



University  
of Glasgow

DOCTORATE IN CLINICAL PSYCHOLOGY

Trainee Handbook Appendices

2024-25



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## APPENDIX 2.1 DOCTORAL PROGRAMME STRATEGY GROUP

### CONSTITUTION Membership

#### Stakeholder NHS Boards

NHS Greater Glasgow & Clyde	Dr Ruth Stocks (Immediate Past Chair)
NHS Ayrshire & Arran	Dr Wendy van Riet
NHS Lanarkshire	Prof Patricia Graham
NHS Highland	Dr Allyson Turnbull-Jukes (Chair from December 2024)

#### Doctorate in Clinical Psychology Programme

Programme Director	Prof Hamish McLeod
Research Director	Recruiting – interim cover by Hamish McLeod
Clinical Practice Director	Dr Gavin Richardson
Head of Mental Health & Wellbeing	Prof Rory O'Connor <sup>2</sup>
Director of Selection	Dr Gavin Richardson
Chair of Supervisors' Sub-Group	Dr Cerys MacGillivray
NHS Education for Scotland	Prof Judy Thomson
DCP (Scotland)	Alison McMullen

Trainee Sub-Committee Representative There are two group representatives in each year. All are eligible to attend.

Service User Representative	David Wright
Local Tutor Representative	Dr Sally Dewis

### Terms of Reference

1. To set and review strategic objectives for the overall organisation, monitoring and development of academic and clinical training of the Programme.
2. To respond to proposals concerning the workforce planning and training and the appraisal of training needs in NHS Boards served by the Programme.

3. Where necessary, to appoint convenors of Sub-Committees and Specialist Working Groups.
4. To provide strategic direction for these Groups, to ratify and to receive and approve reports supplied by them to the PSG (see 3 above)
5. To amend and approve Constitutions of the various Programme Sub-Committees.

## **Standing Orders**

1. The Committee shall meet four times per year.
2. A quorum shall consist of six members (or their depute) with at least three stakeholder NHS Board representatives.
3. A stakeholder NHS Board is defined as any employing NHS Board of the University of Glasgow postgraduate Doctorate in Clinical Psychology Training Programme.
4. The Committee will nominate and elect the Chair and Chair Depute.
5. At least one Trainee representative will attend each of the PSG's meetings whenever possible.
6. The Trainee representative will have equal voting rights to all other members of the PSG. Proposals will be carried by a simple majority.
7. Stakeholder representation will reflect the composition of postgraduate Doctorate in Clinical Psychology Trainees.
8. The Committee shall have the power to co-opt for a specified time any necessary additional members.
9. Members unable to attend a meeting should send a depute or representative.
10. The position of Chair of the PSG will be held by a representative of one of the stakeholder NHS Boards and will rotate sequentially around each board on a two yearly cycle.

## **Sub-Committees**

1. Programme Organisers Group
2. Selection
3. Academic
4. Supervisors
5. Trainees
6. Carers and Service Users Group (CUSP)

## **Reporting Arrangements**

1. NHS Board representatives report through the structures of their respective Boards.
2. University representatives report through the structures of University of Glasgow.
3. Other stakeholder representatives report to their relevant bodies.

## **APPENDIX 2.2 DOCTORAL PROGRAMME STRATEGY GROUP – TRAINEE REPRESENTATION**

### **CONSTITUTION FOR TRAINEE REPRESENTATIVE**

#### **Tenure of Appointment**

Nomination of student representatives shall be made or renewed annually.

Two Trainees (taken from the pool of 6 year group representatives) should be nominated for attendance at each PSG meeting. however except in exceptional circumstances, only one should attend with the other acting as a deputy.

#### **Terms of Reference**

The Trainee representative should have the opportunity to be involved in all facets of PSG business deemed to be appropriate by the other PSG members and/or Trainee representative.

#### **Sub-Committees**

A Trainee will sit on a sub-committee or attend a specific meeting of a sub-committee only when the PSG feel this is necessary or the Trainee representative feels this to be important.

#### **Reporting Arrangements**

The Trainee representative(s) attending the PSG meeting will be responsible for disseminating information from this meeting to all other Trainees on the Programme. They should also endeavour to gain the opinions of other Trainees before providing feedback to the PSG.

## APPENDIX 2.3 SUPERVISORS' SUB-GROUP

### CONSTITUTION

#### Membership

Chair - Elected by sub-committee members.

At least one representative of each NHS Board area.

Members selected in agreement with NHS Board area Psychology

Professional Lead. Members must be on the Programme's list of accredited supervisors.

Local Area Tutors (LAT).

Clinical Tutors from the University of Glasgow

Programme. A Trainee representative

#### Terms of Reference

1. To provide expert opinion to the Programme Strategy Group (PSG) on developments or issues that impact on supervisors.
2. To advise on approval and accreditation processes relevant to supervisors.
3. To represent supervisor issues if approached to do so.
4. To support the trainee competence development agenda as requested by the PSG.
5. To plan and organise the Annual Supervisor Meeting.
6. To advise on professional practice issues.

#### Standing Orders

1. The sub-committee shall meet four times per year.
2. The Chair shall be a member of the Programme Strategy Group.
3. The Chair shall nominate a depute.
4. Sub-committee members shall elect the Chair on a two-yearly basis.
5. The sub-committee shall have the power to co-opt necessary additional members.

#### Links

The Chairperson will report to the Programme Strategy Group.

The group links to the Programme Organisers Group via Clinical Tutors.

Any supervisor can raise issues with the sub-committee.

The sub-committee is responsible for organising the annual supervisors meeting.

## APPENDIX 3.1 PROGRAMME CREDIT STRUCTURE

Module Number	Module Name	Module Code	Credits
1	Year 1; Foundations of Clinical Psychology	MED6027	30
2	Year 1; Foundation Clinical Practice 1	MED6025	45
3	Year 1; Foundation Clinical Practice 2	MED6033	50
4	Year 1; Foundation Knowledge, Understanding & Skills	MED6026	45
5	Year 1; Data Management & Analysis	MED6032	10
6	Year 1-2; Children, Young People and Families Theory & Practice	MED6023	50
7	Year 1-2; Learning Disability Theory & Practice	MED6028	50
8	Year 1-2; Research Design and Statistics	MED6030	15
9	Year 1-2; Research Practice 1	MED6031	45
10	Year 2; Advanced Professional Practice 1	MED6021	10
11	Year 1-3; Service Evaluation & Quality Improvement	MED6024	10
12	Year 2-3; Advanced Clinical Practice 1	MED6020	40
13	Year 3; Advanced Clinical Practice 2	MED6034	40
14	Year 2-3; Psychology and the Law	MED6029	10
15	Year 2-3; Research Practice 2	MED6007	80
16	Year 2-3; Advanced Professional Practice 2	MED6022	10



## APPENDIX 3.2 SUMMARY OF DCLINPSY ILOS MAPPING TO HCPC SOPS AND BPS COMPETENCIES

This mapping exercise is being repeated following the implementation of the new HCPC SOPS in September 2023.

<b>HCPC Standards of Proficiency (SoPs) for Clinical Psychologists (2015)</b>	<b>Examples* of HCPC SoP embedded in University of Glasgow DClinPsy Intended Learning Outcomes</b>
1 be able to practise safely and effectively within their scope of practice	11. work effectively at an appropriate level of autonomy, with awareness of the limits of one's own competence, and accept accountability to relevant professional and service managers
2 be able to practise within the legal and ethical boundaries of their profession	2. display a professional and ethical value base, including that set out in the BPS Code of Conduct, the DCP statement of the Core Purpose and Philosophy of the Profession, the DCP Professional Practice Guidelines, and the HCPC Standards of Conduct, Performance, and Ethics.
3 be able to maintain fitness to practise	11. - take responsibility for one's own personal learning needs and develop strategies for meeting these. - develop strategies to handle the emotional and physical impact of one's own practice and seeking appropriate support when necessary, with good awareness of boundary issues.
4 be able to practise as an autonomous professional, exercising their own professional judgement	11. - work effectively at an appropriate level of autonomy, with awareness of the limits of one's own competence, and accept accountability to relevant professional and service managers.
5 be aware of the impact of culture, equality and diversity on practice	4. show professional competence relating to personal and professional development and awareness of the clinical, professional and social

	context within which the work is undertaken.
	11. - understand the impact of difference and diversity on people's lives, and their implications for working practices.
6 be able to practise in a non-discriminatory manner	11. - understand ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.
7 understand the importance of and be able to maintain confidentiality	2. display a professional and ethical value base, including that set out in the BPS Code of Conduct, the DCP statement of the Core Purpose and Philosophy of the Profession, the DCP Professional Practice Guidelines, and the HCPC Standards of Conduct, Performance, and Ethics.
8 be able to communicate effectively	12. display high level communication and teaching skills  8. - recognise when (further) intervention is inappropriate, or unlikely to be helpful, and communicate this sensitively to clients and carers.
9 be able to work appropriately with others	6. - development and maintenance of effective working alliances with clients, including individuals, carers and services.  7 - use formulations to assist multi-professional communication, and the understanding of clients and their care.  13 - working effectively in multi-disciplinary teams.
10 be able to maintain records appropriately	2 (as above)
11 be able to reflect on and review practice	2. (as above)  3. have high level clinical and research skills and demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation,

	intervention and evaluation.
	5. - demonstrate self-awareness and work as a reflective practitioner.
	- be able to think critically and reflectively.
12 be able to assure the quality of their practice	9. display high level evaluation skills. - audit clinical effectiveness.
	11. - use supervision to reflect on practice, and making appropriate use of feedback received.
13 understand the key concepts of the knowledge base relevant to their profession	1. demonstrate knowledge and understanding of psychological theory and evidence, encompassing specialist client group knowledge across the profession of Clinical Psychology and the knowledge required to underpin clinical and research practice
14 be able to draw on appropriate knowledge and skills to inform practice	3. (as above) 10. - identify and critically appraise research evidence relevant to practice.
15 understand the need to establish and maintain a safe practice environment	11. - understand ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants. 13. - adapt practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues.

*\*Note: examples listed are illustrative, not exhaustive, as the SoPs are addressed across multiple ILOs. Dash denotes sub-section.*

**BPS Accreditation Standards  
(2016, Section 2.2)**

**Overarching goals,  
outcomes, ethos & values**

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological well-being 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

**Examples\* of BPS Standards embedded  
in University of Glasgow DClinPsy  
Intended Learning Outcomes**

2. display a professional and ethical value base, including that set out in the BPS Code of Conduct, the DCP statement of the Core Purpose and Philosophy of the Profession, the DCP Professional Practice Guidelines, and the HCPC Standards of Conduct, Performance, and Ethics.
3. have high level clinical and research skills and demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.
6. 7. & 8. Display high level psychological assessment, formulation and intervention skills.
1. demonstrate knowledge and understanding of psychological theory and evidence, encompassing specialist client group knowledge across the profession of Clinical Psychology and the knowledge required to underpin clinical and research practice
4. show professional competence relating to personal and professional development and awareness of the clinical, professional and social context within which the work is undertaken.

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.

11. - understand the impact of difference and diversity on people's lives, and their implications for working practices.

13. - adapt practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues.

3. have high level clinical and research skills and demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.

13. display high level service delivery skills; - adapt practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues. - working with users and carers to facilitate their involvement in service planning and delivery.

13. - understanding of consultancy models and the contribution of consultancy to practice.  
- working effectively in multi-disciplinary teams.

9. display high level evaluation skills; - select and implement appropriate methods to evaluate the effectiveness, acceptability and broader impact of interventions (both individual and organisational), and use this information to inform and shape practice. Where appropriate this will also involve devising innovative procedures. - audit clinical effectiveness.

10. display high level research skills; -

identify and critically appraise research evidence relevant to practice. - conduct service evaluation

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.

2. (as above)

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.

4. (as above)

5. - demonstrate self-awareness and work as a reflective practitioner; - be able to think critically, reflectively, and evaluatively.

11. display high level personal and professional skills.

*\*Note: examples listed are illustrative, not exhaustive, as the Standards are addressed across multiple ILOs; dash denotes sub-section.*

<b>BPS Core Competencies (2017)</b>	<b>UoG DClInPsy ILOs</b>
1. Generalisable meta-competencies	Display high level transferable skills and meta-competencies
2. Psychological assessment	Display high level psychological assessment skills.
3. Psychological formulation	Display high level psychological formulation skills.
4. Psychological intervention	Display high level intervention skills.
5. Evaluation	Display high level evaluation skills.
6. Research	Display high level research skills.
7. Personal and professional skills and values	Display high level personal and professional skills and values.
8. Communication and teaching	Display high level communication and teaching skills.
9. Organisational and systemic influence and leadership	Display high level service delivery skills.

	Competency	Module 1	Module 2	Module 3	Module 4	Module 5	Module 6	Module 7	Module 8	Module 9	Module 10	Module 11	Module 12	Module 13	Module 14	Module 15	Module 16
BPS Competence Domains																	
Meta-competencies	1	YES	YES	YES	YES		YES	YES		YES	YES	YES	YES	YES	YES		YES
Meta-competencies	2	YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Meta-competencies	3	YES	YES	YES	YES		YES	YES		YES	YES	YES	YES	YES	YES		YES
Meta-competencies	4	YES	YES	YES	YES		YES	YES				YES	YES	YES	YES		YES
Meta-competencies	5	YES	YES	YES	YES	YES	YES	YES			YES	YES	YES	YES		YES	YES
Meta-competencies	6	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Meta-competencies	7	YES	YES	YES	YES	YES	YES	YES		YES	YES	YES	YES	YES		YES	YES
Meta-competencies	8	YES	YES	YES			YES	YES		YES	YES		YES	YES		YES	YES
Psychological Assessment	9	YES	YES	YES	YES		YES	YES			YES		YES	YES	YES	YES	YES
Psychological Assessment	10	YES	YES	YES	YES		YES	YES			YES		YES	YES	YES		YES
Psychological Assessment	11	YES	YES	YES	YES		YES	YES					YES	YES	YES	YES	YES
Psychological Assessment	12		YES	YES	YES	YES	YES	YES					YES	YES	YES	YES	
Psychological Assessment	13	YES	YES	YES	YES		YES	YES			YES		YES	YES	YES	YES	YES
Psychological Formulation	14		YES	YES	YES		YES	YES			YES		YES	YES	YES		YES
Psychological Formulation	15		YES	YES			YES	YES			YES		YES	YES	YES		
Psychological Formulation	16		YES	YES			YES	YES			YES		YES	YES	YES		YES
Psychological Formulation	17		YES	YES			YES	YES			YES		YES	YES			YES
Psychological Formulation	18		YES	YES			YES	YES			YES		YES	YES			YES
Psychological Formulation	19		YES	YES			YES	YES					YES	YES	YES		YES
Psychological Formulation	20		YES	YES	YES		YES	YES			YES		YES	YES	YES		YES
Psychological Formulation	21		YES	YES	YES		YES	YES			YES		YES	YES	YES		
Psychological Formulation	22		YES	YES			YES	YES			YES		YES	YES	YES		
Psychological Formulation	23		YES	YES			YES	YES			YES		YES	YES			YES
Psychological Intervention	24		YES	YES			YES	YES			YES		YES	YES			YES
Psychological Intervention	25		YES	YES	YES		YES	YES			YES		YES	YES	YES		
Psychological Intervention	26			YES			YES	YES					YES	YES	YES		
Psychological Intervention	27			YES			YES	YES					YES	YES	YES		
Psychological Intervention	28		YES	YES	YES		YES	YES			YES		YES	YES			YES
Psychological Intervention	29		YES	YES			YES	YES			YES		YES	YES	YES		YES
Psychological Intervention	30		YES	YES			YES	YES					YES	YES	YES		
Psychological Intervention	31		YES	YES				YES			YES		YES	YES			YES
Psychological Intervention	32		YES	YES			YES	YES			YES		YES	YES			YES
Psychological Intervention	33		YES	YES			YES	YES					YES	YES			
Evaluation	34		YES	YES		YES	YES	YES	YES		YES	YES	YES	YES	YES	YES	
Evaluation	35		YES	YES		YES	YES	YES	YES	YES		YES	YES	YES		YES	YES
Evaluation	36	YES	YES	YES		YES	YES	YES		YES		YES	YES	YES		YES	YES
Evaluation	37		YES	YES		YES	YES	YES		YES	YES	YES	YES	YES		YES	YES
Evaluation	38		YES	YES		YES	YES	YES	YES	YES			YES	YES		YES	



## APPENDIX 3.3 GUIDANCE ON REQUIREMENTS FOR ALIGNED TRAINING PATHWAY

### Clinical Psychology Training in Scotland Guidance on requirements for Aligned Training Pathways

#### **1. Purpose of the guidance**

This guidance has been produced to provide an underpinning framework for nationally commissioned aligned training pathways for any defined clinical population.

The guidance provides information to:

1. enable boards to consider whether they can offer an aligned plan
2. enable descriptions to be made available to applicants
3. inform the content of contracts between NES and the Universities
4. inform the content of the SLA between NES and NHS Boards.

#### **2. General points**

Trainees with training pathways aligned to specific clinical populations will follow all core elements of the training as per BPS and HCPC guidance requirements to qualify as clinical psychologists.

The principle underlying aligned training pathways is one of increasing experience with a defined clinical population and not altering either competencies required or Trainee workload. The main feature that distinguishes the aligned route from the generic route is the advanced specification of the enhanced experience with a defined population. The aim is to help expand workforce capacity in high priority clinical areas.

In order to take account of the variation in service models and current inequity of service provision, flexibility in putting together aligned training plans is required.

#### **3. Clinical practice requirements**

- All training plans will meet the clinical practice requirements for Clinical Psychology as defined by the HCPC and BPS.
- Opportunities for acquiring generic competencies while working with the defined clinical population will be maximised in the training plan.
- Opportunities for acquiring competencies that are specific to the defined clinical population will also be maximized analogous to existing arrangements for elective/specialist placements.
- A coordinating Clinical Practice Supervisor with a minimum of 2 years relevant post qualification clinical expertise will oversee the Clinical Practice training

plan.

- Trainees on aligned training pathways will carry out one or more placements enabling substantial access to the defined population.
- Supervisors may also need to allow for extra time in supervision with trainees and to provide additional reading materials. This is particularly pertinent when Trainees are undertaking work not yet covered in core teaching.
- Trainees following aligned pathways will have preferential and prioritised access to any opportunities for additional experiences relevant to the defined population.

#### **4. Academic requirements**

- All training plans will meet the academic requirements for Clinical Psychology as defined by the HPC and BPS.
- Opportunities for undertaking academic work that is relevant to the needs of the defined population will be maximized.
- Programme Teams will co-ordinate the academic elements of the aligned training plan.
- Wherever possible academic and research assignments will focus upon topics highly relevant to the defined population.
- As part of any aligned training plan, the Trainee will be encouraged to carry out the research components of their training in areas relevant to their defined population. At least one of these components will be relevant to their defined population. In addition the training plan may specify for the major research component to be carried out in an area relevant to the defined population.

#### **5. Implementation advice for specific clinical population training pathways**

Additional advice about implementing the above framework for specific clinical population training pathways will be made available to NHS Board and Programme Teams.

## APPENDIX 3.4 CONSENT TO PARTICIPATE IN CLINICAL TRAINING



### Consent to participate in clinical training

#### Information sheet for trainees

##### **Background: Possible stresses linked to clinical training**

For the most part trainees report that their training programme is stimulating and interesting. However, because of its aims and focus, training in Clinical Psychology can present personal challenges and it is widely recognised that clinical training can be stressful. At some point in their training it is quite likely that trainees will feel uncomfortable or upset by material to which they are exposed. While this is often a transient experience, some trainees may experience a more sustained impact. Examples of “triggers” for this upset might occur when:

- trainees recognise some aspect of themselves in the clinical material
- teaching makes them more uncomfortably aware of long-standing mental health issues which they had previously managed well
- some of the issues being discussed echo current dilemmas or life-events (such as bereavement, or relationship difficulties)
- some of the content of teaching is at variance with the trainee’s personal, cultural or religious beliefs or values

Teaching on the Programme is not restricted to passive listening; it also involves active participation in exercises, which many trainees find rather stressful. For example, most people find it personally challenging to participate in role-plays in front of their peers, disclose personal feelings, or discuss their personal viewpoints. All of these often occur in experiential sessions or in sessions where the focus is on feelings about professional work and career development. Discussion of personal feelings and viewpoints can also be an important part of clinical supervision especially where emotional resonances can occur in relation to placement experiences.

Focusing on the ways in which teaching and training could be stressful is not intended to indicate that there is any intent to make it so. When planning training, the Programme takes into account the potential impact of the teaching content and the teaching method, especially when the topic is a sensitive one. We know

that learning is inhibited by high levels of stress, which means that there are powerful educational reasons for keeping any stresses at an optimal level. All teaching modules are co-ordinated and developed by an academic member of staff in conjunction with an NHS colleague and feedback from trainees is gathered for each module and used to inform and develop both the teaching content and the teaching methods employed. Likewise clinical placements are jointly co-ordinated and monitored by NHS and University Tutors with feedback from trainees.

It is often the case that the title of a lecture in the timetable gives an indication of the nature of the content to be covered. However, some lectures may touch on material that some trainees may find personally resonant but where this was not obvious from the lecture title (e.g. mentioning bereavement in a lecture about dementia, or mentioning childhood trauma in a lecture about formulation). It is not always feasible for lecturers to provide content warnings about all topics they will mention, but the Programme team endeavours to provide lecture slides in advance for trainees to view.

### **Support for trainees**

Although we expect trainees to be appropriately robust in relation to the issues which training presents them with, we also expect them to be able to reflect on and to talk about their feelings. All professionals need to recognise when seeking support from others is the most appropriate action. The Programme Handbook (Chapter 5) contains clear information about sources of support. Although it can be very hard to draw attention to difficult personal experiences, suffering in silence is neither helpful nor a good model for a professional career.

### **Your consent to participate in clinical training**

It is a requirement of the Health and Care Professions Council (HCPC) that when students participate in clinical teaching they have given informed consent to this. For this consent to be meaningful it is important to set out the Programme's expectations and the rights of trainees.

### **Programme expectations in relation to clinical training**

The Programme expects that trainees will actively participate in all aspects of the clinical, academic and research training, including:

- Clinical placements
- Lectures
- Experiential exercises which take place as part of lectures
- Workshops on clinical topics and reflective practice
- Role-play as part of the above activities (this may include taking the role of both therapist and client; giving feedback to peers; and receiving feedback from peers, carers, service users, actors and lecturers)
- Research projects

Where a trainee finds participation difficult they are entitled to withdraw from an exercise, but the Programme expects them to do this in an appropriately professional manner. If their level of personal distress is very high and results (for example) in prolonged withdrawal from specific areas of teaching, it is expected that the trainee take appropriate action to address this, to enable their return to an appropriate level of participation. This would normally include discussion with

their University Adviser, who can advise on ways to appropriately manage difficult reactions to teaching activities.

In practical terms, trainees who find themselves distressed during a lecture or a workshop are entitled to leave, but should do so as quietly as possible, returning if they feel able to, and if possible discussing their absence with the lecturer or workshop leader. Trainees who feel that a workshop task is too personally demanding are entitled not to participate, but should do so in an appropriately negotiated manner, if possible discussing this with the lecturer.

### **Disclosure of personal information**

During training there should be no pressure on trainees to disclose personal information that they feel uncomfortable revealing and especially personal information, which they do not see as relevant to the task of training. However, the nature of the Programme means that discussion of personal feelings in relation to professional development is often appropriate and necessary, and there is an expectation that trainees will be open to discussion of these feelings if these are relevant to their clinical work and professional development.

### **Confidentiality**

Trainees who discuss their experience of stress arising from clinical training (or indeed any personal issue) with a member of staff are entitled to the usual assurance of confidentiality that applies in clinical contexts. This means that information that they disclose will not usually be discussed with third parties without their consent and/or knowledge. As in clinical contexts, a guarantee of confidentiality cannot be absolute, as might be the case if there were serious concerns about the welfare of the trainee. Any such breaches would be rare, and would usually be discussed with the trainee.

The HCPC publishes guidance relating to confidentiality on their website<sup>3</sup>, and this expands on the principles set out in this paragraph.

### **Consenting to participate in clinical training**

At the end of this document is a formal consent form. Signing it means that you acknowledge and accept the expectations set out above and have had a chance to clarify what is expected of you during training. However, although you are consenting to participate in training, this consent is not absolute and includes the right to withdraw from some training experiences if there are exceptional circumstances or good grounds for doing so. In circumstances where withdrawal from a training experience is justified, alternative ways of acquiring and demonstrating the relevant knowledge, skills, and competencies may be negotiated<sup>4</sup>.

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3

<sup>4</sup> This document has been adapted from the form 'Consent for participation in clinical teaching' developed by Professor Tony Roth, Doctoral Course in Clinical Psychology, University College London



University  
of Glasgow

## Doctorate in Clinical Psychology

### Consent to participation in clinical training

	please indicate with a cross
<p>I have read the background information provided by the Programme in Appendix 3.4 of the Handbook which:</p> <p>a) acknowledges the potential stresses inherent in clinical training</p> <p>b) sets out the Programme's expectations of trainees in relation to their participation in clinical training.</p>	
<p>I am aware that I am not obliged to sign this form.</p>	
<p>I am aware of the relevant section (Chapter 5) of the Programme Handbook which provides details of the sources of support offered by the Programme and by external agencies.</p>	

I consent to participate in the clinical training provided by the University of Glasgow Doctorate in Clinical Psychology Programme

Name of trainee: .....

Signature: .....

Date: .....

## APPENDIX 5.1 MATERNITY, PATERNITY, AND PARENTAL LEAVE NOTIFICATION FORM



### MATERNITY LEAVE NOTICE

Trainee Name:

Intake Year:

Matriculation Number:

Intended Start Date of Maternity Leave:

Provisional Return Date:

I confirm that I have formally notified all of the following people:

**Programme Director**  
**Examinations Officer/Academic Director**  
**Clinical Practice Director**  
**NHS Line Manager**  
**NHS Local Area Tutor**  
**Allocated Clinical Tutor**

Comments/Additional Information:

PLEASE SUBMIT THIS COMPLETED FORM VIA EMAIL TO:

[dclinsy@glasgow.ac.uk](mailto:dclinsy@glasgow.ac.uk)

<b>OFFICIAL USE ONLY</b>	MyCampus Updates:
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# APPENDIX 6.1 INDIVIDUAL LEARNING PLAN SAMPLE

## University of Glasgow/West of Scotland Clinical Psychology Training Programme Individual Learning Plan

Name of Trainee:

NHS (Health Board) Area:

Training Duration: 3 years

Intake Date:

End Date:

Year	Training Modules	Planned Placements	Supervisor
1	Foundations of Clinical Psychology Foundation Clinical Practice I (6 month placement plus Adult Mental Health teaching) Foundation Clinical Practice II (5 month placement plus Adult Mental Health teaching) Foundation, Knowledge, Understanding and Skills (Neurosciences, Physical Health, Older Adult, Psychosis, Addictions) Service Based Evaluation	1. Adult Core Competencies (10.5 months)	To be proposed by Locality Tutor / NHS Psychology Manager
2	Children, Young People and Family Theory and Practice (6 month placement plus child/family teaching) Research Methods (Preliminary Research Proposal / Critical Appraisal) Learning Disability Theory and Practice (6 month placement plus Learning Disability Teaching) Research Practice I (Major research proposal, Systematic Review Outline) Advanced Professional Practice I Evidence Based Practitioner (Single n Proposal)	2. Children, Young People & Family (6 months)* 3. Learning Disability (6 months)* *placements in either order	To be proposed by Locality Tutor / NHS Psychology Manager
3	Advanced Clinical Practice I (6 month placement) Advanced Clinical Practice II (6 month placement) Psychology and the Law Research Practice II (Major Research Project) Advanced Professional Practice II	4. Advanced Practice I (6 months) 5. Advanced Practice II (6 months)	To be proposed by Locality Tutor / NHS Psychology Manager

Clinical Research Portfolio Title: .....

Name of Research Supervisor: .....

Signed: ..... (NHS Manager) Date .....

Signed: ..... (Programme Director) Date .....

Signed: ..... (Trainee) Date .....

Review Date 1:

Review Date 2:

Review Date 3:



## APPENDIX 6.2 BPS GUIDELINES FOR CLINICAL SUPERVISION

Please consult Moodle for the most up to date version of this guidance or Check the BPS website: <https://explore.bps.org.uk/content/report-guideline/bpsrep.2024.rep178>

## APPENDIX 6.3 SAMPLE PLACEMENT AGREEMENT

### Placement Agreement Template

<b>Trainee</b>			
<b>Alignment</b>			
<b>Supervisor</b>			
<b>Module number</b>			
<b>Placement Specialty and location</b>			
<b>Start date:</b>		<b>End date:</b>	

The following is a general guide and should be adapted to local circumstances. The document should capture the key elements of the initial placement discussion.

#### Placement paperwork

Supervisor and trainee should agree and acknowledge the following:

	Acknowledge
The placement agreement will be submitted within two weeks of the start of placement	
Both trainee and supervisor have access to TURAS Portfolio where placement activity will be recorded by the trainee and acknowledged by the supervisor	
A formative version of the Supervisor's Evaluation of Clinical Competence (available in TURAS Portfolio) will be completed in advance of the mid placement meeting	
A summative version of the Supervisor's Evaluation of Clinical Competence (available in TURAS Portfolio) will be completed two weeks before the end of placement date	

#### PLACEMENT DAYS (please indicate arrangements for trainee and supervisor)

Trainee:

<b>A.M</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>
<b>P.M</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>

Supervisor:

<b>A.M</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>
<b>P.M</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>

## SUPERVISION MEETINGS

This section should include:

- Day, time and duration of formal supervision session
- Opportunities for informal contact
- Arrangements for cover in the event of planned or unplanned absence of

supervisor:

Where more than one supervisor is involved, please refer to “**split placement**” guidelines.

Name and location of secondary supervisor:

## INTENDED LEARNING OUTCOMES

Supervisor and trainee should refer to the handbook outline of the ILOs for the current module related to the placement and, with the exception of the initial first year placement, draw also from trainee’s end of placement meeting summary form. This provides a review of the trainee’s previous experience and should be

incorporated into any programme recommendations or ILOs (Intended Learning

Outcomes).

## CONTENT

This should include reference to the various direct and indirect activity in which the trainee will be involved over the course of placement and may be structured as follows:

### Induction process

Plans for the early part of the placement including:

- Access to local policies and procedures documents relating to Health, Safety and Welfare policies
- Arrangements for identifying any additional local training that needs to be completed.
- Expectations of the service and the supervisor regarding report writing and correspondence, including expected timescales for completion of clinical

Please note detail here:

reports. Visits to local services which are seen as integral to placement.

### Caseload

This section should include:

- Range and number of cases\*.
- Types of treatment and assessment methods.
- Outline of clinical activity including:
  - Opportunities for direct and indirect clinical work
  - Expectations of the type of clients with whom the trainee will work with, including arrangements to ensure appropriate range and diversity of clients.
  - Therapeutic approaches to clinical work.

- Clinical and professional meetings that the trainee will attend.

*\* It is recommended that, once a full case load is established, this should not exceed 50% of time spent on placement.*

### Supervision

This section should include:

- Day, time and duration of formal supervision session
- Opportunities for informal contact
- Arrangements for cover in the event of planned or unplanned absence of supervisor
- Methods/models of supervision

- Where more than one supervisor is involved, please refer to “**split placement**” guidelines (in Moodle) and specify whether there will be a separate agreement, who will be the co-ordinating supervisor and the process for submitting the Evaluation of Clinical Competence documents

(at mid placement and end of placement).

**Observations**

This section should include:

*Observations of Trainee by supervisor:* Frequency and methods of observations and evaluation including methods; plan for feedback; use of structured observation tools; use of recordings (and associated information governance

processes).

*Observations of supervisor by trainee:* Frequency and timing. Observations of practice/modelling should occur across the placement. Supervisors should attempt to model key stages including assessment, formulation, intervention, and

discharge.

**Further Professional Practice**

This section should include other aspects of professional work to be considered within the context of the placement including ILOs relevant to:

- working within professional guidelines,
- teaching and training other professionals,
- opportunities for the exercise of leadership skills (e.g., supervision, consultation)
- supervising others
- opportunities for service-user consultations and inter-professional learning on placement
- Audit and research

**OTHER PLANNED EXPERIENCES**

This section is for noting other activities e.g., regular meetings, group work, clinics, and hospitals to be attended.

### **FACILITIES**

Trainees should have at minimum:

- appropriate access to desk space,
- appropriate access clinic rooms,
- appropriate access to technology (including remote access where necessary)
- adequate secretarial support (in line with resource provision for the rest of the team).

Acknowledge

Other facilities such as access to resources and library should be described in

this section.

### **DATES OF**

Mid-Placement Review:

End of Placement Review:

SIGNATURE OF TRAINEE .....

SIGNATURE OF SUPERVISOR .....

DATE .....

.....

.....

.....

.....

.....

.....



## APPENDIX 6.4 PLACEMENT DOCUMENTATION INSTRUCTIONS

Documentation	How will the documentation be used?	At what time points will the documentation be used, and by whom?	Programme Submission Date
Placement Agreement	To identify and evidence objectives of the placement in line with Module Intended Learning Outcomes. Set at the outset of placement and used as a basis for monitoring progress.	<b>Beginning of Placement</b> Supervisor and Trainee <b>Midplacement Review</b> Supervisor and Trainee <b>Placement Visit</b> Placement Visitor, Supervisor and Trainee	2 weeks after commencement of placement  Submitted by trainee via Clinical Practice Secretary
Trainee - Portfolio Activity Tracker			
Portfolio Activity Tracker	To identify and evidence Trainee experience on placement	<b>Midplacement Review</b> Supervisor and Trainee <b>End of placement meeting</b> Trainee and Clinical Tutor	Maintain current and complete record of placement activity
Reflective Notes	To identify how developing clinical experience (as evidenced in the Portfolio/Log Book of Clinical Activity) relates to Intended Learning Outcomes	<b>Placement Visit</b> Clinical Tutor, Supervisor and Trainee <b>Individual Learning Plan Review</b> Trainee and Member of the Programme Team <b>End of Placement Meeting</b> Clinical Tutor and Trainee	
Supervisor – Evaluation of Clinical Competence			
Evaluation of Clinical	To identify and evaluate how developing clinical experience	<b>Midplacement Review</b> Supervisor and Trainee <b>Placement Visit</b> Placement Visitor, Supervisor and Trainee	One week before Mid Placement visit: (formative version) submitted in Portfolio

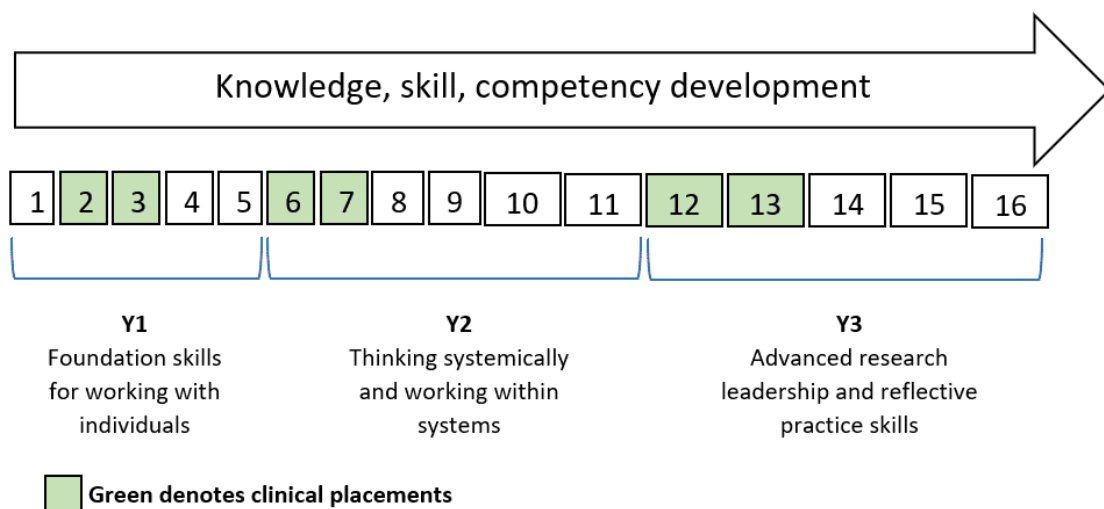
Competence Form	relates to Intended Learning Outcomes	<b>Individual Learning Plan Review</b> Trainee and Member of the Programme Team	Two weeks before end of placement (summative version) submitted in Portfolio
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Trainees also complete and submit written feedback on the placement in the *Trainee Feedback on Placement Form* at the end of the Module placement.

## OVERVIEW

### Three year Pathway

Trainees on the three year pathway will complete **six** clinical placements over the course of their **thirty six months** on the Programme. As you can see in the figure below, trainees on the three year pathway will have two placements across each year.

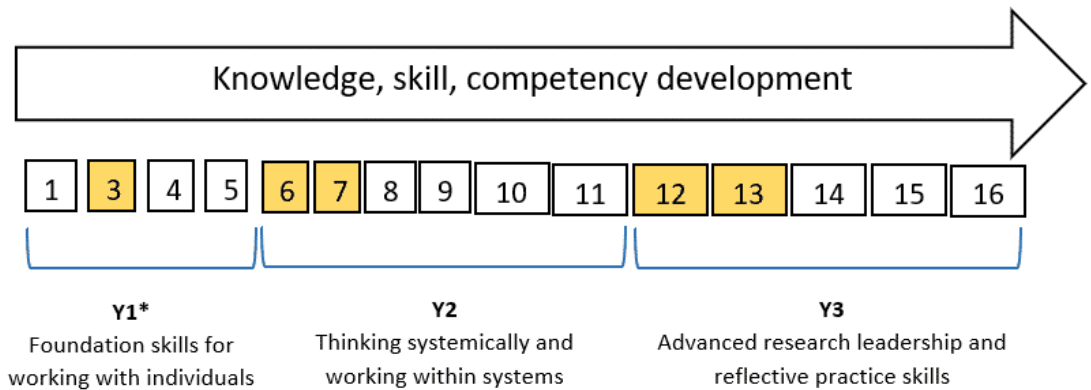


### Timeline of placement modules across the Three Year Pathway through Clinical Psychology doctoral training.

During year two, trainees will complete module 6 and module 7. These can be taken in either order

### Accreditation of Prior Learning (APL) Pathway

Trainees on the APL pathway will complete **five** clinical placements over the course of their **thirty-one months** on the Programme. Trainees on this pathway will have successfully completed one of the two NES funded MSc Programmes delivered in Scotland and spent some time in clinical practice. Further information is available [here](#). APL trainees are accredited with the initial clinical placement (module 2: see below) based on their previous study and experience



## Practice placement module

\* Accreditation of Prior Learning pathway are not required to complete module 2

### Timeline of modules across the APL Pathway through Clinical Psychology doctoral training.

During year two, trainees will complete module 6 and module 7. These can be taken in either order.

## PLACEMENT DOCUMENTATION

For each Module, both Trainee and Clinical Supervisor complete placement documentation.

### Placement Agreement

The placement agreement should be drawn up by supervisor and trainee, in the context of the trainee's previous experience. The placement agreement should incorporate time for the trainee to complete any placement based research (e.g. Service Based Evaluation). The planned experiences during the first half of the placement should also reflect the Intended Learning Outcomes of the relevant Module, as laid out clearly in the relevant Supervisor Evaluation Form.

The Placement Agreement should include:

1. Overall aims and objectives of placement experience
2. A statement of Intended Learning Outcomes relevant to the placement
3. Name and contact details of the back-up supervisor
4. Plans for induction, including health & safety and risk induction
5. Trainee/Supervisor responsibilities including
  - a. Discussion of self care and work/home balance
  - b. Dealing with personal issues that may arise in the course of the trainee's work
  - c. Communication (written and verbal) including service deadlines, access to template/example correspondence
  - d. Review of risk and therapist/service user safety
6. Therapeutic models adopted in the setting

7. Explicit plans for weekly clinical supervision
  - a. Format and style of supervision meetings
  - b. Process for recording content and action points
  - c. Formats for developing theory practice links e.g. case presentation, role play, review of recordings
  - d. Models of supervision/reflective practice
8. How and when supervisor will observe trainee:
  - a) in direct clinical work on at least 5 occasions for each Module (this should include at least part of the assessment phase of both a treatment and a cognitive assessment case, including administration of appropriate assessment instruments; and early, middle and end of (not necessarily the same) treatment case)
  - b) in other settings (e.g. team meetings, liaising with other professionals)
  - c) Use of structured tools during observation and method of feedback
7. How and when trainee will observe supervisor (on at least 5 occasions for each Module) and other professionals (as available).

#### **Reflective Portfolio**

- Portfolio Activity Tracker
- Reflective Notes

As part of the formal examination system and as a reflective record of the development of clinical skills and competencies, trainees are required to complete the Logbook of Clinical Activity and the Reflective Notes documentation while on placement. Together, these documents comprise the trainee's Reflective Portfolio.

The *Portfolio Activity Tracker* must be completed as an ongoing activity while on placement. Portfolio should provide a current and complete record of placement activity. The data within Portfolio will be utilised at specific time points throughout the Course - Midplacement Review, Placement Visit, and ILP Review and end of placement. If gaps in experience are identified, then trainees should consider how these will inform and shape individual learning plans, and include a consideration of further experience needed in the Reflective Notes.

The *Reflective Notes* are designed to assist the trainee in monitoring and reflecting on learning experiences on clinical placement. Each section relates to an important area of professional practice, and relates to intended learning outcomes (ILOs) for the Module. (The document is available electronically and short notes should be typed for submission. The supervisor will use a 'parallel' form with the same competencies, in order to evaluate the trainee's progress and to form a basis for constructive advice.)

Reflective Notes must be completed prior to the Midplacement Review with the placement supervisor(s). This process allows self-assessment of progress so far, but also allows trainee and supervisor to collaboratively identify gaps in experience and to decide upon appropriate action. This review, along with details of the Placement Agreement, will inform discussion during the Placement Visit from a member of the programme team.

The Reflective Notes should be submitted at the end of the Module. The use of a personal reflective diary may be used to aid in the process of reflection. The reflective diary will not be viewed by any other person, and will not be submitted for inspection. It will be a private and personal aid, for trainees to use at key points in the placement to reflect on powerful learning experiences as they occur.

#### **Trainee Feedback on Placement**

The trainee is given the opportunity to give written feedback on training experiences during placement by completing the Trainee Feedback on Placement form. They may comment on the quality of the supervision, the adherence to the Placement Agreement, and on the resources available during the placement. This document is read and signed by both trainee and supervisor.

#### **Evaluation of Clinical Competence**

The Supervisor's Evaluation of Clinical Competence form includes the range of competences trainees are required to develop and demonstrate during the course of training. The Programme recognise that not all competences may be available in every placement. Supervisors are asked to evaluate trainees on each of the individual competences, and to provide relevant comments. Comments are encouraged and aid trainees in reflecting on their development and integrating experiences and development across placements. The SECC is available in two forms within Portfolio

- Formative (Mid Placement) version: This version should be completed and used to guide the mid placement review meeting between supervisor and trainee. This version is designed to support a structured discussion of competence and development ahead of the mid placement visit. This version has no summative element
- Summative (End of Placement) version: This version includes a summative (pass/fail) component and forms part of the end of placement evaluation process. This forms the basis of the recommendation made by the Programme to the exam board

Please refer to the Placement Documentation Instructions for full guidance for supervisors on how to complete this form. Please select the appropriate grade for each ILO according to the definitions below.

This documentation is reviewed by the Clinical Practice Team and any appropriate information will be passed on to the next supervisor. The documentation will also inform the process of the Individual Learning Plan Review. Trainees will let future supervisors see their Individual Learning Plans, as agreed by the Clinical Practice Director, to allow for continuity of training and to facilitate the transferability of skills.

In arriving at a rating, the following points should be considered:

- a) Trainees cannot be expected (nor expect themselves) to perform at a level of established competence on all abilities, all of the time.
- b) Competence is defined as the ability to perform the activities of an occupation to the standards expected in employment or to the standards expected by the profession, as appropriate to level of developmental stage in training.
- c) The use of the "SOME IMPROVEMENT DESIRABLE" rating should *not* be seen as unusual or as necessarily implying negative judgment on the trainee's performance as a whole.

- d) The comments section should be used to illustrate the reasons for the rating given. In the case of a low rating, the supervisors should give guidance on how the trainee may improve development of competence.
- e) These assessments must be partly based on direct observation of the trainee. Supervisors should fully consider the evidence from their supervision notes and observations that lead them to make judgements.

The Evaluation of Clinical Competence Form must be completed prior to the Midplacement Review with the trainee. This process allows the assessment of progress so far, and allows the provision of written feedback to the trainee at this timely point. This document also allows the supervisor to identify gaps in experience and / or difficulties in achieving the appropriate level of competence for the trainee's stage of training. This review, along with details of the Placement Agreement, will inform discussion during the Placement Visit from a member of the programme team. The Evaluation of Clinical Competence Form must also be completed for submission to the Programme Team at the end of each Module.

### **Annual Individual Learning Plan Review**

At the Individual Learning Plan Review meeting with a member of the Programme Team, all Module assessments and documentation, including everything from placement, will be reviewed. This will feed into Individual Learning Plans, which are adapted over time to reflect the development of clinical competence and the training needs of the individual trainee. Any potential gaps in experience can be addressed through appropriate action in placement planning, following the Individual Learning Plan.

## APPENDIX 6.5 SUPERVISOR'S EVALUATION OF CLINICAL COMPETENCE (SAMPLE)

### EVALUATION OF CLINICAL COMPETENCE

Please refer to the Placement Documentation Instructions for full guidance for supervisors on how to complete this form. Please select the appropriate grade for each ILO according to the following definitions. Provide additional comments and feedback as desired.

1. **Competence demonstrated *above* expected level:** The trainee has consistently demonstrated the relevant competence at a level beyond that which would be expected at their stage of training. This rating should only be considered where the demonstrating of competence has been sustained and is clearly exceptional.
2. **Competence demonstrated:** The trainee has consistently demonstrated this competence at a good standard. The standard of rating here suggests that the *skills, knowledge and values* of the trainee are **at a level one would ordinarily expect at this stage of training**.
3. **Competence demonstrated, some improvement desirable:** Competence development is evident, but some improvement is desirable. This rating may be used where a trainee needs to further improve the specific competence. This rating may also be used when supervisors lack evidence to be fully confident that competence is demonstrated satisfactorily. There should be no concern that performance is less than adequate or that remediation is required. This rating must be accompanied by specific recommendations on how the trainee can improve in this area. This may involve gaining further experience or training.
- R/R Remediation required:** This rating implies that a trainee is considered to be performing at a less than adequate standard of competence than would be expected given the level of training. *Specific details should be provided*. In this event the Clinical Practice Director becomes involved to develop a plan of remedial action and to determine adjustment to the Individual Learning Plan.
- N/O No opportunity to demonstrate competence:** The placement has not provided sufficient experience to make any of the above judgments. This rating by a supervisor *should only be used sparingly* (i.e. when none of the above apply) *and*

*requires explanation.* The supervisor should have made every effort to make experience available to the trainee during placement. In this event the Clinical Practice Director becomes involved to develop a plan of remedial action and to determine adjustment to the Individual Learning Plan.

### **GLOBAL ASSESSMENT COMMENTS:**

Trainees are expected to demonstrate a broad range of competences during each placement and at all stages of development. In order to promote discussions around specific areas of development, we have listed the competences individually below.

You will see from the layout that, while we ask for a rating of each competence, they have been clustered into broader areas of functioning for further comment. It is important that trainees are offered specific and tailored feedback for each of the areas as they progress through training. While continual feedback based on a range of evidence gathering approaches including “in vivo” observation, self report and information from colleagues and clients, is an essential component of supervision, the comments on this form will inform the trainee’s future experiences as they progress from placement to placement. The information offered in this form will provide the basis for the “End of Placement Meeting” which will in turn inform the experiences for the trainee in the subsequent placement.

We would encourage supervisors to use the range of available ratings in their evaluation. While a rating of **1** should be reserved for “exceptional” cases, we would encourage that it is used as appropriate to communicate areas of particular strength. Ratings of **3** should be used where trainee’s have demonstrated specific competences but they are not yet established: either not quite at the expected level or not in a sustained way. Offering these ratings can prove difficult, but will support trainees to develop their skills across the range of competences.

While this form remains the supervisor’s means of communicating their professional assessment of trainee’s competence to the trainee, Programme and ultimately the exam board, during the course of placement, trainees will be gathering supplementary evidence of their demonstration of competence. They will be asked



to gather, and have supervisors ratify, additional evidence in the following areas:

- **Assessment, formulation and intervention using specific therapeutic approaches:** Trainees will be asked to gather evidence of key competences in at least two psychological therapies. Trainees will have the means to record evidence in ePortfolio and will in turn ask you as supervisors (or other relevant and appropriate colleagues) to sign off on these activities. The Programme also require supervisors and trainees to use an appropriate structured observational tool on three occasions over the course of each placement. These forms need not be submitted, but the trainees will be asked to record a summary of feedback and outcome from the observations. Competence lists have been derived from nationally recognised frameworks and are available the links below.
  - CBT
  - Systemic therapeutic approaches
  - Other therapeutic approaches where circumstances allow
- **Neuropsychological Assessment:** Trainees and supervisors will have access to a competence list which will help guide trainees through the process and allow supervisors to offer structured feedback on each step. While not all placements will allow opportunity for formal neuro assessment, trainees will be expected to gather the minimum number of experiences over the course of training. Competence list and experience guidelines are available **here**
- **Leadership and influence:** Trainees will be asked to gather additional evidence of their competence in line with the competence list developed. Evidence can be derived from a range of sources including individual, team and service related activities which are clearly related to informing, shaping or influencing others, through to supervision discussion related to aspects fo professional functioning or service delivery. The competence list can be found **here**.

Below you will find the list of competences trainees are expected to demonstrate during placement. Please assign a level to each competence from the drop down menu, using the range of scores available and as appropriate. We would also ask that you add some balanced and constructive feedback to allow trainees to reflect on their experiences and plan future development.

<b>1</b>	<b>Theory</b>	
<b>1.1</b>	Ability to demonstrates knowledge of psychological theory (e.g. cognitive behavioural, behavioural, systemic, psychodynamic) as they apply to the client group.	

<b>1.2</b>	Ability to decide, 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.	
<b>1.3</b>	Ability to work effectively whilst holding in mind alternative, competing explanations.	
<b>1.4</b>	Ability to demonstrate knowledge of 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	
	<b>Comments:</b>	

<b>2</b>	<b>Engagement</b>	
<b>2.1</b>	Ability to develop and maintain effective collaborative working alliances with service users, carers, colleagues and other relevant stakeholders, adapting communication as appropriate	
<b>2.2</b>	Ability to adapt communication style to people with a wide range of cognitive ability, sensory acuity and modes of communication (including the use of visual aids, interpreters etc. where appropriate)	
<b>2.3</b>	Ability to recognise and manage the inherent power imbalance of the therapeutic relationship	
	<b>Comments:</b>	

<b>3</b>	<b>Assessment</b>	
<b>3.1</b>	Ability to demonstrate skills in Therapeutic Interviewing;	
	a	Goal setting
	b	Active listening
	c	Summarising / reflecting back
	d	Provision of accurate and constructive feedback
	e	Pacing and timing
	f	Confrontation (For example manages boundary issues – e.g. consistently late clients. Actively addresses client avoidance of key issues)
<b>3.2</b>	Ability to select, use and interpret a broad range of assessment methods appropriate to the client, and service where the assessment takes place, to gather information on presenting difficulties (e.g. clinical interview, use of rating scales, diaries, standardised psychometric assessments, observations and information from others, including the assessment of social context and organisations).	
<b>3.3</b>	<i>Neuropsychological Assessment</i>	
	a	Ability to demonstrate understanding of the ethical, legal and clinical context and consequences for testing.
	b	Ability to administer tests within structure, being mindful of people's developmental needs, capacity for engagement and response to the situation
	c	Demonstrates ability to interpret results and incorporates into formulation
	d	Demonstrates ability to provide sensitive, constructive feedback, pitched to need of clients, referrers and other agencies
	<i>Risk Assessment</i>  Ability to conduct appropriate risk assessment and use this to guide practice. Is aware of risks and risk assessment / management practices, as appropriate to the client and service setting, e.g. risk of self-harm,	

	suicide, neglect, violence, sexual assault and ,where appropriate raises concerns with colleagues in a timely manner. This includes awareness of ethical and professional practice responsibilities in terms of child protection and protection of vulnerable adults.	
3.4	<b>Comments:</b>	

<b>4</b>	<b>Formulation</b>	
<b>4.1</b>	Ability to use assessment information to develop psychological formulations informed by psychological theory and evidence incorporating interpersonal, societal, cultural and biological factors where appropriate,	
	<b>Cognitive- Behavioural (if applicable to placement)</b>	
	<b>Systemic Therapeutic modalities</b>	
	<b>Other Modalities (please specify as many as relevant)</b>	
<b>4.2</b>	Ability to develop formulations through a shared understanding of its personal meaning with clients in a way which helps the client better understand their experience.	
<b>4.3</b>	Ability to develop formulations collaboratively with service users, carers, teams and services and is respectful of the client or team's feedback about what is accurate and helpful.	
<b>4.4</b>	Ability to ensure that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality. Uses formulations to guide appropriate interventions if appropriate.	
<b>4.5</b>	Ability to lead on the implementation of formulation in services and uses formulation to enhance teamwork, multi-professional communication and psychological mindedness in services	
<b>4.6</b>	Ability to display competence in written communication of psychological formulations and able to clearly present these in verbal and written form for a range of purposes and with appropriate frequency.	
<b>4.7</b>	<i>Reformulation</i>  Ability to reflect on and revise formulations in the light of on-going feedback and intervention	
	<b>Comments:</b>	

<b>5</b>	<b>Intervention</b>	
<b>5.1</b>	Ability to recognise when (further) intervention is inappropriate, or when it is unlikely to be helpful and communicates this sensitively to clients, referring and/or directing to other services as appropriate.	
<b>5.2</b>	<p><b><i>Application of Psychological Models</i></b></p> <p>Ability to apply, evaluate and modify appropriate formulation-based interventions derived from standard psychological models of treatment. Demonstrates application of theory into practice</p> <p><b>Cognitive- Behavioural (if applicable to placement)</b></p> <p><b>Systemic Therapeutic modalities</b></p> <p><b><i>Other Modalities (please specify as many as relevant)</i></b></p>	
<b>5.3</b>	Where intervention is appropriate, demonstrates the ability to use the formulation as the basis to implement psychological therapy or other interventions relevant to the presenting difficulties and to the psychological, systemic, cultural and social circumstances of the client	
<b>5.4</b>	Ability to carry out these formulation driven interventions collaboratively in a range of contexts (e.g. with individuals, couples, families, family carers, professional carers, groups, and services/organisations).	
<b>5.5</b>	Ability to use multi-modal interventions as appropriate to the complexity of the presentation, client context and goals	
<b>5.6</b>	Where appropriate, the ability to implement interventions and care plans through, and with, other professionals, carers and/or family members	
<b>5.7</b>	Ability to conduct interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals.	
<b>5.8</b>	Ability to negotiate a collaborative and constructive end to therapy, utilising relapse prevention strategies as appropriate.	

	<b>Comments:</b>	
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<b>6</b>	<b>Evaluation</b>	
<b>6.1</b>	Ability to select, develop and implements appropriate methods to critically and reflectively evaluate the effectiveness, acceptability and broader impact of interventions (both individual and organisational) and uses this information to inform and shape personal and professional practice.	
<b>6.2</b>	Ability to engage in a critically reflective approach to practice based evidence where both client related activity and professional development are critically reviewed in light of data from all sources including outcome measurement, feedback received in supervision, from service users and from people within services/organisations in which the trainee is working.	
	<b>Comments:</b>	

<b>7</b>	<b>Personal and Professional Skills and Values</b>	
<b>7.1</b>	Ability to demonstrate understanding of the broad role of the clinical psychologist within the health and social care services.	
<b>7.2</b>	Ability to recognise the importance and role of supervision and understand the process for both supervisor and supervisee. Uses supervision to reflect on practice, and makes appropriate use of feedback received.	

<b>7.3</b>	Values and respects individuals and diversity (e.g. understands the impact of difference, cultural, social and religious diversity and social inequality on people's lives including any implications for working practices and always works in an anti-discriminatory and anti- oppressive manner). Understands the impact of one's own value base upon clinical practice. Appreciates the inherent power imbalance between practitioners and	
	clients and how exploitation of this can be minimised.	
<b>7.4</b>	Ability to apply their understanding of ethical issues in complex clinical contexts, ensuring that informed consent underpins all contact with clients and provides clients, families and carers with information necessary to make informed decisions; explains the nature and purpose of specific psychological techniques to clients.	
<b>7.5</b>	Ability to demonstrate self-awareness, the ability to work as a reflective practitioner, and awareness of the need for continuing professional and personal development, for example shows an awareness of the emotional impact of practice on self and develops strategies for managing this and seeks appropriate support when necessary, with good awareness of boundary issues.	
<b>7.6</b>	Ability to use existing supports (including supervision) and develop strategies to manage the emotional and physical impact of clinical work. Demonstrates the capacity to recognise when own fitness to practice is compromised and take steps to manage this risk as appropriate.	
<b>7.7</b>	Ability to function at a level of autonomy and initiative in professional activities appropriate to the stage in training, including managing own personal learning needs, Does not work too independently or fail to take advantage of supervision.	
<b>7.8</b>	Ability to demonstrate and apply adequate knowledge of sharing/disclosing/disseminating confidential information within multi-disciplinary team and multi-agency working.	
<b>7.9</b>	Ability to comply with the policies and practices of NHS Board with respect to time-keeping and record-keeping which includes maintaining accurate, up to date written or electronic records and case-notes.	



<b>8</b>	<b>Communication and Teaching</b>	
<b>8.1</b>	Ability to communicate 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>8.2</b>	Within scope of competence, ability to provide psychological advice/supervision to other professionals / services in relation to clients / groups of clients that trainee is not directly working with (where appropriate)	
<b>8.3</b>	Ability to recognise when intervention by training of others (professional staff, relatives and carers) may be appropriate and supporting others' learning in the application of psychological skills, knowledge and practice.	
<b>8.4</b>	Ability to prepare and deliver teaching and training which takes into account the needs and goals of the participants, for example, by utilising appropriate adaptations to methods and content and communicates the content effectively.	
	<b>Comments:</b>	

<b>9</b>	<b>Organisational and Systemic Influence and Leadership</b>	
<b>9.1</b>	Ability to establish good working relationships and contribute to team functioning, respecting diverse viewpoints, makes appropriate contributions in uni and multi-disciplinary meetings and offers opinions in supervision.	
<b>9.2</b>	Ability to influence service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Promotes psychological mindedness in the service delivery of others.	

<b>9.3</b>	Ability to demonstrate awareness of, and apply the principles of the legislative and national planning contexts for service delivery and clinical practice	
<b>9.4</b>	Ability to demonstrate leadership/influence 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.	
	<b>Comments:</b>	

## OTHER COMMENTS ON LEARNING AND COMPETENCY DEVELOPMENT

What have been the trainee's strengths during placement?

Further training and development: Are there any important areas of learning or experience that have not been available during this placement? What are your recommendations for future learning?

Other Comments

## APPENDIX 6.6 TRAINING PORTFOLIO (TURAS)

The key aim of the Training Portfolio is to ensure there is systematic recording of clinical activity across your time on the Programme. The Programme is required by the Statutory Regulatory Body to gather information on the range of clients with which trainees have contact and activities in which they engage.

The system will also provide a means by which you can not only gather and reflect on evidence of competence, but can use that evidence to demonstrate areas of excellence, special interest or specialist experience. This complexity will offer examining tutors a broader view of your experience and skills development throughout the assessment process.

The data gathered within Portfolio will be used routinely in a range of processes including mid placement visits and individual learning plan meeting. Furthermore, many supervisors will use Training Portfolio to inform supervision meetings. **It is important therefore, that entries are kept up to date throughout placement**

Supervisors will also be able to complete and share with you “Evaluation of Clinical Competence Forms” within the Training Portfolio. You will then have a complete record of your activity and competence development across training.

By gathering evidence in this way over the course of training, you will be able to produce a coherent narrative of which competences have developed, when and under what circumstances, including level of supervision, level of observation, service delivery environment, age range and presenting problem. Alongside meeting the BPS Programme Standards, this system will eventually allow you to use this information for future external validation of specific therapies or skills should you wish. It is also proposed that the portfolio will continue to be available post qualification which will allow you to continue building your CPD record.

**There should be no Patient Identifiable Information (PII) information stored within the database. Trainees and supervisors will be prompted regularly to check all entries for anonymity.**

Full guidance for Training Portfolio is available in Moodle.

### Logging in

The first step is to log into [TURAS](#). Once your first placement has been registered on the system and your Portfolio account has been activated, the “Training Portfolio” tile should appear on your [TURAS](#)

home page. Before you can proceed further, there will be three declarations for you to sign. These should include:

- Programme Communication Policy
- Programme Participation
- Patient confidentiality

Once you have completed these declarations, you will gain access to your Portfolio homepage.

### Home Page

On logging in to your home page you will find your own details along with your supervisor and your clinical tutor. If any of this information is missing, please contact Sophie Garden

### Activity Tracker

The Activity Tracker is where you will record all clinical contact and additional placement experiences.

**Please remember that, beyond the initial demographics, any information entered into Portfolio should relate to you, your activity and development. Entries should not contain patient identifiable information.**

You will see that there are four key areas on the tracker these include:

- **New Case** – used for logging contact with new clients through the “create a new case” button
- **Observing Colleagues** – used for recording when **you** observe other colleagues, including your supervisor
- **Group Intervention** – used for recording when you deliver groups
- **Additional Placement Activity** – used to recording any additional placement activity including service related work, consultation, MDT work etc

Each of these links will take you to a new page where you will be able to input information. Throughout the Training Portfolio, the terms “Relationship” and “case” are used to denote any client that you come into contact with. These may be clients with whom you have long term contact, or you may only have a single contact. Each time you begin working with a new client, you will be required to “create a new case”. Your subsequent contacts with that client will be stored against this relationship.

As you build a case load, a list of relationships will develop on your activity tracker. You will be able to keep track of the number of contacts etc you have had with each. Each of the relationships will have a code; **you and your supervisor will need to be able to cross reference these codes with the client details.** You may wish to develop a “key”. However, this should not be shared with

others and should be destroyed on the completion of placement.

### **Additional Placement Activity**

Alongside individual client work and observing colleagues, there will be a range of more general professional activities on placement. These would not be related to one of the clients with whom you are working but would be relevant to your development. **It is equally important that these are routinely recorded throughout training.** There may be activities that could be entered in more than one category; however we would ask that you only record the activity once. The aim is to gather evidence of the breadth of development opportunities in which you have engaged over the course of training rather than create a complex matrix of activities.

## APPENDIX 6.7 TRAINEE'S REFLECTIVE NOTES (SAMPLE)

### Reflective notes Course 6

CHILDREN, YOUNG PEOPLE & FAMILIES THEORY AND PRACTICE

Trainee Name:

Course Start date:

Course End date:

Main Supervisor:

Other Supervisor(s):

Number of Times Trainee Observed by Supervisor(s):

Signed by Trainee: .....

Signed by Supervisor(s): .....

Date: .....

Office Use:

Reviewed by Clinical Tutor: .....

Date:

.....

Please write a reflective piece about your Personal and Professional Development over Course 6. You might use the ILOs listed below to structure your reflections or you might choose to reflect freely but note which ILOs your reflections refer to. Your reflective diary should provide you with material for this task. Please do not exceed 1000 words.

## CLINICAL SKILLS DEVELOPMENT

### 6.1 THEORY

How have you developed your understanding of major theories and evidence informing clinical practice with children/young people, and their families?

### 6.2 LINKING THEORY TO PRACTICE

Please consider times when you have applied theoretical knowledge to assessment, formulation and intervention with service-users and reflect about your development in these skills over the course of this placement.

### 6.3 EFFECTIVE WORKING ALLIANCES

Reflect about how your skills have developed in terms of initiating and maintaining collaborative working alliances with children/young people, their families / carers and services.

### 6.4 ASSESSMENT

Reflect on the development of your skills in selecting, using and interpreting a wide range of specialised psychological assessment methods appropriate to children/young people and their families, including formal procedures (use of standardised instruments) and other structured methods (e.g. observation or gathering of information from others)

### 6.5 FORMULATION

Reflect on the development of your ability to develop psychological formulations, which integrate assessment information within a coherent theoretical framework (drawing upon psychological theory and evidence and which incorporate cognitive, behavioural, developmental, interpersonal, systemic, societal, cultural and/or biological factors)

6.6 How have you developed your skills in the sharing of formulations, e.g., how you used formulations with children/young people and their families to facilitate their understanding of experiences, and with other professionals to assist multi-professional understanding and communications regarding the service-users.

6.7 Reflect on times when you have had to revise formulations in the light of ongoing intervention.

6.8 How have you developed your skills in this area?

6.9 Indirect Work: Reflect on the development of your ability to implement and record interventions collaboratively through family members, carers, or individuals who are formal professional carers for the child/young person, e.g., social work, school or medical staff.

6.10 Direct Work: How have you developed your competence in the delivery of a range of intervention skills, techniques and practices relevant to children/young people and their families (including use of more than one relevant therapeutic model e.g. cognitive behavioural, behavioural and systemic)?



6.11 How do you recognise when further intervention is inappropriate, or unlikely to be helpful, and communicate this sensitively to clients and their family (including appropriate management of the end of therapy and discharge)?

#### 6.12 EVALUATING INTERVENTION

Reflect about the development of your ability to select and implement appropriate methods to evaluate the effectiveness, acceptability and broader impact of interventions (both individual and organisational). How do you use this information to inform and shape your practice?

#### 6.13 PROFESSIONAL DEVELOPMENT

How do you ensure that your clinical practice is ethical? Please reflect on occasions where you have had to resolve ethical issues during this placement.

6.14 Reflect about your contribution on this placement to multidisciplinary team functioning and work within specialist service systems (including consultancy work and supervision, teaching and training of other professionals).

## APPENDIX 6.8 TRAINEE PLACEMENT FEEDBACK FORM (SAMPLE)

UNIVERSITY OF GLASGOW  
DOCTORATE IN CLINICAL PSYCHOLOGY

### TRAINEE'S PLACEMENT & SUPERVISION FEEDBACK FORM

Name of Trainee:

Intake  
Year:

Name of  
Supervisor(s):

Placement:

Base:

Signed by Trainee .....

Date .....

Signed by Supervisor .....

Date .....

---

*For Office Use:*

Signed by Clinical Tutor ..... Date.....

***This form should be completed by the trainee and signed by both trainee and supervisor before being submitted to the Programme with all documentation. Copies are held in confidence by the trainee, supervisor and the Programme. Please describe the placement briefly under each of the headings below, making any evaluative comments you feel would be helpful.***

---

**1. Early part of placement** (placement agreement, induction, other early placement experiences)

Were you given adequate briefing in terms of Health, Safety and Welfare?

☐ YES

☐ NO

If, No, please elaborate

**2. Case Load** Did the caseload meet your requirements in terms of training needs on placement? (E.g. range of cases, number of cases, assessment and intervention cases, time spent in direct patient contact, group and family work,

work with clients and carers)

☐ YES

☐ NO

If, No, please elaborate

3. **Supervision** (frequency, methodology, opportunities for supervisor to observe trainee and vice versa)

4. **Other Placement Experiences**

5. **Physical Environment and facilities** (desk, room, secretarial support)

6. **Secretarial Support**

7. **Social Environment / Orientation / Ethos**

8. **Did this placement conform with the training plan outlined in your placement agreement?**

YES

YES - Although there were some mi

☐ NO - There were one of more substantial problem areas (specify)

9. **Overall View of Placement, General Comments**

Signed by Trainee .....

Date .....

Signed by Supervisor .....

*For Office Use:*

Seen by.....

Date.....

## APPENDIX 6.9 INDIVIDUAL LEARNING PLAN REVIEW FORM (SAMPLE)

**First Year ILP Review Meeting** Date of meeting:

**1. Reflection on CPD:**

### **2. CLINICAL/PROFESSIONAL PRACTICE**

Has Older Adult Experience been met? Yes ( ) No ( ) – Requirements and plans to meet them:

### **3. ACADEMIC PROGRESS**

### **4. RESEARCH PROGRESS**

**Trainee Feedback (including preferences for training/placement plans)**

**Outstanding items for review in Year II/Essential Action Points:**

**1<sup>st</sup> Year ILP Review completed & signed by:**

Programme Team Member:

Attending NHS Line Manager/Local Tutor:

Trainee:

## APPENDIX 6.10 INDUCTION CHECKLIST

### PRACTICE PLACEMENT INDUCTION CHECKLIST

NHS Board:

Placement Base:

Specialty:

Practice Placement

Dates:

Trainee Name:

Main Supervisor(s):

We confirm that the following topics were formally discussed in relation to practice placement, with consideration of the above placement base, specialty and relevant individual requirements of supervisor and trainee.

Signed by Supervisor(s):

date:

.....

Signed by Trainee:

date:

.....

	<b>Supervisor</b> (initial and date on completion)	<b>Trainee</b> (initial and date on completion)
<b>The Practice Placement setting must provide a safe and supportive environment (SET 5.3)</b>  NHS Health and Safety Policies and local procedures discussed and accessible to trainee (including Lone Working, Incident Reporting, Fire Policies and Procedures).		
<b>The Practice Placement must be conducted in line with relevant Equality and Diversity policies (SET 5.5)</b>  Relevant policies discussed and accessible to trainee (including Equality Act, 2010) and trainee knows what they should do under employment procedures if they feel		

discriminated against.		
<b>Resources:</b> Trainee has access to (at least) shared office space, a telephone and desk.		
<b>Placement Agreement</b> has been jointly written, agreed and signed.		

## APPENDIX 7.1 CODE OF PROFESSIONAL CONDUCT

From September 2024, information on the Code of Professional Conduct and the mandatory declaration of agreement to comply with the code is hosted in a secure online form available at this link:

<https://forms.office.com/e/PyQ7bH1kmh>

# APPENDIX 7.2 GUIDELINES FOR REFLECTIVE SCIENTIST PRACTITIONER

## General Introduction

All trainees are required to submit two reflective accounts during year three. The purpose of the reflective pieces is to allow trainees to demonstrate evidence of their advanced reflective skills by writing about experiences that have prompted personal and professional development over the course of clinical training. Learning experiences used as a foundation for reflection in both reflective submissions can include any experiences that illustrate the beginnings of, or the catalyst for, personal and professional change.

One of the two reflective submissions should have a focus on learning from Service Users/Carers in a non-therapeutic context ([see Service User/Carer activity on Moodle](#)). The other submission can be focused on other learning experiences, including the following examples:

- Clinical work with individual service user/carer or groups, or staff over time,
- Development of an innovative intervention
- Specialist working in the wider political context,
- Experiences of multidisciplinary team working or the dynamics of working within a specialist team,
- Audit or research work completed on placement,
- Strategic, managerial or service development work including issues around clinical governance,
- Ethical, confidentiality or risk issues

Each reflective submission should draw upon and synthesise experiences as they relate to one of (or more than one) the **core competency domains**:

(<https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Clinical%20Accreditation%20Handbook%202019.pdf>):

1. Generalisable meta competencies
2. Psychological assessment
3. Psychological formulation
4. Psychological intervention
5. Evaluation
6. Research
7. Personal and professional skills and values
8. Communication and teaching
9. Organisational and systemic influence and leadership

Each account should be set in the context of relevant literature, with reference to models of reflection, relevant policy and professional guidelines and the relevant evidence base for clinical or professional work undertaken as appropriate.



The final product should focus on personal and professional development and highlight the key learning experiences and reflections that led to change and development over time.

### **Confidentiality**

In line with the NHS Code of Practice on protecting Patient Confidentiality, no individual person should be identifiable in your work. The work should not be a story of one client or professional in which an individual is identifiable. The work should focus on you and how you have changed and developed as a professional.

Take care when giving pseudonyms to others in the work. This style is often a sign that too much focus is being placed on another individual, such as in a case study format.

Professionals' identity must also be protected in the work. The names and bases of workers and agencies should be removed. Trainees must ensure that they consider and respect others' dignity. Make it clear where expressed ideas or feelings are your own, rather than objective fact.

### **Formative Feedback on Draft Reflective Accounts**

Since all clinical cases and professional activities are conducted under supervision, placement supervisors will be able to advise on the selection, assessment and management of clinical and professional work, and help the trainee reflect on the work.

Trainees are advised to discuss and reflect on potentially appropriate experiences with their supervisors and Clinical Tutors as early as possible and throughout placement. General enquiries can be directed to Clinical Tutors.

Draft Reflective submissions for Course 12 and 13 can be read and reviewed by Clinical Tutors prior to final submission, although it is not necessary to submit drafts. Advice may be given on structure and content if the Reflective Accounts fail to meet the required standards, they will be re-written to conform to the necessary criteria (fully informed by feedback) and resubmitted for further review by the clinical tutor. The final submission contributes to the overall pass/fail grade for the module.

### **Content and Format of submissions**

As guidance, both reflective submissions should be 2000 words in length with a 200-300 word reflective review appended. See assessment criteria for further detail on structuring the submissions.

The report layout must include the following:

#### ***Title Page***

Clearly articulated, succinct and relevant title reflecting content of Reflective Account. Name of trainee, matriculation number, date of submission, Course, word count. Trainee name should be included on title page only, and a footnote on each subsequent page should note matriculation number only.

#### ***Introduction***

The introduction should provide an overview of how and why the learning experience(s) was selected for presentation in the account. Relevant theoretical, clinical, professional and / or policy issues relating to the subject matter of the essay may be referred to and introduced in this section. An indication of the model/models used to structure the reflection should also be provided. The introduction may also refer to the process of supervision, the professional development that may be a focus for the account, and/or the context of the learning environment.

### ***Reflection***

The body of the account can be structured in some way by a model or models. However, trainees should not be restricted by one model, or stick only to educational models. Trainees are free to apply whatever theory or model they find helps them with the process of reflection. Most of the educational models involve some description of events, together with impressions and observations, and other relevant background information. Trainees should then actively reflect on the decision-making processes contributing to clinical and professional actions, using guidance from their chosen model, and go on to consider impact on future practice.

This section may also involve discussion of how supervision or other supports were used to aid reflective practice. In the context of the relevant models, trainees should discuss the personal impact, resulting professional learning, and the implications of this professional topic area/role for the wider context of the profession of clinical psychology.

### ***Reflective Review***

A critical reflective review may discuss the experience or the account itself (i.e. a meta-reflection), in the context of any evidence base or later experiences/reflections, and consider alternative approaches, what you may have done differently, or what you may do differently in the future. You may also consider relevant theoretical, empirical, clinical, professional and/or policy documents which may aid reflection on the wider issues of professional development as a clinical psychologist. You may like to critique the models adopted.

### ***Submission and feedback***

The Clinical Tutor will make one of the following recommendations:

1. This account is considered to be suitable for submission. Please make any minor amendments as recommended, and submit a digital copy
2. This account should be amended as recommended and resubmitted in for further review by the Clinical Tutors. Please meet with the named reviewer to discuss changes and hand in for further formative feedback by: specified date.

### ***Assessment criteria***

The assessment rubric in table 2, adapted from the University of Edinburgh Reflective Toolkit, can be used to help trainees demonstrate their reflective competencies, and will be used to offer feedback on reflective submissions (<https://www.ed.ac.uk/reflection/facilitators-toolkit/assessment/criteria>). They can be

considered as a checklist of reflective competences:

<b>Criterion</b>	<b>Reflective novice</b>	<b>Aware practitioner</b>	<b>Reflective practitioner</b>
<b>Analysis/depth of reflection</b>	Trainee makes attempts at applying the learning experience to understanding of self, others, and/or course concepts but the account is descriptive rather than analytic.	The reflection provides a descriptive demonstration of the trainees attempts to analyse the experience but the analysis lacks depth.	The reflection moves beyond simple description of the experience to an analysis of how the experience contributed to trainee understanding of self, others, and/or course concepts.
<b>Appropriate use of model</b>	There is confusion or little to no attempt to relate the learning to an appropriate model that supports and develops reflection and understanding.	The account reflects a reasonable understanding of an appropriate model with an analytical quality to its application used to further understanding.	The reflection and learning is supported and developed by use of at least one appropriate model. The trainee is also able to critique the model/s used and confidently discusses their analysis of their professional/personal development with clear application of the model or learning experience.
<b>Attention to emotion</b>	Recognition but no exploration or attention to emotions	Recognition, exploration, and descriptive attention to emotions	Recognition, exploration, attention to emotions, and gain of emotional insight
<b>Evidence of critical skills in relation to self/other/system</b>	There is some attempt at self-critique, but the self-	The reflection demonstrates ability of the trainee to	The reflection demonstrates ability of the trainee to question their own

<b>s</b>	reflection is predominantly descriptive in quality and does not demonstrate a new awareness of personal biases, etc.	question their own biases, stereotypes, preconceptions .	biases, stereotypes, preconceptions, and/or assumptions and define new modes of thinking as a result.
<b>Evidence of learning and development</b>	There is little to no attempt to demonstrate connections between the learning experience and previous other personal and/or learning experiences.	The reflection describes connections between the experience and material from other courses; past experience; and/or personal goals.	The reflection demonstrates connections between the experience and material from other courses; past experience; and/or personal goals and details evidence of what learning has been achieved and/or identification of continuing learning needs/goals.
<b>Clarity</b>	There are frequent lapses in clarity and accuracy	Minor, infrequent lapses in clarity and accuracy.	The language is clear and expressive. The reader can create a mental picture of the situation being described. Abstract concepts are explained accurately. Explanation of concepts makes sense to an uninformed reader

Table 2. Reflective Assessment Rubric



# APPENDIX 8.1 RESEARCH COSTS & EQUIPMENT

## RESEARCH EQUIPMENT, CONSUMABLES AND EXPENSES

Trainee .....

Year of Programme ..... Intake Year.....

Please refer to latest **stationery costs** list and **departmental test** list (available on Moodle)

Item	Details and amount required	Cost (or state if to request to borrow from department)
Stationery		Subtotal:
Postage		Subtotal:
Photocopying and printing		Subtotal:
Equipment and software		Subtotal:
Measures		Subtotal:
Travel		Subtotal:
Miscellaneous		Subtotal:
<b>Total</b>		

**For any total request over £200 please provide further justification for all items that contribute to a high total cost estimate. Please also provide justification if costing for an honorarium for participants:**

Trainee signature.....

Date.....

University Supervisor signature .....

Date .....

## APPENDIX 8.2 DATA HANDLING PROCEDURES FOR PSYCHOLOGISTS IN TRAINING

This document sets out the procedures to be followed by DClinPsy trainees when transferring, storing and processing clinical research data from NHS participants on University of Glasgow IT systems. Failure to follow these procedures may be treated as a misconduct issue.

**The acceptable procedures described in the tables in this document differ across NHS Boards. Take careful note of which procedures apply to the NHS Board in which you are conducting your research.**

### **Anonymisation/pseudonymisation of data**

- All data must be anonymised or pseudonymised before it leaves the NHS IT system.
- Data that has been anonymised cannot be linked back to the individual's identity. Data that has been pseudonymised could be linked back to the individual's identity, for example by referring to an ID log. Please refer to the Information Commissioner's Office (ICO) guidance for further information on this distinction:

<https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/what-is-personal-data/what-is-personal-data/>

- Advice on how to go about this can be found here: <https://ico.org.uk/media/1061/anonymisation-code.pdf>
- If you have a log that links ID codes with identities, this must not be stored in the same location as the pseudonymised dataset.

### **Transferring data from NHS to University systems**

Table 1 shows the approved methods for transferring data from NHS IT systems to University IT systems.

**Table 1.** Transferring research data from NHS to University

Method	Instructions	Acceptable to NHS Board?			
		NHSA&A	NHSGGC	NHSH	NHSL
Encrypted USB drive (flash drive)	<ul style="list-style-type: none"> <li>Save data from NHS computer/network to approved flash drive (check with your NHS Board which make/model is approved)</li> <li>Do not transfer the ID log and pseudonymised data together on the flash drive at the same time</li> <li>Delete the contents from the flash drive as soon as they have been saved to the University system</li> </ul>	YES	YES	NO	NO
NHS email account with web-based access	<ul style="list-style-type: none"> <li>If you do not have an NHS email account that has web-based access (Board-specific account with Office365 access, or NHS.scot or NHS.net email account), contact your local NHS IT support desk to request this (NB: NHSL staff may need to wait until their system has migrated to Office365)</li> <li>Trainees can either email data to themselves (NHS email to NHS email) or attach it to an NHS email and save as a draft; the trainee then accesses the email via a web browser in the University system to save the data</li> <li>Do not attach the ID log and pseudonymised data together in the same message</li> </ul>	YES	YES	YES	YES
Upload to University Office365 OneDrive via web browser	<ul style="list-style-type: none"> <li>On an NHS computer, open a web browser window and log into your University Office365 account</li> <li>Open the OneDrive in your account</li> </ul>	YES	YES	YES	YES



	<ul style="list-style-type: none"> <li>• Upload the data from the NHS computer/network to the OneDrive</li> <li>• Upload the ID log and pseudonymised data to separate OneDrive folders</li> </ul>				
Upload to University Office365 Teams via web browser	<ul style="list-style-type: none"> <li>• Create a Team for your project (see Table 2 below)</li> <li>• On an NHS computer, open a web browser window and log into your University Office365 account</li> <li>• Open the project Team in your account</li> <li>• Go to the files tab and upload the files</li> <li>• Upload the ID log and pseudonymised data to separate folders</li> </ul>	NO	YES	YES	NO

### **Storing and processing data on University systems**

Table 2 shows the approved University systems on which trainees may store and process research data.

- In each instance, the ID log and the pseudonymised dataset must always be stored in different folders.
- For all systems, the **password requirements** are as follows:

At least 8 characters long, containing a combination of upper and lower case letters and including either a number or a symbol.

- **Always manually lock the screen if you are stepping away from the workstation temporarily and ensure you log out when finished. Do not rely on the automated timeout.**

**Table 2.** Approved University systems for storing and processing research data

System	Instructions	Acceptable to NHS Board?			
		NHSA&A	NHSGGC	NHSH	NHSL

Network filestore accessed via University computer cluster	<ul style="list-style-type: none"> <li>Data are stored in the M drive or K drive: <a href="https://www.gla.ac.uk/myglasgow/it/studentclusters/filestore/">https://www.gla.ac.uk/myglasgow/it/studentclusters/filestore/</a></li> </ul>	YES	YES	YES	YES
Network filestore accessed via Glasgow Anywhere remote desktop	<ul style="list-style-type: none"> <li>Glasgow Anywhere provides virtual access to the same apps and filestore as a University computer, via your own computer <a href="https://www.gla.ac.uk/myglasgow/anywhere/desktop/">https://www.gla.ac.uk/myglasgow/anywhere/desktop/</a></li> <li>Data are stored in the M drive or K drive, as above</li> <li>All processing of data must remain within the remote desktop environment and you must not download or save data to the computer that you are using to access your account</li> </ul>	YES	YES	YES	YES
University-owned laptop running the University standard desktop (e.g. borrowed from DClinPsy student support team or supervisor)	<ul style="list-style-type: none"> <li>When logged in to a University laptop using your GUID you can access your network filestore (M or K drive) as above</li> <li>Since University laptops running the standard desktop (SSD) have whole-disk encryption enabled automatically, you can also store data on the laptop hard drive</li> <li>Be aware that files stored on the hard drive are not automatically backed up and you must do this manually e.g. save copy to network filestore</li> </ul>	YES	YES	YES	YES
University Office365 OneDrive	<ul style="list-style-type: none"> <li>Access the OneDrive via Office365 in your web browser <a href="https://www.gla.ac.uk/myglasgow/anywhere/office365/onedriveforbusiness/">https://www.gla.ac.uk/myglasgow/anywhere/office365/onedriveforbusiness/</a></li> <li><u>Do not use the OneDrive sync client</u> to sync to your computer (stay in the</li> </ul>	YES	YES	YES	YES

accessed via web browser	<p>browser environment only)</p> <ul style="list-style-type: none"> <li>Do not download or save data to the computer that you are using to access your account</li> <li>If you are sharing your OneDrive project folder with your university supervisor, take great care to set this up so that only the supervisor can access it: click 'Share' and then ensure the option selected is 'Specific people', then enter the supervisor's email address; check that they can access the OneDrive folder correctly before you upload any data</li> </ul>				
University Office365 Team accessed via web browser	<ul style="list-style-type: none"> <li>Teams may be preferable to OneDrive if you wish to share files and chat threads with your university supervisor in one place</li> <li>Access Teams via Office365 in your web browser and create a project Team for you and your supervisor <a href="https://www.gla.ac.uk/myglasgow/anywhere/office365/teams/">https://www.gla.ac.uk/myglasgow/anywhere/office365/teams/</a></li> <li>When creating the Team, choose 'Other' for the Team type and ensure that the privacy option is set to 'Private – Only team owners can add members'</li> <li>Add your supervisor and check that they can access the Team correctly before you upload any data</li> <li><u>Do not use the standalone Teams app</u> on a shared device (stay in the browser environment only)</li> <li>Do not download or save data to the computer that you are using to access your account</li> </ul>	NO	YES	YES	NO
Trainee-owned	<ul style="list-style-type: none"> <li>If the computer meets the required encryption standards you can store</li> </ul>	NO	YES	NO	NO

computer (desktop/laptop) <u>not shared with anyone else</u>	<p>data on the hard drive:</p> <p>Whole-disk encryption, preferably with a security application accredited to FIPS 140-2 standard; where no such software is readily available an alternative may be used, applying the Advanced Encryption Standard (AES) as a minimum (the freely available VeraCrypt software claims to meet this standard:  <a href="https://sourceforge.net/projects/veracrypt/">https://sourceforge.net/projects/veracrypt/</a>)</p> <ul style="list-style-type: none"> <li>• For storage and processing of data on an Apple computer, an encrypted folder must be created to store the data and the password set for this folder must comply with the password requirements stated above</li> <li>• Be aware that files stored on the hard drive are not automatically backed up and you must do this manually e.g. upload copy to University OneDrive (see above)</li> </ul>				
--	--	--	--	--	--

### **Inclusion of data in written reports**

Reports based on the data (e.g. service-based evaluation report or major research project paper) must be written in a way that preserves the anonymity of the participants. Do not include information that may identify any individual, either by itself or in combination with other information. Tables of numeric data should be aggregated such that no cell in the table contains information unique to a small number of individuals (e.g. cross-tabulation of a rare diagnosis with a small geographical location). Advice on these issues can be found here: <https://ico.org.uk/media/1061/anonymisation-code.pdf>

Seek feedback from your supervisor to ensure these principles have been followed at the draft stage before submitting the report online via Turnitin/Moodle.

**The following NHS Board staff have approved these arrangements:**

Gillian Bennett, Information Governance Analyst, NHS Ayrshire & Arran

Stewart Whyte, Information Governance Manager, NHS Greater Glasgow & Clyde

Andy Nealis, Information Governance & IT Security Manager, NHS Highland

Michelle Nobes, Information Governance Manager & Data Protection Officer, NHS Lanarkshire

## APPENDIX 8.3 RESEARCH SUPERVISION AGREEMENT

The purpose of this agreement is two-fold. Firstly, to provide structure for the trainee-research supervisor relationship; and secondly, to establish mutual responsibilities associated both with the process and productivity of the research work. By signing this you agree to follow the guidelines in the research chapter in the DClinPsy handbook. You should comply with Research Governance procedures which will include maintaining an up to date research log (appendix 8.6 of handbook) and a Site File.

<b>Trainee</b>	
<b>University Supervisor</b>	
<b>Other Supervisor</b>	
<b>Research Adviser</b>	

**Title of Research Project:**

--

**TOPIC AREAS TO CONSIDER FOR SYSTEMATIC REVIEW:**

--

### **Roles and Responsibilities**

You should agree the frequency of meetings at different stages of the research and define the roles of all collaborators. Guidance as to the roles and responsibilities of academic supervisors, field supervisors and trainees can be found in the handbook (Chapter 8).

<b>Frequency of meetings</b>	
<b>Specific roles of supervisors / collaborators (in addition to those in the Handbook)</b>	
<b>Specific roles of trainees (in addition to those in the Handbook)</b>	

### **Undertaking concerning publication**

If the paper is considered suitable for publication by the trainee and university supervisor, it should be submitted to a relevant journal as agreed with supervisor(s). The date for submission should be agreed between the trainee and the university supervisor. The affiliation of the trainee should be stated as "Institute of Health and Wellbeing, University of Glasgow" at the university department address. It will be normal practice for the postgraduate to be the first author, but with the supervisor identified as the corresponding author. In the event of the paper not being submitted for publication by the agreed date then the supervisor may assume responsibility for submission. An electronic copy of all data files and resources should be provided to the University Supervisor. A copy of any publication should be sent to the Research Director.

### **Administration**

**Signed copies of this agreement should be held by the trainee and supervisor(s) and an electronic copy submitted with the final approved version of your MRP Proposal to Moodle for your efile**

**Trainee**..... **Date** .....

**University Supervisor** ..... **Date** .....

**Other Supervisor** ..... **Date** .....

## APPENDIX 8.4 RESEARCH PROGRESS REPORT

### RESEARCH PROGRESS REPORT

**Part 1 - To be completed by Trainee and emailed to Supervisor(s) and Research Adviser in advance of meeting**

**NAME:** .....

**INTAKE YEAR:**.....

**MRP TITLE:**.....

**SUPERVISOR(S):** .....

**RESEARCH ADVISER:**.....

**DATE OF RESEARCH PROGRESS MEETING:** .....

**\*\* All questions must be answered \*\***

1. Have you uploaded the final approved MRP Proposal to a public repository such as Open Science Framework (this should have been done when you received the Proceed to Ethics letter)? Yes/No
2. Ethics approvals:
  - Is ethics approval required for your project? Yes/No
  - If No, state reason and who has been consulted to confirm this:
  - If Yes, which Ethics Committee(s) have approved your research?
  - Reference number(s) and date(s) approved:
3. NHS Research & Development/Innovation approvals:
  - Is NHS R&D/I approval required for your project? Yes/No
  - If No, state reason and who has been consulted to confirm this:
  - If Yes, which NHS R&D/I department(s) have approved your research?
  - Reference number and date(s) approved:
4. Sponsor approval:
  - Does your project require a Sponsor? Yes/No
  - If No, state reason and who has been consulted to confirm this:
  - If Yes, state the Sponsor organisation and contact person:
5. Other approvals:
  - Are any other organisational approvals required for your project (e.g. third sector; local authority)? Yes/No
  - If Yes, state which organisation(s):
  - Reference number(s) and date(s) approved:
6. Data governance:
  - Have you completed a Data Protection Impact Assessment (DPIA;



required for all human research projects involving personal data<sup>5</sup>)?  
Yes/No

- If No, explain why:

- Does the DPIA need to be reviewed by the University DP Office (required when processing high risk or special category data, including any health data)? Yes/No

- If Yes, has feedback been received from the DP Office?

- Does the project require Caldicott Guardian approval? Yes/No

- If Yes, state the Caldicott Guardian name(s) and date(s) of approval:

7. Please give a summary of progress with data collection / access to datasets (e.g. number of participants recruited; access arrangements):

When do you expect to complete data collection?

8. Please describe how the data are to be analysed:

9. Have you written a detailed data analysis plan and uploaded this to a public repository such as Open Science Framework (this should be done before data analysis commences, and updated as required)? Yes/No

10. Are you keeping a record of the analysis process so that it could, in principle, be reproduced by others (e.g. syntax file for quantitative analysis, or written records and screen-shots for qualitative analysis)? [You will be required to show evidence of this in the thesis] Yes/No

11. What is the systematic review question?

12. Describe progress with the systematic review:

13. Are there any issues or difficulties you wish to discuss?

Trainee signature: ..... Date: .....

---

<sup>5</sup> May not be required if your sponsor/data controller is an NHS Board – check with sponsor's representative

**Part 2 - To be completed by Research Adviser and emailed to  
Trainee, Supervisor(s) and Student Support Team**

Trainee:

Intake Year:

Was Part 1 of the Research Progress Report provided before the meeting?  
Yes/No

**Is progress satisfactory? Yes/No\***

\*If No or borderline, please send a copy of the completed form to the Research  
Director

**SUMMARY OF PROGRESS WITH RESEARCH**

Approvals and governance issues:

Major Research Project:

Systematic Review:

**Action points:**

Signed by Research Adviser: ..... Date: .....

## APPENDIX 8.5 HEALTH & SAFETY FORM

### HEALTH AND SAFETY FOR RESEARCHERS

1. Title of project	
2. Trainee	
3. University Supervisor	
4. Other Supervisor(s)	
5. Local Lead Clinician	
6. Participants (age, group or sub-group, pre- or post-treatment, etc)	
7. Procedures to be applied (e.g. questionnaire, interview, etc)	
8. Setting i) Where will procedures be carried out?	
ii) Are home visits involved?	Y / N
9. Potential risk factors identified (see table overleaf) a. Participants b. Procedures c. Settings	
10. Plan for mitigating risk (for researcher and participant safety) a. Participants b. Procedures c. Settings	

Trainee signature:

Date:

University Supervisor signature:

Date:

## HEALTH AND SAFETY FOR RESEARCHERS: GUIDELINES

Below are points to consider when assessing risk. In each instance make a case for the design being safe or reconsider the design of the study.

Participants	
Levels of Risk	Actions
This participant sample is not normally associated with dangerous or unpredictable behaviour.	Provide details of participants.
This participant sample is associated with impulsive, irrational or unpredictable behaviour, and/or has poor emotional control.	What procedures will be put in place to ensure your safety as a researcher?

Research Procedures	
Levels of Risk	Actions
The procedures in the study are same/similar to those used by clinical psychologists with these participants and are not normally associated with production of significant distress.	Most research procedures have the propensity to cause some level of frustration and/or distress. What can you do to minimise frustration? What would you do if someone became upset? What would you do if the research procedures identified unmet need?
These are novel procedures and/or might produce anger, irritability or distress.	In addition to the above consider ways to design your study that minimises the likelihood of causing anger, irritability or distress.

Settings	
Levels of Risk	Actions
These are clinical or University research settings, charitable organisations or other institutional settings, that participants routinely attend (e.g. a school). They have procedures in place to minimise risk to staff and these are thought to be adequate in the context of the proposed study.	Detail what these are and how they will be adhered to.
Home visits.	Refer to the specific guidance for home visits for research detailed overleaf. Include all points in research design and describe on Health and Safety form.

## Home Visits and Research Guidance

The programme encourages Trainees to avoid research procedures that require them to make home visits. If this is not possible, home visits may be permissible if the following is demonstrated:

1. It is not possible or practical to see the participants in a staffed facility and/or there is a significant risk of sampling bias if participants requiring home visits were excluded from the study.
2. Participants have been seen recently by a member of the clinical team involved with the patient and a risk assessment has been carried out. If the participant has had no recent involvement with a clinical team then a home visit is not permitted.
3. The Trainee will acquaint themselves with the risk assessment details in all cases prior to the visit.
4. The Trainee will discuss potential for risk with a member of the clinical team who has seen the patient recently.
5. As a result of 3 and 4 the risk to the Trainee is deemed to be low. If there is doubt the Trainee will discuss with their University Supervisor and/or a senior member of the clinical team that has responsibility for management of the patient.
6. The overall appraisal of risk must take into account what is known about the participant, a risk assessment of their living environment by the clinical team and consideration of the geographical siting of the visit. This will include assessment of any risk associated with travelling to and from the participant's home.
7. Home visits must be in normal work hours.
8. The lone worker policy for that team (or NHS Board) must be followed.
9. Each of the above points must be covered in the Health and Safety form that the Trainee submits with their MRP proposal.

In addition to NHS policies and procedures relating to home visits, Trainees should also follow the advice set out in the University's Lone Activities Procedure and the Safeguarding Researchers Policy:

<https://www.gla.ac.uk/myglasgow/seps/az/loneandoutofhoursactivities/>

<https://www.gla.ac.uk/myglasgow/ris/researchinitiatives/resources/safeguarding/>  
If there are any doubts or concerns about these processes the Trainee can contact the Research Director for advice.

## APPENDIX 8.6 RESEARCH LOG BOOK

**Trainee Name:**

Part A: Calendar of important dates and deadlines

Part B: Log of research supervision

Part C: Log of other key research meetings (e.g. statistician, local clinician)

Part D: Relevant correspondence

Part E: Letters of submission and acceptance/permission (e.g. ethics)

**To be kept up-to-date and brought to viva examination to be shown to the examiners on request.**

**PART A**

Date of Log Entry	Task/Deadline	Date Due	Date Completed

*(Further copies of this page can be made as required)*

**PART B**

<b><u>RESEARCH SUPERVISION LOG</u></b>
<b>Date of Meeting:</b>
<b>Agenda:</b>
<b>Learning Points:</b>
<b>Actions:</b>
<b>Date of Meeting:</b>
<b>Agenda:</b>
<b>Learning Points:</b>
<b>Actions:</b>

*(Further copies of this page can be made as required)*

**PART C**

<b><u>KEY RESEARCH MEETINGS LOG</u></b>
<b>Date of Meeting:</b>
<b>Agenda:</b>
<b>Learning Points:</b>
<b>Actions:</b>
<b>Date of Meeting:</b>
<b>Agenda:</b>
<b>Learning Points:</b>
<b>Actions:</b>

*(Further copies of this page can be made as required)*



## APPENDIX 8.7 REMOTE EXAMINATION OF THE CLINICAL RESEARCH PORTFOLIO

In certain circumstances, and with the consent of all parties, it is permissible to use an appropriate electronic platform such as Zoom to conduct the viva examination. This would usually be in cases where the external examiner is unable to travel to Glasgow. In this situation, the trainee and internal examiner would attend in person as normal, and the internal examiner would convene the video call with the external examiner. The viva examination would then proceed in the normal manner.

In exceptional circumstances, the University may also permit the trainee and/or internal examiner to attend remotely. We have been permitted to do this during the COVID-19 pandemic and this arrangement will be kept under review in future years. In this case, the internal examiner will convene a video call with the trainee and external examiner, and the viva examination will then proceed in the normal manner, taking note of the following practical considerations:

- The trainee and examiners should ensure they are in a suitable environment to conduct the remote examination (e.g. quiet, free from interruption, with a stable internet connection). If the trainee is attending remotely, no other person should be present in their room, and the trainee and internal examiner will have a briefing call prior to the viva to ensure they are familiar with the set-up and procedures.
- The video call should be set up so that each person can see the others present on the call. If the connection deteriorates during the examination it is permissible for either or both examiners to switch off their camera and participate by audio-only, but the trainee must be visible to both examiners at all times. This is to ensure as far as possible that their performance is not being aided in any way that is not permitted. If such a link cannot be maintained, the examination should be stopped and rescheduled for as soon as is possible thereafter. All other pre- and post-viva procedures would remain the same as for in-person viva examinations. The viva examinations should not be recorded.
- If any party would like to trial the software and test their connection in advance of the viva, we would be happy to facilitate this. Please get in contact via [dclinsy@glasgow.ac.uk](mailto:dclinsy@glasgow.ac.uk) to arrange a convenient time.

Trainees should follow the Good Cause process, as described in Chapter 9 of the Handbook, to notify the Programme if they are unable to attend the viva examination, or their performance in the examination is significantly affected by unforeseen or unavoidable circumstances. In the context of a remote examination, such circumstances may include technical difficulties. If the MyCampus Good Cause portal is suspended, trainees should submit Good Cause claims directly by email to the DClinPsy student support team. This information will be treated in the strictest confidence.

As is standard, if a trainee considers there to have been an unfair or defective assessment procedure applied, they may follow the University's academic appeals process, described in Chapter 9 of the Handbook. However, all parties having agreed to it, the use of video conferencing should not in itself be used as the basis for an appeal.

Finally, please note that the University has requested as much feedback on this process as possible, from all parties, so we would be grateful if you could provide such feedback. This feedback can be provided in whichever format you prefer.

## APPENDIX 9.1 MARKING FRAMEWORK FOR EXAMINATIONS

Unless otherwise stated, examinations are marked using the University's Schedule A, described below. From the Examiner's point of view, the key decision is the categorical judgement of Grade, with Secondary Band being assigned subsequently based on the merits of the work within that Grade. Examiners are encouraged to use the full range of Grades.

Any assessment graded as D1 or below is second marked. The two scores are then combined to provide an average score. In the event that scores fall across two different grades, examiners are required to moderate an agreed grade.

For exams where more than one question is answered, aggregation scores will be used to calculate an average grade.

Primary Grade	Secondary Band*	Aggregation Score	Descriptive comments
<b>A</b>	A1	22	This piece of work shows an excellent grasp of the relevant theoretical, clinical and professional issues. There is clear evidence of incisive critical analysis of the material, and the question is directly addressed throughout. The references that are cited are always directly relevant, up to date, and an evaluative commentary is provided. There is evidence of the Trainee having explored a wide literature. Where appropriate, clinical, ethical and professional materials are used and fully integrated with the piece of work. The presentation of the work (including grammar, spelling and writing style) is excellent. References are cited appropriately in the text.
	A2	21	
	A3	20	
	A4	19	
	A5	18	
<b>B</b>	B1	17	The answer has demonstrated a comprehensive and good grasp of the relevant theoretical, clinical and professional issues. The skills of critical analysis and synthesis of the relevant literature are demonstrated. The answer is well integrated and well structured. References are cited appropriately and overall presentation is good.
	B2	16	
	B3	15	
<b>C</b>	C1	14	This piece of work shows a good grasp of the relevant theoretical, clinical and professional issues. There is some evidence of critical analysis of the material, and the question is addressed fairly clearly throughout. The references that are cited are usually relevant. Where
	C2	13	
	C3	12	

			appropriate, clinical, ethical and professional matters (e.g. ethics) are commented on, although they are not fully integrated with the piece of work. The presentation of the work (including grammar, spelling and writing style) is acceptable. References are cited appropriately in the text, with few errors.
<b>D</b>	D1 D2 D3	11 10 9	Most of the criteria for a clear pass are met, but there are some areas where those criteria are not met. Those deficiencies are not sufficient to mean that the Trainee should fail the work. However, this mark should serve the function of alerting the Trainee to the need to improve subsequent work, to a Doctoral level standard.
<b>E</b>	E1 E2 E3	8 7 6	Some of the criteria for a clear pass are met, but there are many areas where those criteria are not met. Those deficiencies are sufficient to mean that the Trainee should fail the work, but indicate that the work has some merit. This mark should serve the function of alerting the Trainee to the need to significantly improve subsequent work, to a Doctoral level standard.
<b>F</b>	F1 F2 F3	5 4 3	Few criteria for a clear pass are met. Those deficiencies are sufficient to mean that the Trainee should fail the work, and indicate that the work is broadly deficient. This mark should serve the function of alerting the Trainee to the need to improve subsequent work, to a Doctoral level standard.
<b>G</b>	G1 G2	2 1	None of the criteria for a clear pass are met.
<b>H</b>		0	No evidence of attainment of intended learning outcomes.
<b>CR</b>	CREDIT REFUSED		Failure to comply, in the absence of good cause, with the published requirements of the course or programme; and/or a serious breach of regulations.

### Aims

The Examinations are designed to examine the candidate's knowledge of assessment, clinical phenomenology and the theoretical and research base that underpin the practice of clinical psychology.

### Assessment criteria

Candidates must demonstrate a sound grasp of the conceptual frameworks, clinical phenomenology, theory and research and especially the ability to integrate these as appropriate. Professional and ethical issues should be taken into account. Candidates should be able to evaluate the relevant literature critically and

incisively, and to present the work in a coherent and articulate manner.

Depending on the question, examiners award marks to answers on the basis of a number of factors, including:

- Clear attempt to understand and answer the question as set
- Pertinent factual material
- Clear focus on the question
- Acceptable definition and understanding of core concepts and theory
- Clarity of expression
- Structure and organisation of material
- Logical argument
- Well-founded critical analysis and synthesis of the appropriate literature
- Proper consideration of clinical, ethical and professional issues.

## APPENDIX 9.2 COMMUNICATION & CONFIDENTIALITY SHEET

You can expect that information about you and your training is kept confidential, but as for clients in clinical settings, this cannot be absolute. The Programme Communication Policy is the document which describes how information about you is shared and why.

The Programme Communication Policy ensures that those training you and supporting your training are able to do so to the best of their ability and in your best interests. On the Programme, you are not only employees of the NHS, but also postgraduate students at the University of Glasgow and your training is supported by NHS Education for Scotland (NES). So communication is necessary, both within each of these organisations as well as between these organisations. This is similar to communication between professionals in a multi-disciplinary team who share confidential information about clients in order to provide high quality care in the patients' best interests.

It is important that you understand how information about you will be shared, and the group of people within which that sharing will take place. The Programme Communication Policy is therefore reproduced beneath, and you are asked to read this and sign to indicate your understanding and acceptance of the ways, described in the Policy, that information about you will be shared.

If you have any concerns about this, please speak to your Personal Tutor or Clinical Tutor.

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### Programme Communication Policy

#### Background

Successful training of Clinical Psychologists requires the close collaboration and co-operation of multiple stakeholders, of which the principal ones are NES, the NHS and the University of Glasgow. Each of these stakeholders operates its own governance structures and procedures, which can operate independently in most of their other dealings. However, in the case of delivering the programme, these independent structures and procedures are often interdependent, necessitating co-ordinated action by more than one stakeholder or action by only one with the knowledge and involvement of the others. The same can also be true of information sharing. Where information may not usually be disclosed outside one system, the partnership involved in training requires it to be shared with other stakeholders. It is in trainees' best interests that stakeholders communicate openly, as this allows appropriate levels of support to be provided in a timely manner in the various environments where this is required.

The key individuals who may require access to information about trainees and their circumstances are as follows (in alphabetical order):

- Clinical Practice Director
- Programme Director
- Clinical Tutor
- Head of Service
- Line manager
- Local Tutor
- NES (Training Office Manager, Director of Training)
- Supervisor

These individuals are subsequently referred to as “the core group”.

Clarity is required for each trainee regarding the line management arrangements, in that the various functions of management can be provided by different individuals. For example, it is common for trainees to identify their line manager as the Clinical Psychologist with responsibilities in the clinical area in which they work, who fulfils leave, travel and work allocation functions; whereas a different individual, often a Head of Specialty or Department, might fulfil performance review and disciplinary functions.

At the outset of training, the Programme requests a named line manager for each trainee. It is proposed that this be the person viewed as the key individual for communication, who will then take responsibility for informing others within the Board, either day-to-day managers or more senior managers, as appropriate. Similarly, Personal Tutors and Clinical Tutors to whom serious issues are communicated are responsible for involving the Clinical Practice Director or Programme Director, as appropriate. Staff employed by NES, namely Clinical Tutors, Clinical Practice Director, Training Office Manager and Director of Training will take responsibility for communication between each other and with finance colleagues in NES.

### **Principle 1 – Automatic notification**

Any members of the core group will communicate information about a trainee timeously to other members of the core group where that information is relevant and necessary to the work of those other members with the trainee.

If there is uncertainty about whether the information is relevant and necessary or not, then the information should be shared and the appropriateness of doing so should be determined with the recipient in order to clarify for the future.

In many of the communications between members of the core group, this principle is already well understood and embedded in existing processes. For example, supervisors having a concern regarding a trainee’s progress will communicate that to a mid-placement visitor who will, through the standard report, communicate this to the Clinical Tutor and Local Tutor. Similarly, systems exist to ensure that local tutors are informed of trainees’ learning objectives, which will have an impact on their planning of placements. A key element of this system is the Trainee Progress Meeting which takes place monthly and provides an opportunity for core group members to share necessary information as appropriate.

Clear examples of relevant and necessary information across stakeholders would include:

Various kinds of Leave – sickness (of more than 2 weeks), parental, special, compassionate, carer, adoption (not annual leave for which separate communication is detailed in the Handbook)  
Professional behaviour and Conduct issues  
Fitness to practise issues  
Failure of parts of programme  
Disability status where reasonable adjustments are required (see note below)

## **Principle 2 – Information request**

In addition to Principle 1, any members of the core group (named above) can request information held by another member of the core group, or another stakeholder. A reason must be given for the information requested. The request must be considered and a reason given and recorded if the request is not fulfilled.

### **Personal difficulties**

Trainees may sometimes disclose information about personal difficulties affecting their work, either on placement, or on work component, for specialist trainees. Trainees discussing the impact of these difficulties in the past have voiced concern that sensitive information might be disseminated widely. Trainees should be aware of the guidance in the BPS Code of Ethics and Conduct (2021) (Standard of recognising impairment) as well as in the HCPC Standards of Conduct Performance and Ethics (2016) and the HCPC Guidance on Conduct and Ethics for Students (2016, Standard 5: “You should limit your study or stop studying if your performance or judgement is affected by your health”, and Standard 8: “You should communicate effectively with service users and your education provider and placement provider”). This guidance indicates the importance of trainees disclosing such information but particular care should be taken to ensure, consistent with the remainder of this Policy, that only the information that is relevant and necessary to the work of another member of the core group is shared.

### **Disclosures of Disability under the Equality Act (2010) Previously the Disability Discrimination Act (DDA: 1995)**

Under the Equality Act, once a student or an employee has disclosed a disability to certain categories of individual within an organisation, then that organisation is “deemed to know” about the disability under the Act and can be held liable for discriminatory practice such as not providing reasonable adjustments. Thus, communication within organisations is very important and in the context of clinical psychology training, communication between the stakeholders is equally so.

However, individuals disclosing a disability under the definition of the Equality Act are entitled to request that this disclosure be kept confidential. Full confidentiality cannot be guaranteed as the Equality Act does not override Health and Safety legislation with respect to the individual or others. Further details regarding processes for trainees with disabilities are given in the Handbook. In the meantime, anyone receiving a disclosure of disability from a trainee should discuss confidentiality explicitly and discuss the benefits of full disclosure for the trainee and



their training. Clarification should also be obtained as to the extent of information sharing to which the trainee consents, for example all information or just that which is required for reasonable adjustments to be made.

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I have read and understood the above Programme Communication Policy and accept that the stakeholders included in it will share information about me as described in the Policy.

Signed.....

PRINT NAME.....

Date.....

## APPENDIX 9.4 REQUEST FOR APPROVED ABSENCE

From September 2024 the process for requesting absence from class will be made via a restricted access online form available at this link:

<https://forms.office.com/e/rTwbYW8T78?origin=lpLink>

## APPENDIX 9.5 GETTING STARTED WITH UNIVERSITY OF GLASGOW IT SYSTEMS

Once you have your GUID and password, you can access the full range of online services and apps that the University offers. Please keep this list for reference while you get up and running on the DClinPsy programme.

**MyGlasgow** - <https://www.gla.ac.uk/myglasgow/students/>

MyGlasgow is the central point for most of the IT systems that you may need to access. As well as being a portal to other apps such as email, MyGlasgow has useful noticeboards and there is a directory of student services on the MyGlasgow log-in page.

**MyCampus (via MyGlasgow)**

MyCampus is where you can access your registration details, and this is also where students submit Good Cause claims for absences or extensions (see DClinPsy Handbook Chapter 9). To get to MyCampus, first log in to MyGlasgow and follow the links on the right.

**Moodle** - <https://moodle.gla.ac.uk/login/index.php>

Moodle is your digital learning environment. The DClinPsy Student Support Team will enrol you on our core Moodle page, which is called the DClinPsy Common Room. This is where you will be able to view the Handbook and other resources, lecture slides and learning materials, assessment guidance, template forms, etc. In due course, you will also be enrolled on the Moodle submission page for your cohort, where you will submit all summative (graded) coursework and access your results and feedback. You can log in to Moodle via the link above or through MyGlasgow.

**Zoom** - <https://uofglasgow.zoom.us/>

Zoom is the app that we use most often for remote teaching and trainee/staff meetings. The University has an institutional Zoom account; please ensure that you use this instead of your own personal Zoom account, if you need to set up a meeting related to your DClinPsy training. Log in using the link above and download the latest Zoom client to your device. If you need to log back in within the Zoom app, choose the 'Sign in with SSO' option and enter uofglasgow as the domain name.

## **Microsoft 365 (via MyGlasgow and your own device)**

All students and staff have access to Microsoft 365 through the University's institutional account. This allows you to use the full suite of Microsoft apps. Log in to MyGlasgow and click the Microsoft 365 link. As well as the usual apps (such as

Word, PowerPoint etc), two important elements of Microsoft 365 are Teams and OneDrive. **Teams** is a collaboration app through which you can organise/attend online meetings and participate in group projects. **OneDrive** is a remote file storage facility where you can save all your work and access it from anywhere. We strongly recommend that Trainees use OneDrive to store and access all their academic work. Day-by-day teaching schedules will be shared on an ongoing basis via **Outlook Calendar** invitations from the Student Support Team (for remote/hybrid lectures, a Zoom/Teams link will be included in the calendar invitation).

Trainees are able to download Microsoft 365 to their own device for free. Just log in to Microsoft 365 on the web (as above), and look for the 'Install apps' link at the top right of the main page. This means you can use the desktop version of the apps, which is sometimes more convenient than using the web versions. All files saved to the desktop OneDrive folder will sync with the web OneDrive folder.

## **Remote Desktop - <https://www.gla.ac.uk/myglasgow/anywhere/desktop/>**

You can log in to the University's **Glasgow Anywhere** remote desktop using the link above. This is intended to partially replicate the experience of using an on-campus student cluster computer when you are off campus. Some internal University web pages are not viewable unless you are using a University computer, and so the remote desktop is a useful way to overcome this when off campus. It also allows you to access software that you may not otherwise have access to. You will have a file storage 'home drive' here; files stored in this drive can be accessed when you log in to any campus computer or the remote desktop on your own device. This is useful for working off campus but, as noted above, our recommendation is that you use the Microsoft 365 OneDrive as your primary means of remote file storage.

## **University Library - <https://www.gla.ac.uk/myglasgow/library/>**

The University Library has excellent online resources that you can access anywhere. Please familiarise yourself with the range of services on offer. You can also view your individual library account to track loans etc. A huge range of journals and e-books is available by logging in to the Library.

## **Eduroam - <https://www.gla.ac.uk/myglasgow/it/eduroam/>**

Eduroam is the wifi network you can access on campus. See instructions via the link above for how to set this up for the first time. Once this is set up, your device can automatically connect to wifi not only on our campus, but also at participating academic locations worldwide.

## **Helpdesk - <https://www.gla.ac.uk/myglasgow/it/helpdesk/>**

If you encounter difficulties with any of the above, you can use the online self-service UofG Helpdesk to submit a query.

# APPENDIX 9.6 CITIZENSHIP AND MENTAL HEALTH ACTIVITY

## Introduction

This experiential activity sits at the intersection of human rights, professional ethics, and social responsibility and accountability. These three elements are core to a clinical psychologist's practice, management, and leadership within a public health system that promotes an inclusive environment.

In this activity, we provide our trainees the opportunity to engage with systems, organisations, and policies that are of relevance to their professional and social roles. By engaging with these structures, we hope that trainees can build on their human rights education and practice and broaden their understanding of relevant structures that impact on the mental health of the population and wellbeing of the community they serve and exist within.

## Guiding criteria

This is a trainee-led activity. This means that there are a wide range of activities that trainees may choose to engage with and reflect on to be able to develop their skills as rights holders and protectors (social accountability) and to develop their leadership skills and their structural knowledge as trainee clinical psychologists (professional ethics and responsibility).

**Focus:** The focus of the activity has to be related to the mental health and wellbeing of the population or specific groups within the population (e.g., women, children, ethnic minority, LGBTIQ+, older adults, etc.) or mental health and wellbeing in relation to issues of social justice and human rights (e.g., climate change, poverty, discrimination, immigration, etc.).

**Format:** The activities can be conducted individually or as a group. Trainees are free to self-organize.

**Time commitment:** Two full days can be allotted to this activity – trainees can use placement or study time for this activity. If the trainee uses placement time, they need to inform their clinical supervisor and agree a suitable day/s to use. If the trainee uses study time, they need to inform both their research supervisor and clinical tutor on the course and agree a suitable day/s to use.

Some examples (trainees are not limited to the list below) of the kinds of activities trainees may wish to engage with include:

- Review and critical analysis of a relevant policy, linking it to clinical psychology practice
- Visiting and interacting with staff at relevant community or third sector organisations that work with populations of interest or address issues of interest – observe meetings or daily activity, learn about operations, guiding principles, relevant policies, funding routes, etc.
- Attend and facilitate a Hub Monday at the Byres Community Hub engaging organizations around a particular focus/topic
- Contribute to editorial and/or writing activity within the CUSP newsletter or other relevant newsletters
- Interview a human rights advocate who speaks to mental health in relation to issues/populations of interest

*Note: simply attending a meeting or gathering does not constitute citizenship activity. We want trainees to engage with mental health issues*

*experienced by groups of interest or in relation to human rights or social justice issues of relevance.*

### **Programme role**

This activity sits within the EDI training initiative of the Glasgow Doctorate in Clinical Psychology *Human Rights and citizen psychologists: A framework to engaging with principles of equality, diversity and inclusion*

Trainees will engage in several seminars during their time on the course that will offer the basis for this activity:

In Year 1, trainees will engage with the core principles of human rights and citizenship and how those are implicated in mental health, health inequalities, and marginalization. The basic operations of power and privilege and where those sit in society and within systems will be discussed and reflected on. Trainees will also reflect on their level of critical consciousness in reference to social and community issues of relevance.

In Year 2, trainees will build on their learning from Year 1 and expand on it through the incorporation of topics relevant to socioeconomic systems and public policy and their intersection with human rights, health and social care and the wellbeing of the population.

In Year 3, trainees will have an opportunity to engage in learning in relation to leadership and human rights approach to working within the NHS.

Experiential Citizenship and Mental Health activity:

*This is an opportunity for trainees to apply their knowledge and skills through experiential activity*

**Drop-in sessions:** online sessions will be offered to trainees January through April of Year 2 to further discuss the parameters of this activity should they need further guidance.

**Activity registration and approval:** Trainees will be required to register their activity on Moodle by May of Year 2. A 250 word summary of the activity and aims should be included. Approval of an activity will have a two-week turnaround. Even if conducting a group activity, each member will have to register that activity individually and list their team members.

Once the activity is approved on Moodle, the trainees can organise to carry it out.

*Note: We will keep a record of these activities and the reflective summaries (see below) to showcase the work on the doctorate and when engaging with external stakeholders.*

### **Evaluation**

Programme assessment of trainees' learning is formative in nature and occurs through reflections arising from experiences. Trainees will be expected to submit a lay summary of up to 500 words on Moodle summarizing the activity and reflections. Suggested headings include:

Context of activity

Summary of engagement

Reflections on learnings

### **Recommended resources**

- Scotland's Second National Human Rights Action Plan (2023)  
<https://www.snaprights.info/snap-2>

- Human Rights Education For Psychologists (Hagebaars et al., 2020)