that supervisors and programme staff keep abreast of theoretical, research and evidence-based guidance in their fields of work, and participate in continuing professional development. It is important that trainees are encouraged to develop a critically reflective stance to the evidence base and do not seek to apply it in a reductionistic and formulaic fashion.

3. During the academic programme, teachers should be encouraged to use clinical material of their own and of the trainees as a means of elucidating theoretical and research issues.

4. Programmes must consider how they integrate theory and practice throughout the clinical training programme. This should include consideration of issues such as the use of academic knowledge on placement, the use of clinical examples in teaching and how the academic programme as a whole relates to the clinical experience.

5. Since trainees may not all follow the same pathway through training, programmes should have a system for monitoring the level of integration that is achieved between academic teaching and placement training and for developing an action plan to deal with problems.

2.5 Transparency in validating specific competencies:

The hallmark features of training in clinical psychology have been highlighted in the statement of intent at the beginning of this document. These include the capacity to draw from knowledge across the evidence bases of psychological therapies and interventions of what works for whom, and applying that in a critical way to common, as well as complex and co-morbid presentations. The ability to draw across knowledge of different models is key to being able to select the best intervention(s) for the client but this should not be taken to imply that uni-model interventions cannot offer the best approach for a particular client. However, it does indicate that clinical psychologists need to be able to conceptualise in both a uni-model and a multi-model way. The capacity to transfer these competencies across specialisms and populations, service delivery systems and across the lifespan is a defining feature of clinical psychology training. Moreover, the research skills to be effective consumers, but also contributors to the knowledge base, are emphasised. Procedures to achieve these doctoral level competencies underpin current accreditation standards to confer Chartered status with full divisional membership.

However, the Society recognises that some specific employment competencies, which whilst encompassed in clinical psychology training and accreditation standards, are not unique to the training of clinical psychologists. In particular these include competence to deliver specific therapies (i.e. cognitive behaviour therapy plus one other) and test competencies.

2.5.1 Consequently, and in order to facilitate employer and commissioner appreciation of these specific competencies programmes should benchmark their curriculum and placement provision against a competence framework in whichever formal models of psychological intervention they are including in relation to the criteria outlined in 2.1.3 (4) and 2.4.1 (4) above.

a. It should be clear from this exercise that programmes have in place an academic curriculum, placement and supervisory resources required to meet a given competence framework for all trainees, in terms of CBT. Similarly, curriculum, placement and supervisory resources should be in place for the second model of psychological intervention, which will either be agreed by the programme for all trainees, or selected by the trainee in a specific training pathway (thus the second model may vary across trainees within a single programme).

b. The Society recognises that therapy competence frameworks may be operationalised and defined in different ways. The Society would encourage using the competence frameworks developed by the BPS Centre for Outcomes Research and Effectiveness (CORE), as a starting point. These may be utilised as they stand, or programmes may adapt these to make them more relevant to applying (for example) CBT to work outside adult mental health (e.g. with children, people with an intellectual disability, people who hear voices, older adults etc.). The same principle is relevant to the other therapy frameworks. The generic competencies within each competence framework are key here, though programmes are free to formulate competence frameworks for specific presentations if, for example, that is consistent with how they choose to market and define themselves. Programmes may utilise other competence frameworks where appropriate to the skills they say their trainee(s) are competent within. The key principle is that programmes utilise a credible competence framework to quality assure trainee work against. The Society will accredit programmes where this is the case, although the more widely accepted a competence framework is, the more credible these learning outcomes are likely to be in the employment and commissioning market.

c. The Society will accredit a programme as having the required curriculum, placement and supervisory resources required to enable trainees to meet these competencies in principle should the trainee choose a particular placement pathway to obtain these. It should be noted that the Society does not require supervisors to be 'accredited' by any other professional body to supervise specific therapies, though this may of course be the case. Rather, it is the capacity to utilise specific therapy interventions in the practice of clinical psychology which is key and we would expect programmes to have in place ways of identifying supervisors and placements where this is the case.

d. It will thus be incumbent on programmes to have in place monitoring and assessment systems to validate the attainment of competencies in their trainees as specific intervention subsets are likely to vary depending on programme emphases and indeed the placement pathway pursued by individual trainees. In addition to the programme benchmarking the curriculum, trainees are thus required to keep portfolios of clinical experience, certified by their supervisors, which attests to the achievement of given

competencies within a competence framework (e.g. use of behavioural activation, circular questioning, guided discovery, working with transference etc.) across clinical activities. These could be obtained in many placement settings and with varied populations and should not necessarily be required within a uni-modal CBT, or psychodynamic, or systemic placement etc. – although again this would also be satisfactory. A template example of how such a system might look in the clinical practice portfolio is outlined in Appendix 1.

2.5.2 Similar principles should operate in accreditation of a programmes capacity to promote test competencies. The fundamental feature of the competencies defined in 2.1.3 (2 and 5) above is that trainees should be able to choose, use and interpret tests and test results. The curriculum and placement experiences should clearly highlight how these competencies are promoted. Programmes may find the DCP publication on test standards in clinical psychology training (2009) and the more recent competence framework developed by the Division of Neuropsychology (2012) useful in guiding thinking here. Similarly, the clinical portfolio should make clear in which tests (performance and paper and pencil psychometrics) the trainee has experience. Sufficient exposure should be attained to allow generalisability to be inferred and some, at least formative, *in vivo* assessment should pertain here.

Rationale for inclusion

The Society's standards for accredited programmes reflect contemporary theory, research and practice, enabling accredited programmes to develop psychologists who will be fit for purpose for the future. As such, these reflect the optimal academic and professional standards, promoted by the Society through the award of Graduate membership (MBPsS) and the Graduate Basis for Chartered membership (GBC), and Chartered membership (CPsychol) respectively. The Society is keen that these standards create flexibility for programmes to develop distinctive identities, by making the most of particular strengths around research and practice shared by their staff team, or those that are reflected in the strategic priorities of their department or university.

Guidance and signposting

- Education providers are free to map topics in any academically coherent combination, which could range from delivering core content areas within dedicated modules, or embedding coverage across a number of modules. The Society encourages programmes to deliver core content across modules within an integrated curriculum that offers a pedagogical development of trainees' knowledge, understanding, and skills.

- Providers may find it helpful to refer to Chapter B3 of the UK Quality Code, which addresses Learning and Teaching (**www.qaa.ac.uk**).

- The Health and Care Professions Council sets out its requirements around programme design and delivery (including curriculum guidance) and practice-based learning in its Standards of Education and Training (SETs 4 and 5; **www.hcpc-uk.org/education**).

- The Society has produced *Supplementary guidelines for research and research methods on Society accredited postgraduate programmes* (revised April 2017). A further document, *Supplementary guidelines for research and research methods on Society accredited undergraduate and conversion programmes*, was also published in April 2017.

Programme standard 3: Working ethically and legally

The programme must evaluate trainees' understanding of working ethically and legally.

3.1 All accredited programmes must include teaching on the Society's *Code of Ethics and Conduct* and relevant supplementary ethical guidelines.

3.2 Accredited programmes must have mechanisms in place to ensure that all research undertaken by trainees that involves human participants is conducted in line with the Society's *Code of Human Research Ethics*.

3.3 Programmes must ensure that trainees are taught and assessed on ethics beyond the submission of ethics applications for research projects.

3.4 Programmes should familiarise trainees with the distinct role of the Society as the professional body for psychology, and the Health and Care Professions Council as the statutory regulator for practitioner psychologists in the UK. Programmes should ensure that trainees are aware of the legal and statutory obligations and restrictions on the practice of psychology in the UK context.

3.5 Master's and Doctoral programmes are also expected to make trainees aware of the Health and Care Professions Council's *Guidance on Conduct and Ethics for Students*.

Rationale for inclusion

The inclusion of this standard reflects the particular importance of ethics and ethical practice to psychologists, and to the Society as the professional body for psychology and psychological practitioners. Students and trainees on accredited programmes need to be able to: identify the presence of an ethical issue (ethical sensitivity); formulate the morally ideal course of action by identifying the relevant ethical issues and using these principles to consider appropriate actions (ethical reasoning); decide what they wish and intend to do (ethical motivation); and execute and implement what they intend to do (ethical implementation). They also need to develop commitment to the ethical principles of respect, competence, responsibility, and integrity – as appropriate to their level of study. In addition, all prospective psychologists and psychological practitioners need to understand the legislative and regulatory requirements that apply to psychological practice in the UK. This standard therefore differentiates between working ethically and working legally to reflect the above considerations.

Guidance and signposting

- The Society's *Code of Ethics and Conduct*, *Code of Human Research Ethics*, and supplementary ethical guidelines provide clear ethical principles, values and standards to guide and support psychologists' decisions in the difficult and challenging situations they may face. Further information can be found at **www.bps.org.uk/ethics**.

- The Society's Ethics Committee has produced *Guidance on teaching and assessment of ethical competence in psychology education* (2015), available at **www.bps.org.uk/ ethics**, which outlines ethical competencies, and how these may be taught and assessed at different levels of study. Programmes are encouraged to make use of the guidance as appropriate to their provision.

- The Health and Care Professions Council has produced a learning resource that is designed to support the understanding of ethical issues that individuals may encounter. Whilst it is primarily intended to contextualise the HCPC's *Guidance on Conduct and Ethics for Students*, it presents a useful resource for students and trainees at all levels of study (**www.hcpc-uk.org/education/learningresource**).

- All accredited programmes are expected to include formal teaching on ethics, and should be able to demonstrate how working ethically is integral to all aspects of their provision, including research (as outlined below), and placement activities (where applicable). The assessment strategy for the programme should consider understanding of ethical principles as appropriate to the level of study.

- Students need to understand the ethical frameworks that apply to their research, and how to engage with these, as well as understanding the ethical implications of the research that they encounter. They also need to understand ethics as applied to working with people more generally.

- Providers should have in place mechanisms for identifying and dealing with academic and (where applicable) professional misconduct. The programme should consider the ways in which these mechanisms are publicised.

Programme standard 4: Selection and admissions

The programme must apply appropriate selection and entry criteria that are consistent with promoting equality of opportunity and access to psychology to as diverse a range of applicants as possible.

4.1   The programme must implement and monitor equality, diversity and inclusion policies in relation to applicants.

4.2   Programmes should take active steps, including outreach activity, to widen access to entry to the profession of clinical psychology, aiming for diversity within trainee cohorts, and must produce documentary evidence of these strategies. Programmes must periodically review their entry requirements and the ways in which potential to achieve competence is assessed at selection, to ensure that these are consistent with the overall aim of widening access to the profession, and are not discriminatory.

4.3   **Selection and entry requirements:**

    4.3.1   For Doctoral programmes, entry requirements should be established by the education provider in collaboration with stakeholders, as appropriate.

    4.3.2   Programmes must provide clear information to trainees indicating that, in order to be eligible for Chartered membership of the Society and full Division membership, they will need to have completed both a programme granting eligibility for the GBC and an accredited Doctoral programme. The reverse is not permissible.

4.4   **Recognition of prior learning:**

    4.4.1   Where the education provider offers applicants the opportunity to seek exemption from undertaking a proportion of the programme, effective processes should be in place for assessing and recognising their prior learning and experience.

    4.4.2   Doctoral programmes may operate procedures for the recognition of prior learning (RPL) or existing competence (REC) against the learning outcomes of the accredited award. The RPL procedure should ensure that any exemptions against the taught content of the programme are granted on the basis of learning undertaken at level 7 (level 11 in Scotland).

    4.4.3   The REC procedure should ensure that any exemptions against practice requirements are granted on the basis of competence gained following the trainee's achievement of eligibility for the GBC. In addition, any work put forward for REC purposes must have been supervised by an individual who meets the requirements for supervision of professional practice outlined in Programme standard 2.

4.5   For providers that accept trainees on to their postgraduate programmes who do not hold eligibility for the Graduate Basis for Chartered membership of the Society (GBC), a support mechanism should be in place to identify any gaps in such applicants' underpinning knowledge, and ways of addressing these.

4.6   Education providers must demonstrate that the process of selecting candidates for entry on to their programme is based on academic and professional decision-making. Whilst administrative and central services staff play a crucial role in supporting selection and recruitment processes, appropriate academic oversight must be in place. In particular, programme staff should have responsibility for confirming any selection criteria or other

checking and validation processes to be applied, and for adjudicating over any non-standard or otherwise complex applications.

4.7 As part of the selection process, both teaching staff and clinical supervisors must be fully involved in the selection of trainees. There must be opportunities for shortlisted applicants to meet existing trainees.

4.8 The Programme Director(s) must ensure that any additional honorary contracts that are required for trainees above and beyond their contracts of employment are in place at the appropriate juncture. This may include, for example, contracts that are required if trainees are undertaking clinical placements or research outside of their employing Trust, but will be dependent upon local circumstances. Trainees who are not NHS employees must hold honorary contracts or a letter of access with the appropriate NHS Provider, issued before they take up their appointments, and with other agencies where applicable.

Rationale for inclusion

The Society is interested in the ways in which education providers implement their equality, diversity and inclusion policies. It is particularly important that those progressing to undertake professional training in psychology, and therefore those moving into employment as psychologists, reflect the demographics of the populations with whom they will be working. Similarly, the Society is keen to promote diversity in psychology trainees progressing towards careers as academics or researchers. Overall, it is important that psychological knowledge and expertise is reflected across a diverse range of people, and that this diversity is ultimately reflected throughout the Society's membership. Widening access to professional training, including by providing greater flexibility in relation to the order of studies that trainees undertake, is key to enhancing the diversity of the workforce in the longer term. The Society is also committed to ensuring that applicants whose first qualification is in a subject other than psychology, and who have gained eligibility for the GBC through completion of a conversion award, are not unfairly disadvantaged by any selection or recruitment policies operated by the education provider (in particular, in relation to their prior academic attainment).

Guidance and signposting

- Chapter B2 of the UK Quality Code addresses Recruitment, Selection and Admission to Higher Education. Chapter B6 also considers Assessment of Students and the Recognition of Prior Learning. Finally, Part C of the Quality Code outlines expectations around the provision of fit for purpose, accessible and trustworthy information regarding the learning opportunities offered for the benefit of a range of audiences, including applicants and the general public. Providers may find it helpful to review their provision against these resources (**www.qaa.ac.uk**).

- The Health and Care Professions Council sets out its requirements around programme admissions, including the recognition of prior learning and equality and diversity, in its Standards of Education and Training (SET 2; **www.hcpc-uk.org/education**).

- The Office for Fair Access (OfFA) is the independent regulator of fair access to higher education in England. Like OfFA, the Society believes that everyone with the potential and ambition to succeed in higher education should have equal opportunity to do so, whatever

their income or background (**www.offa.org.uk**). Whilst its remit covers England only, OfFA provides a series of resources on widening access that all providers will find useful.

- The Society declares its commitment to promote equality, diversity and inclusion and to challenge prejudice and discrimination, and actively promotes a culture of equality, diversity and inclusion within our discipline. In demonstrating achievement of this standard, education providers are encouraged to hold or be in the process of seeking an Athena SWAN award, along with other relevant equality charter marks. Providers of accredited programmes should take steps to identify underrepresented groups (e.g. men, black and minority ethnic students) and encourage their participation in psychology education and training and in the wider psychological workforce. Individuals' identities are shaped by a range of factors that intersect in different ways, and providers should consider the steps they are able to take to promote and improve the participation of other underrepresented groups and to encourage greater representation (**www.ecu.ac.uk**).

- Doctoral programmes comprise a minimum of three years' full-time study (or the part-time equivalent). For some providers, the first year of study comprises study at level 7 (level 11 in Scotland), with the remainder at level 8 (level 12 in Scotland); for others, the entire programme of study is at level 8 (12). Where procedures for the recognition of prior learning (RPL) or existing competence (REC) are in place, these must operate against the learning outcomes of the accredited award, at whatever level these are validated.

- Whilst it is permissible for providers to accept applicants on to their programmes who do not hold the GBC, our experience suggests that such trainees often require additional support to be able to engage fully in teaching and learning building on the different areas of the GBC curriculum, in particular research methods. Some providers have found it useful to ensure that such applicants have undertaken an empirical research project as part of their undergraduate degree, and have completed a research design and analysis module; it may be more appropriate for students who do not meet this criterion to be counselled to complete a conversion programme and to re-apply at a later date.

- Providers wishing to check whether applicants have gained eligibility for the GBC may establish the accreditation status of any qualifications held by applicants by checking their inclusion on the Society's online database of accredited courses (**www.bps.org.uk/accredited-courses**). Applicants whose qualifications are not accredited by the Society may seek confirmation of their eligibility for the GBC by making an individual application to the Society for Graduate membership (**www.bps.org.uk/graduate**).

Programme standard 5: Trainee development and professional membership

The programme must be able to articulate a strategy for supporting trainees' personal and professional development.

5.1 The programme must have in place mechanisms for the support of trainees' personal development, including the provision of discipline-specific careers advice. This should include a personal tutor system that ensures that students have access to advice on their career development.

5.2 Programmes must have a system for monitoring trainees' progress on an annual basis in clinical, academic and research work and in developing professional roles, that is consistent with relevant NHS recruitment and performance management policies and procedures. This monitoring should look at a trainee's work as a whole and lead to guidance on future development, including both specific goals and career guidance. There must be shared documentation for recording this information that demonstrates that each aspect of the trainee's progress, as outlined above, is explicitly and consistently considered.

5.3 Programmes should ensure that trainees monitor and review their own progress and develop skills in self-reflection and critical reflection on practice. Providers must ensure that their graduates explicitly understand how their learning equips them with transferable skills that are of value to employers. Specific consideration should be given to supporting trainees in being able to articulate the skills they are developing as they progress in their studies.

5.4 Programmes must have mechanisms for helping trainees to manage their own personal learning needs and to develop strategies for meeting these. This will include using supervision to reflect on practice, and making appropriate use of feedback received. Systems for trainee support should empower learners to take personal control of their own development, by providing opportunities for the exercise of choice, decision-making, and responsibility within a supportive environment, in order to promote the development of autonomous learning.

5.5 Programmes should ensure that trainees develop strategies to handle the emotional and physical impact of their own practice and to seek appropriate support when necessary, with good awareness of boundary issues. However, trainees should also have the capacity to monitor their own fitness to practice, recognise when this is compromised, and take steps to manage this risk as appropriate.

5.6 Programme Directors, Tutors and Supervisors should be alert to personal issues that bear on a trainee's professional performance and academic achievement, and which often arise from the stresses of taking part in a clinical training programme. Programmes must make provision for such matters to be discussed with trainees routinely, and have in place written procedures on the systems that provide opportunities for such discussions. Trainees must have access to a range of support mechanisms including those available outside the programme team.

5.7 Trainees who experience severe stress, psychological disturbance, or emotional upset should be given assistance in obtaining appropriate help.

5.8 Programmes must have a written policy on health and safety matters and ensure that this is brought to the attention of trainees, and that adequate training is provided. This

policy will need to draw attention to the various health and safety policies that will be applicable to trainees; e.g. those of the programme base, the trainees' employer(s) and the organisations within which clinical placements are undertaken.

5.9 Trainees should have the capacity to adapt to, and comply with, the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

5.10 Towards the end of their training, trainees should be helped to identify their continuing professional development needs. In particular, programmes must ensure that issues relating to the transition from trainee to qualified clinical psychologist are explicitly addressed.

5.11 The programme must provide trainees with information on the benefits of completing an accredited programme, and gaining membership of the Society and its Member Networks at the appropriate level. Providers should emphasise the benefits of Society membership for trainees' and graduates' professional development.

5.12 Trainees should have access to discipline-specific professional development. Psychologists should be involved in supporting student development, and specific resources should be allocated to this aspect of the provision. For postgraduate professional training programmes, this should include the involvement of practitioner psychologist(s) in providing careers advice.

Rationale for inclusion

This standard is included because close attention to trainees' personal and professional development is key to their employability. Education providers may link with local and/or national employers in a variety of ways, and the Society is keen to develop its understanding of these approaches through partnership visits. Additionally, the Society believes it is important that education providers communicate the benefits of completing an accredited programme to their trainees. Belonging to the Society is an integral part of being a psychologist. It recognises graduates' qualifications and reflects their aspiration to represent the highest possible professional standards.

Guidance and signposting

- Chapter B4 of the UK Quality Code addresses Enabling Student Development and Achievement. Chapter B3 also considers Learning and Teaching, and specifically emphasises the need to enable every student to monitor their progress and further their academic development through the provision of regular opportunities to reflect on feedback and engage in dialogue with staff. Finally, Part C of the UK Quality Code addresses the information that should be provided to students about their programme of study and their achievements. Providers may find it helpful to review their provision against these resources (**www.qaa.ac.uk)**.

- The Society's role is to develop and support the discipline of psychology, and to disseminate psychological knowledge to the public and policy makers. Joining the Society enables trainees to contribute to the Society's work and benefit from the resources the Society provides as they develop professionally.

- Completion of an accredited programme offers graduates a clear route to Society membership at the appropriate level, and therefore access to the full range of membership benefits, including a variety of services, publications, conferences, training and networking opportunities. Society membership also presents graduates with opportunities for developing and influencing the profession as leaders in their field in the future. For more information on the benefits of Society membership, see **www.bps.org.uk/membership**.

- In demonstrating their achievement of this standard, education providers should consider the interface between any careers advice and support that might be provided by their central or School/Faculty-based employability unit, and the guidance that can be provided by practitioner psychologists and other qualified practitioners over the course of the programme.

- Postgraduate programmes should also pay particular attention to professional development where trainees on accredited programmes are taught alongside other trainee groups (for example, those that do not hold eligibility for the GBC, or other professional groups).

Programme standard 6: Academic leadership and programme delivery

The education provider must have appropriate human resources in place to support the effective delivery of the programme, including appointing an appropriately qualified and experienced director or co-ordinator.

6.1 Staffing strategy:

6.1.1 Education providers must be able to outline a clear strategy in relation to the leadership and co-ordination of the programme. The Programme Director must operate with a level of autonomy that enables them to effectively oversee the programme's governance and delivery.

6.1.2 Providers need to demonstrate that their overall staffing strategy supports the long-term sustainability of the provision, and the capacity to continue to meet the Society's accreditation standards on an ongoing basis. In the interests of promoting a holistic learning experience for trainees, the Society would normally expect the core programme delivery team to be located predominantly in one department or on one site.

6.1.3 Programmes must have in place sufficient appropriately qualified staff in order to be able to provide a learning experience that meets trainees' needs, and which is underpinned by competent, research-informed teaching. The staff team as a whole needs to be able to deliver (i.e. teach and assess) across the required programme content (see Programme Standard 2) at the appropriate level, and supervise trainees' research.

6.1.4 Education providers must be able to outline the steps they are taking structurally and culturally to advance equality, and to improve the career prospects of underrepresented groups within the discipline and profession.

6.2 Qualifications of Programme Director and staff:

6.2.1 Programme Directorship: For postgraduate professional training programmes:

- The Programme Director holds overall professional and academic responsibility for ensuring that the programme meets the Society's standards, and for maintaining the accreditation of the programme.

- The Programme Director must be of an appropriately senior academic status within the education provider, such that the Society may be confident that they can take overall responsibility for, or make a significant contribution to, the programme's day-to-day management and strategic direction.

- The Programme Director must have the programme as his/her major commitment, and be free to devote sufficient time to ensure effective and efficient running.

6.2.2 The Programme Director should be a Chartered psychologist (or eligible for Chartered psychologist status) holding full membership of the Division within whose domain the programme falls and must also be a practitioner psychologist registered with the Health and Care Professions Council (in the domain in which the programme falls). It is expected that the Director will have appropriate professional practice skills and experience.

6.2.3 The Programme Director must normally have appropriate academic, professional practice (for awards leading to eligibility for practitioner status), research and management skills, in addition to prior knowledge and experience of training in the relevant area of applied psychology.

6.2.4 **Programme staff:** For postgraduate professional training programmes:

- All staff contributing to the delivery of accredited programmes will normally hold, as a minimum, a postgraduate qualification in psychology and/or a demonstrable track record in research or other scholarly activity of relevance to applied psychology.

- Dissertation or thesis supervision should only be undertaken by psychologists or other suitably qualified individuals who hold a qualification at Doctoral level, or who hold a demonstrable track record of research in applied psychology.

- A Placement Co-ordinator should be identified who holds responsibility and professional accountability for the oversight (quality assurance) and safeguarding (governance) of any supervised practice undertaken as part of the programme. The Placement Co-ordinator role, and the assessment of students' attainment of professional competencies in practice, may only be undertaken by an HCPC registered practitioner psychologist. Placement organisation also includes a range of operational and logistical tasks that support placement delivery. These may be undertaken by administrative and professional services staff.

- Delivery teams for postgraduate professional training programmes must be able to demonstrate appropriate current links to practice, such that the team as a whole has the necessary knowledge, experience and skills to support trainees' learning, and (where appropriate) development of practice competence. It is expected that the majority of staff on the core delivery team for the programme will be qualified in clinical psychology.

6.3 **Staff student ratio:**

6.3.1 Education providers should provide a calculation of their current staff student ratio (SSR) in the evidence they submit in support of an application for accreditation, or in advance of a partnership visit. Postgraduate professional training programmes must operate a minimum staff student ratio of 1:10, based on FTEs.

6.3.2 Given minimum staffing requirements, and the range of tasks that programme staff must undertake in order to deliver a quality trainee experience (see 6.4 below), programmes with small cohort sizes will require an enhanced SSR.

6.4 **Staffing levels:**

6.4.1 There are key roles and functions that the Society considers are essential to the effective and efficient delivery of an accredited programme. Programmes must therefore have sufficient staff with enough time allocated to carry out the range of tasks that are associated with: Teaching; organising, co-ordinating and monitoring placements (if appropriate); training and supporting supervisors or other assessors; research supervision; marking; providing personal support to trainees; supporting their professional development; and liaising with employers, visiting speakers and other external stakeholders.

6.4.2 In the interests of providing a positive and coherent student experience, education providers must ensure that programme staff are readily accessible to students, and that students have clear guidance on arrangements for liaising with staff outside of any core contact hours.

6.4.3 All programmes must pay particular attention to ensuring that staffing levels are such that trainees receive research supervision at a level consistent with the programme's aims and that research supervision loads for staff are appropriate to enable them to provide adequate supervision at the required level.

6.4.4 Where staff have other duties (e.g. other teaching or practice commitments) these must be taken into account in setting staffing levels and must be such that they do not interfere with the execution of the major responsibility of programme delivery. They must also be reflected appropriately in any SSR return.

6.5. Professional services support staff:

6.5.1 Programmes must have access to sufficient dedicated administrative, technical or other learning support staff to support their effective delivery. Postgraduate programmes require specialist administrative support to meet the specific needs of their staff and trainees. This should include awareness of and expertise in overseeing placement/supervised practice activities (where applicable), including an understanding of the fitness to practise procedures that apply.

6.5.2 The education provider must be able to demonstrate that the support that is provided is sufficient to meet the needs of the provision in question. Where shared or distributed arrangements for support staff are in place, the education provider must demonstrate their equivalence to the minimum standards outlined above.

6.6 Staff professional development:

6.6.1 Staff are entitled to expect an institutional culture which values and rewards professionalism and scholarship, and which provides access to development opportunities which assist them in their support for trainee learning. Institutions should support initial and continuing professional development for all staff.

6.6.2 All core members of programme teams are expected to undertake continuing professional development that is necessary to their role within the programme, and, where appropriate, relevant to their professional practice. It is expected that this would include undertaking relevant research, knowledge transfer and other scholarly activity, and/or attendance at relevant conferences. Opportunities for development should be available to all staff who are engaged in, or are supporting, teaching, research and scholarship.

6.6.3 Education providers must have a training and mentoring strategy in place to support early-career staff to undertake core roles, including teaching, supervision and assessment of students' work.

6.6.4 Accredited postgraduate programmes should be conducted within a demonstrable research culture, evidenced by the active current publication record of members of the programme team and other staff allied to the delivery of the programme.

6.6.5 The Programme Director of an accredited postgraduate programme must have sufficient time to conduct research, knowledge transfer, consultancy / organisational and/or clinical work; normally this will be at least one day per week.

Rationale for inclusion

This standard is included as contact with and support from sufficient numbers of appropriately qualified and experienced staff whose professional development is well supported will contribute significantly to the quality of the overall trainee experience. Additionally, the leadership and co-ordination of the programme is central to shaping trainees' experience and their development as psychologists or members of the wider psychological workforce.

Guidance and signposting

- The Society's minimum requirement is that directors of accredited postgraduate programmes are registered with the HCPC as a practitioner psychologist. Whilst it will typically be the case that the Programme Director's qualifications and experience will be specific to the modality in question, colleagues with a broader portfolio of qualifications and experience may also hold directorship roles, provided that delivery of the overall student experience is underpinned by an adequate overall modality-specific resource.

- The Society would encourage Programme Directors to hold Chartered membership and full membership of the relevant Division as a way of demonstrating appropriate qualifications and experience for the role. Information on the requirements for becoming a Chartered Member of the Society can be found at **www.bps.org.uk/chartered-membership** and information about becoming a full member of the division can be found at **www.bps.org.uk/divisional-membership**.

- The Society had produced *Supplementary guidance on staffing for Society-accredited psychology programmes*, available at **www.bps.org.uk/accreditationdownloads**. This provides information to help you meet the Society's staffing standards and calculate your staff student ratio.

- Where appropriate, Programme Directors may be supported in aspects of their role by colleagues with complementary skills and experience to their own. Education providers may wish to consider the roles that other programme team members may take in relation to the leadership and co-ordination of the programme as part of their staff development strategy, particularly in connection with longer-term succession planning or to support the development of leadership potential.

- In the interests of the longer-term sustainable delivery of the programme, providers should have contingency plans in place to ensure that an appropriately qualified and experienced individual has been identified who could deputise for the Programme Director should the need arise (e.g. sickness absence, parental leave, sabbatical).

- The Society expects accredited programmes to be delivered by staff who engage in a range of research activities. A track record of academic and/or practitioner research may be demonstrated in a variety of ways, including successful completion of projects supervised.

- Both the co-ordination and operational components of placement delivery need to be undertaken effectively in order to provide trainees with a supervised practice experience that meets their needs, appropriate to their level of training. The professional oversight and safeguarding aspect of placement co-ordination should be undertaken by an individual who has a good understanding of the professional boundaries within which a trainee should be operating, and how their supervised practice should contribute to their development within the given modality, at the appropriate level. Systems need to be in

place to support consultation across the programme team to ensure that any placements or supervised practice opportunities being identified, selected and undertaken have an appropriate modality-specific focus, and are appropriate to the skills the trainee needs to develop. Any liaison undertaken with placement providers will need to be informed by an understanding of those skills, and of the requirements of the specific programme of training concerned.

- The standards for postgraduate programmes specify certain roles that may only be undertaken by practitioner psychologists. With this in mind, and given the requirement that providers demonstrate that their overall staffing strategy supports the long-term sustainability of the provision, and the capacity to continue to meet the Society's accreditation standards on an ongoing basis, providers should ensure appropriate security across the staff team as a whole. This will ensure that there is some flexibility for the redeployment of resources in the event of staff turnover, and also ensures that responsibility for programme and module development does not sit with a single individual.

- The Society supports the inclusive principles set out in the Equality Challenge Unit's Athena SWAN charter, and would encourage providers of accredited programmes to pursue gaining Athena SWAN recognition and to take steps to improve the career prospects of women psychologists. At undergraduate and postgraduate levels, psychology is a subject that attracts a high proportion of women trainees, and yet the gender balance among senior academics and practitioners reflects a very different picture. Individuals' identities are shaped by a range of factors that intersect in different ways, and providers should consider the steps they are able to take to promote and improve the career prospects of other underrepresented groups and to encourage greater representation. (**www.ecu.ac.uk**).

- Programme providers are encouraged to consult the Society's *Supplementary guidance on the roles and contributions of psychology technical staff* (2014), and its *Supplementary guidance on the roles and contributions of administrative and professional services staff* (2017). (**www.bps.org.uk/accreditationdownloads**).

- Chapter B3 of the UK Quality Code addresses Learning and Teaching, and specifically emphasises the need for higher education providers to assure themselves that everyone involved in teaching or supporting student learning is appropriately qualified, supported and developed. This includes: appropriate and current practitioner knowledge and an understanding of the subject they teach and of the disciplinary scholarship appropriate to the academic level of the students they are teaching; and the necessary skills and experience to facilitate learning in the students they are interacting with, and to use approaches grounded in sound learning and teaching scholarship and practice. Providers may find it helpful to review their provision against these resources (Chapter B3 Indicator 4, **www.qaa.ac.uk**).

- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership, including staffing, in its Standards of Education and Training (SET 3; **www.hcpc-uk.org/education**).

Programme standard 7: Discipline-specific resources

The education provider must have appropriate discipline-specific resources in place to support the effective delivery of the programme.

7.1 The education provider must be able to outline the discipline-specific and general resources and facilities that are in place to support trainee learning. Education providers must offer trainees access to learning resources that are appropriate to the range of theoretical and practical work in which trainees are engaged.

7.2 Education providers should ensure that trainees are advised of the discipline-specific and general learning resources to which they have access, and are provided with the necessary support and/or training to enable them to make appropriate use of these.

7.3 When trainees are on clinical placements they must have access to (at least) a shared office and telephone. There must be adequate arrangements for secretarial and IT support for their placement work, and trainees must be given guidance on the facilities available.

Rationale for inclusion

This standard is included because the learning experience must be underpinned by access to resources that are appropriate to the psychology programme(s) offered by the education provider. The availability of appropriate resources is key to the delivery of psychology as a science, with associated levels of practical work culminating in trainees' completion of individual research at the appropriate level.

Guidance and signposting

- Resources will normally include teaching, tutorial and laboratory space, learning resources (such as texts and journals, available in hard copy and/or electronically, computing facilities), psychological testing materials, specialist equipment supporting psychological research, software supporting data collection and analysis in psychology research, and other IT and/or audiovisual facilities (e.g. to enable the recording of practice role plays and competency assessment tasks), as appropriate to the provision in question.

- Chapter B3 of the UK Quality Code addresses Learning and Teaching, and specifically sets out the expectation that education providers, working with their staff, students and other stakeholders, articulate and systematically review and enhance the provision of learning opportunities and teaching practices, so that every student is enabled to develop as an independent student, study their chosen subject(s) in depth and enhance their capacity for analytical, critical and creative thinking. In particular, there is an expectation that providers maintain physical, virtual and social learning environments that are safe, accessible and reliable for every student, promoting dignity, courtesy and respect in their use (Chapter B3 Indicator 6, **www.qaa.ac.uk**).

- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership, including the resources available to support learning in all settings, in its Standards of Education and Training (SET 3; **www.hcpc-uk.org/education**).

Programme standard 8: Quality management and governance

The education provider's quality management systems must make regular provision for the periodic review of the validity and relevance of the programme, such that it continues to reflect our standards, and meets the needs of the programme's stakeholders.

8.1 Assurance and enhancement of quality:

8.1.1 The quality management mechanisms that are in place should provide for periodic review of the programme's aims and intended learning outcomes and content, the strategies associated with programme delivery, and the assessment methods that are used to evaluate trainees' achievement of the learning outcomes. Overall, they should ensure that the programme continues to reflect contemporary learning, research and practice in psychology.

8.1.2 In order for the Society to be able to accredit a Doctoral programme, the programme must gain and successfully maintain ongoing approval from the Health and Care Professions Council.

8.1.3 Programmes will appoint appropriate External Examiners whose expertise will be of relevance to the breadth and depth of provision being offered. They will ensure that External Examiners are provided with adequate information to support their role, and that systems are in place to monitor action that is taken in response to any issues raised.

8.1.4 The External Examiner for the programme should be a Chartered psychologist (or eligible for Chartered psychologist status) holding full membership of the Division within whose domain the programme falls and must also be a practitioner psychologist registered with the Health and Care Professions Council (in the domain in which the programme falls). Other examiners with a broader range of qualifications and experience may be recruited in addition to undertake specific tasks (e.g. individual thesis examination).

8.1.5 Policies and procedures for the nomination and appointment of External Examiners must be explicit, and, where the programme makes use of additional individuals who are not qualified in the relevant modality (for example, for the individual external examination of trainees' research theses) clear and transparent criteria for their appointment must be in place.

8.2 Stakeholder engagement:

8.2.1 Trainees should have the opportunity to provide feedback on the design and delivery of the programme via the quality management mechanisms that are in place. Programmes should identify ways in which any difficulties identified (whether as informal or formal complaints) may be satisfactorily resolved, and changes to current systems and practices made where appropriate.

8.2.2 Both formal and informal mechanisms of quality assurance should be in place, including regular staff trainee liaison meetings. Issues raised by stakeholders, including trainees, should be documented and contribute to the quality management processes of the provider.

8.2.3 Providers of accredited Doctoral programmes must be able to demonstrate the involvement of appropriate stakeholders in the programme, particularly for the

purposes of internal review and governance. This would normally include trainees, practice placement providers, supervisors, and employers; if appropriate, service users and carers must also be involved.

8.2.4 There must be a clear channel of accountability for the work of the Director(s), acceptable to both the academic institution and psychologists within local health and social care providers. A programme based in a university must be regarded as a collaborative enterprise with the NHS, other healthcare providers, the services associated with the programme and other relevant stakeholders.

8.2.5 The programme must have a Programme Board/Training Committee on which the Director(s), teaching staff, clinical supervisors, relevant DCP subsystems, heads of services, trainees, purchasers of training and service users are represented in a way that reflects the joint enterprise upon which the programme is based. The Programme Board/Committee must have a written constitution and terms of reference. It must ensure that the interests of the different stakeholder groups are respected; it must be involved with the overall policy of the programme and the long-term objectives, and should oversee the work of the programme team and any sub-committee structure. It must be acceptable to the different groups involved in the programme and have wide support.

8.2.6 Programmes must work collaboratively with service users, carers and community representatives to identify and implement strategies for the active participation of these stakeholders in the programme. These strategies, and the practical support available to implement them, must be acceptable to the different groups involved in the programme and have wide support.

8.3 Programme management and organisation:

8.3.1 Programmes will normally be associated with a particular geographical area and it is expected that the major part of the funding, teaching and placement resources required by the programme will be provided from that area. Development of any new programme or a major change in any existing programme (which could affect other existing programmes) must be made in consultation with other programmes and local psychologists within the area to avoid impairing the viability of existing programmes. Such consultation must be undertaken from the earliest stage of programme development.

8.3.2 Funding arrangements must be clear and transparent. Programmes must have sufficient 'core' funding, such that there is normally an agreed minimum number of funded places in order to ensure stability and predictability in planning the programme. The budget must include funding adequate for agreed expenditure. The budget should be held by the Programme Director(s), or if there are other arrangements they must be clear and acceptable to the Programme Director(s), Programme Board/Committee and purchasers. The programme must have a financial plan detailing the funding available and how resources are/will be allocated. When a programme is expanding it is essential that the necessary additional resources required are identified and agreed with the purchasers before new trainees are accepted on to the programme. Similarly, any contraction of a programme must be managed in a clear and transparent way.

8.3.3 Each programme must be able to identify its own limitations and to indicate how it hopes to rectify these. This might include any limitations in providing learning and placement experiences with particular client groups or in particular clinical or service settings, and should indicate the likely impact of this for prospective trainees, commissioners and employers.

Rationale for inclusion

This standard is included because Accreditation through Partnership relies upon education providers having in place robust quality management mechanisms that facilitate self-evaluation of module and programme learning outcomes against the Society's accreditation standards and other indicators of academic standards. The Society recognises education providers' quality management mechanisms as a reliable source of evidence of continued achievement of the standards.

Guidance and signposting

- Part A of the UK Quality Code addresses Setting and Maintaining Academic Standards. Part C addresses the information that providers set out in relation to their arrangements for managing academic standards and quality assurance and enhancement, and the records they maintain of all arrangements for delivering higher education with others. Providers may also find it helpful to refer to a further five chapters from Part B of the Quality Code (**www.qaa.ac.uk**):
    - Chapter B5: Student Engagement, and in particular the role of students as partners in the assurance and enhancement of their educational experience.
    - Chapter B7: External Examining
    - Chapter B8: Programme Monitoring and Review
    - Chapter B9: Academic Appeals and Student Complaints, and in particular ensuring that students have opportunities to raise matters of concern without risk of disadvantage
    - Chapter B10: Managing Higher Education Provision with Others, which specifically highlights that degree-awarding bodies have ultimate responsibility for academic standards and the quality of learning opportunities irrespective of where these are delivered or who provides them.
- External peer review offers a valuable perspective upon the ways in which the programme compares to others of a similar nature nationally. With this in mind, enabling the Society to have sight of internal quality review reports and External Examiners' reports, and the programme's response to these, allows our reviewers to gain insight into the extent to which the education provider's quality management mechanisms function effectively for the benefit of trainees, and the discipline as a whole.
- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership in its Standards of Education and Training (SET 3) together with information about its programme approval and monitoring processes (**www.hcpc-uk.org/education**).
- All providers are encouraged to consider the ways in which employer feedback might be harnessed as part of the quality management and programme development process.

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Appendix 1: Example clinical practice portfolio

DOCTORATE IN CLINICAL PSYCHOLOGY

TRAINEE PORTFOLIO OF CLINICAL PRACTICE

Trainee...

Section A: **Log of clinical experiences**

Section B: **Therapy competencies**

Section C: **Psychological testing competencies**

Section D: **Cumulative record**

Section A: Log of clinical experiences

There are two logs:

1. **Clinical assessments and interventions – principal/joint work**

   Complete for all clinical contacts where you are the principal or joint lead.

Date: Date at which the service user was first seen/contacted.

Initials: Service user initials or other code.

Gender age: Client's gender and age (e.g. M42).

Presentation: Presentation identified or addressed by the trainee, not necessarily identical with those stated at referral (e.g. adjustment difficulties, severe challenging behaviour).

Assessment: Brief summary of assessment methods (e.g. family interview, school observation, neurodevelopmental assessment, case note analysis).

Intervention: Brief summary of any interventions undertaken with the client, family, carers, other professionals etc. (e.g. systemic therapy, CBT, consultancy, indirect work with staff etc).

Contact hours: Number of hours the service user (family, carers etc.) seen in face-to face contact. Each should have only one entry with the number of hours totalled at the end (e.g. 10).

Consultation hours: Number of hours spent consulting with staff, school etc.

All entries will need to be authenticated by a supervisor's signature.

2. **Log of non-therapy experiences**

This section should be used to list other types of clinical activity such as teaching, training, presentations, research activity, inter-professional liaison, multidisciplinary work, supervision, consultancy, service user organisation contacts, leadership experiences etc.

1. Log of clinical contacts – Trainee as Principal or Joint Therapist

Placement number and definition:...

Date	Initials	Gender & age	Presentation	Assessement	Intervention	Client contact hours	Consult hours

Supervisor signature:...

Trainee signature:...

(please add further pages as required)

2. Log of non-therapy experiences

Placement number and definition:...

Key experiences	Brief summary of nature of experience undertaken in this placement
Teaching/training/ supervision	
Consultancy/ indirect work	
Multidisciplinary/ inter-professional work	

Key experiences	Brief summary of nature of experience undertaken in this placement
Inter-agency liaison and influence	
Organisational initiatives and interventions	

Supervisor signature:...

Trainee signature:...

(please add further pages as required)

Section B: Therapy competencies

This section is proposed as one way of tracking the accumulation of model-specific skills across placements. These are examples only and are not meant to be prescriptive. Courses have freedom to choose which approach they teach in addition to CBT: Some may have one additional model, others may have more than one. However each needs to be subject to a systematic means of tracking the level of competence acquired by the trainee.

Cases where therapy competencies have been demonstrated within placements should be shaded in the following tables and certified by the placement supervisor. **Not every skill needs to be covered on all placements!**

A cumulative portfolio of CBT competencies should be kept across placements.

1. Cognitive Behaviour Therapy

*This competence model has been adapted from the CORE CBT competence framework for depression and anxiety disorders (**www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm**). It is intended to offer a means of tracking the development of the range of competencies identified as important in showing evidence of working within a cognitive-behavioural framework.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

Applied CBT in context of:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Adult																				
Older Adult																				
Child/Family																				
Intellectual Disability																				
Other (specify)																				
Other (specify)																				

Applied CBT to specific problems:																				
Phobia/Social Phobia/GAD/Panic																				
OCD																				
PTSD																				

Depression	
Psychosis	
Health related presentations	
Family functioning	
Adjustment and coping	
Addictive behaviours	
Eating disorders	
OTHER (please specify)	
OTHER (please specify)	

Demonstrated generic CBT skills:	
Socialisation and rationale of CBT treatment	
Identified cognitive distortions and biases	
Agreed and collaboratively set agenda for session content and structure	
Developed collaborative hypotheses	
Developed intervention plans	
Planned and reviewed 'homework'	

Used measures and self-monitoring to guide and evaluate therapy			
Demonstrated knowledge of safety behaviours and maintenance cycle and used to inform goals/targets			
Used problem solving			
Ended therapy appropriately and planned for the longer-term			
Selected and applied most appropriate CT and BT method			
Managed obstacles during therapy			

Specific Behavioural and Cognitive Therapy skills:			
Used exposure techniques			
Used Applied relaxation and/or applied tension			
Used activity monitoring and scheduling			
Implemented a contingency programme			
Elicited key cognitions/images			
Used thought records			

Identified and worked with safety behaviours	
Detected, examined and helped client/family/system reality test automatic thoughts/images	
Elicited key cognitions/images	
Identified and helped clients/families/systems modify assumptions, attitudes and rules	
Identified and helped client/family/system modify core beliefs	
Employed imagery techniques	
Planned and conducted behavioural experiments	
Promoted the development of consequential thinking	
Used alternative solution generation	
Parent training programme	
Able to develop formulation and treatment plan premised on a CBT model	
Ability to understand client/family's inner world and response to therapy	

Supervisor signature:...

Trainee signature:...

Date:.........................

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2. Psychodynamic Therapy

*This competence model has been adapted from the CORE psychodynamic competence framework (**www.ucl.ac.uk/clinical-psychology/CORE/psychodynamic_framework.htm**). It is intended to offer a means of tracking the development of the range of competencies identified as important in showing evidence of working within a psychodynamic framework.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied psychodynamic therapy in context of:																				
Adult																				
Older Adult																				
Child/Family																				
Intellectual Disability																				
Other (specify)																				
Other (specify)																				

Applied psychodynamic therapy to specific problems:										
Anxiety presentations										
Depression										
Relationship difficulties										
Personality presentations										
Presentations of childhood										
Health related presentations										
Addictive behaviours										
Eating disorders										
OTHER (please specify)										
OTHER (please specify)										

Experience in core psychodynamic competencies of:			
Assessed for suitability for dynamic psychotherapy			
Engaged client in psychodynamic approach			
Derived an analytic/psychodynamic formulation			

Recognised and worked with unconscious communication								
Explored the unconscious dynamics influencing relationships								
Helped the client become aware of unexpressed or unconscious feelings								
Managed boundaries within the therapeutic relationship								
Used therapeutic relationship as a mechanism of change								
Showed ability to work through the termination phase of therapy								
Able to adapt methods to work with children								
OTHER (please specify)								

Specific analytic/dynamic techniques:

Ability to make dynamic interpretations								
Made use of and worked with transference								
Made use of and worked with counter-transference								
Recognised and worked with defences								

Recognised and made use of projection and projective identification	
OTHER (please specify)	

Supervisor signature:...

Trainee signature:...

Date:...................................

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3. Systemic Therapies

*This competence model has been adapted from the CORE competence framework for systemic psychological therapies (**www.ucl.ac.uk/clinical-psychology/CORE/systemic_framework.htm**). It is intended to offer a means of tracking the development of the range of competencies identified as relevant to systemic approaches. A small 's' is used in tracking basic competencies, which can be used and applied in many areas where 'the system' is taken into account in assessing, developing understandings and interventions which may include a multi-layered definition of who 'the client' is. A big 'S' is used in tracking the specific skills drawn from systemic approaches. Use of a big 'S' implies further study and implementation of specific models of working, as in e.g. Family Therapy.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied systemic therapy in context of:																				
Adult																				
Older Adult																				
Child/Family																				
Intellectual Disability																				
Other (specify)																				
Other (specify)																				

Applied systemic therapy to specific problems:																											
Anxiety presentations																											
Depression																											
Relationship difficulties																											
Presentations of childhood																											
Developmental transitions																											
Family functioning																											
Health related presentations																											
Addictive behaviours																											
Eating disorders																											
OTHER (please specify)																											
OTHER (please specify)																											

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Demonstrated basic systemic competencies of:									
Demonstrated knowledge of systemic influences drawn from psychological and social theories (e.g. group processes, decision making in groups, minority influence, crowd culture)									
Conducted systemic assessment:									
Understood problem from a systemic perspective									
Gathered information from multiple perspectives									
Explained rationale and engaged client(s) in a developmentally appropriate way									
Developed and shared with client(s) systemic hypotheses and/or a systematic formulation									
Provided interventions from a systemic perspective:									
Helped client(s) identify and change problematic patterns									
Promoted change through tasks between sessions									

Monitored and reviewed progress in therapy

Managed endings appropriately

OTHER (please specify)

OTHER (please specify)

Specific Systemic competencies:

Demonstrated knowledge of Systemic principles and theories (e.g., circularity; multiple perspectives; repetitive patterns of interaction; trans-generational patterns)

Employed circular interviewing/questioning

Used reframing techniques to enable client(s) to understand the development and maintenance of the problem

Enabled client(s) to identify individual and family strengths

Used mapping techniques to identify current, historical and trans-generational patterns (e.g., ecomaps; lifelines; family circles)

Demonstrated ability to work with systemic team (e.g., reflecting team; reflection on process in supervision)																						
Demonstrated self-reflexive practice/ personal awareness (e.g., in supervision)																						
Demonstrated awareness of cultural diversity (e.g., in supervision; with reflecting team)																						
OTHER (please specify)																						
OTHER (please specify)																						

Supervisor signature:..

Trainee signature:..

Date:.........................

Section C: Psychological Testing Competencies

All performance and paper and pencil psychometric assessments should be logged in the following table. Tests should only be logged where the trainee has utilised the test as principal/joint lead in a case (not observation only). Supervisors should validate where test use is assured.

A cumulative log should be kept across placements.

Placement number and definition:...

1. Self-report/informant measures

Clinical use/Reason for assessment? (e.g. outcome measure, treatment planning etc.)	Age	Tests used	Administration (check)	Appropriate interpretation (check)	Supervisor signature

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2. Performance based psychometrics

Clinical use/Reason for assessment? (e.g. outcome measure, treatment planning etc.)	Age	Tests used	Administration *(check)*	Appropriate interpretation (check)	Supervisor signature

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Section D: Cumulative training record

The cumulative training records summarise clinical activity as benchmarked across the accreditation criteria for clinical presentations, service settings, age range, modes of work etc. The cumulative record should be used to plan further training requirements in the light of cumulative experiences to date. They also ensure that, by the end of training, a satisfactory range of experience will have been attained on which competencies have been evidenced. One record should be completed during each placement and the cumulative record updated at the end of each placement.

Recording should be done by shading a box for each domain a given case relates to. Each 'case' will undoubtedly have relevance to multiple domains. This process should be completed through discussion with your supervisor at case closure. The record should be signed by you and your supervisor at the end of placement and will be used to plan further placement experiences at appraisal. Records should be consistent with the information recorded in the log of clinical activities (section A).

The cumulative record should be updated at the end of each placement and be used in appraisal to plan future training experiences. This will also be utilised as evidence to inform the final training transcript.

Placement number and definition:...

	1	2	3	4	5	6	7	8	9	10	11	12+
Breadth and diversity of presentation												
Acute												
Enduring												
Mild												
Severe												
Organic												
Psychosocial												
Coping/adaptation												
Problem amelioration												
Challenging behaviour												
Communication difficulties												
Developmental period/age range												
Infancy/Pre-school												
Child												
Adolescent												
Adult												
Older Adult												

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Category	Sub-item
Intellectual functioning	Average
	Mild/specific cognitive deficits
	Moderate/severe cognitive deficits
Service delivery systems	Inpatient
	Residential/Supported
	Secondary
	Primary care
	Other
Levels of intervention	Individual
	Family
	Couple
	Group
	Organisational
	Via carer
Modes of work	Direct
	Indirect – staff/carers/schools

Category	Item
	Multi-disciplinary
	Other
Psychological model/ framework	Cognitive Behaviour
	Psychodynamic
	Systemic
	Humanistic
	Other (define)
Psychometrics	WAIS-IV
	WISC-IV
	WMS-IV
	CMS
	HADS
	SDQ
	IES-R
	Other (list)

Supervisor signature:...

Trainee signature:..

Date:.................................

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Cumulative Summary Record

	1	2	3	4	5	6	7	8	9	10	11	12+
Breadth and diversity of presentation												
Acute												
Enduring												
Mild												
Severe												
Organic												
Psychosocial												
Coping/adaptation												
Problem amelioration												
Challenging behaviour												
Communication difficulties												
Developmental period/ age range												
Infancy/Pre-school												
Child												
Adolescent												
Adult												
Older Adult												

Intellectual functioning		
Average		
Mild/specific cognitive deficits		
Moderate/severe cognitive deficits		
Service delivery systems		
Inpatient		
Residential/Supported		
Secondary		
Primary care		
Other		
Service delivery systems		
Individual		
Family		
Couple		
Group		
Organisational		
Via carer		
Service delivery systems		
Direct		
Indirect – staff/carers/schools		

	Multi-disciplinary								
	Other								
Psychological model/ framework	Cognitive Behaviour								
	Psychodynamic								
	Systemic								
	Humanistic								
	Other (define)								
Psychometrics	WAIS-IV								
	WISC-IV								
	WMS-IV								
	CMS								
	HADS								
	SDQ								
	IES-R								
	Other (list)								

Supervisor signature:...

Trainee signature:...

Date:...............................

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