Doctorate in Clinical Psychology

Placements Handbook 2024

Disclaimer

This document was published in September 2024 and was correct at that time. The department reserves the right to modify any statement, if necessary, make variations to the content or methods of delivery of programmes of study, to discontinue programmes, or merge or combine programmes if such actions are reasonably considered to be necessary by the University. Every effort will be made to keep disruption to a minimum, and to give as much notice as possible.

Preface

This Placements Handbook, one of a set of Handbooks for the Royal Holloway University of London Doctorate in Clinical Psychology, is intended to provide information about the main features of Clinical Placement elements of the Course. We hope that it will be helpful as a point of reference and guide. The **Course Handbook** comprises the full set of Handbooks:

General Handbook
Research Handbook
Placements Handbook
Academic Handbook

While we will attempt to keep this Placements Handbook current and draw attention to changes, it may not always be possible to arrange for changes to be incorporated and trainees should always check with Course staff for information about the current situation if in doubt. Information will be subject to changes consequent on changes in the Department, College or University and Trust Regulations and practices. Although we will endeavour to detail changes as soon as these are available, the most current version will be that on the department's webpages.

It is assumed that all trainees will have read and understood the contents of all the Handbooks. Any matters relating to accuracy or interpretation should be raised immediately with a member of the Course Staff.

Any suggestions for improving the Handbook and making it more relevant are very welcome.

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CONTACT DETAILS FOR THE COURSE AND PLACEMENT ENQUIRIES

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

For any placement related queries, contact the Clinical Tutor Team:
dclinpsy-placements@rhul.ac.uk

For any other Clinical Psychology Course queries, contact: **dclinpsy@rhul.ac.uk**

Main Office Number: **01784 414 388**

Dr Kate Theodore – Clinical Director & Deputy Course Director
Dr Michelle Wilson – Deputy Clinical Director
Mrs Michelle Watson - Student & Course Administration Officer
Mr Chris Watmore - Senior Student & Course Administration Officer

PREPARING FOR PLACEMENTS

This section covers the placement allocation process across the three North Thames DClinPsy courses. In addition, guidance on trainee induction, orientation, and activity organisation is covered.

Placement allocation

All Royal Holloway DClinPsy trainees undertake placement in North Thames. Placements in North Thames are shared between Royal Holloway and the other two Courses at University College London and the University of East London. Placements are sourced and allocated collaboratively between these three Courses. At Royal Holloway, the Clinical Sub-Committee oversees and assesses the appropriateness of placement allocations made by the Course.

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

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

Course	**Placements responsible for**
Royal Holloway	People with Learning Disabilities Health Neuropsychology Forensic
University College London	Adult Mental Health including Long Term Needs Specialist Adult
University of East London	Child (core and specialist) Older Adults

Placements commence in October and April each year. Placements are sourced by emailing supervisors 4 months before the placement is due to start, requesting them to update their placement availability via Qualtrics surveys. Trainees are allocated to placements in February and July and supervisors informed of their allocated trainee about 6-8 weeks before placements commence. Trainees are informed of their placement allocation about 4 weeks before and asked to contact supervisors to arrange a placement visit to confirm placement suitability and arrange practicalities for the placement. The course will confirm placement arrangements in writing. Trainees will provide a brief CV to supervisors.

Trainees are closely matched to placement requirements provided by supervisors. However, given the limited number of placements available, exact matching of trainee to individual placement needs is not always possible. Supervisors should contact the Course immediately if they feel that an allocated trainee is not suitable for their clinical placement.

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

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

Induction and Orientation

At the pre-placement meeting or initial supervision meeting it is important to discuss the trainee's previous experience, their needs and interests and the opportunities provided by the placement. Trainees will provide a brief CV. Supervisors should provide any necessary placement required reading. Supervisors should inform their line manager and colleagues that a trainee will be working in the service and discuss implications.

Camden and Islington NHS Foundation Trust (due to become North London Foundation Trust over 2024/25) provide trainees with an employment induction which should fulfil all the mandatory training requirements that trainees need prior to going on placement, including Breakaway; Conflict Resolution; CPR; Equality, Diversity and Human Rights; Fire Safety; Health, Safety and Welfare; Infection Prevention and Control; Information Governance and Data Security; Manual Handling; Mental Capacity Act; Safeguarding Adults & Children Level 3. Annual mandatory training will be completed by trainees, and they are required to keep a record of this to show to placement supervisors. Some Trusts may require a separate Trust induction, which should be arranged by the placement supervisor.

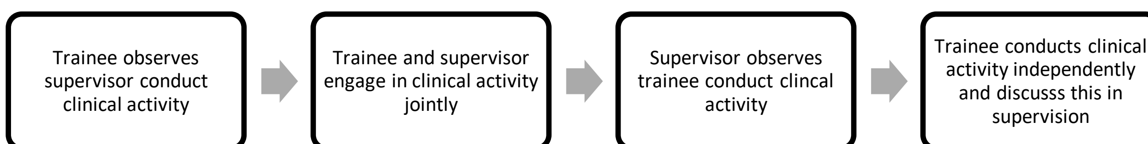
At the start of placement all supervisors must provide an induction to Local Trust Health and Safety policies, safeguarding and clinical risk management procedures (including home visit/lone working policies where applicable), and information governance procedures. The induction process must include a comprehensive employee health and safety induction given by a designated health and safety coordinator (or similar) covering topics such as first aid provisions, fire safety and incident reporting. They must also ensure an induction is provided to orientate the trainee to systems for recording in clinical notes and making room bookings. The trainee should also be informed of all local and team meetings that they are expected to attend. Trainees will be expected to conform to all local Trust policies and relevant local service policies. Some supervisors develop an induction pack of placement information to ensure trainees are provided with everything they need to know to function effectively in the service.

Ideally trainees will be provided with relevant IT resources (i.e. NHS Trust / organisation laptops and mobile phones) by the placement for use in their clinical work over the period of the placement. However, where this is not possible, the Course will check with trainees in advance of the placement if they have personal laptops available for placement-related work, in which case it would be expected that any confidential service material would be accessed via a virtual private network (VPN) organised by the NHS Trust / placement organisation.

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

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

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



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

Time on placement

The trainee will be on placement for an average of 2.5 days per week. This varies from 2-5 days per week according to their stage of training. **Trainees are expected to be on placement for a minimum of two days per week at all times, unless they are on annual leave**. See General Handbook for further guidance on attendance and annual leave.

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

	Academic days
1st years	Mon, Tues,
2nd years	Thurs, Fri
3rd years	Weds (with reduced teaching days from Spring Term of third year)

A placement planning grid is provided to assist the supervisor and the trainee in allocating placement, study, research, and annual leave days. The number of days for each activity is clearly specified, but

the particular days of the week is left flexible to fit with the needs of the trainee, the supervisor and the service. There are two elements to the placement planning grids:

- A sample placement grid for each 6-month placement, which gives the number of days for each activitie (i.e. placement, academic, research, annual leave etc) to be allocated for the 6-month period
- A template placement grid excel document, for trainees to map their individual placement / research / annual leave etc days, around the fixed days, such as academic teaching days or bank holidays. Please see below for example of the sample placement grid. Copies of these are available on Moodle for Students and RHUL website for supervisors.

YEAR 1 - Placement 1 (P1) for Intake 2024

College Week	Term	Placement 1	Mon AM	Mon PM	Tue AM	Tue PM	Wed AM	Wed PM	Thu AM	Thu PM	Fri AM	Fri PM
Week 6	1	28/10/2024	A	A	A	A	P	P	P	P	P	P
Week 7	1	04/11/2024	A	A	A	A	P	P	P	P	P	P
Week 8	1	11/11/2024	A	A	A	A	P	P	P	P	P	P
Week 9	1	18/11/2024	A	A	A	A	P	P	P	P	P	P
Week 10	1	25/11/2024	A	A	A	A	P	P	P	P	P	P
Week 11	1	02/12/2024	A	A	A	A	P	P	P	P	P	P
Week 12	1	09/12/2024	A	A	A	A	P	P	P	P	P	P
Week 13		16/12/2024	A	A	A	A	P	P	P	P	P	P
Week 14		23/12/2024	AL	AL	AL	AL	BH	BH	BH	BH	AL	AL
Week 15		30/12/2024	AL	AL	AL	AL	BH	BH	AL	AL	AL	AL
Week 16		06/01/2025	P	P	P	P	P	P	P	P	P	P
Week 17	2	13/01/2025	A	A	A	A	P	P	P	P	P	P
Week 18	2	20/01/2025	A	A	A	A	P	P	P	P	P	P
Week 19	2	27/01/2025	A	A	A	A	P	P	P	P	P	P
Week 20	2	03/02/2025	A	A	A	A	P	P	P	P	P	P
Week 21	2	10/02/2025	A	A	A	A	P	P	P	P	P	P
Week 22	2	17/02/2025	A	A	A	A	AL	AL	AL	AL	AL	AL
Week 23	2	24/02/2025	A	A	A	A	P	P	P	P	P	P
Week 24	2	03/03/2025	A	A	A	A	P	P	P	P	P	P
Week 25	2	10/03/2025	A	A	A	A	P	P	P	P	P	P
Week 26	2	17/03/2025	A	A	A	A	AL	AL	AL	AL	AL	AL
Week 27	2	24/03/2025	A	A	A	A	P	P	P	P	P	P
Week 28	2	31/03/2025	A	A	A	A	P	P	P	P	P	P
Week 29		07/04/2025	R	R	R	R	P	P	P	P	P	P
Week 30		14/04/2025	R	R	R	R	P	P	P	P	BH	BH

		Total days to be allocated to each activity for P1
Placement days	P	64
Academic days	A	40
*Research days	R	4
Annual Leave	AL	13
Bank holidays	BH	4

*NB - the **4 allocated research** days in this placement must be used in **the second half of the placement**. They are to support you with the research mathcing process

YEAR 1 - Placement 2 (P2) for Intake 2024

College Week	Term	Placement 2	Mon AM	Mon PM	Tue AM	Tue PM	Wed AM	Wed PM	Thu AM	Thu PM	Fri AM	Fri PM
Week 31		21/04/2025	BH	BH	AL	AL	AL	AL	AL	AL	AL	AL
Week 32		28/04/2025	AL	AL	AL	AL	AL	AL	AL	AL	AL	AL
Week 33	3	05/05/2025	BH	BH	A	A	P	P	P	P	A	A
Week 34	3	12/05/2025	A	A	A	A	P	P	P	P	P	P
Week 35	3	19/05/2025	A	A	A	A	P	P	P	P	P	P
Week 36	3	26/05/2025	BH	BH	A	A	P	P	P	P	P	P
Week 37	3	02/06/2025	A	A	A	A	P	P	P	P	P	P
Week 38	3	09/06/2025	A	A	A	A	P	P	P	P	P	P
Week 39	3	16/06/2025	A	A	A	A	P	P	P	P	P	P
Week 40	3	23/06/2025	A	A	A	A	P	P	P	P	P	P
Week 41	3	30/06/2025	A	A	A	A	A	A	A	A	P	P
Week 42	3	07/07/2025	A	A	A	A	A	A	P	P	P	P
Week 43		14/07/2025	P	P	P	P	P	P	P	P	P	P
Week 44		21/07/2025	R	R	AL	AL	AL	AL	AL	AL	AL	AL
Week 45		28/07/2025	P	P	R	R	P	P	P	P	P	P
Week 46		04/08/2025	P	P	R	R	P	P	P	P	P	P
Week 47		11/08/2025	AL	AL	R	R	P	P	P	P	P	P
Week 48		18/08/2025	R	R	R	R	P	P	P	P	P	P
Week 49		25/08/2025	BH	BH	R	R	P	P	P	P	P	P
Week 50		01/09/2025	R	R	R	R	P	P	P	P	P	P
Week 51		08/09/2025	R	R	R	R	P	P	P	P	P	P
Week 52		15/09/2025	R	R	R	R	P	P	P	P	P	P
Week 1		22/09/2025	R	R	R	R	P	P	P	P	P	P
Week 2		29/09/2025	R	R	R	R	P	P	P	P	P	P

		Total days to be allocated to each activity for P2
Placement days	P	63
Academic days	A	22
Research days	R	17
Annual Leave	AL	14
Bank holidays	BH	4

Supervisors should ensure that they agree the plan for the allocation of days with trainees at the start of the placement. This will include the scheduling of study days and annual leave. Planning should be based around a number of key guidelines, including:

- Trainees are expected to complete placement for a minimum of two days a week at all times, unless they are on annual leave.
- Any academic, study or research days must be taken in a pattern that ensures there are always two days per week on placement. It must not be taken in blocks unless this is specifically requested by the supervisor and agreed by the Course.
- Exam study leave of approximately 2 weeks is normally taken in June or early July of the first year of training. The spread of study (block or occasional days) should be agreed with the supervisor and be in line with service demands.
- Clinical Study time: One half day per five placement days is allocated to the trainee for clinical study. This time is set aside for reading material relating to their clinical / placement work. Study time may be taken either weekly or fortnightly as agreed between supervisor and trainee; however, it cannot be accumulated beyond one day in any 10 placement days and it may not be accrued for use as a longer study break. Trainees may spend study time at the placement base or elsewhere according to the needs of the service and agreed with the supervisor.
- Academic Study time: Academic study is taken outside of placement time and is largely scheduled on University days. Trainees may occasionally also need to attend University for meetings on study or placement days.
- Service-Related Research Project: This is expected to be carried out on placement. 13 days are set

aside for this project over the course of training. Trainees often complete this project in their first year of training.

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

Annual Leave

Most trainees will have 27 days of annual leave. This must be negotiated with the supervisor in advance and taken in each placement block. Due to course requirements, annual leave cannot be carried over between 6-month placements. This means trainees are expected to take either 13 or 14 days per each 6-month placement. With supervisor and Course agreement, 5 days of annual leave can be carried over to the second 6 months of a 12-month placement.

Travel to placement

Guidance for claiming back travel within placement (e.g. home visits) or travel to and from placement, including whether trainees are eligible to claim such travel claims, are outlined in the Travel Claims section on Moodle.

Research on Placement

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

- Capability of identifying, small-scale, locally driven, service-oriented research questions reflective of local service needs;
- Competence in research skills, including refining research questions, demonstrating an understanding of ethical issues, choosing appropriate methods and analyses, reporting outcomes;
- Working collaboratively with others (e.g. service users, other colleagues);
- Awareness of the relevant legislative and national planning context of service delivery and clinical practice;
- Ability to facilitate appropriate service user involvement in relevant aspects of the project, e.g. development of project rationale, selection of measures, dissemination of findings, etc.
- Understanding change processes in service delivery systems;
- Ability to present the results using appropriate scientific style;
- Ability to communicate service-related evaluation results to relevant individuals within a service in a manner that provides sufficient basis to enable decisions relating to the service to be made.

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

TRAINEE AND SUPERVISOR RESPONSIBILITIES

This section covers trainee and supervisor responsibilities. This includes information about responsibilities around line management, professional standards, as well as the support structures available to trainees. Guidance on clinical risk management, confidentiality and consent, record keeping, and non-discriminatory practice are also covered.

Employment & Line Management

All training places are commissioned by NHS England. Trainees are employed full-time by Camden & Islington NHS Foundation Trust (due to become North London Foundation Trust over 2024/25), who complete all employment and DBS checks. Trainees are also full-time registered students at Royal Holloway, University of London. The Clinical Director at Royal Holloway is Dr Kate Theodore, Clinical Director, and line management responsibilities for each cohort are shared across Professor Helen Pote, Course Director, Dr Kate Theodore, Clinical Director, Dr Michelle Wilson, Deputy Clinical Director and Dr Olga Luzon, Academic Director.

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

Whilst on placement, supervisors act as proxy line managers and are responsible for monitoring trainee attendances, absences, performance conduct and fitness to practise. Trainees are expected to conform to BPS and HCPC codes of conduct. Trainees should inform their supervisors and the Course should any absences, concerns or complaints arise on placement. Supervisors must inform the Course immediately should any supervision, conduct, complaints, or fitness to practice issues arise on placement. If there needs to be any change to supervision arrangements the trainee and supervisor should also inform the Course as soon as possible using dclinpsy-placements@rhul.ac.uk . Clinical Supervisors are also expected to monitor travel within placement and sign the trainee's monthly travel expenses if applicable. This will be submitted to the course by the trainee and countersigned by Course staff. Guidance for claiming back travel to and from placement are outlined in the Travel Claims section on Moodle.

Disclosure & Barring Service (DBS)

Camden & Islington NHS Foundation Trust (North London Foundation Trust) complete all employment checks for trainees, including DBS at the point of trainee onboarding.

Wellbeing and Fitness to Practice

The Course recognises that the training process is intensive and stressful. It is important that trainees understand the importance of monitoring and maintaining their own mental and physical health, and develop appropriate self-care and wellbeing strategies. This is essential for being able to manage the physical, psychological, and emotional impact of the Course, and for being able to maintain fitness to practice as a clinician. This is in line with the **HCPC (2023) Standards of Proficiency**. More specifically, trainees must learn to identify anxiety and stress in oneself, and be able to recognise the potential impact that this may have on their professional practice. Furthermore, they must take action to seek appropriate support, if their health is impacting on their ability to practise safely and effectively. This is also an important part of a trainee's personal and professional development.

If trainees have any concerns that they are suffering significant stress or other psychological, emotional, or physical health problems, which are impacting on their functioning or clinical work, or any concerns about their fitness to practice, they should notify their supervisor and a member of Course staff (usually

their Clinical or Personal Tutor) as soon as possible. This notification will be considered as a sign of positive professional behaviour and the supervisor/course staff will work with the trainee to develop a plan of action. This will include identifying additional sources of support, and developing and adopting clear strategies for physical and mental self-care and self-awareness (HCPC, 2023).

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

The University also has Fitness to Practice procedures for courses that lead to a professional qualification in a health care discipline. These procedures are designed to be implemented when there are issues relating to suitability to practice that may not be picked up by normal assessment procedures.

The Course also has a protocol for Confidentiality and the Sharing of Information about trainees, (see General Handbook) which outlines the principles and procedures around management of information about personal circumstances of trainees.

Wellbeing Support

In addition to the usual support offered on placement by supervisors, trainees are offered personal-professional support throughout their training which may help them monitor and maintain their wellbeing as a means of maintaining their fitness to practise in line with the HCPC (2023) Standards of Proficiency. In addition to support from supervisors, Trainees have a Personal Tutor - a member of the Course staff who will support and monitor the trainee's personal- professional development. Trainees are expected to meet with them ate least once a term. Other support options are also available including facilitated reflective practice groups, access to an independent personal advisor, student wellbeing services and Camden & Islington NHS Foundation Trust (North London Foundation Trust) Occupational Health and employee wellbeing services. If trainees or supervisors are concerned about a trainee's welfare they should inform a member of course staff immediately. Further Trainee Wellbeing Resources have been compiled for trainees to access, and are available on Moodle.

Professional Standards

Introduction:

Trainees and Supervisors are expected to conform to HCPC and BPS codes of professional conduct and ethics and adhere to their supervision guidelines. The following section details some key points from the policies below which are most relevant to placements but should be read in conjunction with the professional practice guidelines, Camden & Islington NHS Foundation Trust (North London Foundation Trust) employee policies and local placement Trust policies. Details of current employment policies can be found in the "C&I Policies" folder on Moodle.

- British Psychological Society (2017) Professional Practice Guidelines
- British Psychological Society (2021) Code of Ethics and Conduct
- BPS (2023) Guidance on the use of social media
- BPS (2014) Division of Clinical Psychology Policy on supervision
- BPS (2019) Standards for the accreditation of Doctoral programmes in clinical psychology
- British Psychological Society (2019) Electronic Records Guidance
- Health & Care Professions Council (2023) Standards of Proficiency for Practitioner Psychologists
- Health & Care Professions Council (2024) Standards of Conduct, Performance & Ethics
- Health & Care Professions Council (2024) Guidance on Conduct and Ethics for Students.

- Health & Care Professions Council (2024) Guidance on Social Media
- Health & Care Professions Council (2018) Confidentiality Guidance for Registrants.
- Health & Care Professions Council (2017) Standards of Education and Training
- Data Protection Act (2018) & General Data Protection Regulation (2018)
- Mental Capacity Act (2005) Code of Practice

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

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

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

Any concerns about a trainee's professional practice or conduct on placement should be immediately referred to Dr Kate Theodore, Clinical Director (See contacts on page 3).

Where a trainee fails to meet the expected standards of general behaviour or professional standards, then the normal disciplinary procedures will be followed:

- University procedures related to student conduct are available on the RHUL website.
- As employees of Camden & Islington NHS Foundation Trust (North London Foundation Trust), trainees are also subject to Trust disciplinary procedures.

Managing risk

The management of risk is covered in several different forums throughout training. These include: formal teaching in the first-year induction (clinical skills teaching; adult assessment and formulation; employer mandatory training such as safeguarding adults and children and lectures on suicidality and self-harm, and anger management). Within these lectures trainees are signposted to the relevant BPS and HCPC documents on managing clinical risks, including:

- British Psychological Society (2017) Professional Practice Guidelines
- British Psychological Society (2021) Code of Ethics and Conduct
- Health & Care Professions Council (2024) Standards of Conduct, Performance & Ethics
- Health & Care Professions Council (2024) Guidance on Conduct and Ethics for Students.
- Forensic Faculty (2006) Occasional Briefing Paper No 4 Risk Assessment and Management.

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

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

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

Ending of Clinical Work

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

Client Confidentiality and Consent

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

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

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

Consent

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

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

- Health & Care Professions Council (2023) Standards of Proficiency for Practitioner Psychologists
- Health & Care Professions Council (2024) Standards of Conduct, Performance & Ethics
- Health & Care Professions Council (2024) Guidance on Conduct and Ethics for Students.
- Health & Care Professions Council (2018) Confidentiality Guidance for Registrants.
- BPS (2017) Practice Guidelines
- BPS (2018) Code of Ethics and Conduct

Informed Consent to be seen by a Trainee Clinical Psychologist

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

When clients are offered the option of seeing a trainee clinical psychologist, information should be provided to them about what seeing a trainee is likely to involve. This will usually include, for example, that the trainee will be regularly supervised, the nature of the trainee's training and

experience, the length of time that the trainee will be available, what may happen when the trainee's placement comes to an end, any audio recording that may be planned, that the work may be written up for academic purposes, and that the client may be asked to comment on the trainee's performance (see **RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form,** standard and easy read versions, on Moodle). Clients have the option of consenting to specific elements of this, for example, they may consent to being seen by a trainee and to having anonymised information included on the ACE clinical log, but not consent to having anonymous information included in a case report or to audio recording.

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

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

Adapted from HCPC Guidance

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

Written Consent

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

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

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

When written consent is not possible but verbal consent is possible

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

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

Consent for anonymous information to be stored on ACE
Trainees are required to explain the purpose of collecting anonymised data in terms of training requirements, what data is collected and how it is stored. Trainees are required to gain client's consent to hold their data in this way.

Where written consent is not possible using the RHUL Consent to Being Seen by a Trainee Clinical Psychologist Form, verbal consent from clients is also acceptable for ACE.

The following is a suggestion as to how this requirement may be verbally explained to clients. This sort of statement should be used when gaining verbal consent from clients to store their data on ACE, and can also be used when introducing the written consent form:

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

A record of the written consent or verbal consent gained should be noted on the client's clinical records. Trainees should also indicate on the client's anonymised ACE record whether the individual client has consented to being seen by a trainee and to having information recorded on ACE.

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

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

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

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

This sort of statement may also be used for clarification when a client gives written consent, but you are unsure whether they have fully understood what they have agreed to.

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

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

There may be specific circumstances to consider where trainees' wish to write up group work for a

Report of Clinical Activity. Where possible, consent should be sought from clients attending a group facilitated by a trainee, for the trainee to include details of the group on ACE, or if they wish to present the work of the group for a Report of Clinical Activity. If this is not possible, or if only some of the group members consent, it is suggested that the Report of Clinical Activity is presented in a way that focuses only on any clients who have consented, and any clients who have not consented should only have very minimal, aggregate information presented as part of the presentation of the group work.

Consent for Audio or Video Recording of Clinical Work

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

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

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

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

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

The Mental Capacity Act came into force in 2005, providing a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It covers people with dementia, learning/intellectual disabilities, acquired brain injury and some mental health problems. The Act sets out clear principles and steps for assessing whether a person lacks capacity to make a particular decision at a particular time. No-one can be labelled 'incapable' due to a particular medical condition or diagnosis. Guidance on the Act has been provided in the Mental Capacity Act Practice. In line with the Mental Capacity Act and HCPC guidance, you should assume that adult service users have sufficient capacity unless there is evidence to suggest otherwise. Guidance on the Act has been provided in the Mental Capacity Act Code of Practice.

For people lacking capacity to give informed consent to be seen by a trainee clinical psychologist, those responsible for their care in accordance with professional guidelines and local Trust policies will need to make a decision regarding whether it is in the individual's best interests to be seen by the trainee clinical psychologist.

It is important that the Course can assess the full range of work conducted by trainees as part of their training, which may include psychological input conducted in the Best Interests of clients deemed to lack capacity to consent to being seen by a trainee. This ensures that all work conducted during Clinical Psychology training has the potential to be submitted to the same processes of academic rigour.

Therefore, if a trainee wishes to write a Report of Clinical Activity or present a Case Presentation for a piece of work conducted in the Best Interests of a client who lacks capacity, those professionals / others who contributed to the Best Interests decision making and / or those in the network who may have been involved in the psychological intervention, should be consulted on whether they agree to the work to be written up for academic assessment.

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

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

Children and Young People

The above guidance is largely applicable to adult service users. You should treat young people (aged 16 and 17) in the same way as adults and presume they have capacity to make a decision about their care, unless there is significant evidence to suggest otherwise. For children under 16, you may need to get consent from someone with parental responsibility, which may include the child's parent, legally appointed guardian, or local authority designated to care for the child. However, some children under 16 can give consent if they can fully understand the information given to them (known as 'Gillick competence'). If a child under the age of 16 years has sufficient understanding about the specific decision they need to make they may sign a consent form for themselves, and parents/carers should be made aware their child is consenting to be seen by a trainee and/or that the trainee intends to include details of the work on ACE or use the work for a Report of Clinical Activity. Where the child is unable to consent for themselves, it is good practice to involve the child where possible, and where child is able to give consent, it is also good practice to involve the parent or carer, where this is possible. Specific consent forms for use with children and young people are available on Moodle.

Confidentiality and anonymity obligations during training

The requirements of the Data Protection Act (2018) apply to the Clinical Doctorate. Everyone responsible for using personal data has to follow strict rules called 'data protection principles'. They must ensure the information is:

- used fairly, lawfully and transparently
- used for specified, explicit purposes
- used in a way that is adequate, relevant and limited to only what is necessary
- accurate and, where necessary, kept up-to-date
- kept for no longer than is necessary
- handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage

Trainees must ensure that they consider and respect clients' dignity in all written and spoken communications about their clinical work. It is important for trainees to consider whether their clients would feel respected if they were to read or hear any of the information being shared about them.

Trainees must ensure that client and carer confidentiality is protected in all work submitted for university requirements. BPS guidance is clear that academic / training documents (including training case reports or case presentations, published reports / articles) should never identify clients to which they relate, even by means for example of initials, service name or date of appointment, as any such potential identifiers could be used to trace the client and therefore make the document a part of the

clinical record, subject to relevant data protection legislation. The HCPC 'Guidance on conduct and ethics for students' states that students should remove anything that could be used to identify a service user from academic work or assessments (HCPC, 2024).

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

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

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

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

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

To further protect the confidentiality of clinical information, all written information relating to any aspect of Course work should be stored on an encrypted memory stick.

Trainees must adhere to the Trust guidelines where they are on placement regarding use of audio-recording equipment. In general, clinical work should be recorded using digital recorders or 'Dictaphones' designed for this purpose, unless the placement service endorses the use of another type of device. Personal mobile phones should not be used for the audio-recording of clinical work.

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

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

Record keeping

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

- HCPC Expectations for Record Keeping set out in Standards of Proficiency (HCPC, 2023) and Standards of Conduct, Performance & Ethics (HCPC, 2024)
- British Psychological Society (2019) Electronic Records Guidance
- British Psychological Society (2008) Record Keeping: Guidance on Good Practice

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

Guidance for trainees and supervisors:

- A record in an NHS context is defined as "anything which contains information (in any media) which has been created or gathered as a result of any aspects of the work of NHS employees" (HSC 1999/53, Appendix A, para 5.1 – taken from DCP Record Keeping: Guidance on Good Practice, 2008).
- Ownership of the clinical records belongs to the Trust where the trainee is on placement. It is important for trainees to clarify with supervisors what the service's procedures for notes and documentation are.
- In line with HCPC (2018, 2023, 2024) guidance, trainees should keep appropriate and timely records for all clinical contacts. Trainees should ensure that all records are clear, accurate, written up promptly (usually on the same day or the day after) and handled in accordance with applicable legislation, protocols, and guidelines.
- Trainees should use digital record keeping tools, where required, in accordance with placement guidance. Trainees should familiarise themselves with electronic health record systems used by the Trust and undertake the required Trust training to use these systems reliably. Trainees should be familiar with BPS guidelines on electronic health records.
- Supervisors are not required to validate all clinical record entries completed by the trainee unless this is the policy of the placement Trust. It will be essential for supervisors to audit trainee notes from time to time to ensure that they are adhering to good practice guidelines in their record keeping.
- Written records are now rarely used in the NHS, but in some cases, trainees might be asked to complete them (e.g., in case of electronic system outages). If asked, trainees should follow the basic principles of good written records: use the paper provided by the organisation; write in black ink; don't leave spaces between lines/entries; sign and date alterations; record date and time of session, attendees, location, key points discussed, actions and outcomes; write your name and sign and date entries.
- Activity recording of the amount of clinical contacts should be completed by the trainee if this is a Trust requirement.
- Trainees should contribute to team records, and they have a professional responsibility to inform other professionals involved in the care of the client about their involvement.
- Sharing of records should be restricted to a need-to-know basis, but absolute confidentiality of records cannot be assured. Trainees should be aware of the circumstances in which records may be requested for legal and clinical purposes.
- Trainees should normally obtain consent from clients for the disclosure of any records, restricting the scope of disclosure of records for professional purposes.
- Trainees should make sure that they inform clients at the first contact about what records will be kept in relation to their care. This includes the ACE record kept for training purposes.
- Trainees and supervisors are requested to keep a record of the main discussion and action points from supervision. The DCP recommends that the supervision record should include: copies of contracts; date and duration of each supervision session; a supervision log book with minimal notes on the content of supervision, decisions reached and actions agreed; and a

written record of reviews of supervision (e.g. MPR).
- Where appropriate discussion and decisions from supervision should also be reported in the clinical record. This is particularly relevant if risk issues have been discussed.
- Trainees and supervisors should be aware that from a legal standpoint anything that identifies the client forms part of their record and could be called upon as part of the usual clinical record for legal purposes. In practice some supervision reflections and notes to aid the trainee's learning are often kept in an anonymised form.
- Letters, reports and notes in clinical records must be signed appropriately. Accepted terminology is to be used. The British Psychological Society requires the following: "Trainee Clinical Psychologist working under the supervision of…. (name of supervisor)". Supervisors share clinical responsibility for the work undertaken by the trainee, and so the usual practice is for supervisors to countersign trainees' letters and reports. Trainees should check with supervisors what is the expected practice within the Trust that they are working in, e.g. whether supervisors also need to countersign entries into clinical notes. Letters should be sent out in a timely fashion.
- Every case would usually have a brief case ending / closure report prepared by the trainee and given to the supervisor at the end of their involvement, identifying who is responsible for any further work and follow-up. Normally, responsibility is assumed to remain with the supervisor.

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

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

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

Guidance on the use of Social media

When using social media and networking sites trainees and supervisors need to be aware of issues relating to clinical boundaries and professional presentation. Guidance from the HCPC and BPS regarding responsible use of social media in clinical psychology is available (BPS, 2023). Trainees are advised to review their own social media in relation to these guidelines at the start of the Course.

- BPS (2023) Guidance on the use of social media
- Health & Care Professions Council (2024) Guidance on Social Media

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

Equality, diversity, inclusion and non-discriminatory practice

In line with BPS (2019) accreditation criteria and HCPC Standards of Proficiency (2023), the Course is

committed to ensuring trainees practice in a culturally sensitive, inclusive and non-discriminatory manner. Trainees should familiarise themselves with professional and placement guidelines regarding non-discriminatory practice. As part of developing practitioners who recognise the impact of culture, equality and diversity on practice, in line with HCPC (2023) Standards of Proficiency, the Course is committed to supporting trainees to:

- Respond appropriately to the needs of all groups and individuals in practice, recognising that this can be affected by difference of any kind including, but not limited to, protected characteristics (namely age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity), intersectional experiences and cultural differences, and to understand the impact of differences of any kind on psychological wellbeing or behaviour, including how these differences may result in experiences of marginalisation
- understand equality legislation and apply it to their practice
- recognise the potential impact of their own values, beliefs and personal biases (which may be unconscious) on practice and take personal action to ensure all service users and carers are treated appropriately with respect and dignity
- understand the duty to make reasonable adjustments in practice and be able to make and support reasonable adjustments in their and others' practice
- recognise the characteristics and consequences of barriers to inclusion, including for socially isolated groups, and actively challenge these barriers, supporting the implementation of change wherever possible
- recognise that regard to equality, diversity and inclusion needs to be embedded in the application of all HCPC standards, across all areas of practice, and understand the requirement to adapt practice to meet the needs of different groups and individuals

The Course is committed to creating learning environments that are inclusive, supportive, and thoughtful about the similarities and differences that exist between all of us. This extends to the learning environment that is created as part of clinical placements. We recognise that learning and working environments are more likely to be experienced as inclusive by individuals who are part of a majority, whether that be in terms of race, ethnicity, sexual orientation, gender, ability, faith, amongst other characteristics. We are committed to providing training that:

- is actively inclusive, anti-racist, and non-discriminatory
- invites trainees to think critically about the models that shape our knowledge
- integrates thoughtful consideration about difference throughout all aspects of training
- gives trainees access to multiple and regular examples of working clinically with difference

To support supervisors in working towards these aims we have developed some guidance for placement supervisors, and trainees, on **Creating inclusive learning environments within DClinPsy placements**, available Moodle for Students and RHUL website for supervisors. Specific guidance has also been developed regarding supporting Muslim trainees during Ramadan, and supporting Jewish trainees (Moodle/website). There are also further references and resources to support this available here.

Trainees' development in line with these aims is monitored and reviewed through the MPR and EPR assessment process, as well as through their annual Developmental Reviews with their Personal Tutors.

Service user and carer involvement

Key to developing a non-discriminatory approach is ensuring service user and carer (also known as Expert by Experience) involvement in all aspects of the Course. Service user and carer involvement is seen as integral to the Doctorate in Clinical Psychology at Royal Holloway, and is highly valued by both trainees and staff. The Course aims to help trainees:

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

The Course has a well-established and active Service User and Carer Involvement Group (SUCIG), which acts as an advisory group and provides input across all aspects of the Course. With regard to clinical placements, it is an expectation that service user and carer involvement takes place across placements in several ways, including trainees actively seeking and using feedback from service users and carers on their experience of being seen by the trainee (see section on *Client feedback on Competence*), involvement of service users or carers in Service Related Research Projects, active encouragement of trainees to become involved in work on placement that embodies service user and carer involvement, co-production, including work with service user organisations. Trainees' opportunities and development of competence in this area is monitored and reviewed through the MPR and EPR assessment process, as well as through their annual Developmental Reviews with their Personal Tutors.

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

COURSE REQUIREMENTS FOR PLACEMENTS

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

Supervision

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

- BPS (2019) Standards for the accreditation of Doctoral programmes in clinical psychology
- BPS (2024) Supervision Guidance for Psychologists
- CORE Supervision Framework.

Amount

The course recommends 1½ hours per week of formal supervision. Naturally, the type and amount of supervision needed will depend partly upon the stage of training and partly on the needs of the trainee. The BPS requires that there be "a formal scheduled supervision meeting each week that must be of at least an hour's duration… The total contact between the trainee(s) and Supervisor(s) must be at least 3 hours a week and will need to be considerably longer than this at the beginning of training". Therefore, in addition to supervision, it is anticipated there will be contact at other times for joint work or observation. It is additionally recommended that there are appropriate opportunities for individual supervision per week in addition to any group supervision.

Eligibility

Trainees will normally have one named main supervisor who will be a qualified Clinical Psychologist, who is appropriately experienced, as recommended by the BPS. Supervisors should be HCPC registered. BPS guidance on supervision highlights that trainees may be supervised by professionals other than Clinical Psychologists over the course of training, however, the majority of a trainee's supervision will be provided by appropriately qualified Clinical Psychologists.

Members of other professions who are providing supervision to trainees on should normally be registered with an appropriate professional or statutory body. When these arrangements are in place, it is desirable that trainees have access to a practitioner psychologist. Where the supervisor is not an appropriately qualified Clinical Psychologist, but has qualification in and experience of psychological practice (e.g., Counselling Psychologists or high intensity IAPT practitioners) the Course will consider their eligibility on an individual basis. When initially supervising trainees from the Course, these supervisors may be required to have their supervision overseen by an appropriately qualified Clinical Psychologist. The Clinical Psychologist will also sign off the placement documentation (Contract & Placement Evaluation Form at MPR/EPR). If the Course determine that quality standards for placements and supervision are met, the supervisor may not require additional support for future placements.

As the profession becomes more specialised, it is often difficult for one supervisor to provide the full range of experiences needed. Increasingly, placements are created on a modular basis, with one named supervisor taking a lead role in structuring the placement, monitoring the trainees' development, and co-ordinating with other supervisors. Trainees may also conduct specific pieces of clinical work with additional supervisor(s) who can be from other professional disciplines. Where discrete pieces of trainees' clinical work are supervised by a professional from a non-psychologically trained profession (e.g., Occupational Therapist or Social Worker), an appropriately qualified Clinical Psychologist will always bear primary responsibility for overseeing this supervision.

It is expected that all supervisors will understand the context of Clinical Psychology training, and will have completed training in supervision provided by the Course. **Supervisors' workshops** are provided jointly by the North Thames Courses (RHUL, UEL, UCL), which include introductory training for all new supervisors, and opportunities for refresher training for existing supervisors. Details are on Moodle/Website.

Responsibilities

Trainees and Supervisors should inform the course as soon as possible of any changes to supervision arrangements or concerns that a trainee's wellbeing, physical or mental health is negatively impacting their functioning or fitness to practice. Supervisors should plan supervision cover in the event of unexpected absence, holidays, illness etc and document these arrangements in the Placement Contract. The Course should be informed of alternative supervision arrangements if they are required.

Supervisors should ensure that they know what a trainee is doing – as they will share responsibility for their actions. Supervisors should be aware that trainees are employed by Camden & Islington NHS Foundation Trust (North London Foundation Trust) with line management responsibilities devolved to senior Course staff members (Course Director, Prof. Helen Pote; Clinical Director, Dr Kate Theodore; Deputy Clinical Director; Dr Michelle Wilson; Academic Director, Dr Olga Luzon). Supervisors should make their expectations clear about trainee attendance and time management e.g., leave, illness, absence, required meetings.

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

Supervision should afford trainees and supervisors a forum to support trainees to monitor and manage their wellbeing, as a means of maintaining their fitness to practice and functioning in the workplace. It is well recognised that various aspects of clinical work can give rise to personal stress or distress. Trainees also need personal support and to be invited in supervision, in an appropriately professional way, to discuss any stressors or personal feelings which may arise in connection with their clinical work. If in the course of this process, it becomes apparent that a trainee may need to seek out additional help or support to manage a personal issue, supervisors are not expected to provide personal therapy or counselling. Indeed, this is seen as inappropriate. It would be reasonable, however, for supervisors to provide advice on accessing the necessary help. See Wellbeing and Fitness to Practice section of this Handbook, and further resources available on Moodle, including Trainee Wellbeing Resources.

Supervision standards

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

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

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

- Regular supervision should be conducted in scheduled, weekly and uninterrupted sessions.
- Supervision must occur on premises at which the placement is arranged.
- Trainees and supervisors should discuss supervision experiences and styles to negotiate a

working agreement for supervision sessions.
- Trainees and supervisors need to be prepared to discuss personal issues as they arise and are relevant to the trainee’s clinical practice.
- Development of an inclusive and supportive learning space, where reflective conversations around difference and diversity can take place.
- Tolerance on both sides, of differences in style and theoretical orientation.
- Empathy for the trainee on the part of the supervisor and a willingness to give positive as well as negative feedback.
- Openness on the part of the trainee to hear and learn from constructive criticism.
- Mutual observation and joint work.
- Supervisor should facilitate theory-practice links, and provide reading material, relating to the casework and service for subsequent discussion.
- Supervisors and trainees should shape the content of supervision together and plan supervision sessions. An agenda would:
    - Be broader than ‘what happened in the last session?’
    - Encourage thought about the cycle of competence: Assessment / Formulation / Intervention / Evaluation.
    - Vary learning methods e.g. presentation of formulations, discussion of case material, reading of clinical papers, role plays, video-taping and feedback.

Supervisors may also find it helpful to refer to the CORE Supervision Competences Framework. This is a pan-theoretical outline of supervision competences, though model specific (e.g., systemic, CBT) competences for supervision are also detailed.

Exploring Diversity in Supervision
Royal Holloway DClinPsy is committed to creating learning environments that are inclusive, supportive, and thoughtful about the similarities and differences that exist between all of us. Guidance has been developed to help support trainees and supervisors in facilitating conversations about diversity, equality, and inclusion. We thoroughly recommend that all supervisors and trainees read the guidance and agree together how they may be able to implement the ideas and suggestions given. These areas will be reviewed at Mid Placement Reviews, and the Course is welcoming of any feedback from trainees or supervisors about how we can further develop resources and support in this area.

The document, entitled “**Equality, Diversity, Inclusion and Anti-Racism: Creating inclusive learning environments within DClinPsy placements**” can be found on the RHUL Website and on Moodle.

Joint Supervision
In cases where there is more than one supervisor involved in a trainee's placement, a primary supervisor would usually be identified who will take responsibility for the planning and co-ordination of the trainee's placement, supervision and assessment and for liaison with Course staff (BPS, 2014, 2019). In this situation, it may be that only the primary supervisor attends the Mid Placement Review, incorporating feedback from the other supervisor. Where there is more than one supervisor, supervision time is commonly more than 1.5 hours in total per week.

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

We recommend regular communication (minimum monthly) between the two supervisors regarding the trainee; this helps trainees to feel supported and contained and monitors the joint caseload effectively. Where there is a primary supervisor, they should take responsibility for completing the relevant

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

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

Supervisor Training

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

All workshops are free of charge to supervisors. They are run jointly with the Tutors from RHUL, UCL and UEL. These workshops are held currently online, or may be in person in London at the Royal Holloway base at 11 Bedford Square WC1, at UCL or at UEL. Further details can be obtained here or from Michelle Watson, Student & Course Administration Officer (Clinical Psychology), dclinpsy-placements@rhul.ac.uk or clinpsyworkshops@rhul.ac.uk or on 01784 414388. Details of the workshops are on Moodle/Website.

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

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

Additional supervisor workshops for new or existing supervisors are available across a range of topics including workshops to support neuropsychology supervision, CBT or systemic supervision, developing leadership competencies in trainees, and to support supervisors to develop their skills in understanding equality, diversity, inclusion and anti-racist practice in supervision.

Caseload

Placement experience makes up half of the clinical psychology training and is the main opportunity for trainees to develop their clinical skills and link theory to practice. The learning opportunities, support and supervision provided on placement are key for trainees in developing their clinical confidence and achieving their learning goals. Though the learning outcomes of the placement are generally defined in terms of attainment of competences, having sufficient clinical experience to develop skills and broaden knowledge is essential for the development of a competent and clinically confident trainee. Supervisors should plan an introduction to clinical work at a pace negotiated with the trainee, but make sure that this is not too slow. The range and number of cases on the clinical caseload should be planned and monitored carefully by supervisors. The planning should consider the usual rate of drop-

out/no-shows in order that the caseload does not take too long to establish. Supervision should enable a regular review of the caseload.

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

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

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

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

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

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

Variations on the expected workload

In some settings the pattern of service delivery might mean that trainees undertake fewer "pieces" of work. Examples might be where:

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

- there is a model of intensive supervision associated with each case

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

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

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

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

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

Multi-disciplinary team work
Developing an understanding regarding the functioning of the unit or system within which they are working will be helpful both for the trainees' understanding of the placement and their knowledge of the functioning of the health service. It is also helpful to support the trainee's understanding of how the service works collaboratively and constructively with service users and carers, to facilitate their involvement in service planning and delivery, within the therapeutic relationship and beyond.
Some discussion of team working, leadership, and management issues will be helpful in deriving a context for the treatments offered, and this will be particularly important where work is done in a multidisciplinary team.

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

Leadership
The Course aims to support all trainees to develop knowledge and skills on placement which contribute to their development as effective leaders. Trainees and supervisors are sometimes concerned that encouraging trainees to take on leadership roles will be too premature or go beyond the competences of trainees. The BPS, HCPC and the Course take the view that newly qualified clinical psychologists should undertake leadership and service development roles early on in their career, as undertaking these responsibilities under supervision during training is essential in ensuring clinical psychologists become effective leaders in the future. The BPS Accreditation Criteria (2019) places emphasis on leadership skills

and competencies in consultancy, supervision, teaching and training, working collaboratively and influencing psychological mindedness and practices of teams. HCPC (2023) view leadership as an attribute all health professionals should demonstrate in their roles and emphasize the need for professionals to identify their own leadership qualities, behaviours and approaches, taking into account the importance of equality, diversity and inclusion. There is specific **course guidance on developing leadership competencies** (Moodle) for trainees at all stages of training.

Observations of Practice

The trainee must have the opportunity to observe the supervisor working clinically and the supervisor must observe the trainee working clinically before the Mid Placement Review. Most trainees need to begin by observing their supervisors, before moving progressively to more independent work. It is usually helpful to move through clear phases of (a) trainee watches supervisor (b) trainee and supervisor work together (c) supervisor watches trainee.

The Course requires that for observation and competence assessment:

- The trainee must **observe the supervisor at least 3 times.**
- Trainees' clinical practice must be **observed at least 3 times** during each 6-month placement. This should include 'live' observation of their clinical assessment and intervention skills. Recordings of sessions may also be used to supplement this.
- **Two formal ratings of competencies** using standard competence rating scales must be completed per 6-month placement, or every 6 months for 12-month placements, with **at least one having been completed by the MPR**. Both the trainee and supervisor should complete these ratings based on 'live' observations and/or recorded sessions. A range of measures are available via the course (e.g., Cognitive Therapy Scale Revised, Systemic Practice Scale) for observations of both direct and indirect work. It is recommended that where possible, mutual observations take place at different stages of clinical work with clients; that is, that therapy/intervention sessions are observed, as well as assessment sessions. It is expected that observations of trainees' practice reflect the work they are doing on placement, i.e. for largely direct clinical focused placements, it is expected that observations are of trainees conducting direct clinical work, however where placements are focused on leadership, observations are likely to be of their leadership work / meetings etc. Please note that the respective ratings and any feedback based on the rating scales should be formative and discussed in supervision. The subsequent strengths and areas for development, and the type of rating scale used should be recorded in the MPR and EPR documents. The completed rating scales do not need to be returned to the course.
- For observations both ways, at least one of these observations should be 'live' (which could also be conducted through joint clinical work between supervisor and trainee) and other observations of trainee or supervisor may use recorded material (audio or audio-visual recording).

Client feedback on competence

All trainees must obtain feedback about their clinical work from their service users and/or carers using **Client Feedback Questionnaires** (See Moodle). The Course has developed a range of specific Client Feedback Questionnaires (standard, easy read, carer feedback) and these have also been translated into several languages. If the service already has in place a different Client Feedback Questionnaire that the trainee can use to gather this feedback, this version can also be used.

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

Feedback forms do not need to be completed at the end of therapy sessions, and may be useful earlier in the therapy process; however trainees should consider the fact that it may easier for service users to be honest when therapy has finished as opposed to the middle of therapy sessions. In using the

feedback for reflective practice, trainees should also consider issues such as ‘power imbalance’, and a ‘need to please’, which may influence the way service users complete questionnaires.

RHUL do not ask for the forms to be submitted but ask supervisors to record as part of MPR and EPR forms whether / how client feedback forms has been elicited and discussed in supervision.

COMPETENCE EVALUATION

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

Introduction to monitoring clinical competence

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

Ultimately, it is the trainee's clinical tutor who holds responsibility for monitoring their clinical competence and ensuring that the professional standards and competences are achieved across the 3 years of training.

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

Specific Competence standards trainees are expected to achieve across the 3 years of training are outlined on Moodle/Website.

Placement Contract & MPR-EPR Form

Placement Contracts outline the learning outcomes for each placement. That is, they outline the areas of competence a trainee will need to achieve in order to pass the placement. The placement contract will also identify the required clinical experience to facilitate the achievement of those clinical skills, including expectations around caseload over the course of the placement. Placement Contracts are required for each 6-month placement. If the placement is of 12 months duration the contract will be reviewed and updated at the 6-month stage after the first EPR. The Course list **Specific Competence Standards** (see below) which should be used to inform the Contract content. A signed copy of the Placement Contract needs to be submitted to Moodle 2-4 weeks after placement start date. Placement Contract can be found on Moodle/Website.

The MPR-EPR Forms are tools for monitoring the placement experience and evaluating the achievement of clinical and professional competencies. The forms were developed using the BPS competence framework and the HCPC professional standards. The MPR-EPR is a detailed form, which is first completed at MPR and subsequently updated at EPR. The MPR-EPR Form can be found on Moodle/Website.

In summary, to monitor the experience and competence of the trainee, trainees and supervisors will be expected to complete the following documentation, and trainees will submit these documents to Moodle. All documents are available on Moodle/Website:

1. **Placement Contract** - Completed 2-4 weeks after placement start date.
2. **MPR-EPR Form -** Completed at the middle of placement and updated at the end of placement, as

follows:

- **Mid-placement review meeting (MPR) -** Between weeks 8-12 of placement a member of the course staff will visit the trainee and supervisor to evaluate and record progress. MPR-EPR Form including the goals agreed with the MPR is submitted 2 weeks after the MPR window.
- **End of placement review meeting (EPR) -** Final evaluation meeting usually conducted between trainee and supervisor in the final week of placement. MPR-EPR Form, update with the EPR ratings etc, should be submitted no later than 2 weeks after the end of Placement with signed ACE Log.

3. **Three observations of trainee practice and two formal ratings of competences** based on these observations must be completed every 6 months. Tools for observation are available from Royal Holloway. Completion of these are reported in the MPR-EPR Form.
4. **ACE Log** - electronic record of clinical experience and competences will be prepared for review at MPR and EPR. A signed copy is submitted with EPR documentation (ACE log needs to be reviewed, but does not need to be submitted to Moodle at MPR). Client permission is required for data to be recorded on the ACE system (see Consent section in this Handbook).

In addition, trainees will need to review and raise outstanding competence targets with new supervisors. The clinical targets agreed at the end of the previous placement will be provided to the new supervisor by the trainee and should be included in the placement contract.

Trainees are also required to complete regular updates on their clinical competency development in line with the specific competence standards, as well as any other training or personal requirements, using Qualtrics surveys / forms completed to support placement planning ahead of each placement allocation (usually completed in May of first year to inform Placement 3 allocation, in January of second year to inform the Mid Training Competency Review and Placement 4 allocation, again in May of second year to inform Final Year placement allocations, and around January of the third year to review and confirm outstanding clinical competencies have been / are on track to be met by the end of training).

Placement Documentation Deadlines:

	Documentation	Completed by	Deadline
Start of Placement	Contract	Trainee & Supervisor	Trainee submits to Moodle 2 weeks after start of placement
MPR	ACE Log	Trainee	Trainee emails to MPR visitor 1 week prior to the MPR
	MPR-EPR Form	Trainee & Supervisor	Draft completed and emailed to MPR visitor 1 week prior to the MPR
		MPR Visitor	MPR visitor completes within 2 weeks of MPR Trainee submits signed form to Moodle 2 weeks after MPR window
EPR	ACE Log	Trainee	Trainee submits form and ACE Log to Moodle 2 weeks after the end of placement.
	MPR-EPR Form	Trainee & Supervisor	
	Note for first years or third years on one-year placements there needs to be 2 EPRs; one at the end of the first six months and one at the end of the year.		

Audit of Clinical Experience - ACE

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

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

Trainees are required to explain the purpose of collecting this data in terms of training requirements, what data is collected and how it is stored. Trainees are required to gain clients' consent to hold their data in this way. See Consent section of this Handbook for more information. As with other electronic client records such as RIO, ACE records fall under the Data Protection Act and clients can request a copy of the information that is held about them in this way.

ACE BASIC REPORTS (LOG)

This needs to be reviewed at MPR and EPR. A validated copy by the supervisor is submitted at EPR. For further information, please refer to the **Short Guide to ACE** (see Moodle/Website)

Security of ACE

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

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

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

The Mid Placement Review (MPR) & End of Placement Review (EPR) process

The MPR and EPR are important aspects of the placement experience. They are both an opportunity for trainees to provide constructive feedback and reassurance, as well as a formal evaluation of the

placement experience and trainee's competence. It is an opportunity for the placement to be evaluated in relation to its learning outcomes and feedback on placement quality to be sought. The process is usually a helpful one for trainees and supervisors as it affords an opportunity to reflect and set targets for future development.

To ensure continuity of monitoring / placement evaluation and to minimise paperwork for supervisors and trainees, the MPR-EPR Form has been designed to be completed at MPR, and then updated at EPR. The MPR-EPR Form is available on Moodle/Website.

Points to remember when making evaluations, and when giving and receiving feedback:

- Both parties should be aware that feedback is a two-way process.
- All ratings of competence are evaluations of performance appropriate for the current stage of training.
- Both supervisors and trainees must try to set aside personal feelings, either negative or positive, when making evaluations.
- Quantitative ratings must be clear; for example, half ratings between acceptable and unsatisfactory are not permissible.
- Qualitative feedback is essential both for the trainee and supervisor. Please operationalise your feedback and give concrete examples where you can and note which areas of clinical activity you have been able to observe directly. **This is particularly important where minor or significant concerns about placement quality are raised or where trainee is working below expected level for stage of training.**
- Feedback needs to be detailed, constructive and designed to facilitate change. Evaluations should usually be based around objective factors.
- Feedback about clinical performance should combine information about areas of strength and areas for development and should ideally be communicated in the context of a good, supportive supervisory relationship. The better this relationship is, the more likely that feedback will be listened to and subsequently acted upon.
- Supervisors and trainees should raise doubts about supervision, performance, or competence as early in the placement as possible. They should raise these formally at the time of the MPR or they may even wish to talk to the Clinical Tutor / Mid Placement Visitor, in advance of the MPR. It is bad practice to "spring" new information at the time of the MPR or EPR, where there should be "no surprises" in the information shared.
- If supervisors or trainees are in any doubt about how to give feedback or what to say, they should contact the individual responsible for the trainee's Mid-placement visit or Clinical Tutor for help as soon as possible.
- If, at any stage, the supervisor judges the trainee's performance to be on the borderline of failure, then they must inform the Clinical Tutor or Mid-placement Visitor as soon as possible. The trainee should be told and given the opportunity to discuss the problems.
- Situations where the feedback is entirely negative should be avoided. Wholly negative feedback of a trainee's performance is unlikely to facilitate the development of a range of effective therapeutic skills. However, if a supervisor is seriously unhappy with a trainee's performance, they need to regard themselves as under an obligation to the profession to indicate this.
- Supervisors and trainees should be familiar with the guidelines on passing and failing placements, and procedures to deal with dissatisfaction about outcomes including grievances.

Mid Placement Review (MPR)

The MPR consists first of completion of the **MPR-EPR Form** (see Moodle/Website) by the supervisor or trainee. Trainees and supervisors need to prepare independently or conjointly, their ratings on the MPR-EPR Form, as the visitor will also use this as a basis for the MPR visit discussion. Specific recommendations for developing these areas and goals for the remainder of the placement should be suggested.

This is followed by an MPR visit by the Course MPR Visitor to support the trainee and the supervisor in evaluating the placement to date and to set targets for the remainder of the placement. We expect that

supervisors and trainees have had an opportunity to discuss their feedback before the MPR meeting.

It is the trainee's responsibility to liaise with their supervisor and MPR visitor and co-ordinate a convenient time to meet. Ideally, the date of the MPR should be included in the placement contract. The MPR should take place between the 8th and 12th week of the placement. However, if the MPR cannot be in the middle of the placement, an early review is preferable to a later one.

Preparation for the Visit

At the MPR, all parties will require a copy of:

- Placement Contract
- MPR-EPR form
- Audit of Clinical Experience (ACE) - MPR *BASIC REPORT*

Trainees should email copies of these to the MPR visitor, at least 5 working days in advance of the meeting.

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

During the visit

The visitor first meets independently with the trainee, then with the supervisor and finally jointly with both trainee and supervisor to discuss the MPR-EPR form.

After the visit

Any additional comments arising from the meeting will be added to the MPR-EPR Form. The visitor will also complete the relevant sections of the MPR-EPR Form, including the goals for the next part of the placement and any additional comments from the MPR visitor (Appendix 1 of the MPR-EPR Form). If there are concerns about successful completion of the placement at MPR, an Action Plan (Appendix 2 of the MPR-EPR Form) is completed by the MPR Visitor. The MPR-EPR Form will then be forwarded to the trainee within 2 weeks of the MPR.

Changes to supervisor and trainee comments will only be accepted if they are corrections of facts reported at the meeting and can only be made by or in agreement with the person who made the comment. Any other comments that trainees or supervisors wish to provide will be added as an addendum to the report. **A signed copy of the MPR-EPR Form should be submitted by the trainee to Moodle by 2 weeks after the MPR window.**

Very occasionally, at MPR the placement supervisor may find it difficult to provide ratings of trainee competence for core elements of the placement, e.g. due to unexpected delays to clinical work on the placement. Where there are several such areas at MPR, potentially impacting the capacity of the supervisor to evaluate whether a placement is on track to pass, it would be usual for the MPR Visitor or Clinical Tutor to arrange a follow up to review progress of the placement prior to the EPR, e.g. arranging a follow up 1 month after the MPR.

End of Placement Review (EPR)

The End of Placement Review is the time when feedback about the clinical skills and competences of the trainee and the quality of the placement are collected formally. The placement is evaluated in relation to its learning outcomes. In an ideal world the EPR should contain no surprises; ideally the trainee will

know about their strengths and weaknesses and the supervisor will know the good and bad points about the placement.

EPR Process

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

Completion of the EPR Documentation

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

Trainees need to submit a signed:

- MPR-EPR Form
- Audit of Clinical Experience (ACE) - *BASIC REPORT*

EPR Targets should be routinely passed onto the next placement supervisor by the trainee. These targets are usually agreed towards the end of placement / at the EPR by the trainee and the supervisor and written on the form (Part 6 of MPR-EPR Form: Feedback for the next supervisor). It is the trainee's responsibility to then share these targets routinely with the next placement supervisor, and include these as part of the Placement Contract for their next placement. A member of course staff will routinely review EPR documentation submitted, including the appropriateness of these targets and where appropriate will consider any amendments/additions required to support competence development.

A signed copy of the MPR-EPR Form as completed at EPR and the ACE Basic Report should be submitted by the trainee to Moodle 2 weeks after the end of placement date. Late submissions may lead to placement failure and the trainee should contact dclinpsy-placements@rhul.ac.uk if there are serious reasons why a late submission is likely.

Facilitated EPR

Although a member of Course staff does not routinely attend the EPR meeting, there may be circumstances where this is requested in advance by the trainee, the supervisor or the Course staff. This usually occurs in circumstances where:

- Any party has concerns about giving or receiving feedback,
- There are concerns that the placement may be awarded a fail or refer to tutor grade,
- Specific targets have been set for the placement which would benefit from review by the course staff,
- Learning targets from a previous failed or referred placement, or specific trainee wellbeing or support needs, are being monitored by the Course.

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

It is usual following a facilitated EPR (whether this is a failed placement or not) for agreed targets to be forwarded to the next placement supervisor along with the full end of placement documentation. The

course team will liaise with the next placement supervisor to ensure there is clarity in the learning targets and supervision capacity to support the student in meeting these targets.

A signed copy of the MPR-EPR Form as completed at EPR and the ACE Basic Report should be submitted by the trainee to Moodle 2 weeks after the end of placement date.

Mid Placement Review (MPR) Visitor

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

One-year placements and placement documentation

Placement Documentation varies slightly from the normal procedures on one-year placements.

- ***Contracts***: One-year contracts should be based on the usual placement contract, but they will need to be adapted to include arrangements for phasing of different aspects of clinical experience. The contract should be formally reviewed and developed after 6 months of the placement, usually at or soon after the first EPR.
- ***MPR***: For one-year placements there will be two MPRs (approx. months 3 and 9) with MPR-EPR Forms completed each time. Any serious problems arising on placement should be raised with the trainee's placement visitor. If serious problems emerge early in the placement, following discussion with all parties, and granted the placement visitor/clinical tutor considers it appropriate, it may be possible to convert the placement into a six-month placement.

EPR: For trainees undertaking one-year placements, an EPR and MPR-EPR Form is required at the end of the first 6 months, and at the end of the year.

Mid Training Competency Review, and Clinical Competency Reviews throughout training

Approximately 18 months into training, trainees meet individually with the clinical tutors to validate the clinical competencies they have achieved so far and consider future learning and competence needs, as well as training and career aspirations. This information is used to develop a placement plan for achieving the outstanding competences over the remainder of the course and to support trainees in progressing towards their desired NHS employment. Following the submission of information about competencies by the trainee, via Qualtrics survey / form, and subsequent to the Mid Training Competency Review Meeting, the Clinical Tutors will meet to determine any competence targets which must be met during the remainder of training. This is used to inform future placement planning.

Trainees are required to regularly provide information and updates on their clinical competency development in line with the specific competence standards, as well as any other training or personal requirements, using Qualtrics surveys / forms completed and reviewed by Clinical Tutors. These are used to support placement planning ahead of each placement allocation. Qualtrics competency review / placement planning surveys are usually completed by trainees in May of first year to inform Placement 3 allocation, in January of second year to inform the Mid Training Competency Review and Placement 4 allocation, again in May of second year to inform Final Year placement allocations, and around January of the third year to review and confirm outstanding clinical competencies have been / are on track to be met by the end of training.

Specific Competence standards

Trainees are expected to demonstrate clinical competence with a range of client groups and across a range of clinical settings. However, it is impossible for trainees to complete placements with all clinical client groups, and the Course follows a 'core competence' model to ensure that trainees meet at least minimum clinical competence in core areas across their 3 years of clinical placements. For example, trainees may not complete specific placements in older adult, adult learning disability or psychosis contexts, but will be expected to meet minimum competencies in these areas. For this reason, the course reviews trainees' clinical competence gained across all areas, but pays particular attention to how competence will be demonstrated in particular areas, including across the lifespan and with clients that possess developmental or acquired disabilities.

Responsibility for monitoring the achievement of clinical competence and experience is shared between trainees, supervisors, and the course staff. Several monitoring mechanisms within and across placements are used to determine experience gained and the progress and achievement of clinical competence. These include the ACE clinical log system, the Placement Contract, the MPR-EPR Forms, the Mid Training Competency Review and submission of competency update information via Qualtrics surveys / forms. Clinical tutors are responsible for assessing clinical competencies achieved and trainees must ensure that the MPR-EPR Forms, ACE and competency updates submitted via Qualtrics surveys / forms are completed in a timely manner to enable evaluation of competence.

Course guidance for the development of specific clinical competencies have been developed in the following areas, in conjunction with members of the Course Clinical Sub-Committee and in consultation with guidance from the CORE frameworks and BPS DCP faculty guidance. Details of basic and advanced competencies have been developed in each of these specific areas:

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

For the purposes of bringing this together in one place, we have developed a Clinical Competencies: Overview, Map and Specific Competence Standards document, to help trainees, staff and supervisors to visualise how clinical competencies can be developed over the course of training, together with guidance on the minimum core clinical competencies and specific competence areas. This document also outlines what are the expectations around essential (minimum) core clinical competencies in the areas where trainees may not all complete a specific placement, namely: Older Adults, Learning/Intellectual Disabilities, Psychosis, Severe and Enduring Mental Health, Inpatient, Conducting Cognitive Assessments, Work with Carers Families and Wider Systems, and in relation to core competencies in CBT Plus One Other Model of Therapy.

This 'Clinical Competencies: Overview, Map and Specific Competence Standards' document can be found on Moodle/Website.

BABCP CBT and AFT Systemic Accreditations

The Course runs a CBT pathway, which has Level 2 accreditation with the British Association of Behavioural and Cognitive Psychotherapies (BABCP). This means that trainees who follow a designated pathway through the Course will, upon completion of the Course, meet minimum standards for accreditation with BABCP. Not all trainees will follow this pathway. Detailed information about this BABCP pathway is provided in the CBT Pathway Handbook.

The Course has also developed a Foundation Level Systemic Pathway, piloted from September 2023. We will apply for accreditation by the Association of Family Therapy for this pathway. All first year trainees will be offered the opportunity to complete the Foundation Level Systemic Pathway. Detailed information about this systemic pathway is provided separately in the Systemic Pathway Handbook.

PLACEMENT GRADINGS – PASS/FAIL/REFER TO TUTOR

This section outlines the criteria and processes around placement 'refer to tutor' or 'fail' gradings.

At the end of each placement, the supervisor will recommend a grade for the placement. Ultimately, as with other graded pieces of work that need to be completed as part of the DClinPsy Course, two grades are available as an outcome of the placement: "Pass" or "Fail". If it is impossible for a supervisor to determine the placement as a pass or fail, a "Refer to Tutor" decision will be recommended. All gradings consider the stage of trainees' training. Though most placements are passed without concern, sometimes a fail grade (or Refer to Tutor) is warranted due to: lack of opportunities to achieve competencies; failure to achieve competences despite opportunity; or, (very rarely) failure due to misconduct. The specific criteria are outlined below.

Criteria for Fail grading

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

- Failure to reach minimally acceptable levels of core competence, despite repeated supervisor attempts to address this shortfall through teaching and practice.
- Failure to reach minimally acceptable levels of core competence related to impairment that cannot be sufficiently resolved despite reasonable adjustments being in place where appropriate.
- Persistent unprofessional practice.
- Single examples of unprofessional or unethical practice, if of sufficient seriousness.

Examples that might constitute placement failure include serious lack of sensitivity to clients and/or colleagues; professional misconduct; failure to complete a sufficient amount of work, etc.

Refer to Tutor

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

Procedure for Fail grading or Refer to Tutor

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

The grade given by a supervisor is always a recommendation to the Course; should this recommendation be a 'fail' or 'refer to tutor' grade, it would then be considered carefully by a subgroup of the Course Executive (which would usually include relevant Course staff such as the Placement Visitor / Clinical Tutor / Clinical Director / Course Director / Personal Tutor as appropriate), to recommend whether the fail grade should be upheld, or whether minimum standards for a pass have been met. This recommendation would then be provided to the Course Executive and Board of Examiners who will consider the grade in the context of any extenuating circumstances, and where the decision will be made on whether outcome of the placement is a pass or fail.

Course regulations require trainees to pass six 6-month placements. Therefore, if a placement is deemed a fail, the placement will need to be re-taken with specific targets agreed for future placement(s) and shared with future supervisor(s). Targets from subsequent placements will be reviewed at Clinical Tutor Meetings for agreement of outstanding competences met and those to be continued forward to future placements. Decisions will be ratified at the Exam Board.

PLACEMENT QUALITY, COMPLAINTS AND SERIOUS INCIDENTS ON PLACEMENT

This section outlines how concerns about placement quality, complaints and serious incidents on placement are managed.

Concerns about Placement Quality

The North Thames DClinPsy courses routinely monitor the quality of all clinical placements through the mid and end of placement review processes. From time to time there will be concerns about the quality of the placement opportunities or supervision offered. The course takes these concerns seriously and endeavours to address all concerns in order to continually develop placement and supervision quality. The North Thames Courses have developed a protocol for dealing with these concerns and for auditing placement quality. This **Placement Quality Management** protocol is available on Moodle/Website and provides further detail of the processes followed.

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

As documented in the North Thames DClinPsy Placement Quality Management protocol, 'amber' level concerns may relate to minor difficulties in the placement quality or supervision, such as irregular supervision, difficulty establishing a good supervisory alliance, or limited placement opportunities. Such concerns are usually managed at the Mid Placement Review process, through direct discussion and negotiation between the placement visitor, trainee and supervisor, with actions set and reviewed, and resolution often met by the end of the placement.

More serious or significant problems would be rated as 'red' level concerns. This can include, e.g. extremely limited opportunities for supervision, serious concerns about the quality of supervision falling significantly below expectations for a qualified psychologist, or evidence of unethical professional practice including discrimination, racism, bullying or harassment. Where this is reported, the Placement Quality Management procedures are followed carefully and sensitively; this would include an investigation into the concerns raised, and the outcomes from this investigation can include actions being put in place to address the concerns raised.

We recognise that it can be very difficult for trainees to raise concerns, and sometimes trainees request that any direct discussions with the supervisor regarding concerns about the placement occur only after they have left the placement, because of concerns that trainee feedback may influence the supervisor's evaluation of their performance. Wherever possible, we will always be attentive to such requests, and manage such situations sensitively, but also in accordance with codes of conduct, HCPC guidance etc, to ensure that appropriate action is taken as needed at the appropriate time.

In addition to raising any concerns about discrimination on placement with the Clinical Tutor team and / or Clinical Director, Dr Kate Theodore, or Deputy Clinical Director, Dr Michelle Wilson, trainees also have the following means of reporting such concerns available to them:

- Royal Holloway System for Reporting incidents of bullying, sexual violence etc. See RH BE HEARD

- Camden & Islington NHS Foundation Trust (North London Foundation Trust) Guide for Reporting Bullying, Harassment or Discrimination

Serious incidents on Placement

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

The NHS Trust in which the trainee is on placement will have their own policies for reporting serious incidents, and trainees must be aware of and follow such policies in the first instance. This is likely to involve following the incident reporting procedures specific to the NHS Trust or other organisation where they are on placement. However, trainees should also report any serious incident that occurs to their clinical tutor or other Course staff member. The trainee's line manager can then follow up with Camden & Islington NHS Foundation Trust as the trainee's employer. Should any Health and Safety concerns occur on a trainee's placement, the Clinical Tutor and Clinical Director, Dr Kate Theodore, or Deputy Clinical Director, Dr Michelle Wilson, should also be notified so that the incident can also be reported to the Health & Safety Coordinator of the Department.

Where a serious incident has had an impact on the physical, mental or emotional health and wellbeing of a trainee, this should be discussed with the trainee's Clinical or Personal tutor, and support can be sought from Camden & Islington NHS Foundation Trust (North London Foundation Trust) Occupational Health and employee support services. Further Trainee Wellbeing Resources have been compiled for trainees to access, which are available on Moodle. These include some specific supports available to NHS employees e.g. bereavement support available to staff where a client has died by suicide.

Duty of Candour and Serious Incidents on Placement

This duty of candour should be considered in line with Trust incident reporting procedures and appropriate apologies should be offered by staff to clients. Trainees should discuss these procedures and responsibilities with their supervisors. Further information is available from NHS Resolution.

Witnessing poor practice on placements

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

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

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

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

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

Further details regarding the North Thames DClinPsy **Placement Quality Management** protocol and procedures used to manage such concerns, can be found on Moode / RHUL Website.

Suspension or Removal from Placement

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

Guidance on specific procedures for suspending registration can be found in the Code of Practice for the Academic Welfare of Postgraduate Students, available here

Grievances and Complaints

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

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

Further details regarding academic appeals processes, grievances and student complaints can be found in the General Handbook.