PROGRAMME HANDBOOK

2023

Postgraduate Diploma in Psychological Therapies Practice

Severe Mental Health Problems Cognitive Behavioural Therapy for Psychosis and Bipolar Disorder

Postgraduate Diploma in Psychological Therapies Practice

Severe Mental Health Problems Cognitive Behavioural Therapy for Personality Disorder

Year 1 CBT for Depression and Anxiety Disorders

Separate Handbooks will be available for year 2

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Introduction and Welcome to CEDAR at the University of Exeter

We are pleased to welcome you to the Postgraduate Diploma (PGDip) in Psychological Therapies Practice Severe Mental Health Problems (SMHP) Cognitive Behavioural Therapy.
This programme is part of our highly successful clinical training portfolio that is delivered through Clinical Education Development and Research (CEDAR). The portfolio includes the Doctorate in Clinical Psychology, the MSc Psychological Therapies, the IAPT programmes for adults and children, and Perinatal Mental Health. We have a firm commitment to evidence based psychological practice and as such we endeavour to ensure all of our training programmes are firmly embedded within current research and national competency-based curriculums. This commitment is in no small way aided through the Mood Disorders Centre which is involved in undertaking clinical research which has national and international significance.
These are exciting and challenging times for us all as there is an increased recognition of the need and support for evidence-based care in mental health in this country. The team of highly experienced clinical trainers will endeavour to deliver the highest quality training to enable you to work competently and effectively as an evidence-based practitioner in CBT SMHP.

It is likely that you will find the training intensive and challenging, but hopefully enjoyable and especially practice enhancing.

Professor Catherine Gallop, Director of Post Graduate Training

Introduction and Welcome to the SMHP CBT Programme

These PGDiplomas are part of the portfolio of CBT training programmes offered by the Clinical Education Development and Research (CEDAR) at the University of Exeter. It is also part of the Health Education England (HEE) funded training programme for the development of NHS mental health services, focussing on CBT for people living with severe mental health problems.

The overall aim of this HEE investment is to support a transformation in mental health services and so too the clinical/personal outcomes for people with severe mental health problems, and for their families/carers, by improving access to evidence-based psychotherapeutic interventions.

We hope this handbook will answer trainees' questions and provide trainees with information about the first year of the course. Trainees will receive a separate handbook for the second year of the course.

If the answer is not to be found within, please do approach the Programme Team or email the Programme Administrator (cbt-psychosis@exeter.ac.uk). In addition, there is the university website that has detailed information regarding all aspects of university life and procedures here at the University of Exeter http://www.exeter.ac.uk/. The handbook will be updated and amended as necessary as the course progresses, the most recent version will be found on the Exeter Learning Environment (ELE). There is an accompanying CEDAR Handbook which details CEDAR and university guidelines, rules and processes. This is available to everyone on ELE.

We hope you enjoy the training and look forward to working with you over the coming months.

The Post Graduate Diploma SMHP CBT Year 1 Anxiety Disorders and Depression Programme Team

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Programme Academic Tutors: Carmen Corbett, Kathy Cooper, Katie Sellwood

Diversity and Inclusivity

It is our intention that students from all diverse backgrounds and perspectives be well served by this course, that students' learning needs be addressed both in and out of teaching sessions, and that the diversity that students bring to this cohort be viewed as a resource, strength and benefit. It is our intention to present materials and activities that are respectful of diversity: gender and gender identify, sexuality, disability, age, socioeconomic status, ethnicity, race, and culture. Your suggestions are invited, encouraged and appreciated. Please let us know ways to improve the effectiveness of the course for you personally or for other students or student groups. In addition, if any of our training sessions conflict with your religious events, or if you have a disability or other condition necessitating accommodation, please let us know so that we can make the necessary arrangements for you.

(Adapted from a diversity statement from the University of Iowa, College of Education)

Our goal as a learning community is to create a safe environment that fosters open and honest dialogue. We are all expected to contribute to creating a respectful, welcoming, and inclusive environment. To this end, classroom discussions should always be conducted in a way that shows respect and dignity to all members of the class. Moreover, disagreements should be pursued without personal attack and aggression, and instead, should be handled with grace and care. This will allow for rigorous intellectual engagement and a deeper learning experience for all.

(Adapted from a diversity statement from Yale University - Dr. Carolyn Roberts, Assistant Professor, History of Science & History of Medicine, and African American Studies)

Ground Rules for Groups, Tutorials and Supervision

- Work with respect for each other even if you disagree
- Accept individual responsibility for individual behaviour
- Pay attention to issues of difference such as gender, age, race and culture remembering that each person's experience is true for them and valid
- Clarify limits of confidentiality and adhere to these
- Make your own decisions about how much information you wish to share about personal or occupational matters

Aims: PGDip PTP (CBT SMHP)

The course will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills in the following areas:

- To develop practical competency in Cognitive Behaviour Therapy for severe mental health problems (SMHP) and commonly comorbid psychiatric disorders such as depression, anxiety disorders and PTSD within the context of secondary care services.
- To develop critical knowledge of the theoretical and research literature relating to CBT in the context of SMHP.

The course aims to develop trainees' clinical, academic, and personal/professional skills and knowledge, specifically on completion trainees should be able to:

1. **Specialised Subject skills knowledge and experience:**
    a. Construct maintenance and developmental CBT conceptualisations for SMHP and common mental health disorders (depression and anxiety)
    b. Develop CBT specific treatment plans
    c. Practice CBT for SMHP and common mental health disorders systematically, creatively, and with good clinical outcomes
    d. Deal with complex issues arising in CBT practice and secondary care settings

2. **Academic Discipline Core skills and Knowledge:**
    a. Practice as a scientist practitioner, advancing your knowledge and understanding and develop new skills to a high level
    b. Explain in detail the principles of CBT and the evidence base for the application of CBT techniques
    c. Explain in detail CBT theory and therapeutic models for SMHP and common mental health disorders
    d. Describe and critically evaluate the theoretical and research evidence for cognitive behaviour models

3. **Personal/ Transferable/ Employment skills knowledge and experience:**
    a. Take personal responsibility for clinical decision making in straightforward and more complex situations
    b. Tackle and solve therapeutic problems with self-direction and originality

c. Adapt CBT with sensitivity, ensuring equitable access particularly with respect to issues of diversity e.g. age, culture, religious beliefs and values

Course Overview Summary

The PGDip PTP (CBT SMHP) is aimed at qualified mental health professionals with experience of delivering mental health interventions (such as Nurses, Social Workers, Occupational Therapists, Clinical/Counselling Psychologists, Psychotherapists, Counsellors, and Psychiatrists) and with experience of working with people experiencing severe mental health problems. It is also aimed at those with the equivalent knowledge, skills and attitudes, as demonstrated by the BABCP KSA portfolio. It provides intensive skills training in accordance with British Association for Behavioural and Cognitive Therapies (BABCP) guidelines for good practice.

During the course, as trainee Cognitive Behavioural Psychotherapists, you will assess and treat clients with anxiety disorders, depression, PTSD, SMHP (psychosis and bipolar disorder, or personality disorder) and clients with comorbid common mental health problems using Cognitive Behavioural Therapy (CBT). CBT is recommended in the National Institute for Health and Clinical Excellence (NICE) guidelines as part of the evidence-based care packages for most anxiety disorders, depression, PTSD and severe mental health problems.

The course prepares trainees to develop the competencies required to deliver NICE concordant CBT as outlined by Roth and Pilling (2007, 2013) and to provide CBT within secondary care mental health services. The course of study is designed to deliver to the content of these competency frameworks and their associated curriculum. CBT maintains a firm commitment to evidence-based clinical practice and as such the course endeavours to ensure that it is firmly embedded within current research.
The PGDip Psychological Therapies Practice (CBT for SMHP) programme is a 24-month part-time programme of study at National Qualification Framework (NQF) level 7.

The course involves a mixture of teaching sessions, clinical skills practice and clinical supervision.
The course is assessed through clinical practice and academic assignments including a theoretical essay, case reports, oral presentations, competency evaluation through evaluated practice, supervisor reports and a clinical portfolio.

Preparing for the course

Registering with the University

Once you are offered a place on the course, you will be notified of how to accept and then register with the university. Registering with the university is a requirement as it will allow you to access your IT account and so use of university email, university library, and ELE (Exeter Learning Environment).

Training Caseload

You will need to ensure access to clients in February 2023 and have four clients experiencing depression engaged and ready to start CBT; two for university supervision and two for your workplace supervision. One of the university depression cases will be used as your 'Completed Client 1' (see p18 for further info on completed clients). From May 2023 when the depression work is coming to an end, we suggest that you start working with at least one client with an anxiety disorder (not PTSD), these will be taken to workplace supervision. In August 2023 you will be expected to start working with two clients with an anxiety presentation to bring to university supervision, one of which will be used as your 'Completed Client 2'. Around this time, you will also need to work with at least one client with PTSD, using trauma-focused CBT, this will be supervised in your workplace and will be counted as your 'Completed Client 3'. It is important to work with your workplace to ensure you are ready to start with clients at the times stated above.

In 2024 you will work with *at least*, depending on your chosen specialism, 2 clients experiencing bipolar disorder and 2 clients with psychosis, or 4 clients with personality disorder. Supervision will be shared between the workplace and university.

This order of client presentations is important as it aligns your clinical practice development with the theoretical learning journey and course assignments.

In the first year of the course, some services choose for the trainee caseload to be taken from primary care services, such as IAPT. Services will need to set up an agreement with primary care services in order to work with these clients. If trainees access clients from another service they should ensure that they have time for being inducted into that service's systems/policies such as their clinical notes, risk management policy and discharge policy.

Ability to Record, Store, and Transfer Training Caseload Sessions

You will need to ensure you have the use of recording software and equipment, authorised by your workplace. For clients taken to university supervision (and a backup client) all therapy sessions must be recorded and stored within GDPR and your NHS Trust or employer policies governing GDPR. Trainees will benefit from also recording therapy sessions with any other clients they are working with where the client gives consent.

Ideally, both the therapist and the client would be fully recorded. However, if the client does not initially consent to this, the recording does not need to show an image of the client, only that of the trainee; the client, however, does need to be audible.

Trainees should speak with their service (and IT and IG department) about recording equipment and processes, so they are ready to record when they start working with clients.

Consent

Consent to record, store, and use recordings for training purposes such as assessments and live supervision, must be obtained from your university supervised clients and back-up clients using the appropriate university Consent Form prior to any recording activity. A copy of this consent form must be shared with your university clinical supervisor for your university and workplace back-up clients. For any other workplace clients, a workplace consent form should be used. All processes must be GPDR adherent and adherent to your NHS Trust IG policies.

Consent forms are also required to be uploaded as instructed for submitted assignments.

BABCP Membership

All trainees must apply for membership of the British Association of Cognitive and Behavioural Psychotherapists and so be bound by their professional code during training. The website for this is https://www.babcp.com/Membership/Join.aspx.

The BABCP is the accrediting body for CBT psychotherapists and for CBT training courses, and this course adheres to the BABCP minimum standards for CBT training, its good practice guidelines, and its Professional Code http://www.babcp.com/files/About/BABCP-Standards-of-Conduct-Performance-and-Ethics-0917.pdf. The course is not yet accredited but provides all of the criteria for BABCP Individual Practitioner Accreditation. The Clinical Portfolio required to complete this award is designed to easily support post-course accreditation with the BABCP.

The CBT SMHP programme has no financial interest in the BABCP.

Please provide the Programme Administrator with your BABCP membership number.

Programme Content

Each PGDip consists of six modules, detailed in the table below, three are joint modules completed in year 1 covering the fundamentals of CBT, and CBT for depression, anxiety disorders and PTSD. Each specialism (psychosis and bipolar or personality disorder) then completes its three specialism-specific modules in year 2. The full module descriptors are available on ELE.

Module Code	Module Title	Description
The PGDip PTP Joint Year 1 (SMHP CBT Anxiety Disorders and Depression)		
PYCM104	The Fundamentals of Cognitive Behavioural Therapy (CBT)	This module will focus on delivering a systematic knowledge of the fundamental principles of CBT and on core clinical competencies (skills) necessary in undertaking CBT. The module will aim to enable you to develop an understanding of how scientific principles inform CBT clinical practice.
PCYM105	Cognitive Behavioural Therapy (CBT) for Anxiety and Depression - Theory	These modules will focus on the common mental health disorders: depression and anxiety disorders. The module aims to develop advanced skills in Cognitive Behavioural Therapy (CBT) for these disorders, improving proficiency in the fundamental techniques of CBT, and developing competencies in the specialist techniques applied to depression and anxiety disorders. Specific models, evidence base, assessment and specialist treatment strategies will be covered in workshops on a range of disorders including depression, social anxiety, post-traumatic stress disorder (PTSD), panic disorder, obsessive compulsive disorder, health anxiety and generalised anxiety disorder (GAD). In the Theory module, you will be encouraged to develop a critical understanding of the theoretical and research evidence for cognitive models and an ability to evaluate the evidence. In the Clinical Practice module, you will be encouraged to develop your clinical practice of CBT through the effective use of CBT Clinical Supervision and focus on the application of the theory.
PCYM106	Cognitive Behavioural Therapy (CBT) for Anxiety and Depression – Clinical Practice	

Module Code	Module Title	Description
The PGDip PTP (SMHP CBT Psychosis and Bipolar Disorder) Year 2 Specialist Modules		
PCYM107	Working with Complexity: Essential Competencies for Working with People with Psychosis and Bipolar Disorder	The module will build on The Fundamentals of Cognitive Behavioural Therapy, focussing on the essential knowledge and clinical competencies (skills) required to undertake Cognitive Behavioural Therapy (CBT) with people with psychosis and bipolar disorder in a variety of mental health care contexts. This will include developing the use of CBT within service contexts and sustaining practice, managing endings and service transitions, using measures and supervision, and delivering group-based interventions in psychosis and bipolar disorder. It will consider psychosis/bipolar disorder across the lifespan, suicidality, the power of psychological modelling of psychosis, and the impact of stigma.
PCYM108	Cognitive Behavioural Therapy (CBT) for Psychosis and Bipolar Disorder - Theory	These modules will provide a strong foundation in the evidence base for working with CBT and for psychosis and bipolar disorder and address the most up-to-date research developments. Workshops and clinical skills tutorials will cover specific cognitive behavioural models of psychosis and bipolar disorder, evidence base, assessment and specialist treatment strategies. The clinical workshops will provide you with a strong foundation in the evidence base and address the most up-to date research developments. The module will be underpinned by training in knowledge and skills in a therapist stance, values and style that is consistent with good practice in the implementation of CBT with people with psychosis and bipolar. In the Theory module, you will be encouraged to develop a critical understanding of the theoretical and research evidence for CBT cognitive models and an ability to evaluate the evidence.
PCYM0109	Cognitive Behavioural Therapy (CBT) for Psychosis and Bipolar Disorder - Clinical Practice	

Module Code	Module Title	Description
		In the Clinical Practice module, you will be encouraged to develop your clinical practice of CBT through the effective use of CBT Clinical Supervision and focus on the application of the theory.
The PGDip PTP (SMHP CBT for Personality Disorder) Year 2 Specialist Modules		
PYCM110	Working with Complexity: Essential Competencies for Working with People with Personality Disorder	This module will focus on the following: • Phenomenology, diagnostic classification and epidemiological characteristics of personality disorder • Understanding the association between early development and trauma/adversity with neurological development, core beliefs, behavioural patterns and the emotional and relational difficulties associated with a personality disorder diagnosis. • Understanding child development (both normal and abnormal) and how this can impact on the development and maintenance of persisting emotional and interpersonal difficulties
PYCM111	Cognitive Behavioural Therapy (CBT) for Personality Disorder - Theory	These modules will provide a strong foundation in the evidence base for working with CBT and for personality disorder and address the most up-to-date research developments. Workshops and clinical skills tutorials will cover specific cognitive behavioural models of personality disorder, evidence base, assessment and specialist treatment strategies. The clinical workshops will provide you with a strong foundation in the evidence base

Module Code	Module Title	Description
PYCM112	Cognitive Behavioural Therapy (CBT) for Personality Disorder - Clinical Practice	and address the most up-to date research developments. The module will be underpinned by training in knowledge and skills in a therapist stance, values and style that is consistent with good practice in the implementation of CBT with people with personality disorder. In the Theory module, you will be encouraged to develop a critical understanding of the theoretical and research evidence for CBT cognitive models and an ability to evaluate the evidence. In the Clinical Practice module, you will be encouraged to develop your clinical practice of CBT through the effective use of CBT Clinical Supervision and focus on the application of the theory.

Supervised Practice Component

As part of the PGDip PTP (CBT SMHP) developmental journey, you will participate in Clinical Supervision at the university **and** in your workplace. Clients cannot be taken to both Clinical Supervision types unless where actively required by the course and you will be informed of these circumstances. When university supervision is not scheduled in the timetable, please seek supervision from your workplace for your university supervised client.

It is required that trainees complete university and workplace supervision logs. The records must be completed and signed at least termly by the supervisor (electronic signatures). This task is each trainee's responsibility, and these logs are a required entry into the clinical portfolio which is a required element of the course. **Please keep separate Supervision Logs for all of your clients (one log per client).**

Eight Completed Clients

A completed client will have been seen from engagement to completion for at least 5 sessions (and probably more) for depression/anxiety clients (year one) and taken to at least 5 supervision sessions. For SMHP clients (year two) completed clients will have been seen from engagement to completion for at least 8 sessions (and probably more) and taken to at least 6 supervision sessions. These eight completed clients are the minimum requirement to complete the course and will meet BABCP Accreditation, although trainees will require more clients than 8 over the two years to achieve the required 200 hours of clinical practice required for the course.

Closely supervised

Of the 8 completed clients, 3 will be closely supervised and all of these 3 closely supervised clients are taken to university supervision across the two years. A closely supervised client involves:

- Submission of a summative CTSR with accompanying paperwork
- Submission of either a summative oral presentation or written case report

Completed clients

Client number	Presenting difficulty	Minimum number of therapy sessions	Minimum number of times taken to supervision	Supervision	Assignments
1	Depression	5	5	University	Summative Oral Presentation & Formative CTSR
2 (closely supervised)	Anxiety Disorder	5	5	University	Summative Case Report & Summative CTSR
3	PTSD	5	5	Workplace	None
4 (closely supervised)	Bipolar or PD	8	6	University	Summative Oral Presentation & Summative CTSR
5 (closely supervised)	Psychosis or PD	8	6	University	Summative Case Report & Summative CTSR
6	Bipolar/Psychosis/PD	8	6	Workplace	None
7	Bipolar/Psychosis/PD	8	6	Workplace	None
8	Any – recommended Bipolar/Psychosis/PD	5/8	5/6	Workplace	None

A completed client will include assessment, formulation, intervention, and a blueprint/relapse prevention plan/therapeutic ending letter. For depression/anxiety/PTSD the minimum number of therapy sessions is 5, although more would be expected in line with NICE guidelines and treatment protocols. For SMHP the minimum number of sessions is 8 to be considered a completed client, however many more would be expected, in line with guidelines and protocol. These clients will have been taken to supervision for discussion either 5 (for depression/anxiety/PTSD) or 6 (for SMHP) times.

200 Hours of Supervised CBT Practice

The course aligns with the BABCP Minimum Training Standards and so requires trainees to have conducted 200 hours of appropriately supervised CBT clinical practice. Clinically Supervised Practice Hours are the clinical hours you spend with your clients in session, undertaking CBT.

All clients taken into therapy which you intend to use to gain these 200 hours should be clinically supervised by a BABCP accredited therapist. You will require more than the 8 completed clients to achieve 200 hours. All hours need to be included in the practice hours log, there is one log for completed clients (see definition above) and one log for non-completed clients.

We advise all trainees to keep a log of their practice hours from the beginning so that you are always aware of the expected trajectory of supervised practice hours and can accommodate your CBT practice hours to address any shortfall.

Service Time for Training Caseload

Health Education England, who fund this training for NHS employees under the Transformation Agenda (2019) require that at least 2 days are dedicated to your clinical training caseload and development of CBT clinical practice. Currently one day a week is expected to be ring-fenced for your attendance at university, and at least one day a week for clinical practice. There are also some block teaching weeks at the start of some of the terms throughout the two years where trainees attend for 3-5 days per week. At the beginning of year 1, teaching is front-loaded to support trainees' competency development.

University Clinical Supervision

At university, you will receive regular sessions of CBT clinical supervision from a BABCP Accredited Cognitive Behavioural Psychotherapist (CBP); these sessions will take place in the mornings of the course teaching days as per the timetable. Additional Individual Supervision sessions will be agreed with your university clinical supervisor as per the timetable.

Trainees will receive clinical supervision in small groups of approximately 4 trainees remotely via MS Teams. All trainees must be MS Teams connected and proficient. Trainees must ensure that the environment where they receive supervision is acceptable and protects the confidentiality of the clients and the other trainees.

University Supervision Sessions

Attendance at all scheduled university supervision sessions, and preparation and active participation, is a requirement of the course. Preparation documents are available on ELE to support you in this. These aspects will be evaluated by your clinical supervisor in the Supervision Reports.

Your role as a trainee:

- Complete a Supervision Contract, which includes identifying your learning goals for the supervision process.
- Prepare for each supervision session using a Supervision Preparation Form and developing a supervision question using the form. This also includes bringing your formulation (which may be in draft form) to supervision.
- Present a short clip (5-10 minutes) to your group related to your supervision question.
- Document your learning from supervision and complete Supervision Log.
- Complete the HASQ (Supervision Feedback form).

Formative Peer Practice Competency Assessments

Once a term, each trainee is required to share a whole clinical session recording in the supervision session with their fellow supervisees. As the session is watched together, the supervisees and the supervisor use the CTS-R to record their feedback. This feedback is then shared and discussed within the group. This is a learning activity, designed to collaboratively support each trainee's development – much is learned from watching others' practice and reflecting on your own development.

Calculating Individual Equivalency Supervision Hours

The course requires all trainees to attended university supervision. Overall trainees require a total of 70 hours of supervision across two years.

For Group Supervision, the course provides an equation that allows for the calculation of what the group time means in terms of individual hours – or *individual equivalency*. In order to do the calculations for a group's individual equivalent time and put this on your supervision hours log sheet, you need to record how many people were present in the group for each session, and how long the clinical supervision component of the group ran for.

The calculations are then as follows:

Individual Equivalency = (total time of clinical supervision component divided by the number of people in the group) multiplied by 2

e.g. A 180 minute clinical supervision time with two attendees:

180/2 = 90 x 2 = 180

Individual Equivalency is 180 minutes of supervision

e.g. A 180 minute group clinical supervision time with three attendees:

180/3 = 60 x 2 = 120

Individual Equivalency is 120 minutes of supervision

e.g. A 180 minute group clinical supervision time with four attendees:

180/4 = 45 x 2 = 90

Individual Equivalency is 90 minutes of supervision

Enter this Individual Equivalency total in the relevant column on your Supervision Hours Log.

Supervision Reports

Your clinical supervisors will complete across the two years four supervision reports covering your participation in and use of supervision, and progression of your learning and skill acquisition during the course. The reports are as follows:

- Report 1: formative year 1 report
- Report 2: summative year 1 report
- Report 3: formative year 2 report
- Report 4: summative year 2 report

The four reports must be included in your clinical portfolio. Your clinical supervisor will discuss each report with you. Workplace supervisors and university supervisors regularly liaise throughout the year about trainees' progress and reports will consider feedback from both supervisors.

Difficulties in Supervision

Rarely, difficulties occur within clinical supervision groups that detract from the ability of the group to operate as a participatory peer learning environment. Such difficulties can occur between group members or between the supervisor and a group member. If the supervisor is aware of the difficulties they may choose to work with the group, or to speak separately with a group member. If a trainee is finding difficulty with their supervisor and cannot address it with the supervisor, then they should speak to their Academic Personal Tutor or another member of the course team as soon as they feel able and be supported through a resolution process. Supervisors have regular meetings with the Clinical Lead and the Programme Team to support them in their roles and ensure high quality supervision is provided for the trainees.

Workplace Clinical Supervision

The provision of appropriate Workplace Supervision is essential to progressing on the course. Workplace supervisors should be BABCP Accredited psychotherapists, they do not need to be accredited supervisors. In year 2, supervisors will be required to demonstrate experience and/or qualification in the given SMHP specialism. If your supervisor is not accredited with the BABCP, please contact the course team, to discuss whether they are accreditable and so sufficiently experienced to supervise the trainee in SMHP CBT.

Trainees are expected to follow the university protocol with their workplace supervisor by being prepared for each session, utilising a five-minute excerpt from a recorded session to illustrate their prepared supervision question, taking notes, and completing a signed supervision log. Trainees and workplace supervisors are also expected to follow the policies and procedures for the service where the client is accessing. For example, if clients are accessed through an IAPT service, then IAPT's policies and procedures should be followed regarding DNA's, risk management, note taking etc.

Workplace supervision needs to be a minimum of an hour of individual supervision per fortnight during the course or, if done on a group basis, one hour of individual equivalent clinical supervision as defined by the university – please see above under Calculating Individual Equivalency Supervision Hours for more information. Supervision provision should be increased appropriately for trainee caseload.

Managing caseload difficulties

Under normal circumstances, an identified university supervised client will be the focus of your supervision sessions at university, your case presentations/case reports, and your competency evaluations (CTS-R). In circumstances where this identified university client leaves treatment before it is completed and it is not possible to have an ending with the client, you may need to bring a workplace supervision client into university supervision and proceed with them. For this reason, you need to be working with your university client and a workplace client on a similar trajectory who acts as a 'back up' client. This 'back up' client will also need to be recorded in order to submit CTSR recordings for submission. If a client begins to miss numerous sessions or ends treatment early, please speak to the course team as soon as possible so that you can be guided on the next steps to ensure you can meet the course requirements. The course team will liaise with the workplace supervisor to support this process.

General Trainee Course Information

Timetable of Study

The timetable will be easily accessible on ELE once the course has begun. Any changes to the timetable will be notified to all trainees through ELE at the earliest possible opportunity. Assignment Submission Dates will also be available on ELE.

A supplementary timetable of teaching hours will be compiled and made available prior to the completion of the Clinical Portfolio to allow trainees to include this in their portfolio and align it with any Missed Learning Activities (MLA) required.

The course runs over six terms, Spring, Summer, Autumn, Spring, Summer, and Autumn, from January 2023 to December 2024, with the Clinical Portfolio due in January 2025. Each term has a reading week around the halfway point.

For year 1, following the end of the front-loaded teaching in term 1, the usual course day is a Thursday. This is expected to be used as a university day even when you are timetabled for self-study and remote learning. In year 2, the usual teaching day will be a Friday.

Hours of Study – Taught and Self-Study

We are aware that the course is an intensive clinical training course with requirements for clinical work and academic assignments at master's degree level, as well as attending teaching sessions and clinical supervision. This teaching, clinical supervision, and training clinical work amount to at least 2 days a week.

Each teaching day is a 5 ½ hour day, as per the timetable, running from 9:30am until 4:30pm, with a one hour lunch break usually from 12:30-1:30pm, plus short morning and afternoon breaks.

There are self-study days indicated in the timetable and during these days trainees are expected to be engaged in self-directed or course-directed study, and trainees need to be available for any one-to-one meetings with the course team.

Attendance

We expect trainees to attend all teaching, clinical skills, university supervision and meetings, unless there are exceptional circumstances (such as ill health). A register is maintained by the Programme Administrator from the Zoom meeting attendance log. Where attendance becomes a concern, a member of the course team will contact the trainee and their service to discuss how to overcome any difficulties with attendance.

For each teaching session missed, a Missed Learning Activity must be agreed with your Tutor and completed. It must meet the learning objectives of the missed session and equate to a similar length of time as the missed session. Missed Learning Activities can only be used to a maximum of 40 hours across the course; over this, if the trainee remains on the course, hours must be made up by evidencing attendance at clinically relevant BABCP Accredited Workshops, agreed in advance with your tutor.

Notifying the Programme if you are Absent

If you are unable to attend any session or a day, it is imperative that you email the CBT SMHP Programme Administrator and copy in your Academic Personal Tutor, and your Supervisor if appropriate. Attendance is monitored, and poor attendance will be reviewed under university policies and procedures.

Missing Learning Activities

The PGDip/PGCert PTP (CBT SMHP) requires a high level of attendance in order to meet both the university and the BABCP required standards for the award as noted in the handbook. However, we appreciate that unforeseen crises do arise that make it difficult to attend occasional sessions, we therefore have provision to complete missed session learning activities. This does not apply to missed University supervision sessions. Neither does it apply to multiple missed sessions where this would need to be discussed with yourself, members of the course staff team and your service.
If you miss a session, you will need to identify an appropriate missed session learning activity. The activity should be based on the learning objectives from the missed session which are usually available from the session handout on ELE or from the lecturer. The learning outcomes should be recorded on the 'Missed Session Learning Activity Record'

The missed session learning activity should include active and creative engagement with the material in order to address the missed learning. It is often useful to determine whether any other students

have missed the session and complete the activity together, allowing peer discussion, skills practice, and deeper reflection on the material. Students may also utilise small group work with peers, who may or may not have missed the session, and are willing to participate in an additional learning exercise to supplement their own knowledge and skill development. This allows for the use of role play and enhances applied clinical skills as well as theoretical knowledge. Learning activities are likely to include reflection on two or three relevant texts and / or recorded material linked to the learning outcomes.

Your learning activity will take approximately the duration of time missed e.g. a 5 ½ hour learning activity for a missed teaching day.

A required part of any plan is evidence of active learning – discussion, role play or similar – with your peers / clinical supervisor / tutor or relevant workplace colleagues (e.g. workplace supervisor, other CBT therapists).

The missed session learning activity *should be agreed with your Academic Personal Tutor prior to completion of the activity.* Your Academic Personal Tutor will sign the plan twice – once to confirm agreement with the proposal, and once to confirm completion of the activity. If the initial signature is not sought, you may need to complete a further learning activity.

All completed MLAs are required to be included in your Clinical Portfolio.

Missed Learning Activities can only be used to a maximum of 40 hours across the course; over this, if the trainee remains on the course, hours must be made up by evidencing attendance at clinically relevant BABCP Accredited Workshops, agreed in advance with your tutor.

Post-course BABCP Accreditation

For successful completion of the course, trainees must submit a Clinical Portfolio. The Clinical Portfolio needs to be retained for a number of years by the university. Your copy of this portfolio can, subsequent to a successful award, be presented to the BABCP for the Accreditation process. The requirements of the BABCP for this include:

- 450 hours of study on CBT, of which 200 must be taught by recognised trainers. The taught hours and the expected independent study on the course cover this.

- 200 hours of supervised therapy and 40 hours of individual equivalent clinical supervision, the supervision hours will be provided by the course and the workplace. The 200 hours of supervised practice will not necessarily all be obtained during the course. However, clinical hours supervised by work-place supervisors will all count towards this and so this entirely depends on the hours of practice available in the work place.
- The supervisor for the 40 hours of individual equivalent clinical supervision must be appropriately qualified (e.g. BABCP accredited) – this is met by the course – do ensure you have an appropriate workplace supervisor.
- A minimum of 8 cases must be completed with at least 3 closely supervised - met by course requirements.
- Three case reports or oral presentations. This is within the course requirements.
- An extended case report. This is also within the requirements of the course.
- An essay demonstrating understanding of theoretical aspects of CBT – met by course requirements.

All of the criteria for provisional accreditation by the BABCP will have been met if the course is successfully completed.

Sources of support

We recognise that the training course is likely to be stressful at specific points in the programme, due to course deadlines and/or personal circumstances. University attendance, clinical practice and independent study may at times be difficult to balance, and students may also have personal life events which may at times impact on stress levels and the ability to balance the demands of the course with other areas of their lives.

Within the training programme we hope to promote a mutually supportive atmosphere in which trainees feel able to share concerns and issues with one another, with the programme team and with their clinical supervisors. However, we recognise that the programme team and supervisors cannot necessarily provide all the support that may be required, and other sources of support may at times need to be accessed, detailed below.

Course team

The programme, academic and clinical lead are available to all trainees to provide advice and support. Please do not hesitate to contact a member of the team if you are having difficulty in any area. The trainees are welcome to get in touch at any stage where they may have concerns or

difficulties. The Academic Lead oversees academic assignments, teaching and workplace liaison (e.g. difficulties with course progress, attendance etc.). The Clinical Lead oversees clinical supervision, clinical assignments (CTSR and supervision reports) and workplace liaison (e.g. difficulties with accessing appropriate clients, workplace supervision arrangements etc.).

Academic Personal Tutor

Each trainee is allocated a personal tutor to support them over the course. Trainees have individual time with their Tutor on a termly basis, although tutorials can be arranged more regularly if required. Please talk with your tutor (or any member of the course team) if you begin to experience difficulties in any aspect of the course. In the event of significant difficulties that may impede with your ability to study the staff team will support you in discussions with your Workplace Manager or Workplace Clinical Supervisor to discuss a supportive way forward, and it is likely that the Programme, Academic and/or Clinical Lead will also liaise with you and your service in such circumstances.

Tutors also deliver clinical skills and teaching sessions on the course.

Information sharing

Please note that staff members share information about trainees in order to support trainees' wellbeing and their development on the course. The staff team will also liaise with trainees' workplaces around wellbeing and progress on the course.

Wellbeing and Welfare Services

There is also a University Wellbeing Service that is free and confidential and available to all trainees. Appointments are available during term time by emailing wellbeing@exeter.ac.uk and a reduced service is offered during the vacation (01392 724381).

Accessibility

If you are living with an illness or a disability, the university has guidelines and procedures to support you in your studies, for example Dyslexia Marking Guidelines which seek to relieve penalties on assessed work due to dyslexia rather than academic issues. The Wellbeing Services also operate the AccessAbility Pathway to support students, please refer to the Exeter University website for the

most up-to-date details or follow this link https://www.exeter.ac.uk/students/wellbeing/support/. You can contact the team on Accessability@exeter.ac.uk.

Communication with Services

The training is funded by HEE (Health Education England) and is run in partnership with the employing Trusts and Services that have nominated trainees to attend. As such, supervisors' reports and outcomes of training assessments (i.e. marking feedback) **will** be shared with trainees' managers. Please ensure the university has up to date details of your workplace manager.

To build on communication workplace supervisors will meet with university supervisors once per term, and a workplace supervisor report is requested once per year.

In line with our professional and ethical responsibilities and BABCP Code of Conduct, Performance and Ethics we will also take seriously the need to protect the safety of the vulnerable clients with whom trainees work and as such will communicate any concerns about practice with services. We will also liaise with services around any difficulties trainees may be having with the course, such as with assignments or gaining and maintaining an appropriate clinical caseload. We run meetings throughout the year for supervisors and managers to attend to be updated on the course.

Reading List

A comprehensive Reading/Resources List is provided on ELE, and trainees are expected to supplement and deepen their learning through accessing the suggested texts as a minimum. The course aims to support the deepening of understanding of CBT theory, and the development of applied CBT.

Sessional and Module e-Feedback – A Requirement for Trainees

Trainees are **required to evaluate each teaching and learning activity at the end of each session** and evaluate each module as it is complete. These evaluations are completed through ELE or through Accelerate (online university systems).

Feedback is an important part of the governance of the programme of study and allows the programme to be responsive to the needs, experiences, and thoughts of the trainees. Feedback is collated anonymously and presented at the course Governance meetings, and also made available to

the External Examiner. It has a protective function for the trainee experience, and is used more widely in determining the future of courses and also for university-wide governance.

The university includes the following in its academic processes guidelines:

*Programme members are **required** to complete:*

- *Teaching Feedback*
- *Module Feedback*
- *Programme Feedback*

Participation in the evaluation process is then, a requirement of the university and so too, the course, and participation in the feedback process is linked to successful completion of the course. Trainees will also be asked to provide feedback to their Clinical Supervisors on the end of their reports and on specific feedback forms during the course of their supervision journey (e.g. HASQ).

Trainee Confidentiality Statement

The teaching team aim to facilitate an open learning environment in which information is shared appropriately and respectfully between staff, trainees and relevant others to enable trainees to develop and to ensure appropriate patient care. Trainees should expect that information about day-to-day aspects of training will be shared with relevant individuals (e.g. the trainees' lead/service manager/workplace supervisor as identified). This will routinely include sharing trainees' marks for the assessments within the programme and sharing an overview of the trainees' progress. The course team also share information about trainee wellbeing and any difficulties they may be facing. Trainees will have consented to having this information shared as part of the signed Memoranda of Agreement. It is likely that trainee personal matters will be discussed in the course of discussions within the university course staff team. This can, of course, be confidential and in these circumstances, there should be a discussion about how best to handle confidentiality. Where personal matters are discussed that may impact on the trainee's performance on the programme/ability to provide appropriate patient care, there should be a discussion about how best, and with whom, to share concerns. Trainees should expect that the teaching team will need to discuss with one another how best to handle any issues. As far as possible this should be with the trainee's informed consent. If necessary, a confidentiality agreement can be drawn up between the trainee and appropriate staff/supervisors.

In extreme cases however, if a trainee discloses information highlighting personal risk of suicide or indicating a wider risk to self or others, in accordance with standard mental health practice the

course team may consider it necessary to inform their service and/or their GP. Trainees will have consented to this as part of the course additional information form during the application process. Where risk is a concern the teaching team would always seek to inform others with the trainee's full knowledge.

Trainee Confidentiality Guidelines

i. The details of any personal material remain confidential within the context in which it is shared

ii. It is not fitting for any trainee to disclose information about another, in their absence or presence, within the course or in conversation outside of sessions, without agreed permission

iii. The only exception to (ii) is if you have concerns about an individual's safety (child or adult). In such cases you should consult your Programme Lead, and when possible, inform the person concerned that you are doing this and explain why

iv. Where client material is shared programme members will do so:

   a. in a manner most likely to protect the identity of the clients

   b. in a manner which honours the limits of confidentiality, explained previously to a client

   c. with an understanding that no member of the group will disclose any information about such clients outside the sessions

PGDip Psychological Therapies Practice (SMHP CBT) Assessments

The PGDip includes both formative and summative assessments, and assessments are spread out across the course. You will require your clinical training caseload to align to the focus required in the assignments.

Formative Assessments are developmental and are not graded as Pass or Fail, rather they are an opportunity to gain feedback about your development.

Summative Assessments are graded as Pass or Fail and are required to be passed on either the first submission or the resubmission. All assessments have a number of marked domains in alignment with the generic university marking guidelines for academic level 7 work. The pass mark for assessments is 50%.

Failed Assessments and Resubmission

If you are unfortunate enough to fail a summative assessment, you will have the opportunity to resubmit about 4 weeks after receiving your feedback. Your feedback will specify why the assignment has failed and detail how to amend towards becoming a passing assignment. You will then resubmit the work, along with a copy of the original marking sheet and a brief bullet-pointed list of the amendments you have made. Please contact either the Academic or Clinical Lead to discuss any failed assignments and the feedback to support you with the resubmission.

You are only allowed one resubmission for each failed assignment except in exceptional circumstances. Not passing an assignment leads to not passing a module, which leads to failing the course except in exceptional circumstances.

The important message is: **unless you have exceptional circumstances, you will only have two attempts to pass a summative assignment.**

Marking Feedback Sheets

All of the Marking Feedback Sheets are available to view on ELE and it is helpful to familiarise yourself with the marking criteria and grids for each type of assessment. The academic criteria for the generic Level 7 Masters Level academic work are included later in this handbook. There are specific marking feedback sheets for the Case Reports, Oral Presentations, and the Essay. The CBT

Competency Evaluations are marked on the CTS-R which will be introduced during the course, the marking feedback sheet reflects the CTS-R competency assessment. There is a separate marking feedback sheet for the accompanying CTS-R documentation and the required Reflective Piece for the CTS-R.

Timetable of Assessments

Module	Assessment	Formative/Summative		First Submission Date	First Submission Feedback Date	Resubmission Date	Resubmission Feedback Date
PYCM105	Essay	Summative		08.03.2023	29.03.2023	26.04.2023	17.05.2023
PYCM104	CTS-R Client 1 Depression	Formative in Supervision Group		April/May2023 as per TT and in agreement with Supervisor and Group	n/a	n/a	n/a
PYCM104	CTS-R Client 1 Depression	Formative Formally Submitted		14.06.2023	12.07.2023	n/a	n/a
PYCM105	Oral Presentation Client 1 Depression	Summative		22.06.2023	13.07.2023	07.09.2023	28.09.2023
PYCM105	Supervision Report	Formative		10.08.2023	n/a	n/a	n/a
PYCM106	CTS-R Client 2 Anxiety Disorder	Formative in Supervision Group		September/October 2023 as per TT and in agreement with Supervisor and Group	n/a	n/a	n/a
PYCM106	CTS-R Client 2 Anxiety Disorder	Summative		01.11.2023	29.11.2023	03.01.2024	31.01.2024
PYCM104	Case Report Client 2 Anxiety Disorder	Summative		08.11.2023	29.11.2023	03.01.2024	24.01.2024
PYCM104	Reflective Essay	Formative		22.11.2023	13.12.2023	n/a	n/a
PYCM106	Supervision Report	Summative		14.12.2023	As negotiated with Programme Team		

Success Criteria for Assessments

The pass mark for summative assessments is 50%, and in the event of a fail grade the trainee is able to resubmit their assignment. The marking process is for each assessment to be marked by an appropriate marker and to be moderated following university guidelines.

Initial marks released to trainees are provisional and are ratified through university processes at a later date. You will be informed of your mark usually in three to four weeks from submission, by email from the course Administrator.

The External Examiner (EE) is also sent a selection of assessments to support the governance processes. The EE sends feedback to the Programme Lead and this is presented in Programme meetings and required reports.

For successful Resubmissions, a mark is given, but the module pass is capped at 50%.

For unsuccessful resubmissions, there are university processes to support the trainee in resolving the situation. The first thing to do is to contact the Academic, Clinical or Programme Lead.

The table below summarises the success criteria for all summative assessment types:

Table of Success Criteria for Summative Assessments

Assessment Type	Pass Criteria
Oral Presentation	Overall 50%
Written Case Report and Extended Case Report	Overall 50%
CTS-R	>50%, or a score of 36/72, with a minimum rating of at least 2 on EVERY item. In addition, ALL accompanying documentation must be submitted and receive a Pass
Essay	Overall 50%

Communication with Workplace about Progression

Workplace Service Leads/Managers and workplace supervisors will be routinely informed of trainees' marks on their academic assignments (e.g. essays, case reports), clinical assignments (e.g. competency CTS-R assessments) and feedback from Supervision Reports. Workplace Service Leads/Managers and Supervisors are invited to make contact with the Academic, Clinical or Programme Lead should any concerns about a trainee's development arise throughout the year.

Submission Procedures

Assessments will be submitted as per CEDAR guidance and procedures. However, it is likely that submissions will use TURNITIN through ELE supplemented not by eBART but by arrangements with the Programme Administrator who will confirm to all trainees what will be required and expected. Please do read the CEDAR Assessment guidelines in terms of expected presentation.

Supervisor Signed Assessment Cover Sheets

Please ensure that your University Supervisor signs the Cover Sheets for ALL of your assessments except the Essay and Reflective Essay prior to uploading the assessments through ELE. This is a CBT Programme governance requirement to verify that the clinical work described in the submitted assessments has been undertaken by the trainee and supervised by the university. Please note that University Supervisors work part-time and so you will need to give them plenty of time to sign your cover sheet (e.g. two weeks).

Anonymised Consent Forms to Accompany Submissions

Please ensure that your client consent forms are submitted with your assessments/assignments. Please note for submissions that require a consent form, the consent form must also be submitted by the submission deadline. If you believe you have grounds for an extension, please see your ELE page https://vle.exeter.ac.uk/course/view.php?id=13537 for further information under 'Submissions'.

Failure to Submit Required Accompanying Paperwork and Client Consent Form

Failure to do this will lead to the submission being rejected by the Programme Administrator and a requirement that the assignment AND the consent form and/or required accompanying paperwork are submitted again. This could impact on your mark as you will need to submit again the correct paperwork with your assignment immediately. Your marking feedback will also be delayed.
If you do not respond to the request to submit again with the appropriate paperwork within two weeks from the initial deadline date, your work will be given a FAIL grade and a resubmission be requested. Remember that there is only initial submission and resubmission, so this is highly stressful for trainees who then absolutely need to pass the resubmission in order to remain on the training course.

Resubmission Instructions

If your work is assessed as not meeting 'Pass' criteria, it will need to be resubmitted. You will receive notification of this, along with resubmission instructions and a resubmission date. You will have 4 weeks to resubmit.

Resubmitted work should be submitted alongside:

- A copy of the previous marking and feedback
- A cover sheet that shows how you have addressed the issues identified

Where assessments for part or all of a module are referred (Passed at Resubmission) the whole module must be capped at 50% for postgraduate modules.

Mitigation for Submissions

There are occasionally good reasons i.e. illness or clients disengaging from therapy, for being unable to submit an assessment on its required deadline. In such circumstances, you are required to submit a mitigation request. Please see your ELE page for details.

Mitigation must only be used in exceptional circumstances.

Accessibility

If you are living with an illness or a disability, the university has guidelines and procedures to support you in your studies, for example Dyslexia Marking Guidelines which seek to relieve penalties on assessed work due to dyslexia rather than academic issues. The Wellbeing Services also operate the AccessAbility Pathway to support students, please refer to the Exeter University website for the most up-to-date details or follow this link https://www.exeter.ac.uk/students/wellbeing/support/.

Client and Service Confidentiality and Confidentiality Breaches

Case Report Confidentiality

1. In Case Reports there should be no identifiable information in relation to the client or the client's service.
2. A minor breach in Case Reports is, for example, when more than one name for the client has been used, service has been identified, client name appears on worksheets included in appendices. This breach will usually be picked up by the marker within the marking period. Once this has been noticed, the marking process stops and the marker instructs Admin to contact the trainee and explain the situation and the breach. The trainee has 48 hours from

being notified by Admin to reply, correct the error in their scripts and submit their work again. If this process is completed in 48 hours, the submission is considered a first submission. If Admin are not contacted and the work is not corrected and submitted again within 48 hours, the work will receive a FAIL and a resubmission will be required.

3. Where there is a major confidentiality breach by the trainee, this leads to an automatic fail and a corrected resubmission will be required. If the breach is judged to be unethical or unprofessional, then university processes for managing such unacceptable conduct may be pursued and the trainee's workplace informed.

Oral Presentation Confidentiality

1. No identifiable information should be presented on the slides or within the discussion.
2. For a minor breach, the marker instructs Admin to contact the trainee and explain the situation and the breach. The trainee has 48 hours from being notified by Admin to reply, correct the error in their presentation and submit their work again or respond to Admin about the breach if it was verbalised during the presentation. If this process is completed in 48 hours, the submission is considered a first submission. If Admin are not contacted and the work is not corrected and submitted again within 48 hours, the work will receive a FAIL and a resubmission will be required.
3. Where there is a major confidentiality breach by the trainee, this leads to an automatic fail and a corrected resubmission will be required. If the breach is judged to be unethical or unprofessional, then university processes for managing such unacceptable conduct may be pursued and the trainee's workplace informed.

Clinical Portfolio Confidentiality

1. In the clinical portfolio, the trainee and the service can be identified but no identifiable information on clients should be included.
2. If confidentiality breaches occur in relation to clients, this is marked as an automatic FAIL and the trainee will be asked to address the area of concern for Resubmission
3. Where there is a major confidentiality breach by the trainee, this leads to an automatic fail and a corrected resubmission will be required. If the breach is judged to be unethical or unprofessional, then university processes for managing such unacceptable conduct may be pursued and the trainee's workplace informed.

Confidentiality Guidelines for Submissions

There are strict rules for maintaining the confidentiality of clients who are the subject of assessments. Pseudonyms must be used; do make them humanising, i.e. not 'X', and do remember which pseudonym you give to which client as real identifiers will need to be included on your logs in your portfolio and linked to the pseudonym given to the client in your summited work. Do check all appendices and included worksheets etc. in your submissions to ensure all personal identifiable information has been appropriately redacted. **A statement to this effect must be present in all submissions where this has been done.**

Personal Identifiable Information (GDPR 2018)

All personal identifiable information (PII GDPR 2018) must be protected appropriately by the author and by those privileged to read a case report or watch a presentation. Personal data is defined as any information relating to a person who can be identified, directly or indirectly, by reference to an identifier such as a name, an identification number, location data, or an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

Confidentiality Breaches and Ethical Concerns in Submissions

Confidentiality Breaches are classified as minor and major. For major breaches, the assessment will be failed on this ground alone, irrespective of the content of the rest of the submission.
For minor breaches, e.g. where a real first name has been left on a photocopied and included worksheet, the assessment will be returned to the trainee and they will be given 48 hours to submit with the error corrected. This does not count as a resubmission. Where there are ethical concerns arising from the submitted or presented work, the assessment will be given a failing grade regardless of the quality of the rest of the assessment and the trainee will be required to arrange a meeting with a member of the staff team.

Academic Honesty and Plagiarism

Trainees are required by the university to complete the Academic Honesty and Plagiarism e-Training module. This training is found on your ELE page and on completion you are required to complete a quiz which the staff team will use to determine that you have completed the training. This training also has a link to an APA Referencing guide.

Turnitin, Plagiarism, & Academic Misconduct

Turnitin is an e-process used in assessment submissions through ELE which compares assessments to material held on the Turnitin database, allowing submissions to be checked for originality. It does not make decisions about plagiarism but highlights sections of text and returns an overall percentage of material that has been found in other sources. Turnitin produces a report on its findings for the CBT SMHP Programme, which is checked by the Marking Team. Submissions with high scores for non-originality will be checked by the Moderator and, if there is cause for concern, the trainee is reported to the Academic Misconduct Officer in line with university academic policy http://as.exeter.ac.uk/academic-policy-standards/tqa-manual/aph/managingacademicmisconduct/ . It is important that all trainees complete their Academic Honesty and Plagiarism teaching module on ELE as described earlier in the handbook. Training will also be provided during the Induction Day.

Self-Practice / Self-Reflection Tasks and Formative Reflective Essay

This assessment is a formative assessment and receives developmental feedback. It is not a pass/fail summative assessment. CBT is all about facilitating change; it is an important part of your CBT development that you gain an appreciation of how this is experienced by your clients. This assessment will be a reflective and experiential one, underpinned by the teaching you will undertake during the first year.

Trainees will have the opportunity to engage throughout the course in pre-set self-practice CBT tasks designed to prepare for or deepen learning in the concurrent taught components of the course. Trainees will be required to complete a minimum of **5 self-practice / self-reflection tasks**. Trainees are encouraged to keep a record/journal of their experiences of completing the tasks.

A list of the minimum of 5 self-practice/self-reflection (SP/SR) tasks will be submitted with a reflective summary of learning for formative assessment (see guidelines and criteria for SP/SR summary below).

The formative self-practice/self-reflection reflective summary of learning (500 words) may follow a similar format as the CTS-R reflections but may cover a number of themes that have emerged from the overall experience of engaging in the self-practice/self-reflection tasks.

Useful reading:

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *29*, 203-220.

SP/SR Formative Reflective Essay Guidelines

The purpose of the formative SP/SR reflective summary is to demonstrate your ability to:

- Reflect on your experience of CBT SP/SR
- Critically analyse and make sense of that experience (informed by CBT theory and literature where appropriate)
- Extract useful learning and plan for change

A minimum of 5 completed SP/SR tasks should be listed in the reflective summary.

You will be formatively assessed on the following dimensions:

Introduction of topic of reflection
• Clear identification of themes/issues relevant to SP/SR tasks. • Description of reflective process used (e.g. may have involved the use of a model such as Kolb's learning cycle, discussion with supervisor or peers, use of blog, use of own thought records, conceptualisations etc.)
Experience and observation
• Description of the relevant concrete experience within SP/SR e.g. observations of therapist's automatic thoughts, emotions and behaviours in relation to process (rather than content) of self-practice.
Critical Analysis
• Analysis of experience and observations of completing the SP/SR tasks and beyond taking an objective and critical stance and presentation of alternative interpretations in order to help make sense of experiences. • Analysis would usefully be informed by therapist formulation.
Understanding and use of theory
• Use of existing knowledge of CBT and/or relevant CBT literature/research to help understand and critically analyse experiences of SP/SR • Demonstration of understanding of theory and integration of theory to practice
Summary and implications for future practice
• Summary of learning extracted from SP/SR

• Description of concrete and specific plans for active experimentation, further learning and clinical practice (including awareness of own assumptions etc.)
Structure & style:
• Clear structure with a logical flow • May use existing models of reflection such as Kolb's learning cycle to structure • A minimum of 5 completed SP/SR tasks MUST be listed the reflective summary
Spelling / Grammar / Typos
• Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone else to proof read your reflective summary before submitting. If you need support in this area please use the study skills department.
References
• References should conform to APA (7th Edition) both in text and at the end of your reflective summary (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Word count:500

Summative Essay

You will need to submit one essay during the course. An important learning domain on the course is the theoretical underpinning of CBT and the developing of the ability to apply critical analysis to therapy, practice, and research. This essay offers an opportunity to illustrate your knowledge and skill in these academic areas to complement the more applied learning from the course.
The essay is a 4000-word submission.

Summative Essay Assessment Guidelines

Trainees will be assessed on the following dimensions for the summative essay:

*Interpretation of title
Marks will be awarded for your ability to answer the essay question posed. Therefore ensure you read the essay question clearly and that you understand it; if not ask. In order to pass this section you will need to clearly address all elements of the essay question.
***Understanding of theory**
Marks will be awarded where you demonstrate a clear understanding of relevant theory and the ability to apply this understanding to answer the essay question.
***Critical analysis**
Marks will be awarded where you demonstrate an ability to not only pull together relevant information but also to analyse this critically, for example weighing it against evidence that does not fit with the point you are making and demonstrating a thoughtful reflective approach or commenting on the rigor of the evidence cited. You should clearly differentiate your own opinions from those critiques reported from the work of other authors.
***Summary of arguments & implications**
Marks will be awarded where you demonstrate an ability to summarise your arguments *and* comment on the implications they may have for clinical practice and or future research. The essay should not be a purely theoretical exercise and it is important that you demonstrate your ability to apply your conclusions to the broader context within which you are working.
Use of sources
You need to ensure that the points you make are backed up by relevant literature. We would expect you to use a wide source of references e.g. journals, books and websites. An absolute minimum of 10 references would be the norm.
Structure & style
Marks will be awarded for a well-structured essay. The essay should flow well with a clear introduction (including essay plan), middle and end. Make use of summaries to help the reader through your arguments. Think about what point you are making and why, make your point and

where available support it with evidence, and then reflect and summarise the point. Be mindful of your use of language both the use of colloquialisms and jargon. Where appropriate you may use diagrams, tables and bullet points. These should be used to aid clarity. If used, subheadings should relate to subsequent material presented and help to structure your essay. If used, appendices and footnotes should be used appropriately and not to help with word count. Key information needs to be in the main body of the text. Appendices should be clearly referred to and labelled and come after the reference section.
References
References should conform to APA (7th Edition) both in text and at the end of your essay (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.
Spelling, grammar, typographical errors and presentation
Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone else to proof read your essay before submitting. If you need support in this area please use the study skills department.
Word count
Word count excludes: essay title, tables, the reference list, figures and appendices. **The word limit is** **All other words are counted. Work exceeding this limit will not be marked and will not receive credit.**

***** Indicates a key area; failure on more than one of these areas is likely to result in an overall fail.

Oral Case Presentation

Trainees give two summative oral case presentations across the two years. In year 1, the oral case presentation is based on the client brought to university supervision in terms one/two who has a presentation of depression. Trainees are required to deliver the oral case presentation to a small group of their peers. The oral presentation should last about twenty minutes, leaving ten minutes for questions from their peers. Presentations are live marked. Trainees are marked on the content of

their case presentation rather than on their presentation skills. The peer audience is required to ask questions of the presenter for a maximum of ten minutes following the end of the slide presentation. The marker will only ask a question if clarification is required or an omission has been noticed. Answering questions raised by the audience will allow the presenter to expand on areas of the presentation and to reveal further their CBT knowledge and practice.

It is recommended that trainees familiarise themselves with the case presentation guidance in the handbook and use the guidance as a structure for the presentation. The purpose of the case presentation is to demonstrate trainees' grasp of the application of cognitive theory to clinical practice and to demonstrate their therapeutic skills including = assessment, formulation, intervention and measuring change.

Trainees need to use anonymised biographical data throughout the presentation - no identifiable information should be presented on the client or the service. i.e. change any names and identifying information. Confidentiality of the client must be protected at all times and a statement should be made noting this during the presentation. Pseudonyms are acceptable and preferable to numbers or letters.

Submission and Paperwork for the Audience

Handouts to support the presentation are required to be released to the audience and the marker/moderator and submitted formally, along with a cover sheet signed by your university clinical supervisor to verify the work is accurate and has been taken to supervision. The audience handouts are required to be deleted and/or destroyed at end of each presentation.

Summative Oral Case Presentation Assessment Guidelines

Trainees will be assessed on the following dimensions for the summative oral case presentation:

***Assessment**
Should include: • Reason for referral and for seeking treatment at this point. • Presenting problem(s), diagnosis and co-morbidity including presentation of DSM criteria and full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures).

- Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances.
- Risk assessment.
- Identified treatment goals for therapy (focus on SMART goals).
- Issues relating to engagement and the therapeutic alliance.
- Issues of diversity and difference (or similarity) between client and therapist and its impact on the therapeutic relationship.
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used, reasons for this should be given).
- A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours.
- Socialisation to the model and suitability for CBT.
- Scores on relevant service outcome and assessment measures.
- Relevant disorder/symptom specific assessment questionnaires (if not a reason should be given).

***Conceptualisation / Formulation**

- Where a particular model has been used to guide formulation this should be accurately described including an accurate description of the theory underpinning the model.
- There should also be a description of the case conceptualisation and clarified by a diagrammatic representation of the conceptualisation. The diagrammatic representation can be provided on a separate handout or included in the slides.
- Ensure that the arrows on any diagrammatic formulations should make sense, flow accurately and reflect both the theory and actual experience of the client.
- The formulation should link and explain the presence of maintenance factors of the presenting problem(s) and where relevant the development of the problem.
- The formulation should relate to the client's goals and flow from the assessment.
- Ensure a focus on collaboration with explicit client contribution.

***Intervention**

- Interventions (carried out or planned) should directly relate to and flow from the client's identified goals and the case conceptualisation, to demonstrate how treatment was idiosyncratic
- For Year 1 Diploma trainees (depression case), a minimum of 5 sessions should have been completed, including treatment/interventions. For Year 2 Diploma / Certificate trainees, a minimum of eight sessions should t have been completed with the client, including some interventions/change methods with a shared formulation already in place.
- Clear rationales for the interventions carried out should be given based on the theory, goals and case conceptualisation.
- Enough detail should be given in the text so that it is clear what was done, but a blow-by-blow account of each session is not required.
- The relapse prevention plan should be included.
- Include reference to relevant NICE guideline(s).
- Identify any difficulties experienced and relate back to the case conceptualisation where possible.

***Critical evaluation/outcome**

- You need to evaluate the interventions as applied and the outcome of the case.
- You need to demonstrate evaluation over the course of therapy (not just at the end) so that you can demonstrate that you are on track with the intervention.
- Present relevant outcomes for the client (ideally also through depiction of a graph) and critically discuss scores, considering also fluctuations in scores and why these may have occurred
- You should re-administer and report on all measures that were used at assessment (if not a reason should be given).
- Outcomes should be clearly related back to the identified goals of therapy.
- You should critically evaluate the work and outcome to date; e.g. why you think the changes have occurred? Or if no changes have occurred why this may be? Where possible relate this back to the case conceptualisation and/or the theory/model.
- Where an intervention has not been completed you need to present the current outcome in relation to the identified goals.
- Refer back to relevant NICE guideline(s), where possible.

***Therapeutic relationship/obstacles**

- You need to give a description of the therapeutic relationship
- You should refer to theory/literature regarding the therapeutic relationship
- The therapeutic relationship should be considered with reference to the idiosyncratic formulation
- You should consider potential obstacles to therapy and provide a description/plan for how those obstacles may be overcome

***Link of theory to practice**

This is covered to some extent in previous areas.
Within the presentation you will need to evidence a satisfactory understanding of the relevant cognitive-behavioural theory and disorder specific model. This should be described in sufficient detail prior to presenting the idiosyncratic formulation and planned intervention.

Throughout the presentation you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models.
- Use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case.
- Refer to and make use of the relevant literature pertaining to this case.

Self reflectivity

Throughout the presentation you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process. For example we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future. You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, a reflective model, thought records, listening to session recordings etc.).

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, e.g. awareness of:

- Issues of risk
- Ethical issues
- Power dynamics
- Issues of diversity and difference and its impact on the therapeutic relationship.
- Client confidentiality - anonymised biographical data must be used throughout the presentation, i.e. you need to change any names and identifying information and make it clear that this has been done **

Structure and style of presentation

Marks will be awarded for a well-structured and well-presented case presentation. Use of PowerPoint is encouraged. The case presentation should flow in a logical manner and any slides/hand-outs provided should be relevant and aid the marker. Be mindful of your use of language, both regarding the use of colloquialisms and jargon. Where appropriate you may make use of diagrams, tables and bullet points in the presentation to clarify information. Diagrams of the case conceptualisation can be provided on a separate handout or included in the slides.

A possible structure could be based on the marking criteria e.g.: Introduction to the presentation, reason for referral, presenting problem(s), assessment, formulation, intervention plan and critical evaluation/discussion. Theory to practice links, self-reflectivity and professional issues could be covered throughout the presentation. An introduction should be included, clearly outlining the structure of the case presentation and material to be covered.

Your case presentation should be clearly presented and you may wish to consider practising your presentation before you record it where possible.

References

References should be given throughout the presentation slides and provided in a reference section at the end. References should conform to APA (7th Edition) - see University guidance. Please check references in terms of accuracy and consistency and ensure that all citations in the slides are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, grammar, typographical errors

The information in your slides should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone else to proof read your slides before submitting. If you need support in this area please use the study skills department.
Length of Presentation
The case presentation should be a maximum of 20 minutes' duration. There will be up to 10 minutes of questions from the group/marker. **Any information not presented will not receive credit, and so trainees should aim to present all the information within 20 minutes. Trainees will have the opportunity to answer questions and answers provided during this time will also be marked.**

***** Indicates a key area; failure on more than one of these areas is likely to result in an overall fail.

Summative (Written) Case Report

There is one 4000 word written case report to be submitted during the PGDip course in Year 1. The case report is to be written on your client taken to university supervision in Term 3, who has an anxiety disorder (not PTSD). A case report gives an opportunity for you to demonstrate your ability to synthesise CBT theory and CBT practice and skills to the assessment, formulation and intervention with an individual client.

A minimum of five sessions must have been completed with the client and you need to be into change methods/interventions with a shared Formulation already in place. You and the client need to be beyond 'initial assessment and formulation' and working together towards change in order for your work to meet the criteria for the case reports. You need to include a statement about this in your report. You must ensure that personal details are altered so as not to breach confidentiality, and you should add a statement to this effect; **failure to do so may result in failure.**

Summative (Written) Case Report Assessment Guidelines

Trainees will be assessed on the following dimensions for the summative (written) case report:

***Assessment**
Should include: • Reason for referral and for seeking treatment at this point.

- Description of the presenting problem(s)/symptoms, diagnosis and co-morbidity including use of DSM-5 criteria and full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures)
- Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances.
- Risk assessment.
- Identified treatment goals for therapy (focus on SMART goals).
- Issues relating to engagement and the therapeutic alliance.
- Issues of diversity and difference (or similarity) between client and therapist and the impact on the therapeutic relationship.
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used reasons for this should be given). For depression cases, the Beck model should be used.
- A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours.
- Socialisation to the model and suitability for CBT.
- Scores on relevant service outcome and assessment measures.
- Relevant disorder specific assessment questionnaires (if not a reason should be given).

***Conceptualisation / Formulation**

- Where a particular model has been used to guide formulation this should be referenced and accurately described including an accurate description of the theory underpinning the model.
- There should be a narrative description of the case conceptualisation within the text, and clarified, where possible, by a diagrammatic representation of the conceptualisation.
- The formulation should link and fully explain the maintenance factors of the client's presenting problem(s) and where relevant the development of the problem.
- Ensure that the arrows on any diagrammatic formulations make sense, flow accurately and reflect both the theory and actual experience of the client.
- The formulation should relate to the client's goals and flow from the assessment.
- Ensure a focus on collaboration with explicit client contribution.

***Intervention**

- Interventions (carried out or planned) should directly relate to and flow from the client's identified goals and the case conceptualisation, to demonstrate how treatment was idiosyncratic
- A minimum of 5 sessions should have been completed, including treatment/interventions
- Clear rationales for the interventions carried out should be given based on the theory, goals and case conceptualisation.
- Enough detail should be given in the text so that it is clear what was done, but a blow-by-blow account of each session is not required.
- The relapse prevention plan should be included.
- Include reference to relevant NICE guideline(s).
- Identify any difficulties experienced and relate back to the case conceptualisation where possible.

***Critical evaluation/outcome**

- You need to evaluate the interventions as applied and the outcome of the case.
- You need to demonstrate evaluation over the course of therapy (not just at the end) so that you can demonstrate that you are on track with the intervention.
- Present relevant outcomes for the client (ideally also through depiction of a graph) and critically discuss scores, considering also fluctuations in scores and why these may have occurred
- You should re-administer and report on all measures that were used at assessment (if not a reason should be given).
- Outcomes should be clearly related back to the identified goals of therapy.

- You should critically evaluate the work and outcome to date; e.g. why you think the changes have occurred? Or if no changes have occurred why this may be? Where possible relate this back to the case conceptualisation and/or the theory/model.
- Where an intervention has not been completed you need to present the current outcome in relation to the identified goals.
- Refer back to relevant NICE guideline(s), where possible.

***Therapeutic relationship/obstacles**

- You need to give a description of the therapeutic relationship
- You should refer to theory/literature regarding the therapeutic relationship
- The therapeutic relationship should be considered with reference to the idiosyncratic formulation
- You should consider potential obstacles to therapy and provide a description/plan for how those obstacles may be overcome

***Link of theory to practice**

This is covered to some extent in previous areas.

Throughout the report you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models throughout.
- Use theory/research/literature to guide your assessment, formulation, intervention plan and critical evaluation.
- Refer to and make use of the relevant literature to show how this was guiding your thinking about this case.

Self reflectivity

Throughout the case report you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process. For example we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future. You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, a reflective model, thought records, listening to session recordings, SP/SR etc.).

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, e.g. awareness of:

- Issues of risk including how risks were managed and reviewed
- Ethical issues
- Power dynamics
- Issues of diversity and difference and the impact on the therapeutic relationship.
- **Client confidentiality; anonymised biographical data must be used throughout the report and there should be no identifiable information in relation to the client or service i.e. you need to change any names and identifying information and make it clear that this has been done

Structure and style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language both the use of colloquialisms and jargon. Trainees should refer to themselves as 'the author' rather than 'I' within academic writing.

Where appropriate you may use diagrams, tables and bullet points. These should be used to aid clarity of information in the main text. Key information needs to be in the main body of the text and any information in tables/diagrams needs to be at least summarised within the main text. Key information such as each of the '5 Ps', risk, differential diagnosis, narrative description of the formulation, interventions, critical evaluation, and the theory underpinning the work all needs to be described within the text.

If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Appendices should be clearly referred to, labelled and follow the reference section.

A possible structure could be based on the marking criteria e.g.: Outline/introduction to the client and the case report, reason for referral, presenting problem(s), assessment, formulation, intervention plan and critical evaluation. Theory to practice links, self-reflectivity and professional issues could be covered throughout in the previous sections or as separate sections.

References

References should conform to APA (7th Edition) both in text and at the end of your case report (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, grammar, typographical errors and presentation

Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone else to proof read your case report before submitting. If you need support in this area please use the study skills department.

Word count

Word count excludes: case report title, tables, figures, headings for tables/figures, the reference list, and appendices. **All other words are counted. Work exceeding this limit will not be marked and will not receive credit. The word count is 4000 words.**

Summative (Written) Extended Case Report

In year 2 trainees write a longer case report, 7000 words, on a client with SMHP. Further guidance will be given in year 2. The assessment guidelines are similar to the case report written in year one, however further writing is required on a 'theme' of the trainees' choice.

Summative (Written) Extended Case Report Assessment Guidelines

Trainees will be assessed on the following dimensions for the summative (written) extended case report:

***Assessment**
Should include: •Reason for referral and for seeking treatment at this point. •Description of the presenting problem(s)/symptoms, diagnosis and co-morbidity including use of DSM 5 criteria and full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures) •Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances. •Risk assessment. •Identified treatment goals for therapy (focus on SMART goals). •Issues relating to engagement and the therapeutic alliance. •Issues of diversity and difference (or similarity) between client and therapist and the impact on the therapeutic relationship. •Use of the relevant model to guide assessment, formulation and intervention (if it is not used reasons for this should be given). For depression cases, the Beck model should be used. •A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours. •Socialisation to the model and suitability for CBT. •Scores on relevant service outcome and assessment measures. •Relevant disorder specific assessment questionnaires (if not a reason should be given).
***Conceptualisation / Formulation**
•Where a particular model has been used to guide formulation this should be referenced and accurately described including an accurate description of the theory underpinning the model.

- There should be a narrative description of the case conceptualisation within the text, and clarified, where possible, by a diagrammatic representation of the conceptualisation.
- The formulation should link and fully explain the maintenance factors of the client's presenting problem(s) and where relevant the development of the problem.
- Ensure that the arrows on any diagrammatic formulations make sense, flow accurately and reflect both the theory and actual experience of the client.
- The formulation should relate to the client's goals and flow from the assessment.
- Ensure a focus on collaboration with explicit client contribution.

***Intervention**

- Interventions carried out should directly relate to and flow from the client's identified goals and the case conceptualisation to demonstrate how treatment was idiosyncratic.
- The main body of the intervention must be completed (the client may still be seen for follow-up or relapse prevention). The relapse prevention plan should be included.
- Clear rationales for the interventions carried out should be given based on the theory, goals and case conceptualisation.
- Enough detail should be given in the text so that it is clear what was done, but a blow-by-blow account of each session is not required.
- Include reference to relevant NICE guideline(s).
- Identify any difficulties experienced and relate back to the case conceptualisation where possible.

***Critical evaluation/outcome**

- You need to evaluate the interventions as applied and the outcome of the case.
- You need to demonstrate evaluation over the course of therapy (not just at the end) so that you can demonstrate that you were on track with the intervention.
- Present relevant outcomes for the client (ideally also through depiction of a graph) and critically discuss scores, considering also fluctuations in scores and why these may have occurred
- You should re-administer and report on all measures that were used at assessment (if not a reason should be given).
- Outcomes should be clearly related back to the identified goals of therapy.
- You should critically evaluate the outcome; e.g. why you think the changes have occurred? Or if no changes have occurred why this may be? Where possible relate this back to the case conceptualisation and/or the theory/model.
- Refer back to relevant NICE guideline(s), where possible.

***Therapeutic relationship/obstacles**

- You need to give a description of the therapeutic relationship
- You should refer to theory/literature regarding the therapeutic relationship
- The therapeutic relationship should be considered with reference to the idiosyncratic formulation
- You should consider potential obstacles to therapy and provide a description/plan for how those obstacles may be overcome

***Link of theory to practice**

This is covered to some extent in previous areas.

Throughout the report you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models throughout.
- Use theory/research/literature to guide your assessment, formulation, intervention plan and critical evaluation.
- Refer to and make use of the relevant literature to show how this was guiding your thinking about this case.

***Critical appraisal of themes**

You need to clearly identify one or two key themes or issues that were relevant to this case.

You should critically appraise:

- The literature around these themes
- The work/intervention with reference to this literature.

You should take an objective and critical stance to the work carried out.

Self reflectivity

Throughout the case report you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process (e.g. the use of supervision), **specifically in relation to your chosen theme(s**). For example we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future. You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, reflective models, thought records, listening to session recordings, SP/SR etc.). You may wish to include a transcript of sessions with this client to illustrate your points and provide material for reflection.

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, e.g. awareness of:

- Issues of risk including how risks were managed and reviewed
- Ethical issues
- Power dynamics
- Issues of diversity and difference and its impact on the therapeutic relationship.

- **Client confidentiality - anonymised biographical data must be used throughout the report and there should be no identifiable information in relation to the client or service i.e. you need to change any names and identifying information and make it clear that this has been done.

Structure and style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language both the use of colloquialisms and jargon. Trainees should refer to themselves as 'the author' rather than 'I' within academic writing.

Where appropriate you may use diagrams, tables and bullet points. These should be used to aid clarity of information in the main text. Key information needs to be in the main body of the text and any information in tables/diagrams needs to be at least summarised within the main text. Key information such as each of the '5 Ps', risk, differential diagnosis, narrative description of the formulation, interventions, critical evaluation, the theory underpinning the work and critical appraisal of theme/s all needs to be described within the text.

If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Appendices should be clearly referred to and labelled and come after references.

A possible structure could be based on the marking criteria e.g.: Outline/introduction to the client, the case report and key themes that will be discussed; reason for referral; presenting problem(s); assessment; formulation; intervention plan; and critical evaluation and reflective analysis. Theory to practice links, critical appraisal of theme/s, self reflectivity and professional issues could be covered throughout in the previous sections or as separate sections.

References

References should conform to APA (7th Edition) both in text and at the end of your case report (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, grammar, typographical errors and presentation

Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone

else to proof read your case report before submitting. If you need support in this area please use the study skills department.

Word count
Word count excludes: case report title, tables, figures, headings for tables/figures, the reference list, and appendices. **All other words are counted. Work exceeding this limit will not be marked and will not receive credit. The word limit is 7000 words.**

CBT Practice Competency Assessments

Over the course you are required to be evaluated via 8 recorded sessions used for assessment of competency, on the CTS-R.

Five of these sessions are Formative assessments to support competency development. Formative assessments are not marked to a pass/fail grading but are opportunities to gather feedback about your competency development and support further practice development. Three are summative assessments and must be passed at first or second submission in order to progress on the course.

You must **formally submit** 4 recordings, two in year 1 and two in Year 2, with the required accompanying documentation. Three of these are summative assessments, but the first one on your Depression Client 1, is formative.

You will receive training on the CTS-R measure and manual, and each will be found on ELE.

There are two modes of assessment, Formative Competency Assessments (Supervision Group In-Session) and **formally submitted** assessments. Each university client will be the focus of two competency assessments, one formative and one summative apart from client 1 on whom both recordings are formatively assessed through the in-session and the **formal** submission process.

The session submitted should demonstrate CBT change methods/interventions in line with the relevant CBT theory/model and associated idiosyncratic formulation. Change methods could include cognitive methods such as cognitive change diaries, continuums, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring etc. Behavioural change methods could include behavioural diaries, behavioural experiments, role play, graded task assignments, response prevention etc. If you are unsure, please ask the Clinical Lead.

Formative Competency Assessments *'Supervision Group In-session Peer Supported Practice Competency Evaluations'*

There are four of these across the course, two in the first year and two in the second year. Trainees agree with their fellow supervisees and their supervisors the dates, within a period specified on the timetable, when they will share their recorded sessions with their supervisor and their fellow supervisees. The whole session recording is then watched together in a supervision session and all group members and the supervisor use the CTS-R to note down feedback to share with the presenter. After viewing the session, there is time for a feedback discussion within and by the group. The required accompanying documentation must be completed as required and given to the supervisor for review. Please note the difference in word count for these formative assessments versus the summative submissions.

Please ensure confidentiality is protected at all times.

This is an opportunity for peer-supported competency development and all supervisees have a responsibility to sustain a safe and supportive learning environment within their supervision group.

Formally Submitted Recorded Sessions

There are four formally submitted recorded sessions and accompanying documentation, the first Formative and the other three are Summative assessments which must achieve a Pass grade in first or second submission (resubmission). You must pass these assignments at first or resubmission in order to proceed with the course. The Programme Administrator will inform you how to submit these recordings and the accompanying Paperwork for assessment.

Accompanying Required Documentation

The Competency Assessments are not about the recorded session in isolation. There are six pieces of documentation required to complete your submission and the submission is incomplete without this accompanying documentation. For a Formative assessment, this will be noted but for a summative assessment this may lead to a Fail and require a Resubmission.

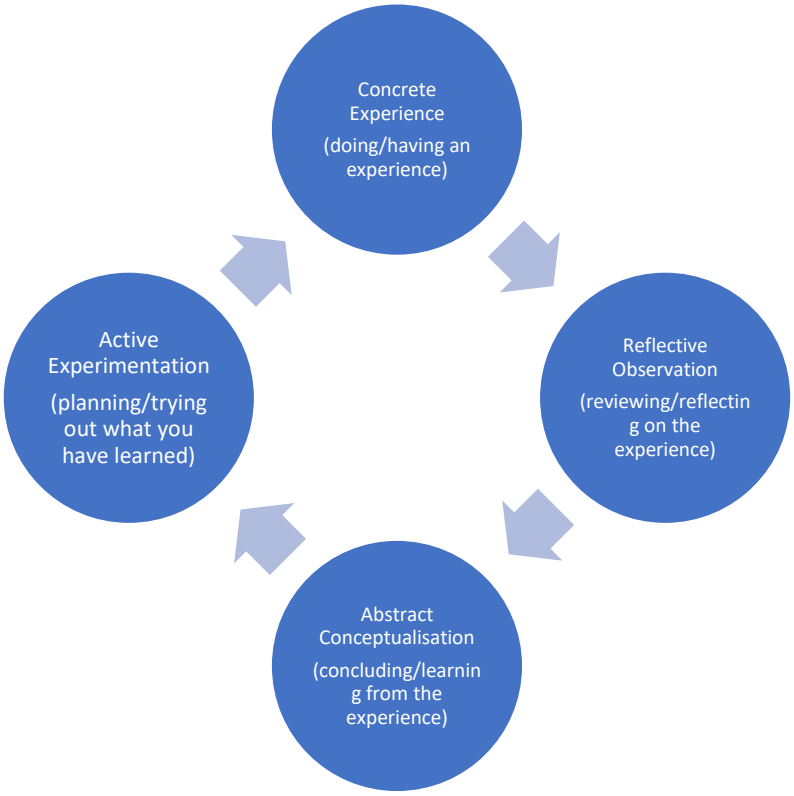
Accompanying Documentation

1. CTS-R self-evaluation - with brief comments and timing of observations as well as scores, including noting the timing of the 'event' used for the Reflective Piece.
2. Assessment Cover Sheet - using Trainee name for Formative recordings and Trainee number for Summative submissions, signed by your university supervisor (please give the supervisor enough time to sign this e.g. two weeks before submission).

3. Redacted Consent Form - signed and dated by yourself and the client, consenting to the recording of the session and to its assessment as part of your progression through the course. **Please redact the client's name on the sheet, leaving the signatures and dates visible.**
4. A 500-word Client Summary and Brief Session Outline
    - including:
        i. A brief description of the client and their identified difficulties
        ii. Identified goals and treatment plan
        iii. Session details: session number, agreed agenda, aim of the session
        iv. Brief summary of the whole session
5. A Diagrammatic Shared Formulation
6. A 500-word Reflective Piece

Reflective Piece

The Reflective Learning piece uses Kolb's model of reflective learning (1984) to support and structure a brief exploration and reflection of the use of this skill in the session, concluded by a plan for future use of this skill



Please structure your Reflective Learning piece into the following framework:

- **Introduction** - choose one skill which you apply during the session (it is helpful to choose an area from the CTSR or a specific change method). Identify the skill clearly and support this skill use in CBT from the literature.
- **Concrete Experience:** What happened? At what point in the tape could this be seen? What did you noticed or became aware of during the application of the skill under scrutiny. This is the concrete facts of the event under scrutiny.
- **Reflective Observation:** What was your subjective experience? Think about your own response to the situation, the client, CBT practice, yourself as a therapist and as a person.

  Now make sense of what happened by being curious and reflective. Develop your reflection to reflective analysis by:

  - Searching for understanding
  - Relating it to previous experience and CBT literature
  - How does the experience fit with the shared formulation?

  Ensure you include support from the literature and research to help you reflect and make sense of your experience in session and so inform practice development
- **Abstract Conceptualisation:** What conclusions can you draw following your reflection? Is there anything in your practice you need to be more aware of or change?
- **Active Experimentation**: With the new understanding, how can I take this forward? What specific things do I need to achieve this?

Your work should demonstrate your ability to reflect on your practice and in particular in relation to the formulation of this client's presentation.

The reflective analysis should provide a brief critical evaluation of the therapy skills that you demonstrate within the recording, **drawing, in brief, on relevant CBT theory, research and literature,** and then in the plan, identify learning from this reflective analysis for your future practice.

Success Criteria on the CTS-R for Summative Submissions

The CTS-R is used to assess competency in applied CBT. For success on Summative Competency Assessments, as assessed on the CTS-R, the following criteria must be reached:

- A overall score of 50% or more (>36/72)

And

- a minimum rating of at least 2 on EVERY domain
- In addition, ALL accompanying documentation must be submitted

The Marking Feedback Sheets for the CTS-R and the Reflective Piece are included at the end of this section.

Reminders for Competency Assessments

There are seven elements to this Assessment, the recorded session and the 6 pieces of accompanying documentation:

- the Recorded Session

  AND
- CTS-R self-evaluation
- the Assessment Cover Sheet signed by your supervisor
- the Consent Form
- the 500-word summary
- the diagrammatic formulation
- the 500-word Reflective Piece

ALL **must** be submitted. If any of the required accompanying documentation are not submitted, the assessment may receive a Fail and the missing documentation will be required at Resubmission.
This assessment is not marked on the Notched Marking Scheme used for academic assignments because the CTS-R is a clinical training competency evaluation. It is therefore possible to fail with a mark of 49% which is not possible on academic assignments marked to the university's Notched Marking Scheme.
Because there are competency-led, additional marking criteria on the CTS-R measures, it is possible to achieve a score of over 50% yet still fail the assignment. Please do refer to the Success criteria for the measures. These additional criteria ensure that the measures are validly and reliably measuring competency in CBT rather than, for example, in well-developed interpersonal skills which do not necessarily lead to a competent CBT session.

This assignment is required to be written to an academic level 7 standard (Masters) so the following criteria will be assessed and impact on final rating:

- Structure & style: Clear structure with a logical flow

- References: References MUST conform to APA both in text and at the end of your essay (see University guidance). Please check and double check references in terms of accuracy, consistency and ensuring that all references in the text are referred to in the reference section.
- Spelling, grammar, typographical errors: You will be marked down for typographical, grammatical and spelling errors. Work should be double spaced and page-numbered.

Ref: Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. Behavioural and Cognitive Psychotherapy, 29, pp. 203-220.

2022 - 2024 Marking Feedback Sheet – Competency Assessments

PGCert Psychological Therapies Practice (SMHP CBT)

Cognitive Therapy Scale – Revisited (CTS-R)

Name of Trainee (Formative): Date:

Trainee Number (Summative): Module:

Client number: Client initials:

CTS-R Items	**Item Score**	**Strengths and Key Points (Evidence)**	**Areas for Development** ***(bullet-pointed)***
1. Agenda setting and adherence Did the therapist set a good agenda and adhere to it?			
2. Feedback Were there statements and/or actions concerned with providing and eliciting feedback?			

3. Collaboration Were there statements and/or actions encouraging the patient to participate appropriately, and preventing an unequal power relationship developing?			
4. Pacing and efficient use of time Were there statements and/or actions concerning the pacing of the session, helping to ensure the time was used effectively?			
5. Interpersonal Effectiveness Was a good therapeutic relationship evident (trust, warmth, etc.)?			
6. Eliciting appropriate emotional expression Were there questions and/or actions designed to elicit relevant emotions			

and promote a good emotional ambience?			
7. Eliciting key cognitions Were there questions and/or actions designed to elicit relevant cognitions (thoughts, beliefs, etc.)			
8. Eliciting and planning behaviours Were there questions and/or actions designed to elicit dysfunctional behaviours and engage the patient in planning for change?			
9. Guided discovery Were there questions and/or actions designed to promote self-reflection, helping the patient to make his/her own connections and discoveries?			
10. Conceptual integration Were there statements and/or actions designed to promote the patient's understanding of the models underpinning CT?			

11. Application of change methods Did the therapist facilitate in-session learning and change through a change method (cognitive and behavioural)?			
12. Homework setting Did the therapist set an appropriate homework effectively?			
Total Score		Additional Comments	
Percentage *See end of sheet for calculation*			
For success, the following criteria must all be met:		**Criteria** / **Met** An overall score of 50% A minimum rating of at least 2 on EVERY item	
Category		*circle as appropriate* FAIL PASS MERIT DISTINCTION	

Calculation of overall percentage:

Scale Score of 0 – 35 equates to 0 – 49 **or** not all Success Criteria Met FAIL (multiply scale score by 1.4 to get percentage score)

Scale Score of 36 - 45 equates to 50 -59 **and** all Success Criteria Met PASS

Scale Score of 46 – 55 equates to 60 -69 **and** all Success Criteria Met MERIT

Scale Score of 56 - 72 equates to 70 -100 and all Success Criteria Met DISTINCTION (use table below to convert Scale Score to percentage)

Scale Score	Percentage	Scale Score	Percentage	Scale Score	Percentage	Scale Score	Percentage
36	50	46	60	56	70		86
37	51	47	61	57	71	65	87
38	52	48	62		72	66	88
39	53	49	63	58	73		89
40	54	50	64		74	67	90
41	55	51	65	59	75		91
42	56	52	66		76	68	92
43	57	53	67	60	77		93
44	58	54	68		78	69	94
45	59	55	69	61	79		95
					80	70	96
				62	81		97
					82	71	98
				63	83		99
					84	72	100
				64	85		

2022 - 2024 Marking Feedback Sheet – Reflective Piece

PGDip Psychological Therapies Practice (SMHP CBT)

To be used in conjunction with the generic Level 7 marking criteria

Required Documentation	**Present**
Supervisor Signed Cover Sheet	
Self-Rated CTS-R/CTS-Psy	
500-word Client Summary & Session Outline	
Diagrammatic Formulation	

For Summative Reflective Pieces, if any part of the required Accompanying Documentation is not submitted, the assessment will receive a Fail and a Resubmission including the missing document will be required

Trainee Number (for Summative Submissions) **Overall Grade: Satisfactory/ Unsatisfactory**

Trainee Name (for Formative Pieces) **Additional Feedback:**

Introduction of topic of reflection *(Links to Domain 1 on the Generic Level 7 Marking Grid: Knowledge & understanding of subject)*	Clear identification of required assignment focus, supported from the literature	**Satisfactory/ Unsatisfactory** **Strengths and Key Points (Evidence):** **Areas for Development and/or Requirements for Resubmission (Summative):** •

Concrete Experience ***(Links to Domain 1 on the Generic Level 7 Marking Grid: Knowledge & understanding of subject)***	Description of the relevant concrete experience of the identified focus	**Satisfactory/ Unsatisfactory** **Strengths and Key Points (Evidence):** **Areas for Development and/or Requirements for Resubmission (Summative):** •
Reflective Observation – Subjective Experience ***(Links to Domain 1 on the Generic Level 7 Marking Grid: Knowledge & understanding of subject and Domains 2 and 3: Cognitive/intellectual skills; Research skills & Use of research-informed literature)***	Observations of the subjective response to the identified focus Reflective Analysis of experience and observations to the identified focus extended by reference to the literature	**Satisfactory/ Unsatisfactory** **Strengths and Key Points (Evidence):** **Areas for Development and/or Requirements for Resubmission (Summative):** •

Abstract Conceptualisation (*Links to Domain 1 on the Generic Level 7 Marking Grid: Knowledge & understanding of subject and Domains 2 and 3: Cognitive/intellectual skills; Research skills & Use of research-informed literature)*	Clear conclusions drawn from the reflective analysis	**Satisfactory/ Unsatisfactory** **Strengths and Key Points (Evidence):** **Areas for Development and/or Requirements for Resubmission (Summative):** •
Planning for future practice *(Links to Domain 4 on the Generic Level 7 Marking Grid: Skills for life and professional employment)*	What is your developmental learning for future practice?	**Satisfactory/ Unsatisfactory** **Strengths and Key Points (Evidence):** **Areas for Development and/or Requirements for Resubmission (Summative):** •
Diagrammatic Formulation:		Is the formulation cohesive and person-centred? Have factors regarding culture and/or ethnicity been considered within the formulation? Is it theoretically adherent? Does it inform the work undertaken in the assessed session?

Self-evaluated CTS-R		Is it an accurate evaluation of skills?

Clinical Portfolio

The Clinical Portfolio is required to be kept up to date as the course progresses and be discussed with your Academic Personal Tutor (APT) at each Tutorial. More details will be given about the compiling of the Clinical Portfolio as the course progresses. Please direct any queries that are not addressed here to your Tutor.

Please title documents as below

Folder 1

☐ Clinical Portfolio Cover Sheet

☐ Teaching Hours Log

☐ Missed Learning Activities

☐ Confirmation of attendance and adequate participation in e-feedback

☐ University Supervision Report 1

☐ University Supervision Report 2

☐ University Supervision Report 3

☐ University Supervision Report 4

☐ Workplace Supervision Report 1

☐ Workplace Supervision Report 2

☐ Academic Essay Cover Sheet

☐ Academic Essay

☐ Academic Essay Marking Feedback

Folder 2 – Depression client 1

☐ Client 1 Summary Sheet

☐ Client 1 Diagrammatic formulation

☐ Client 1 Supervision Log

☐ Client 1 Client Consent to Record

☐ Client 1 CTS-R Cover Sheet

☐ Client 1 CTS-R Marksheet- *formally submitted CTS-R*

☐ Client 1 Reflective Piece

☐ Client 1 Reflective Piece Marking Feedback

☐ Client 1 Oral Cover Sheet

☐ Client 1 Oral presentation slides

☐ Client 1 Oral Marking Feedback

Folder 3 – Anxiety Client 2

☐ Client 2 Summary Sheet

☐ Client 2 Diagrammatic formulation

☐ Client 2 Supervision Log

☐ Client 2 Client Consent to Record

☐ Client 2 CTS-R Cover Sheet

☐ Client 2 CTS-R Marking Feedback

☐ Client 2 Reflective Piece

☐ Client 2 Reflective Piece Marking Feedback

☐ Client 2 Written Case Report Cover Sheet

☐ Client 2 Written Case Report

☐ Client 2 Written Case Report Marking Feedback Sheet

Folder 4 – Bipolar/PD client 3

☐ Client 3 summary sheet

☐ Client 3 Diagrammatic formulation

☐ Client 3 Supervision log

☐ Client 3 Client Consent to Record

☐ Client 3 CTS-R Cover Sheet

☐ Client 3 CTS-R Marking Feedback – *formally submitted CTS-R*

☐ Client 3 Reflective Piece

☐ Client 3 Reflective Piece Marksheet

☐ Client 3 Oral Cover Sheet

☐ Client 3 Oral presentation slides

☐ Client 3 Oral Marking Feedback

☐ Client 3 End of Therapy letter

☐ *or for PD* Client 3 Narrative formulation letter

Folder 5 – Psychosis/PD client 4

☐ Client 4 summary sheet

☐ Client 4 Diagrammatic formulation

☐ Client 4 Client 4 Supervision log

☐ Client 4 Client Consent to Record

☐ Client 4 CTS-R Cover Sheet

☐ Client 4 CTS-R Marking Feedback

☐ Client 4 Reflective Piece

☐ Client 4 Reflective Piece Marking Feedback

☐ Client 4 Extended Case Report Cover Sheet

☐ Client 4 Extended Case Report

☐ Client 4 Extended Case Report Marking Feedback

☐ Client 4 End of Therapy Letter

☐ *or for PD* Client 4 Narrative formulation letter

Folder 6 – Workplace completed clients

Client 5 – PTSD

☐ Client 5 Summary sheet

☐ Client 5 Diagrammatic formulation

☐ Client 5 Supervision log *signed by BABCP Accredited Workplace Clinical Supervisor*

Client 6 - SMHP

☐ Client 6 Summary sheet

☐ Client 6 Diagrammatic formulation

☐ Client 6 Supervision log *signed by BABCP Accredited Workplace Clinical Supervisor*

☐ Client 6 End of Therapy letter

☐ *Or for PD* Client 6 Narrative Formulation Letter

Client 7 - SMHP

☐ Client 7 Summary sheet

☐ Client 7 Diagrammatic formulation

☐ Client 7 Supervision log *signed by BABCP Accredited Workplace Clinical Supervisor*

☐ Client 7 End of Therapy letter

☐ *Or for PD* Client 7 Narrative Formulation Letter

Client 8 – Any – recommended SMHP

☐ Client 8 Summary sheet

☐ Client 8 Diagrammatic formulation

☐ Client 8 Supervision log *signed by BABCP Accredited Workplace Clinical Supervisor*

☐ Client 8 End of Therapy letter

☐ *Or for PD* Client 8 Narrative Formulation Letter

Folder 7 - Logs

☐ **Overall practice hours log** - *evidencing minimum 200 hours of supervised CBT practice. Your 8 completed clients should make up a significant proportion of this amount of practice hours as the CBTpd protocol is up to 30 sessions and CBTp protocol is 26 sessions.*

☐ **Uncompleted client log** – *signed by workplace supervisor evidencing your hours of CBT which did not lead to completed intervention or showing CBT still in progress signed by workplace supervisor or university supervisor if there was a uni client who disengaged prior to completion.*

Notes

The expectation is that your university clients are all completed and closely supervised. If due to extenuating circumstances i.e., bringing in a backup client it has not been possible to be closely supervised please highlight which 3 are the closely supervised cases on the client summary sheet.

The course cannot be successfully completed, or the award made, without submission of a completed portfolio.

The Clinical Portfolio will prepare you to submit for BABCP Individual Accreditation as a CBT therapist as well as evidencing that you have reached the required criteria for the award of PGDip

SMHP CBT.

Assessment Scheme (Postgraduate)

The following marking scheme and criteria are adopted as a framework. This underpins all Programme specific Marking Feedback Sheets on ELE:

Range	Award	Marking Criteria
70% - 100%	Distinction	Work of exceptional standard reflecting outstanding competence / knowledge of material and critical ability.
60 - 69%	Merit	Work with a well-defined focus, reflecting a good working competence / knowledge of material and good level of competence in its critical assessment.
50 - 59%	Pass	Work demonstrating adequate competence / working knowledge of material and evidence of some analysis.
0 - 49%	Fail	Lacking in basic competence / knowledge and critical ability.

To ensure consistency in the University, including in the preparation of transcripts, marking is numerical. Marks returned by the Board for both assessment components and the overall module mark should be integers.

The marking criteria used to assess Masters level academic work is detailed below. This should be used to give students some indication as to the grading criteria used when the academic components of the programme are assessed.

Generic Criteria for Assessment for Masters Programmes

Marks **Assessment categories**	**0-49** **(Fail)**	**50-59** **(Pass)**	**60-69** **(Merit)**	**70-85** **(Distinction)**	**86-100** **(Distinction)**
Knowledge & understanding of subject	~ demonstrates little knowledge or understanding of the field ~ demonstrates significant weaknesses in the knowledge base, and/or simply reproduces knowledge without evidence of understanding	~ demonstrates a sound knowledge and understanding of material within a specialised field of study ~ demonstrates an understanding of current theoretical and methodological approaches and how these affect the way the knowledge base is interpreted	~ produces work with a well-defined focus ~ demonstrates a systematic knowledge, understanding and critical awareness of current problems and/or new insights, much of which is at, or informed by, the forefront of the academic discipline, field of study or area of professional practice	~produces work of exceptional standard, reflecting outstanding knowledge and understanding of material ~ displays exceptional mastery of a complex and specialised area of knowledge and skills, with an exceptional critical awareness of current problems and/or new insights at the forefront of the field	~ This work meets and often exceeds the standard for distinction, as described in the 70-85 band, across *all* sub-categories of criteria: knowledge and understanding of subject; cognitive skills; research skills; use of research-informed literature; and skills for life and professional employment. ~ This work is of

Cognitive/ intellectual skills	~ very little or no critical ability ~ poor, inconsistent analysis	~ provides evidence of relevant and sound analysis within the specialised area, with some ability to evaluate critically ~ is able to analyse complex issues and make appropriate judgements	~ is able to evaluate methodologies critically and, where appropriate, to propose new hypotheses ~ is able to deal with complex issues both systematically and creatively, making sound judgements in the absence of complete data	~ shows outstanding ability to evaluate methodologies critically and, where appropriate, to propose new hypotheses ~ is able to deal with a range of complex issues both systematically and creatively, making excellent judgements in the absence of complete data	publishable quality, with only very minor amendments, and would be likely to receive that judgement if submitted to a peer-reviewed journal. ~ Work is of such a quality that the student is clearly highly capable of doctoral research in the discipline and, in principle, should be prioritised for a postgraduate research grant. ~ This work meets and often exceeds the standard for distinction, as described in the 70-85 band, across *all* sub-categories of criteria: knowledge and understanding of subject;
Research skills Use of research-informed literature	~ demonstrates little or no skill in selected techniques applicable to own research or advanced scholarship ~ lacks any understanding of how established techniques of research	~ demonstrates understanding of and skills in selected techniques applicable to own research or advanced scholarship ~ shows some originality in the application of	~ displays a comprehensive understanding of and skills in techniques applicable to own research or advanced scholarship ~ shows originality in	~ employs advanced skills to conduct research and, where appropriate, advanced technical or professional activity, accepting accountability for related decision making	

	and enquiry are used to create and interpret knowledge ~ failure to evidence or discuss/apply appropriate examples of literature relating to current research and advanced scholarship in the field ~ references to literature/ evidence and use of academic conventions are flawed, and/or inconsistent ~ argument absent, or lacking any clarity and/or logic	knowledge, and some understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the discipline ~ can evaluate critically examples of literature relating to current research and advanced scholarship in the field ~ makes consistently sound use of appropriate academic conventions and academic honesty ~ able to communicate argument, evidence and conclusions clearly to specialist and non-specialist audiences	the application of knowledge, together with a good understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the discipline ~ is able to evaluate critically a range of literature relating to current research and advanced scholarship in the discipline ~ makes consistently good use of appropriate academic conventions and academic honesty ~ able to communicate very effectively arguments, evidence	~ displays an exceptional grasp of techniques applicable to own research or advanced scholarship ~ shows originality in application of knowledge, and excellent understanding of how established techniques of enquiry create and interpret knowledge in the discipline ~ is able to evaluate critically, with exceptional insight, a range of literature relating to current research and advanced scholarship in the discipline ~ makes consistently excellent use of	cognitive skills; research skills; use of research-informed literature; and skills for life and professional employment. ~ This work is of publishable quality, with only very minor amendments, and would be likely to receive that judgement if submitted to a peer-reviewed journal. ~ Work is of such a quality that the student is clearly highly capable of doctoral research in the discipline and, in principle, should be prioritised for a postgraduate research grant.

			and conclusions to specialist and non-specialist audiences	appropriate academic conventions and academic honesty ~ able to communicate at a very high level arguments, evidence and conclusions to specialist and non-specialist audiences	
Skills for life and professional employment	~ significant weaknesses evident in key areas such as communication , problem-solving and project management ~ inability to adapt ~inability to work flexibly, independently and/or as part of a team	~ shows a consistently good level of employability skills, including team working, project management, IT/computer literacy, creativity and flexibility ~ demonstrates capabilities to support effective communication in a range of complex and specialised contexts ~ shows consistent ability in	~ shows a high level of employability skills, including team working, project management, IT/computer literacy, creativity and flexibility ~ demonstrates very effective communication in a range of complex and specialised contexts ~ demonstrates self-	~ shows a very high level of employability skills, including team working/leadership, project management, IT/computer literacy, creativity and flexibility ~ demonstrates very high level communication skills in a range of complex contexts, and ability to write at publishable	

		tackling and solving demanding problems ~ can plan and direct own learning ~ demonstrates ability to advance own knowledge and understanding, and to develop new skills ~ demonstrates the independent learning ability required for continuing professional development	direction and some originality in tackling and solving demanding problems ~ can act autonomously in planning and implementing tasks at a professional or equivalent level ~ demonstrates the skills and attitudes needed to advance own knowledge and understanding, and to develop new skills ~ demonstrates the independent learning ability required for continuing professional development	standard ~ demonstrates autonomy and notable originality in tackling and solving demanding problems ~ shows a high level of consistency and autonomy in planning and implementing tasks at a professional or equivalent level ~ demonstrates the skills and attitudes needed to advance own knowledge and understanding, and to develop new skills to a high level ~ demonstrates the independent learning ability required for continuing professional development	

Marks for M level	**0-39 (Fail)**	**50-59 (Pass)**	**60-69 (Merit)**	**70-85 (Distinction)**	**86-100 (Distinction)**

Notched Marking

The College of Life Sciences, including CEDAR, has adopted a Notched Marking Scheme for all assignments where there is no separate national criteria set. Within this Marking Scheme, only certain marks may be used within each grade. The marks available are described in the table below with the accompanying marking classification and description.

On the SMHP CBT Programme, notched marking is used for essays, oral presentations, and case reports, but is not used for the Live Competency Assessments (e.g. CTS-R/ CTSpsy) and a bespoke success criteria exists for these.

Notched Marking Scheme Grid

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
100, 95	First class	Distinction	**Outstanding** The work is unique, outstanding and original and attains the highest standards of scholarship expected for the discipline at the appropriate level without the need for revision. It would be difficult to recommend improvements in any way. The work goes far beyond that expected of a good output at the appropriate level, with the higher mark demonstrating even greater comprehension, insight and originality at this level. The work is of publishable quality and would be likely to receive that judgement if submitted to a peer-reviewed journal, or attains the professional standards expected for the discipline without need for revision. The lower mark effectively represents the need for very minor revision to achieve publishable standard.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
88, 85, 82	First class	Distinction	**Exceptional** The work is exceptional. It shows originality, a critical awareness of the principles and practices of the discipline, thorough comprehension of the assessment's requirements and the subject matter, exceptional ability, insightfulness, and fully realises learning outcomes for the assessment and develops them far beyond normal expectations. It shows excellent evidence of outside reading and synthesis of the primary literature. It would be difficult to recommend more than minor improvements. The work goes well beyond that expected of a good output at the appropriate level, with the higher mark demonstrating even greater comprehension, insight and originality at this level.
78	First class	Distinction	**Excellent** The work is excellent. It shows real insight and originality, is articulate with a clear logical structure, and demonstrates a comprehensive understanding and coverage of the subject, engagement with scholarship and research, very good analytical ability, and contains no major flaws. It shows very good evidence of outside reading. It would be possible to recommend some improvements. The work goes beyond that expected of a good output at the appropriate level.
75	First class	Distinction	**Excellent** The work is excellent but shows minor deficiencies in either comprehension, insight or originality.
72	First class	Distinction	**Excellent** The work is excellent but shows minor deficiencies in two or more aspects from among comprehension, insight and originality.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
68	Upper second class	Merit	**Very Good** The work is very good. It demonstrates a very good comprehension of all of the assessment's requirements and presents a good selection of relevant examples. It is sound and well thought out, and well expressed with a clear logical structure, demonstrating an organised knowledge of the subject, very good evidence of outside reading, and use of critical references. It realises the intended learning outcomes, and demonstrates very good analytical skills. The work is slightly above the standard expected from a good output at the appropriate level (see benchmark statement). The higher mark indicates that more critical evaluation of theory and empirical evidence has been demonstrated.
65	Upper second class	Merit	**Good** The work is good. It demonstrates a good comprehension of all of the assessment's important requirements and presents a good selection of relevant examples. It demonstrates a secure knowledge of the subject, with some evidence of outside reading, and appropriate use of references. It broadly realises the intended learning outcomes, and demonstrates good analytical skills. The work is at the standard expected from a good output at the appropriate level (see benchmark statement). The work may show some limitations in writing style or presentation.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
62	Upper second class	Merit	**Fairly Good** The work is fairly good. It demonstrates a fairly good comprehension of the assessment's important requirements and presents a selection of relevant examples. It shows some knowledge of the subject, is generally sound but is in parts unclear or lacking structure, with limited evidence of outside reading. It generally realises the intended learning outcomes, and demonstrates satisfactory analytical skills. The work is slightly below the standard expected from a good output at the appropriate level (see benchmark statement). The work tends to be more descriptive, lacks depth, contains some flaws or errors or demonstrates limitations in writing style or presentation.
58	Lower second class	Pass	**Competent** The work is competent. It demonstrates comprehension of some of the assessment's important requirements and presents a selection of relevant examples. The work is descriptive, showing an adequate or routine knowledge of the subject, with some limitations in understanding or writing style. It lacks a clear structure or shows weaknesses in presentation, analysis or interpretation of results. The work is below the standard expected from a good output at the appropriate level. It makes a reasonable attempt to realise the intended learning outcomes.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
55	Lower second class	Pass	**Fairly Competent** The work is fairly competent. It demonstrates comprehension of some of the assessment's requirements and presents an adequate selection of relevant examples. It makes a reasonable attempt at achieving learning outcomes but does not cover all the necessary material and lacks depth. The work is largely descriptive, confused in places with limitations in understanding or writing style. The work is below the standard expected from a good output at the appropriate level. It lacks a clear structure with incorrect or poor interpretation or analysis of data.
52	Lower second class	Pass	**Adequate** The work is adequate. It demonstrates some comprehension of the assessment's requirements and presents some relevant examples. It makes a reasonable attempt at achieving learning outcomes but does not cover all the necessary material and lacks depth. The work is clearly below the standard expected from a good output at the appropriate level. The work is descriptive, contains inaccuracies and false statements, is poorly organised and/or is illogical.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
48	Third class	Fail	**Weak** The work is weak. It demonstrates some comprehension of some of the assessment's requirements and presents few relevant examples. It shows some evidence that the learning outcomes have been achieved, but is muddled, poorly argued, and lacks focus and depth of understanding. Some critical elements are missing, there are errors, and the work reveals some deficiencies in presentation, analysis or interpretation. Marks at the upper end indicate a fair attempt at answering the question. The work is well below the standard expected from a good output at the appropriate level.
45	Third class	Fail	**Very Weak** The work is very weak. The work contains deficiencies as described above, but also contains significant errors, or significant deficiencies.
42	Third class	Fail	**Extremely Weak** The work is extremely weak. The work contains deficiencies as described above, but also contains significant errors and serious deficiencies.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
38, 35, 32	Fail	Fail	**Fail** The work is poor. There is little or no evidence of the subject that is relevant to the assessment. There is little or no evidence that the learning outcomes of the assessment have been achieved. The work is marred, although at the upper end of the mark range there may be brief signs of comprehension. The work shows basic misunderstandings or misinterpretations, and demonstrates little ability to meet the requirements of the assessment. The work is significantly below the standard expected from a good output at the appropriate level. Work at the lower end is incomplete, irrelevant and does not meet the requirements of the assessment. Or The work demonstrates evidence of fairly detailed, module-derived knowledge, but the work is based on an identifiable misinterpretation of the assessment's requirements. Marks at the lower end of this scale are for work whose poor attributes are significant and/or serious.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
25	Fail	Fail	**Very Poor Fail** The work is very poor. The intended learning outcomes for the assessment have not been realised. The work is irrelevant, confused, and incomplete. The work demonstrates an unacceptable and minimal understanding at the appropriate level of the requirements of the assessment. The work is significantly below the standard expected from a good output at the appropriate level. The work shows some knowledge and understanding at the appropriate level of material relevant to the general area of the topic, but not directly relevant to the specific question or assignment. Or The work demonstrates evidence of fairly detailed, module-derived knowledge, but the work is based on a major, identifiable misinterpretation of the assessment's requirements.
15	Fail	Fail	**Extremely Poor Fail** The work is extremely poor. The intended learning outcomes for the assessment have not been realised. The work is irrelevant, confused, and incomplete. The work demonstrates an unacceptable and minimal understanding at the appropriate level of the requirements of the assessment. The work is significantly below the standard expected from a good output at the appropriate level. The work shows some knowledge and understanding at the appropriate level of material relevant to the general area of the topic, but not directly relevant to the specific assessment.

Mark (%)	Corresponding UG classification	Corresponding PGT classification	Description
5	Fail	Fail	**Incompetent fail** There is virtually no evidence that the assessment's requirements have been understood. Relevant content is virtually absent.
0	Fail	Fail	**Complete fail** There is a total misunderstanding of the requirements of the assessment with no relevant content whatsoever, even to the general area of the topic, or a non-submission or blank script with no evidence of mitigating circumstances.