PGCERT/GRADCERT PSYCHOLOGICAL THERAPIES (LOW INTENSITY COGNITIVE BEHAVIOURAL THERAPIES)

Trainee Handbook Cohort 32

September 2022

ELE Cohort 32 homepage: Click here

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CEDAR
Clinical Education Development and Research

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How to use this handbook

Ensure you have used the course 'Quick Start and How-to Guide' to get up and running for Induction Day. This handbook then provides all the detail you need to know about the course, teaching, assessments, submission and relevant policies.

This handbook is split into two parts:

1. **Part 1**: Short, quick-access and concise guidance – find the things you need to know quickly and 'at a glance' (pages 1-33).
2. **Part 2**: Appendices giving full details, policies, marking schemes etc. (pages 34 onwards)

Supervisor notes

Part 1 outlines the content and assessments of each of the three modules. At the end of each section there are notes for supervisors with guidance on how they can support their trainee(s) not only do well on the course, but to become confident, practised, reflective, evidence-based practitioners. Every supervisor should also have a copy of the 'Supervisor Handbook' which contains the same notes.

Protection of dignity at work and study

The University of Exeter aims to create a working and learning environment that respects the dignity and rights of all staff and students and where individuals have the opportunity to realise their full potential.

We aim to create an environment and culture in which bullying and harassment are known to be unacceptable and where individuals have the confidence to deal with harassment without fear of ridicule or reprisal.

The University will not tolerate any form of harassment or bullying and is committed to ensuring that staff and students are able to work and study without fear of victimisation.

The University regards any incident of harassment or bullying as a serious matter and will respond promptly and sensitively to formal complaints, and where appropriate take disciplinary action. Additionally, staff and students will be encouraged to resolve concerns informally through a network of trained Dignity and Respect Advisors.

For more information please see: http://www.exeter.ac.uk/staff/equality/dignity/policy/ .

Part 1 - Quick Reference Guide

Course contacts

Please contact the programme team at any time with queries by phone or email.

- **Personal tutors** will have up-to-date knowledge of progress and any taught components, please contact the teaching team on **LI_tutor-support@exeter.ac.uk**.
- **The programme administrator** will be able to answer information about course procedures and protocols, e.g. attendance, submission, mitigations etc.

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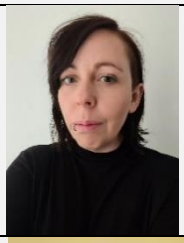
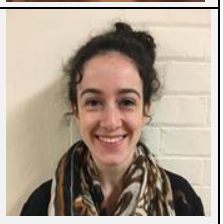
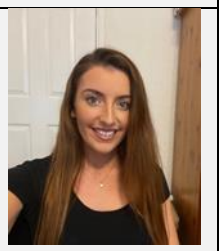
Dona-Marie Anderson Lecturer *D.Anderson4@exeter.ac.uk*		**Siobhan Gilliam** Lecturer S.Gilliam@exeter.ac.uk	
Sarah McGahey Lecturer *S.McGahey@exeter.ac.uk*		**Senga Clarke-Côté** Lecturer *S.Clarke-Cote@exeter.ac.uk*	
Urte Gustainyte Lecturer *U.Gustainyte@exeter.ac.uk*		**Megan Whitworth** Associate Lecturer *M.Whitworth@exeter.ac.uk*	
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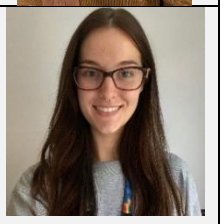
Rose Wysocka Associate Lecturer RA396@exeter.ac.uk		**Grace Riley** Associate Lecturer GR383@exeter.ac.uk	
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Communication

For day-to-day communication, including results notifications, we use trainees' University of Exeter email addresses, so **it is essential that trainees check this address regularly or set up forwarding** to their main email address.

Trainees: please ensure you use your University email to contact tutors and programme team members, rather than your service or personal accounts.

Course overview

The course follows the National Curriculum for the Education of Psychological Wellbeing Practitioners (updated March 2015) see: https://www.uea.ac.uk/documents/246046/11991919/PWP+Curriculum+3rd+Edition+2015.pdf/a300b754-7f0e-4241-8130-7d729b2d8b13) and is accredited by the British Psychological Society.

All accredited PWP training courses, including that of the University of Exeter, follow this national curriculum because it is founded on evidence-based approaches. Service practises may differ but this national curriculum and the assessment and treatment protocols taught are based on the evidence about what constitutes effective, safe, patient-centred assessment and treatment as part of the IAPT service model and in line with NICE guidelines.

The programme's aim is to develop the core knowledge and competencies required for PWPs to safely, effectively, ethically and inclusively work within a stepped care IAPT service using evidence-based practices, and to continue developing as safe, effective, evidence-based practitioners throughout their careers.

To achieve this, trainees must also be shadowing, observing, practising and working under competent supervision by a fully trained practitioner within a fully functioning IAPT service.

Key facts about the course

- **Trainees can take the course at degree level (GradCert) or postgraduate level (PGCert).** Teaching, assessments and the pass mark for clinical assessments are the same, however at GradCert the pass mark for academic assignments is 40% and at PGCert the pass mark is 50%.
- **Trainees must also be shadowing, observing, undertaking in-service clinical skills development and working under competent supervision by a fully trained practitioner** within a fully functioning IAPT service.
- **The course consists of an Induction Day and 3 modules across 25 taught days** (teaching theory and clinical skills) **and 20 University directed study days** (directed study, role-play, Self Practice/Self Reflection, problem-based learning etc.). **Each module has 3 assessments**: one clinical, one academic and one service-based. NB all trainees will need to make time for additional private study, for example for assessment preparation, exam revision, further reading etc.
- **Teaching locations and times:** Locations for each taught session are detailed on the Timetable (Appendix 1). **At the time of writing, all sessions and assessments are being delivered remotely**. Remote sessions run from **9am – 5pm**, with half an hour to prepare from 9am, and then the training programme starting at 9.30am and finishing at 5pm. There is a minimum of 45 minutes allocated for a lunch break, plus two 15-minute breaks throughout the day.
- As a student of the university, **you have full access to all of the university's support services** (see Appendix 6) **and all campus services and resources** (See Appendix 8).
- **ELE:** All timetables, day schedules, course materials and resources are on the course intranet ELE (Exeter Learning Environment) https://vle.exeter.ac.uk/ . Each trainee has a unique log in to this protected area.

- **Attendance & absence:** Attendance is expected to be 100% in line with national IAPT requirements. All training activity is monitored and logged and regular reports are made to the trainee's service and to the course commissioners. Any absences are noted to the trainee's service. For the sake of clarity, this means that all scheduled activities should be undertaken at the times specified in the day schedule, and all UDD tasks completed prior to the next taught day. **If any trainee cannot attend or undertake the activities at these times, they MUST send an email to the teaching team on LI_tutor-support@exeter.ac.uk .** In some cases, a 'catch up' option may be agreed, but if this is not possible then an absence will be noted, and the trainee's service will be notified. **If a trainee's attendance drops below 80%,** for example through illness or adverse circumstances, **the trainee may not be able to continue training, may not be awarded their qualification or may be required to undertake incomplete modules again.** If illness or unexpected circumstances affect a trainee's ability to engage with the course at the present time, the option of interrupting studies (suspending studies and then resuming at a later date – see Appendix 5) may be available.

- **Timekeeping and attention:** Timekeeping and attention on the programme are expected to be as rigorous as at the workplace. Timekeeping is monitored and any recurrent lapses are notified to the trainee's supervisor. Similarly, trainees' full attention and engagement in the teaching and associated activities is expected, just as in the workplace. Any recurrent lack of engagement will be notified to the service supervisor and may result in ceasing the programme place.

- **Support, study support, accessibility, and wellbeing:** All trainees are allocated a personal academic tutor to provide support for personal or service issues that arise and impact a trainee's ability to attend or engage, and as main point of contact for their service supervisor. In addition, all trainees can access the University's study skills support, AccessAbility team, IT support, Wellbeing services and English Language Skills Development - see Appendix 6 for full details. **Trainees who may need an Individual Learning Plan (ILP) to support their learning due to physical or learning needs or other additional needs are advised to contact the AccessAbility team as soon as possible**, preferably prior to starting the course, as there are many adjustments (including extensions to deadlines and extended examination times) that the teaching team can make, but only where there is a documented ILP in place advising such. Also, trainees whose first language is not English, looking to develop their academic English and literacy skills for academic study, and to build communicative and intercultural competence for life in the UK, are eligible for English Skills Development Course offered by University of Exeter.

- **Liaison with managers/supervisors/clinical leads:** Academic tutors discuss marks, performance and any difficulties with service supervisors/clinical leads. At the end of Modules 1 and 2 feedback calls to service supervisors are offered to discuss their trainee's course performance to date, give details of upcoming modules/assessments and to offer clarification on any aspect of the course as needed. Service supervisors may contact a trainee's personal tutor or any member of the programme team at any time to discuss course requirements or trainees' needs.

- **Professional practice:** All trainees must always seek to act within the Codes of Practice and Professional Conduct as defined by their service and a professional and/or accreditation body. As such trainees are encouraged to join an appropriate professional body, such as the British Association of Behavioural and Cognitive Psychotherapies or British Psychological Society.

- **Confidentiality:** Trainees must ensure that at all times, when discussing or describing their work and their personal response to their work, that they protect patient, colleague and family and friends' confidentiality by not revealing information that could identify an individual in **any way**.

The only exception is if they have concerns relating to the safety of a cohort peer or risk of harm to others. In such exceptions, they should discuss with the teaching team to whom information should be disclosed and to what extent. For full guidelines see Appendix 7.

Course content, assessments and passing or failing the course

- **There are 3 modules**
    - **Module 1 - Engagement and assessment of patients with common mental health problems**
    - **Module 2 - Evidence-based Low Intensity treatment for common mental health disorders**
    - **Module 3 - Values, diversity and context**
- **Each module has three assessments**:
    - **1 clinical competency assessment** (assessing the trainees' clinical procedural skills)
    - **1 academic assessment** (testing understanding of the theory and evidence behind LI working)
    - **1 service assessment** (a Clinical Outcomes Document documenting evidence to their service supervisor that they can perform the required competencies in their day-to-day work, signed off as pass or fail by their service supervisor)
- **Trainees must also complete 80 hours of clinical practice** with patients, **20 hours of case management supervision** and **20 hours of clinical skills supervision** to complete the course. By the end of the course, they must also have competently worked with patients using all four of the main treatment interventions: Behavioural Activation, Worry Management, Exposure & Habituation, and Cognitive Restructuring.
- **To pass the course, trainees must pass all the assessments and have a minimum of 80% attendance**. Clinical assessments must be passed with a mark of at least 50% overall and with at least 50% in each of the compulsory pass sections, including risk assessment which is an auto-fail section. Academic assignments must be passed with a mark of at least 50% for the PGCert award and at least 40% for the GradCert award. Clinical Outcomes Documents for each module must be signed off as competent by in-service supervisors (Pass or Fail).
- **Two attempts for each assessment are allowed**. Second attempts are capped at the pass mark. The overall mark for the module is also capped at the bare pass mark. Failure of a second attempt results in failure of the programme and termination from the course. (See Appendix 2 and Appendix 3)
- **Failing the course:** Failure of a second attempt at an assessment (less than 50% for clinical assessments or less than 40% for an academic assessment) results in termination from the programme. Under such circumstances training cannot be completed and no academic credit is awarded for any modules with individual assessments failed. (See Appendix 2 and Appendix 3)
- **Assessment submissions and late or non-submissions:** (See Appendix 3). All work must be submitted on time through the procedures specified and according to the Cohort timetable. Late submissions of first attempts within an hour of the deadline will be docked 5 marks. Late submissions within 24 hours of the deadline are capped at the pass mark; submissions beyond 24 hours are considered non-submissions and therefore score 0, capping the whole module at the pass mark. For second attempts and first attempts with a 3-week mitigation there is no late period; submitting beyond the assessment deadline will result in a fail mark being recorded (and also results in a failure of the course). Extensions cannot be granted except by Mitigation. **Any**

trainee experiencing difficulties with submitting work on time should speak to their personal tutor as soon as possible.

- **Adverse circumstances, Mitigation and Interruption:** If a trainee is unable to submit an assignment of appropriate quality within the deadline due to short term circumstances beyond their control (e.g. short term illness, difficulties with caseloads etc.) they may request Mitigation by submitting a mitigation request via the form on ELE. The Mitigation Committee reviews the request and decides whether to grant mitigation, such as an extension. If a trainee experiences longer term circumstances that impact severely on their ability to engage with the programme, it may be possible to Interrupt, i.e. to pause studies and resume them again at a later date. See Appendix 5 for full details. **In all cases trainees and/or supervisors are advised to speak to their course tutor if experiencing difficulties.**
- **Marking turnaround and results:** The turnaround time for marking of academic work is 3 weeks, and 5 weeks for clinical assessments. Results are sent out via email to the trainee's University email account and copied to designated service supervisors.

The role of the clinical supervisor

The role of the trainee's clinical supervisor is paramount as trainees cannot pass the course without shadowing, observing, practising and working under competent supervision by a fully trained practitioner within a fully functioning IAPT service.

A clinical supervisor provides general support but also monitors, develops and assesses the trainee's clinical skills through a variety of methods. These could include role-play; questioning and answering; direct observation/shadowing of a trainee's assessment and treatment sessions; reviewing taped sessions; reviewing a trainee's patient contact and assessment submissions against the marking schemes; supervising case management supervision; facilitating clinical skills supervision; reviewing trainee reflections and case studies and so on.

Be aware that when a clinical supervisor signs off a trainee as competent, they are accepting clinical responsibility for that trainee's competency.

Specific roles of the clinical supervisor

The below list is not exhaustive, but identifies the key roles and actions of the clinical supervisor:

1. **Be familiar with the course structure, timetable, key clinical competencies, assessment dates and marking schemes** and liaise with programme materials and academic staff as much as necessary to fill any gaps in current knowledge.
2. **Negotiate, sign and date a supervision contract** clarifying boundaries and responsibilities of the supervisor and supervisee.
3. **Facilitate ongoing opportunities and experience for the trainee to develop appropriate competence in clinical skills** across face-to-face (where possible), telephone, group and cCBT modes of delivery (this includes not just LI specific assessment and treatment skills but also common factor skills, clinical note taking and record keeping, effective signposting, collaborative care, seeking ad hoc supervision etc.). Opportunities may be through role-play or actual patient contact with Step 2-appropriate patients, as appropriate to trainees' developing skills.
4. **Monitor and adjust trainee's caseloads** to ensure clinical safety and efficacy. This could include pacing or reducing a trainee's caseload so it does not build too rapidly, reallocating away patients with presentations beyond the trainee's current competency, and reallocating to the trainee Step 2 suitable patients from other PWP's caseloads or waiting lists so that trainees can develop skills with appropriate patients and meet clinical assessment requirements.
5. **Carry out observation of a trainee's work and competence directly and indirectly** - initially through role-play and then through direct shadowing of assessments and treatments, reviewing tapes of sessions, reading and reviewing case notes, trainee referrals etc.
6. **Facilitate, monitor and develop trainee skills in case management supervision and clinical skills supervision** in line with IAPT and PWP national curriculum guidelines.
7. **Practice-mark assessment and treatment sessions against the marking schemes**, to identify strengths, weaknesses and the key areas of development needed to meet the required competencies, initially through role-play then through live or recorded sessions.

8. **Review and practice-mark treatment formative and summative tapes prior to submission**, identify any shortfalls in development, set objectives for meeting these with the trainee and liaise with academic staff where needed/difficulties are envisaged. Sign (or remote equivalent) cover sheets for live recordings to attest as true recordings of actual patient sessions with patients on the trainee's caseload that have been reviewed in case management supervision.

9. **Ensure the trainee has opportunity to meet their clinical competencies for each module within the time period of that module**, including the Clinical Outcomes Document which requires allocated supervisor time for review and sign-off prior to the deadline.

10. **Where necessary, raise issues around a trainee's progress** with appropriate members of staff, both within the service and the University.

11. **Make a final decision on whether a trainee has achieved the clinical practice outcomes for each module** and document this in the Clinical Outcomes Document within the allocated time periods by signing off as Successful or Unsuccessful.

12. **Monitor trainee's accumulation of clinical contact hours and supervision hours** (both clinical skills and case management), ensure records are kept and sign off these as true and accurate.

13. **Monitor trainee's accumulation of patient contact and sign off at the end of the course** to state that the trainee has achieved the following (or requested an extension if not met):

    a. a minimum of **80 clinical contact** hours (40 hours of assessments and 40 hours of treatment sessions, with no more than 10 treatment hours from groups and/or cCBT and the rest from face-to-face and/or telephone)

    b. a minimum of **20 hours of clinical skills supervision**

    c. a minimum of **20 hours of case management supervision**

14. **Monitor through supervision the trainee's delivery of a complete treatment protocol** with at least one patient for each of the following interventions**:**

    i. **Behavioural Activation**

    ii. **Worry Management** (including Worry Time with or without Problem Solving)

    iii. **Exposure and Habituation**

    iv. **Cognitive Restructuring** (with or without Behavioural Experiments)

Module 1: Engagement and assessment of patients with common mental health problems

Module 1 Learning objectives and key topics covered

This module covers the knowledge and competencies to:

- **engage and assess patients with common mental health** problems using a range of assessment types
- **collaborate with patients to identify an appropriate, evidence-based treatment pathway**

Key topics covered

1. **Introduction to IAPT and stepped care** treatment
2. **Understanding key concepts and models** of mental health and mental illness and **diagnostic category systems** (such as DSM-V and ICD-11)
3. **Understanding CBT models**
4. **Models of understanding and diagnostic symptom patterns** around the following common mental health conditions:

    - **Depression**
    - **GAD**
    - **Panic Disorder**
    - **Agoraphobia**
    - **Specific Phobias**
    - **OCD** *(not treated at Step 2, except with additional, specific training)*
    - **Health anxiety** *(not treated at Step 2)*
    - **Social Anxiety** *(not treated at Step 2)*
    - **PTSD** *(not treated at Step 2)*

    (NB: we also ask trainees to familiarise themselves with diagnostic symptom patterns of Bipolar Disorder in order to be able to recognise this within assessments.
    We do NOT, through the teaching days or study days, ask them to familiarise themselves with other conditions that they may encounter and need to recognise within Step 2 assessments such as psychosis, eating disorders, Chronic Fatigue, MUS, personality disorders etc. This is something services may wish to cover within service training to support their PWPs).

5. **How to conduct a patient centred, collaborative PWP assessment** (using CBT-specific and common factors) consisting of:

    - **Introduction**
    - **Problem-based assessment:** presentation, triggers, ABC(E) symptoms, impact etc.
        - **ROMS**: PHQ-9 and GAD-7 routinely, disorder specific measures where needed
        - **IAPT Risk Assessment**
        - **General information gathering** including maintenance factors (e.g. drugs, alcohol, medication, caffeine, previous episodes, onset, current and past treatments, goals, etc.)

- **Information giving** (if Step 2/3 appropriate): probable diagnosis based on recognition of gathered symptom patterns; CBT cycle including maintenance; CBT treatment rationale, Guided Self Help introduction (if Step 2 appropriate)
- **Shared decision making** (if Step 2/3 appropriate): COM-B analysis; treatment pathway; intervention planning including mode of treatment and initial home practice (if Step 2 appropriate)
- **Ending**: problem statement, next contact etc.

6. **Common factor skills** (empathy, non-judgment, funnelling, collaboration, reflection, summarising, timing)
7. **Disorder specific measures**
8. **Medication support**
9. **Clinical decision making** for appropriate disorders for Step 2 and Step 3, see Table 1
10. **Accurate recording** of assessments and questionnaires using paper and electronic systems

Table 1

Disorder	**Step 2 Intervention Taught** (for Mild to Moderate Presentations)
Depression	Behavioural Activation (with or without physical activity) or, as an alternative CR (with or without Behavioural Experiments), or Problem Solving
GAD	Worry Management including Worry Postponement and Problem Solving
Panic Disorder	Cognitive Restructuring (with or without Behavioural Experiments)
Agoraphobia and Specific Phobias	Exposure & Habituation
OCD	(Not taught on this course, ERP can be used at Step 2 for mild presentations but only with specific additional training)
PTSD	No current Step 2 intervention, step up
Social Phobia	No current Step 2 intervention, step up
Health Anxiety	No current Step 2 intervention, step up

Module 1 Assessments

Module 1 Clinical assessment

- **Role-play with an actor simulating a 45-minute Step 2 PWP assessment** according to National Curriculum Guidelines.
- **Submission** - live role-play on the day of assessment via video call. Role-plays are videoed for marking and moderation purposes.
- **Marked** using the Competency Assessment Marking Scheme (see Appendix 3)
- **To pass a trainee must gain: 50% overall, with a minimum of 50% in sections 2, 3, 4, and 6 and minimum 50% in the risk assessment section.**
- **Failure in this assessment will result in a maximum fail mark of 49.**
- Please note the following:
    - **The Risk Assessment is an auto-fail section**, i.e. failing the risk assessment means failing the whole assessment.
    - **Overall section mark is NOT an average of each item in the section**, but rather an indication of the overall level of competency demonstrated in that section. It is possible to score well on most items in a section but still fail the section if the trainee has missed something significant or failed to meet a very important competency, for example failing to ask about problem-specific symptoms such as physical symptoms, behaviours or thoughts in section 2; failing to make an adequate probable diagnosis in section 3; failing to explain a probable diagnosis and/or CBT model sufficiently clearly to a patient in section 4; failing to demonstrate sufficient common factor skills as marked in section 6. (These are examples only, and not exhaustive).
- **Results are given 5 weeks from date of assessment,** via email to the trainee (using their University email address) and service supervisor
- **In the event of failure,** trainees will receive detailed feedback and be invited to attend a Skills Top-Up Day.
- **Reassessment:** 4 weeks from the Skills Top-Up Day. Marks for reassessments are capped at 50%, and the overall module mark is also capped at the bare pass mark.

Module 1 Academic assessment

- **1500-word essay** demonstrating the ability to critically evaluate aspects of the Module 1 learning objectives with reference to the evidence base.
- **Submission** via Ebart portal (link on ELE) by no later than 11 am on the date of assessment and accompanied by associated cover sheet (available on ELE). Please note that the essay and the coversheet are submitted separately.
- **Marked using University-wide marking criteria** for Level 6 (GradCert) and Level 7 (PGCert) assessments using the College of Life and Environmental Science (CLES) notched marking scheme (See Appendix 3), focusing particularly on the following:

- **Structure and organisation:** Looking for clear writing, with a good structure including an effective introduction, main body and conclusion. Points made should be well referenced and clearly link together into easy to follow arguments that stay closely focussed on answering the question.
- **Knowledge and understanding and theory into practice:** Looking for clear familiarity with and understanding of the key topics and issues covered to date, the evidence base/literature and how this translates into real-world practice.
- **Critical evaluation:** Looking for the ability to effectively identify and evaluate the evidence base and literature around the key topics, including evidence for and against a particular viewpoint and the ability to evaluate the relevance and reliability of source materials.
- **Use of source material:** Looking for evidence of familiarity with the course reading materials and beyond, and the ability to use APA referencing appropriately.

- **To pass** a trainee must gain **50% or more for the PGCert qualification**, and **40% or more for the GradCert certification.**
- **Results are given 3 weeks after the date of assessment,** via email to the trainee (using their University email address) and service supervisor
- **In the event of failure,** trainees should contact the teaching team to receive detailed feedback.
- **Reassessment:** 4 weeks from the date initial results were provided. Second attempts are capped at the pass mark. The overall mark for the module is also capped at the bare pass mark.

Module 1 Clinical Outcomes Document

- **This document (see ELE) provides a portfolio of a trainee's work-based evidence showing the following. It requires 'signing off' by the appropriate supervisor(s) – where hand signatures are not possible due to remote working see 'Submission' below for remote signing instructions.**
    - **Demonstrates competency in undertaking and recording a range of assessment formats.** This should include both triage within an IAPT service and problem focused assessments.
    - **Demonstrates experience and competence in the assessment of presenting problems across a range of problem descriptor** including depression and two or more anxiety disorders.
    - **Demonstrates the common factor competencies necessary to engage patients** across the range of assessment formats**.**
- **Evidence** can be: direct observation by the clinical supervisor; via discussion and questioning by the clinical supervisor; testimony from other colleagues; written case records; audio/video recordings of patient sessions; reflective accounts of how the trainee has achieved the outcome(s) drawing upon the research evidence base; feedback volunteered by patients etc.
- **Cumulative hours log –** trainees should enter the total cumulative hours **to date** of patient contact (assessments), case management supervision and clinical skills supervision. They should ensure these tally with the individual logs described below and are signed off by the supervisor as a true record.

- **Log of clinical contact hours with patients** - by the end of the course this should show a minimum of 80 patient contact hours in total with a minimum of 40 assessment hours and 40 treatment session hours. For Module 1, trainees should record assessments only and record each day's patient contact to date (in minutes), signed off by both trainee and clinical supervisor as a true record. Contact hours can be telephone/videocall or face-to-face assessments.
- **Log of case management supervision hours** - a minimum of 20 hours of formal case management supervision is required by the end of the course. Trainees should record and sign off each supervision session to date (in minutes), then the supervisor countersigns as a true record.
- **Log of clinical skills supervision hours to date** - a minimum of 20 hours of formal clinical skills supervision is required by the end of the course. Only formal clinical skills sessions can be recorded: they must be pre-arranged 1-1 or small group sessions focussed on case review and/or clinical skills development AND led by a qualified practitioner. Record each session (in minutes), each signed off by the trainee and countersigned by clinical supervisor as a true record.
- **Multiple supervisors** – if multiple supervisors are signing the outcome document, each of their names, signatures (if applicable) and contact details must be on page 1 of the document.
- **Submission** - via Ebart portal (link on ELE) by no later than 11 am on the deadline date. Trainees must print the document, hand sign it themselves and have it reviewed and countersigned by their service supervisor **on each of the required pages and alongside each of the recorded hours**, then scan the signed document and submit as a pdf. **Where printing and/or hand signing is not possible use the remote sign off procedure as follows:**

    1. Trainee signatures – name can be typed
    2. Supervisor signatures – name can be typed
    3. The document can then be uploaded to ELE as usual
    4. **In addition, the supervisor should email LI-IAPT@exeter.ac.uk with the completed document attached and the appropriate statement included in the body of the email:**

        a. **If all competencies are met** include in the email body "I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email".

        b. **If a trainee has failed one or more competencies** include in the email body "I can confirm I am signing off all elements of the module outcome document for [trainee name], as attached to this email, except for the signatures on pages [pages relating to competencies where supervisor is not yet happy to sign trainee off]"

    If more than one supervisor has signed the document, only one supervisor should email but they should state they are signing on behalf of the other named supervisor(s) who have signed off the document.

- **To pass,** the trainee's service supervisor must review the document and evidence within and sign off all elements (including the logs and the Final Statement of Achievement) by hand signing or using the remote signing procedure described above. All elements must also be signed off by the trainee. The document must then be submitted as above.

- **To fail,** the service supervisor is making themselves accountable for the competency of the trainee, therefore the supervisor should NOT sign the trainee as competent on an outcome if they feel the trainee has not demonstrated the required competency. Instead, following discussion with the service clinical lead, the academic tutor and the trainee, supervisors should leave unsigned any outcomes not yet fully met, sign off the trainee as 'Unsuccessful' in the Final Statement of Achievement and include a short report detailing why the trainee has not yet met the competencies and the proposed actions to be taken by the trainee to remedy the situation. Then submit as above.
- **Errors** - any minor errors noted after submission by programme staff will be reported to the trainee with a 2 week turnaround to correct. Any major errors will be reported to the trainee with a 6 week turnaround to correct. Correcting the errors within the allocated timeframe leads to no penalties. Failing to resubmit a corrected and appropriately signed off document within this correction period counts as a fail.
- **In the event of failure,** the trainee's academic tutor will meet with the supervisor and trainee to agree and record an action plan designed to achieve the failed competency, and agree a resubmission date. The overall module mark will be capped at the bare pass mark.
- **Reassessment:** 4 weeks from the feedback being given (or as agreed in discussions).

Supervisor helpful notes

1. **Developing, monitoring and managing trainee caseloads**
   Each service has its own policy around when trainees may start assessing patients and how many assessments they may conduct each week. Although trainees acquire theoretical and procedural skills through their University training and role-play practice, the majority of trainees find translating this into effective, real-world clinical practice difficult. To ensure patient safety, adequate clinical standards and staff wellbeing, trainees would benefit from building their assessment caseloads very gradually whilst receiving routine support, observation and immediate supervision for each session until their skills have fully 'bedded down', which may take some weeks. Many trainees find developing their IAPT assessment skills, supervision skills and clinical note taking skills – alongside their University training and assignments - extremely stressful and may need close monitoring and assistance.

2. **Additional role-play**
   Trainees are given role-play opportunities within University taught and study days, but without further role-play opportunities within service will find it difficult to achieve competency. Trainees would benefit from a wide range of role-play partners, including appropriately trained and qualified staff (e.g. recently qualified PWPs, Senior PWPs etc.). Familiarity with the course requirements, particularly the marking scheme, is highly beneficial for this to be effective. Role-plays can be full or partial, focussing on particular components or skills such as information gathering, risk assessment, information giving, common factors etc.

3. **Marking scheme**
   The University marking scheme for PWP assessments (Appendix 3) is designed to assess the degree of competency in the key skills needed to engage patients, build the therapeutic relationship and to both get and give the most accurate information with the least room for error. If supervisors would like an update on the marking scheme in order to have a full understanding of what each item is looking for, please contact the trainee's academic tutor. Note that Risk is an auto-fail section, but this is not the only way a trainee may fail. Trainees must gain 50% overall, but they must also be marked as at least competent in Section 2 (information gathering, ROMS, risk), Section 3 (information giving around probable diagnosis, CBT cycle and treatment), Section 4 (shared decision making regarding treatment pathway, mode and intervention planning) and Section 6 (common factors). Failing to do something essential in a compulsory section could result in a fail, as could running out of time.

4. **Questioning skills (Funnelling)**
   Inability to elicit full, relevant symptoms and impacts is a common reason for trainees to fail their competency assessments. For PWPs to be effective diagnosticians and practitioners, excellent questioning skills are needed so that they are able to quickly, succinctly and fully identify diagnostic symptoms and for differential diagnosis. Trainees need to learn how to start with open questions - in order not to bias or limit what is discussed - and then, once a symptom is indicated, how to move to specific open questions and finally closed questions in order to get full, accurate details. This is called funnelling and is an acquired skill. Additional practice with qualified practitioners on effective questioning, particular around eliciting full details for differential diagnosis and identification of co- or multi-morbidity, is therefore very helpful.

5. **Assessing risk**
   Risk is an auto-fail section, meaning a trainee will fail the whole assessment if they do not conduct a competent risk assessment. The course teaches risk assessment protocols as below

(and see Appendix 9). Service protocols may differ and may include additional checks or information given. Trainees will not be marked down for additional risk gathering or risk information given, but they MUST show at least the minimum as follows:

All questions must be asked clearly and separately, without leading or assumptions and funnelling as necessary to gain full details such as frequency, intensity, duration, triggers etc:

- **Risk assessment introduction** - clearly and without apology introducing and explaining the risk assessment and why this is conducted.
- **Suicide** - current thoughts, plans and actions and past thoughts and actions.
- **Suicide protective factors**
- **Self harm** - current thoughts and actions, and past actions.
- **Current risk to others** - of any kind, e.g. physical, emotional, financial etc.
- **Current risk from others** - of any kind, e.g. physical, emotional, financial etc.
- **Current self-neglect** - e.g. personal hygiene, eating, drinking, sleep, taking medication etc.
- **Current dependents** - both under 18 and adult, anyone who may depend on the patient for any aspect of their care.
- **Current neglect of others –** if dependents, check any neglect of dependents separately and then neglect of anyone else. If no dependents check neglect of anyone else.

In addition trainees should:

- **Check PHQ9 Q9 against risk information given, corroborating with the patient.**
- **Summarise risk information given, and final question asking if anything is incorrectly understood or needs adding.**

6. **Information giving**
   Trainees may fail competency assessments on inability to give information well. Providing patients with succinct, easy to follow information about their diagnosis and treatment options is an essential skill for all PWPs. Trainees should be able to give clear, normalising explanations of common mental health conditions, their related CBT 'vicious cycles' and how CBT therapy breaks into these cycles to promote recovery. It is therefore highly beneficial to supervise trainee practice of giving information around the core Step 2 and 3 diagnoses, explaining the associated CBT cycle and showing how treatment breaks that cycle down. Trainees must also be able to clearly and succinctly describe what Guided Self Help entails and how Step 2 sessions work and, for non-Step 2 diagnoses, how the patient will access appropriate treatment and what to expect.

7. **Timing**
   Failing to complete the competency assessment within time is a common way for trainees to fail. Facilitating trainees to practise full role-plays and learn how to become more efficient, effective and succinct is therefore very beneficial. Trainees may find it helpful to break the assessment down into the distinct sections and attach rough timings to each section to aid this.

8. **Clinical Outcomes Document**
   It can take some time to review, discuss and sign this document, so it can be helpful to arrange time for this well in advance of the deadline. Supervisors must review and consider the evidence contained within, combine it with their knowledge of the trainee's practice and decide whether the trainee has or has not fully met each competency. Supervisors signing off trainees as successful are accepting clinical responsibility for the competency of the trainee and as such should only sign if they feel the trainee fully meets the detailed competencies. (See above for how to complete this document.)

Module 2: Evidence-based Low Intensity treatment for common mental health disorders

Module 2 Learning objectives and key topics covered

This module covers the knowledge and competencies to:

- **maintain the therapeutic alliance and manage problems within it**
- **support patients to use medication and a range of evidenced-based Low Intensity CBT interventions (Guided Self Help)**
- **support patients through face-to-face, telephone, group and cCBT modalities**
- **conduct reflective practice**

Key topics covered

1. **How to conduct a patient centred, collaborative PWP treatment session** (using CBT-specific, disorder-specific and common factors) consisting of:
    - **Introduction:** including name, agenda and timing
    - **General information gathering:** problem statement versus current presentation review including focus for treatment; other treatments including medication support and adherence/GP review; ROMs; IAPT risk assessment
    - **Intervention information gathering:** review of home practice undertaken; COM-B to review barriers experienced; identification of progress with and difficulties in the patient's use of the intervention including lack of understanding of the intervention steps to date and/or inaccuracies in lists, hierarchies, evidence recording etc. likely to lead to ineffective use of the intervention
    - **Information giving:** collaboratively checking patient's understanding, filling gaps in knowledge of the intervention rationale and how and why each part of intervention is done focussing particularly on any difficulties with using the intervention already identified, likely next steps and common pitfalls/factors for success
    - **Shared decision making:** collaboratively identifying next step(s) of the treatment plan, COM-B to identify barriers and tailor the plan according, clarification of home practice and self-management of intervention
    - **Ending:** summary of session including key findings, statement of home practice by the patient, next contact established
2. **Recording patient sessions**: guidance on gaining consent for and recording patient sessions face-to-face and by telephone

3. **LI-CBT interventions:** supporting patient self-management of intervention use including the rationale, intervention steps and common problems/factors for success of:

    - Behavioural Activation with and without physical activity
    - Cognitive Restructuring & Behavioural Experiments
    - Worry Management & Problem Solving
    - Exposure & Habituation
    - Sleep Management
    - Relapse Prevention

4. **Self practice/self reflection:** trainees use the interventions on themselves and blog a reflective commentary about the experience – see Appendix 1

5. **Telephone working, cCBT and group working:** an introduction to delivering patient sessions across a variety of modes

6. **Motivational interviewing:** introduction to an evidence-based clinical approach to increasing positive behavioural change through focussing on eliciting patients' own reasons for change

7. **Sleep Management:** including both broad and CBT-specific sleep improvement techniques

8. **Relapse prevention and ending treatment:** evidence-based relapse prevention techniques as a self-guided intervention and managing ending treatment sessions

Module 2 Assessments

Module 2 Clinical assessment

- **Live, unedited recording of a 35 minute Step 2 patient treatment session** delivered according to National Curriculum Guidelines with a Step 2 appropriate patient from the trainee's current in-service caseload.

- **All submissions must be of an appropriate Step 2 treatment session** - ensure the Step 2 appropriate diagnosis is accurately recorded on the cover sheet and reflected in the problem statement, and the session is using a Step 2 intervention taught during the module that is appropriate to the patient's diagnosis, as according to NICE guidelines. Your submitted session must include reviewing a home practice where a patient has actively used one of the core steps of the intervention (e.g., RPN list, classification of worries, exposure activity etc.), not a first session or review of a CBT cycle, or just reading etc. You should then support your patient with information giving around that intervention and subsequently reach an appropriate shared decision regarding use of that Step 2 intervention moving forwards.

- **Submission** – by 11am on the day of submission, remotely by uploading to a secure form (link on ELE), or, only where agreement exists between the University and the service, via NHS portal. Note the following essential submission criteria:

    - **All submissions must be accompanied by appropriate patient consent (see Appendix 4).** For in-person sessions (i.e. where trainee and patient are together in the same place) a form is signed by the patient and trainee. For remote sessions consent is indicated by a form signed by the PWP, and additionally a short audio file containing the patient's verbal consent is recorded. **Every recorded session must also start with** a specified short re-affirmation of

consent by the patient. (Note: marking and associated timing will only start after the consent statement has been given and the treatment session has clearly begun, so trainees still have the full 35 minutes for the session). See Appendix 4 for full details of gaining and recording consent and of making, storing and transporting recordings.

- **All submissions must be accompanied by a cover sheet, signed by trainee and countersigned by the clinical supervisor.** The supervisor is signing off to acknowledge this is a genuine, unedited recording with a patient of the service on the trainee's caseload at the time of recording whose treatment has been reviewed in case management supervision. If remote working prevents printing and hand signing, please use the remote sign off procedure describe below. In addition to the specified information, the cover sheet should also contain any clarifying information necessary to make it clear to markers that this is a safe, evidence-based treatment session. For example if safeguarding concerns are referenced on the tape, that these have been addressed through supervision/referral; or if depression is being treated but anxiety is mentioned on the tape, that treatment of the depression as the primary diagnosis has been discussed and agreed with the patient and in supervision.
- **Recording, cover sheet, consent and consent audio file must all be submitted as separate files,** clearly identifiable and with the trainee's name in the filename eg 'firstname_lastnamerecording.wav', 'firstname_lastnameverbalconsent.wav'
- **All submissions must be recorded, saved and transported via secure, encrypted mechanisms that meet the trainee's service policies** and ensure the confidentiality and security of the patient's data contained within.
- **Where remote working prevents printing and hand signing of the cover sheet, use the following remote sign off process:**
    - The trainee completes the cover sheet and types their own and their supervisors' names, then submits this along with the recording and other documents via SharePoint as described above.
    - **In addition the supervisor should email LI-IAPT@exeter.ac.uk** from their work email address including a statement that says "I can confirm that the tape submitted by [trainee name] is a live patient recording of a patient I know to be on [trainee name]'s caseload, who I have overviewed in supervision/know has been overviewed in supervision". As the coversheet has personal patient information (e.g. problem statement, potentially other info) **the cover sheet should NOT be attached to the email**, just the statement above.

- **Marked** using the Competency Assessment Treatment Marking Scheme
- **To pass, a trainee must gain: 50% overall, with a minimum of 50% in sections 2, 3, 4, 5 and 7 and minimum 50% in the risk assessment component.** Please note the following:
    - **Risk Assessment is an auto-fail section**, i.e. failing the risk assessment means failing the whole assessment. See Appendix 9.
    - **Overall section mark is NOT an average of each item in the section**, but rather an indication of the overall level of competence demonstrated in that section. It is possible to score well on most items in a section but still fail the section if the trainee has missed something

significant or failed to achieve a key competency. Examples are failing to explore home practice appropriately or failing to clearly provide accurate intervention information.

- **Failure in this assessment will result in a maximum fail mark of 49.**
- **Results are given 5 weeks from date of assessment,** via email to the trainee (using their University email address) and service supervisor
- **In the event of failure** trainees receive detailed feedback and can attend a Skills Top-Up Day.
- **Reassessment:** 6 weeks from the Skills Top-Up Day. Marks for reassessment are capped at 50%, and the whole module is capped at the bare pass mark.

Formative clinical assessment

NB there is a formative version of this assessment several weeks prior to the summative, which is marked but only for feedback and development purposes. Detailed feedback is provided to trainees though a telephone/video call by a member of the teaching team. Trainees are encouraged to submit a live recording of a real patient treatment session in order to gain the most useful feedback. However, if trainees are unable to do this, they can submit a role-play based on a scenario provided by the University.

All details for submission are as for the summative, except in cases of a role-play where no consent forms are needed and neither PWP nor supervisor signs the cover sheet. Trainees must also listen to and mark their recording, and provide reflective feedback and an improvement action plan (on a form available from ELE) for submission with their recording, for discussion with their tutor.

Module 2 Academic assessment

- **1 hour Multiple Choice Questions (MCQ) Exam** consisting of 40 questions on any aspect of Module 2 as taught or directed in study days by the date of the exam. Negative marking is applied (i.e. -1 is scored for each wrong answer, +1 for each correct answer, 0 for no answer).
- **Content:** any aspect of Module 2 taught to date or as covered in the directed study days can be tested. Trainees are encouraged to revise literature and evidence base authors, dates etc. that are referred to directly on teaching PowerPoint slides or on associated Padlets or homework sheets.
- **Submission** remotely via ELE.
- **Marked automatically.**
- **To pass** a trainee must gain **50% or more for the PGCert**, and **40% or more for the GradCert.**
- **Results are given 3 weeks after date of assessment,** via email to the trainee (using their University email address) and copied to service supervisor.
- **In the event of failure,** a trainee should contact the teaching team for further information.
- **Reassessment:** 4 weeks from the date results are provided. Marks for reassessments are capped at 50%, and the whole module is capped at the bare pass mark.

Module 2 Clinical Outcomes Document

- **Document (see ELE) providing a portfolio of a trainee's work-based evidence showing the following. It requires 'signing off' by the appropriate supervisor(s) – where hand signatures are not possible due to remote working see 'Submission' below for remote signing instructions.**
    - **Demonstrates experience and competence in the selection and delivery of treatment of a range of presenting problems using evidence-based Low Intensity interventions** across a range of problem descriptor including depression and two or more anxiety disorders
    - **Demonstrates the ability to use common factor competencies to manage emotional distress and maintain therapeutic alliances** to support patients using LI interventions
    - **Demonstrates high quality case recording and systematic evaluation of the process and outcomes of mental health interventions**, adapting care on the basis of these evaluations
- **Evidence** can be: direct observation by the clinical supervisor; via discussion and questioning by the clinical supervisor; testimony from other colleagues; written case records; audio/video recordings of patient sessions; reflective accounts of how the trainee has achieved the outcome(s) drawing upon the research evidence base; feedback volunteered by patients etc.
- **Cumulative hours log** - supervisors should enter the total cumulative hours **to date** of clinical (patient) contact, case management supervision and clinical skills supervision. They should ensure these tally with the individual logs described below and are signed off by the supervisor as a true record.
- **Monitoring log for interventions** - by the end of the course trainees must have demonstrated delivering a complete treatment protocol with at least one patient on their caseload for each of the following Step 2 interventions: Behavioural Activation; Worry Management (including Worry Time with or without Problem Solving); Exposure & Habituation; Cognitive Restructuring (with or without Behavioural Experiments). Supervisors should indicate here for which intervention a full protocol has been competently delivered, as monitored through supervision.
- **Log of clinical contact hours with patients** - by the end of the course this should show a minimum of 80 patient contact hours: 40 from assessment and 40 from treatment sessions. Trainees should record each day's patient contact to date (in minutes), signed off by both trainee and clinical supervisor as a true record. Contact hours can be telephone or face-to-face assessments, follow ups and treatment sessions. A maximum of 10 treatment hours can come from cCBT support and facilitation of groups. Calculate group contact time by length of group session divided by number of facilitators, e.g. a 2 hour group session with 2 facilitators = 1 hour.
- **Log of case management supervision hours** - a minimum of 20 hours of formal case management supervision is required by the end of the course. Trainees should record and sign off each supervision session to date (in minutes), then the supervisor countersigns as a true record.
- **Log of clinical skills supervision hours to date** - a minimum of 20 hours of formal clinical skills supervision is required by the end of the course. Only formal clinical skills sessions can be recorded: they must be pre-arranged 1-1 or small group sessions focussed on case review and/or

clinical skills development AND led by a qualified practitioner. Record each session (in minutes), each signed off by the trainee and countersigned by clinical supervisor as a true record.

- **Multiple supervisors** – if multiple supervisors are signing the outcome document, each of their names, signatures (if applicable) and contact details must be on page 1 of the document.
- **Submission** - via Ebart portal (link on ELE) by no later than 11 am on the deadline date. Trainees must print the document, hand sign it themselves and have it reviewed and countersigned by their service supervisor **on each of the required pages and alongside each of the recorded hours**, then scan the signed document and submit as a pdf. **Where printing and/or hand signing is not possible due to remote working use the remote sign off procedure as follows:**
  - Trainee signatures – name can be typed
  - Supervisor signatures – name can be typed
  - The document can then be uploaded to ELE as usual
  - **In addition, the supervisor should email LI-IAPT@exeter.ac.uk with the completed document attached and the appropriate statement included in the body of the email:**
    - **If all competencies are met** include in the email body, "I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email".
    - **If a trainee has failed one or more competencies** include in the email body, "I can confirm I am signing off all elements of the module outcome document for [trainee name], as attached to this email, except for the signatures on pages [pages relating to competencies where supervisor is not yet happy to sign trainee off]"

  If more than one supervisor has signed the document, only one supervisor should email but they should state they are signing on behalf of the other named supervisor(s) who have signed off the document.
- **To pass,** the trainee's service supervisor must review the document and evidence within and sign off all elements (including the logs and the Final Statement of Achievement) by hand signing or using the remote signing procedure described above. All elements must also be signed off by the trainee. The document must then be submitted as above.
- **To fail,** the service supervisor is making themselves accountable for the competency of the trainee, therefore the supervisor should NOT sign the trainee as competent on an outcome if he/she feels the trainee has not demonstrated the required competency. Instead, following discussion with the service clinical lead, the academic tutor and the trainee, supervisors should leave unsigned any outcomes not yet fully met, sign the trainee as 'Unsuccessful' in the Final Statement of Achievement, include a short report as to why the trainee has not yet met the competencies and proposed actions to be taken by the trainee to remedy the situation. Then scan and submit as above.
- **Errors** - any minor errors noted after submission by programme staff will be reported to the trainee with a 2 week turnaround to correct. Any major errors will be reported to the trainee with a 6 week turnaround to correct. Correcting the errors within the allocated timeframe leads to no penalties. Failing to resubmit a corrected and appropriately signed off document within this correction period counts as a fail.

- **In the event of first attempt failure,** the trainee's academic tutor will meet with the supervisor and trainee to agree and record an action plan designed to achieve the failed competency, and agree a resubmission date. The overall module mark will be capped at the bare pass mark.
- **Reassessment:** 4 weeks from the feedback being given (or as agreed in discussions).

Supervisor helpful notes

1. **Monitoring and managing trainee caseloads**

   Many trainees report Module 2 as the most stressful time on the course as they try to: continue to develop their assessment skills; acquire the knowledge and clinical skills to deliver treatment sessions and interventions; support patients towards recovery whilst still learning the skills to do this well; build a caseload which may mean encountering complexity they have not yet trained for; utilise CMS, CSS and clinical note-keeping effectively; and complete course assignments including live recordings. It can take many weeks to develop the clinical knowledge and skills to work to adequate clinical levels. During this time it may be very beneficial to closely monitor trainee caseloads in order to prevent caseloads growing too quickly, reallocate patients beyond the trainee's current competency to qualified PWPs and consider reallocating to the trainee Step 2 suitable patients from other PWP's caseloads or waiting lists. This will allow trainees to develop their emerging skills with appropriate patients and ensure trainees can meet clinical assessments, particularly the live recordings.

2. **Additional role-play**

   Role-play is an essential clinical learning tool throughout this module and alongside patient contact. Trainees are given role-play opportunities within University taught and study days, but are unlikely to achieve competency without further role-play opportunity within service. Rather than just role-playing with their fellow service trainees, they would benefit from a wide range of role-play partners, particularly appropriately trained and qualified staff (e.g. recently qualified PWPs, Senior PWPs, PWPs with supervisory training etc.). Familiarity with the course requirements, particularly the marking scheme, is highly beneficial for this to be most effective. Role-plays can be full or partial, focussing on particular components or skills such as intervention information gathering, risk assessment, information giving, common factors etc.

3. **Selecting a patient treatment session for the clinical assessment (live recording)**

   The Module 2 clinical assessment is assessing the ability of the trainee to deliver a standard Step 2 treatment session within the standard time of 35 minutes. Trainees should present a recording of a live treatment session with a Step 2 appropriate patient, treating a Step 2 appropriate diagnosis with a Step 2 appropriate intervention as taught on the course and indicated by NICE guidelines. The treatment session submitted should allow the trainee to demonstrate the ability to review previously set home practice, check and supplement the patient's understanding of the intervention rationale and steps, and collaboratively set further appropriate home practice in order to improve the patient's use of the intervention. Risk, severity or complexity is not a barrier, provided these are within Step 2 boundaries, that standard Step 2 treatment is agreed as appropriate in supervision, and no additional time or adaptations are required. (Note that patients with diverse needs benefitting from adaptations are the topic of the Module 3 clinical assessment; early identification of suitable cases and gaining of patient consent can be very helpful).

4. **Live recordings and equipment**

   Submitting a recording of a live patient treatment session (Appendix 4) is encouraged for the formative clinical assessment and mandatory for the summative one. Trainees are strongly encouraged to request consent from all their patients and record all their consented sessions for two reasons. Firstly, so they have an adequate selection from which to choose their final

submission. Secondly, so that they and their clinical supervisors can listen to, reflect on and learn from their developing work with patients. It is essential that trainees have good recording equipment and support in using it from the start of the module and that trainees are encouraged to record and listen to their sessions (both with and without their clinical supervisors) as standard.

5. **Marking scheme**
   The University marking scheme for PWP treatment sessions (Appendix 3) is designed to assess the degree of competency in the key skills needed to engage patients, build the therapeutic relationship and to both get and give the most accurate information with the least room for error. If supervisors would like an update on the marking scheme in order to have a full understanding of what each item is looking for, please contact the trainee's academic tutor. Note that Risk is an auto-fail section, but this is not the only way a trainee may fail. Trainees must gain 50% overall, but they must also be marked as at least competent in the compulsory sections 2, 3, 4, 5 and 7. Failing to do something essential in a compulsory section, e.g. failing to explain an intervention rationale or steps well in Section 4, or failing to adequately explore a patient's home practice or identify difficulties in Section 3 could result in a fail. Running out of time is also a very common way for trainees to fail.

6. **Assessing risk**
   Risk is an auto-fail section, meaning a trainee will fail the whole assessment if they do not conduct a competent risk assessment. The course teaches the following risk assessment protocols (also see Appendix 9). Service protocols may differ slightly and may include additional checks or information given. Trainees will not be marked down for additional risk gathering or risk information given, but they MUST show at least the IAPT minimum as follows:

   For each item trainees should clearly reflect back their understanding from previous session(s) and ask if there have been any changes, funnelling as necessary to gain full details. There should be no leading or assumption.

   a. **Suicide** - current thoughts, plans and actions. If any risk was identified previously these must be addressed separately. If no risk was identified previously the trainee can group questions on thoughts, plans and actions together, e.g.: "When we last met you said you didn't have any thoughts of suicide, hadn't made any plans to end your life and hadn't taken any actions towards ending your life, has that changed?"
   b. **Suicide protective factors**
   c. **Self-harm** - current thoughts and actions. If any risk was identified previously these must be addressed separately. If no risk was identified previously the trainee can group questions on thoughts and actions together, e.g., "When we last spoke you told me you weren't having any thoughts of harming yourself and you hadn't taken any self-harming actions, has that changed?"
   d. **Current risk to others**
   e. **Current risk from others**. If any risk was identified previously risk to and from others must be addressed separately. If no risk in either was identified previously the trainee can group risk to and from others together, e.g., "When we spoke before you didn't feel at risk of harm from anyone else, or at risk of harming anyone else yourself, has that changed?"
   f. **Current self-neglect**
   g. **Current dependents** - dependents should always be checked separately from other risk items.

h. **Current neglect of others.** This should always be checked even where there are no dependents. If there are dependents ensure your check clearly includes risk to dependents and separately risk to anyone else. If no risk of self-neglect or neglect of others was previously identified these can be grouped together e.g. "Last time we spoke you told me you didn't feel you were neglecting yourself, any of your dependents or anyone else, has that changed?"

In addition trainees should:

i. **Check PHQ9 Q9 against risk information given,** corroborating with the patient.
j. **Summarise risk information understood,** and final question asking if anything is incorrect or needs adding.

7. **Information Gathering: Intervention**

Being able to collaborate with a patient to fully explore their experience of barriers to and benefits or difficulties arising from home practice is an essential skill that takes practice to develop. Without these skills PWPs cannot effectively identify where a patient is unable to use an intervention optimally for improved clinical outcomes (and therefore go on to address these difficulties in their information giving). Additional practice around review of home practice is therefore particularly helpful.

8. Information Giving

It takes time to acquire the skills needed to effectively check and supplement a patient's understanding of the intervention rationale and both why and how each relevant step of the intervention is done. It is highly beneficial to facilitate both unsupervised and supervised practice of giving information. This practice should include effective checking and supplementation of a patient's understanding of: the maintenance cycle of Step 2 diagnoses and how the intervention breaks down this vicious cycle (the intervention rationale); and both why and how each step of the intervention is done (including common pitfalls). Trainees should develop giving information in a way that is collaborative, an interactive discussion between PWP and patient and that allows patients to reach their own understanding, so that they can ultimately use the intervention unaided. The focus in this section should be on ensuring patients have a full, accurate understanding of the parts of the intervention used to date (including addressing any difficulties) and of the immediate next steps that may be done as home practice. In addition, patients should have at least a headline understanding of future steps and how what they are doing now will fit with later steps to lead to recovery.

9. Timing

The Module 2 clinical competency assessment is assessing a trainee's ability to effectively deliver a standard Step 2 treatment session, within the standard timing of 35 minutes. No changes can be made to the timing for this assessment. Failing to complete the competency assessment within time is a common way for trainees to fail. Facilitating supervised and unsupervised practise of full role-plays in order to learn how to become more efficient, effective and succinct without sacrificing interpersonal skills is therefore very helpful.

10. Clinical Outcomes Document.

It can take some time to review, discuss and sign this document, so it can be helpful to arrange time for this well in advance of the deadline. Supervisors must review and consider the evidence contained within, combine it with their knowledge of the trainee's practices and decide whether the trainee has or has not fully met each competency. Supervisors signing trainees as successful are accepting clinical responsibility for the competency of the trainee and as such should only sign if they feel the trainee fully meets the requirements.

Module 3: Values, diversity and context

Module 3 Learning objectives and key topics covered

This module covers the core knowledge and competencies trainees need to:

- **Operate as an inclusive practitioner, recognising, valuing and respecting diversity and adapting practice to facilitate the best outcomes for individual patients**
- **Recognise the limitations of their role and be able to signpost, step up and step out effectively**
- **Use supervision effectively for case management and practice development**

Key topics covered

- **Case management and clinical skills supervision within IAPT and the specific competencies needed for effective Step 2 working** (actual teaching takes place during Module 2)
- **Diversity and inclusion within IAPT** – the core principles of recognising, valuing and adapting for diversity and increasing access for under-represented groups
- **Adapting practice to accommodate diverse needs** including adaptations for: physical needs including long term health conditions; BAME communities; the use of interpreters; older adults; sensory needs; learning difficulties and disabilities
- **Patient engagement** - difficulties engaging patients, managing ruptures and maintaining the therapeutic alliance
- **Power** - recognising power imbalances in clinical relationships, and ways to minimise negative impacts
- **Employment**, **social inclusion and signposting** to support wider work, social and economic needs
- **High Intensity treatment** - understanding stepping up
- **PWP on-going development** - an introduction to the opportunities and challenges for PWPs throughout their careers

Module 3 Assessments

Module 3 Clinical assessment

- **Pre-recorded 15 minute clinical case presentation** submitted via secure form (link on ELE), showcasing trainees' understanding of adapting practice to meet diverse needs through presentation of a patient case from their own caseload.

- **Content:** Trainees should, using an anonymised patient case from their caseload, present how they identified where their usual practice would have created barriers to engagement and treatment efficacy for an individual patient, and how they altered their usual practice to remove or reduce these barriers. The presentation should show how the trainee researched the evidence base and collaborated with their patient to identify and overcome these barriers through adaptations to their assessment and treatment sessions. It should be a critical reflection drawing strongly on the evidence base and identifying learning to be carried forward. The need for adaptation can arise through personal, cultural, family, social and spiritual differences between the PWP and the patient. Adaptations are any evidenced-based changes to usual practice where, without that change, usual practice would present a barrier to the patient being able to engage or benefit fully from treatment. If trainees are in any doubt about whether a diverse need or adaptation is suitable for the clinical case presentation, they should contact the PWP teaching team email address.

- **Submission – via secure form (link on ELE).** The presentation should be a narrated PowerPoint. Note the following essential submission criteria:

    - **Consent MUST be gained from the patient** and evidenced through submission of a signed consent form or audio file of patient verbal consent (different consent processes are used depending on whether consent is gained in-person or remotely, use the correct consent form from ELE).

    - **The consent form/consent audio file and an electronic copy of the presentation MUST be submitted via the secure form (link on ELE) by 11 am on the day of the submission deadline.**

    - **Confidentiality MUST be maintained (failure to do so results in auto-fail).** Trainees must anonymise their presentation removing all reference to actual patient names or possible identifying features (including but not limited to: place of residence, service within which patient was seen, family or children names, ages, anything too specific regarding their circumstances, rare health conditions, background, job etc. that could lead to possible identification). See Appendix 7.

    - **Confidentiality and ethics statement must be included** in the initial presentation slides, this statement is available on ELE. (NB: Marking and associated timing will only start after the statement has been given.)

    - **All presentations must be appropriate to Step 2 working according to IAPT and NICE guidelines.** For example, a presentation should not be about treatment planning for a diagnosis or intervention not suitable at Step 2.

- **Marked** using the Presentation Marking Scheme (see ELE for full details). Marks are awarded according to:

    - **Structure & organisation 10%**
    - **Delivery & timing 10%**
    - **Knowledge & understanding 30%**
    - **Theory into practice 40%**
    - **Use of source materials 10%**
    - **Confidentiality** - no marks but auto-fail if not adhered to

- **To pass, a trainee must gain: 50% overall (this is for both the GradCert and PGCert pathways), and pass the confidentiality requirements.**
- **Failure in this assessment will result in a maximum fail mark of 49.**
- **Results are given 5 weeks from date of assessment**, via email to the trainee (using their University email address) and service supervisor.
- **In the event of failure,** trainees can receive detailed feedback from the teaching team.
- **Reassessment:** 4 weeks from the day results were provided. Marks for reassessment are capped at 50% and the whole module is capped at the bare pass mark.

Module 3 Academic assessment

- **2000 word reflective assignment** (see ELE for full details) demonstrating knowledge of case management supervision and clinical skills supervision within Low Intensity working and providing a critically reflective account of the trainee's supervisory practice in the use of both case management and clinical skills supervision for a patient case.
- **Content:** the assignment is divided into three sections, see the guide below for examples.
    - **Section 1 (approx. 500 words)** demonstrating knowledge, with reference to the literature base, of case management supervision and clinical skills supervision particularly with reference to Low Intensity working.
    - **Section 2 (approx. 500 words)** describing why and how case management supervision and clinical skills supervision was used for a patient on the trainee's caseload.
    - **Section 3 (approx. 1000 words)** providing a critical reflection, with detailed reference to both supporting and contrasting views from the evidence base, of an aspect or aspects of the trainee's approach to and use of supervision as described in Section 2, including any wider implications for their clinical practice, patients and service. From this, trainees should draw conclusions about ways forward to improve their use of supervision. NB, an Action Plan may be optionally included as an Appendix (additional to the main word count but within a maximum of 500 words).
- **Submission** via Ebart portal (link on ELE) by no later than 11 am on the day of assessment and accompanied by the associated cover sheet (available on ELE). Note the following essential submission criteria:
    - **Confidentiality MUST be maintained (failure to do so results in auto-fail).** Trainees must anonymise their case removing all reference to actual patient names or identifying features (including but not limited to: place of residence, service within which patient was seen, family or children names, ages, anything too specific regarding their circumstances, health conditions, background, job etc. that could lead to possible identification).

- **Marked using University-wide marking criteria** for Level 6 (GradCert) and Level 7 (PGCert) assessments using the College of Life and Environmental Science (CLES) notched marking scheme (Appendix 3), focussing particularly on the following:
    - **Structure and organisation** - trainees are expected to clearly adhere to the required structure for this reflective piece, and for their writing to be clear and accessible with points made linking into clearly understandable arguments/viewpoints.
    - **Knowledge and understanding** - trainees are expected to display a sound breadth and depth of knowledge and understanding of supervision, particularly as it relates to LI working, and the ability to show relevant and correct information about the chosen topic, with references to the literature base.
    - **Theory into practice links** - trainees should use literature and the evidence base to support their knowledge, understanding and reflections on their supervision practice.
    - **Critical reflection** - trainees should demonstrate the ability to reflect on their use of supervision using a critical and evaluative stance taking into account varied standpoints evidenced in the literature base, then to draw conclusions from these reflections about ways forward in the future.
    - **Sourcing** - trainees must demonstrate the depth and breadth of their reading, use a variety of literature to support their writing, show ability to critically evaluate sources and use APA referencing protocols appropriately.
- **To pass** a trainee must gain **50% or more for the PGCert** or **40% or more for the GradCert.**
- **Results are given 3 weeks after date of assessment,** via email to the trainee (using their University email address) and copied to service supervisor.
- **In the event of failure,** trainees should contact the teaching team to receive detailed feedback.
- **Reassessment:** 4 weeks from the date feedback was provided. Marks for reassessments are capped at the pass mark, and the whole module is also capped at the bare pass mark.

Module 3 Clinical Outcomes Document

- **Document (see ELE) providing a portfolio of trainee's work-based evidence showing ability to meet following competencies. It requires 'signing off' by the appropriate supervisor(s) – where hand signatures are not possible due to remote working see 'Submission' below for remote signing instructions.**
    - **Demonstrates the ability to engage with people from diverse demographic, social and cultural backgrounds in assessment and Low Intensity interventions.** This could include adaptations to practice when working with older adults, using interpretation services/self-help materials for people whose first language is not English, adapting self-help materials for people with learning or literacy difficulties, to name just a few.
    - **Demonstrates the ability to effectively manage a caseload including referral to step up, employment and signposted services.**
    - **Demonstrates the ability to use supervision to the benefit of effective case management and clinical skills development**. This should include:

    - **a report on a case management supervision session** demonstrating ability to review caseload, bring patients at agreed pre-determined thresholds and provide comprehensive and succinct case material.
    - **a report on use of clinical skills supervision** including details of clinical skills questions brought, learning and implementation.

- **Evidence** can be: direct observation by the clinical supervisor; via discussion and questioning by the clinical supervisor; testimony from other colleagues; written case records; audio/video recordings of patient sessions; reflective accounts of how the trainee has achieved the outcome(s) drawing upon the research evidence base; feedback volunteered by patients etc.
- **Cumulative hours log –** trainees should enter the total cumulative hours of clinical (patient) contact, case management supervision and clinical skills supervision. They should ensure these tally with the individual logs described below and are signed off by the supervisor as a true record. Cumulative hours should show a minimum of: 40 hours of assessment contacts; 40 hours of treatment contacts of which no more than 10 should be from cCBT and/or group working; 20 hours of case management supervision; 20 hours of clinical skills supervision.
- **Contact and Supervision Requirements Final Statement of Achievement** - supervisors should sign off to indicate if the trainee has been successful or unsuccessful in meeting the required cumulative patient and supervision hours. In addition, the supervisor should indicate if the trainee has delivered a complete treatment protocol, monitored through supervision, for at least one patient for each of the following Step 2 interventions: Behavioural Activation; Worry Management (including Worry Time with or without Problem Solving); Exposure & Habituation; Cognitive Restructuring (with or without Behavioural Experiments).
- **Log of clinical contact hours with patients** - trainees should record each day's patient contact to date (in minutes) undertaken during this module, signed off by both trainee and clinical supervisor as a true record. Contact hours can be remote, e.g. telephone or video-call or in-person assessments, follow ups and treatment sessions. A maximum of 10 treatment hours can come from cCBT support and/or facilitation of groups. Calculate group contact time by length of group session divided by number of facilitators, e.g. a 2 hour group session with 2 facilitators = 1 hour.
- **Log of case management supervision hours** - a minimum of 20 hours of formal case management supervision is required by the end of the course. Trainees should record and sign off each supervision session to date (in minutes), then the supervisor countersigns as a true record.
- **Log of clinical skills supervision hours to date** - a minimum of 20 hours of formal clinical skills supervision is required by the end of the course. Only formal clinical skills sessions can be recorded: they must be pre-arranged 1-1 or small group sessions focussed on case review and/or clinical skills development AND led by a qualified practitioner. Record each session (in minutes), each signed off by trainee and countersigned by clinical supervisor as a true record.

- **Multiple supervisors –** if multiple supervisors are signing the outcome document, each of their names, signatures (if applicable) and contact details must be on page 1 of the document.
- **Submission** - via Ebart portal (link on ELE) by no later than 11 am on the deadline date. Trainees must print the document, hand sign it themselves and have it reviewed and countersigned by their service supervisor **on each of the required pages and alongside each of the recorded**

hours, then scan the signed document and submit as a pdf. **Where printing and/or hand signing is not possible due to remote working use the remote sign off procedure as follows:**

- Trainee signatures – name can be typed
- Supervisor signatures – name can be typed
- The document can then be uploaded to ELE as usual
- **In addition, the supervisor should email LI-IAPT@exeter.ac.uk with the completed document attached and the appropriate statement included in the body of the email:**
    - **If all competencies are met** include in the email body, "I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email".
    - **If a trainee has failed one or more competencies** include in the email body, "I can confirm I am signing off all elements of the module outcome document for [trainee name], as attached to this email, except for the signatures on pages [pages relating to competencies where supervisor is not yet happy to sign trainee off]"

  If more than one supervisor has signed the document, only one supervisor should email but they should state they are signing on behalf of the other named supervisor(s) who have signed off the document.

- **To pass,** the trainee's service supervisor must review the document and evidence within and sign off all elements (including the logs and the Final Statement of Achievement) by hand signing or using the remote signing procedure described above. All elements must also be signed off by the trainee. The document must then be submitted as above.
- **To fail,** the service supervisor is making themselves accountable for the competency of the trainee, therefore the supervisor should NOT sign off the trainee as competent on an outcome if they feel the trainee has not demonstrated the required competency. Instead, following discussion with the service clinical lead, the academic tutor and the trainee, supervisors should leave unsigned any outcomes not yet fully met, sign off the trainee as 'Unsuccessful' in the Final Statement of Achievement, include a short report detailing why the trainee has not yet met the competencies and the proposed actions to be taken by the trainee to remedy the situation. Then submit as above.
- **Errors** - any minor errors noted after submission by programme staff will be reported to the trainee with a 2 week turnaround to correct. Any major errors will be reported to the trainees with a 6 week turnaround to correct. Correcting the errors within the allocated timeframe leads to no penalties. Failing to resubmit a corrected and appropriately signed off document.
- **In the event of failure,** the trainee's academic tutor will meet with the supervisor and trainee to agree and record an action plan designed to achieve the failed competency, and agree a resubmission date. The overall module mark will be capped at the pass mark.
- **Reassessment:** 4 weeks from the feedback being given (or as agreed in discussions).

Supervisor helpful notes

- **Additional role-play, practise, shadowing and observation**
  Trainees are given role-play opportunities within University taught and study days, but will find it difficult to achieve competency without further opportunity to practise skills within service. In particular trainees will need additional practice around: adaptations for individual patient needs (including LTCs); overcoming difficulties in engagement of patients; managing challenges in the therapeutic relationship; and both case management supervision and clinical skills. Rather than just role-playing with their fellow service trainees, they would benefit from a wide range of practise partners, particularly appropriately trained and qualified staff (e.g. recently qualified PWPs, Senior PWPs, PWPs with supervisory training etc.). Familiarity with the course requirements and/or skills relative to the course elements would be highly beneficial for this to be most effective. In addition, trainees would benefit from shadowing and observing experienced or specialist colleagues, and being shadowed or observed in their own practice.

- **Supporting trainees to make adaptations to their practice**
  The principle behind adapting practice is to recognise where usual practice would provide a barrier to a patient's ability to engage with treatment or gain full benefit from an intervention, and adapt accordingly. So, for example, using audio or braille materials for a patient with sight impairments means the patient can access and benefit from treatment, whereas standard practice would constitute a barrier. A number of protocol adaptations are taught on the course e.g., SOC to identify activities where ones formerly engaged in are no longer possible; goal setting for those experiencing life transitions; physical symptom diaries to monitor the relationship between physical and mental health symptoms; pacing as an adaptation to behavioural interventions where pain or fatigue could act as a barrier etc. However trainees are encouraged to collaborate with the patient to recognise any instance where usual practice would constitute a barrier and then to both independently research and collaborate with the patient to identify and implement evidence-based adaptations that serve to remove or reduce those barriers without diminishing treatment efficacy. Many trainees need additional support to understand and implement this. Shadowing of skilled colleagues and undertaking clinical skills sessions geared towards this can be very helpful.

- **Selecting a patient case for the clinical case presentation**
  NB: Consent must be sought from the patient for the use of their case details for this assignment; see Appendix 4. The clinical case presentation is an opportunity for trainees to use a clinical case example from their own practice to demonstrate: their recognition of where standard practice would act as a barrier to a patient on their caseload; their ability to consult with the patient and conduct research in order to identify suitable adaptations in order to overcome these barriers; their ability to reflect and learn from this experience in order to inform their practice going forward. Trainees may need help to identify a suitable case from their caseload, which should ideally allow the trainee to discuss how adaptations were selected for both assessment and treatment, and the learning from this process. The case may be ongoing or have resulted in recovery, step up or step out. Where opportunities are limited, it would be helpful to reallocate to the trainee suitable patients from other PWP caseloads or waiting lists.

- **Review of clinical case presentation and reflective commentary**
  The clinical and academic assessments for Module 3 are testing the developing skills of trainees

in their use of critical reflection, supervision and adaptations to practice. Review by a clinical supervisor or appropriately trained, qualified colleagues with supervisory training would be beneficial prior to submission for both the clinical case presentation and the critical reflection assignment**.**

- **Additional clinical skills or case management sessions**
  Trainees sometimes struggle to accumulate sufficient clinical skills hours prior to the submission deadline for the Outcomes Document. Advance planning may be needed to arrange additional supervision sessions to meet the required hours. Contact the trainee's academic tutor in advance if difficulties meeting the required hours are anticipated.

- **Developing a trainee's signposting**
  Trainees, particularly those new to an area, may need support developing or accessing a store of appropriate signposting and referral contacts to help support patients with their wider social, economic and employment needs.

- **Clinical Outcomes Document**
  This takes some time to review, discuss and sign off so supervisors may find it helpful to make time for this in advance of the deadline. Supervisors must review and consider the evidence contained within the document and combined this with their knowledge of the trainee's work and practices in order to decide whether the trainee has or has not fully met each competency. Supervisors signing off trainees as successful are accepting clinical responsibility for the competency of the trainee and as such should only sign off if they feel the trainee fully meets the detailed competencies. (See above for how to complete this document, including remote sign off.) If there is any concern that required hours of patient contact, case management supervision or clinical skills sessions will not be met within the deadline, please contact the academic tutor to discuss, as extensions are usually possible.

Part 2 - Appendices

Appendix 1: Timetable, locations and teaching and learning methods

The cohort timetable, available on ELE, details the content and locations for each of the taught days and specifies the number of University directed study days. **The training day runs from 9am to 5pm**, with half an hour to prepare from 9am, and then the training programme starting at 9.30am and finishing at 5pm. There is a minimum of 45 minutes allocated for a lunch break, and there are two 15-minute breaks throughout the day.

Locations

All sessions and assessments are currently being delivered remotely.

Teaching and learning methods

The course is taught across 25 taught days and 20 University Directed Self-Study Days. However additional private study is needed for assignment preparation, revision, further reading etc. Across the course, a number of key teaching and learning methods are used following a declarative, procedural, reflective model of learning (Bennet-Levy, 2006).

Together these methods allow the trainee to:

- Acquire theoretical understanding of mental health distress and clinical methods of identifying and treating this;
- Learn techniques and procedures for applying this knowledge effectively in clinical settings in a patient-centred way;
- Develop effective reflective capacity on their own knowledge, practice and biases as a therapist so they are able to continue developing as a practitioner long after the course has ended.

These methods are:

- Lectures
- Small group working/seminars
- Role-play, observation and feedback
- Clinical skills groups
- Guided independent study through University Directed Study Days undertaking a number of independent or peer-group tasks such as reading literature, working through online tutorials and resources, role-playing, self-practice/self-reflection, reviewing service procedures and policies, etc.

In addition, trainees are expected to implement their learning directly into their in-service clinical practice and receive case management and clinical skills supervision in their workplace.

Self-Practice, Self-Reflection (SP/SR)

Developing and Enhancing Clinical Competence

Within the course, key emphasis is placed upon the development of competence across a range of Low Intensity interventions. A major focus within the University taught days and study days is the

trainees' own practice and the rehearsal of the interventions presented during the programme. To help structure and formalise this component of the programme the Self-Practice, Self-Reflection (SP/SR) model of supervision (Bennett-Levy et al., 2001; Farrand et al., 2010) is adopted.

This model of supervision requires trainees to initially undertake the Low Intensity interventions taught during the course on themselves, and then reflect upon their use. Rather than specifying areas for reflections around each intervention - which can be unnecessarily limiting - trainees are encouraged to provide widespread reflections on anything that arises concerning their self-practice.

All trainees then post their individual reflections on the respective SP/SR blog set up for each intervention. Links to all the blogs are on ELE; each blog is set up with restricted cohort-only access, meaning only members of the teaching team, trainees on the programme and ELE IT support staff can view the posts. The themes from these blogs then form the basis of group clinical supervision sessions as part of University taught days.

References:

Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. Behavioural and Cognitive Psychotherapy, 34(1), 57-78.

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(2), 203-220.

Farrand, P., Perry, J., & Linsley, S. (2010). Enhancing self-practice/self-reflection (SP/SR) approach to cognitive behaviour training through the use of reflective blogs. Behavioural and Cognitive Psychotherapy, 38(4), 473-477.

Appendix 2: Passing or failing the course and Appeals

Passing the course and final awards

Trainees must pass all three module assessment to pass a module, and pass all three modules to pass the course. Attendance must be no less than 80%. Final awards are calculated on an average of the module marks. Modules are weighted as follows:

Module weighting

- **Module 1: Clinical assessment - 70%, Academic assessment - 30%**
- **Module 2: Clinical assessment - 70%, Academic assessment - 30%**
- **Module 3: Clinical assessment - 50%, Academic assessment - 50%**

Final award calculation:

Final awards are calculated by adding the overall marks from each module and dividing by 3 and are as follows:

GradCert

Qualifies for Distinction award	A final credit-weighted mark greater than or equal to 69.50% or A final credit-weighted mark greater than or equal to 68.00% and modules to the value of at least 50% with a module mark greater than or equal to 70%
Qualifies for Merit award	A final credit-weighted mark greater than or equal to 59.50% or A final credit-weighted mark greater than or equal to 58.00% and modules to the value of at least 50% with a module mark greater than or equal to 60%
Overall pass mark	A final credit-weighted mark greater than or equal to 40.00%

PGCert

Qualifies for Distinction award	A final credit-weighted mark greater than or equal to 69.50% or A final credit-weighted mark greater than or equal to 68.00% and modules to the value of at least 50% with a module mark greater than or equal to 70%
Qualifies for Merit award	A final credit-weighted mark greater than or equal to 59.50% or A final credit-weighted mark greater than or equal to 58.00% and modules to the value of at least 50% with a module mark greater than or equal to 60%
Overall pass mark	A final credit-weighted mark greater than or equal to 50.00%

Receiving certificates

All final marks are ratified by the exam board before certificates can be issued. Once the exam board ratification has occurred, the certificate will be made ready for presentation to the trainee at the graduation ceremony. Any trainees who do not attend graduation will have their certificates sent to their home address, as recorded on the University of Exeter Student Record System. This process may take 2 – 3 months after final marks are awarded. Trainees should ensure that any changes of address are notified to the University.

Graduation

As a student of the University of Exeter, all trainees that pass the course will be invited to attend one of the University's graduation days. Trainees will be notified of the dates and invited via email to their University of Exeter email address. Two ceremonies take place a year, one in the summer and one in the winter. However, please note that your graduation ceremony may not be the one closest to the end of your course, so check with the graduation team before making any advance bookings.

Failing the course

Trainees must pass all three assignments in a module to pass the module, and all three modules to pass the course.

If a trainee fails a first attempt at an assignment, they are allowed a second attempt. If a trainee submits a second attempt at an assessment late, fails to submit or the assignment is marked as a fail (less than 50% for clinical assessments or 40% for academic assessments), then they fail the whole module and this therefore constitutes a programme fail.

Training ceases and registration on the course is ended. Programme failure may also affect service employment, as most trainee contracts are dependent on completing the course.

Trainees should also note that both the IAPT National Team and Health Education England (HEE), which funds training places for PWPs, have a national policy of not providing a second training place if a first place fails, so gaining a further PWP training post in the future is not usually possible in the event of a programme fail.

Appeals

All students of the University have the right of appeal against academic decisions and recommendations made by the Assessment, Progression and Awarding Committee (APAC) and Faculty Boards (or Deans acting on their behalf) that affect their academic progress.

If considering an appeal, trainees are strongly advised to read the Appeals page on the main University website. Trainees can also contact their academic tutor, the Programme Lead and the Course Administrator for further advice and guidance.

Appendix 3: Assignment guidance and submission

Specific assignment guidance

For each assignment, detailed guidance is given on ELE. Trainees can refer to ELE and click the appropriate links under each module.

Assignment marking schemes

Clinical assessment marking schemes

For each clinical assessment there is an associated marking scheme, which is geared towards assessing the clinical competencies necessary for safe, effective, patient-led assessment and treatment.

The clinical assessment marking schemes and can be found on ELE. Each marking scheme attempts to track the degree of competency in each of the important elements of an assessment or treatment session. As such they are a highly useful tool to aid trainee development and trainee and supervisor reflections on role play and patient practice. **Also on ELE are interactive marking schemes** where you can click on any section of the marking scheme to view additional notes about that element.

Please note: for the competency assessments the overall section mark is NOT an average of marks for each element within that section, but rather a reflection of the overall degree of competency for that section. As such, if a trainee fails to achieve competency in one or more important areas their overall section mark may be below competent (less than 3).

Academic assessment marking schemes

Academic assessments are marked with consideration given to the following components:

- **Structure and organisation** - trainees are expected to clearly adhere to the required structure for any assignment and for their writing to be clear and accessible with points made being well referenced and linking into clearly understandable arguments/viewpoints which stay strictly focussed on the assignment topic.
- **Knowledge and understanding** - trainees are expected to display a sound breadth and depth of knowledge and understanding of the topic, particularly as it relates to LI working, and the ability to supply relevant and correct information.
- **Theory into practice** - trainees should use literature and the evidence base to support their knowledge, understanding and reflections on their practice.
- **Critical evaluation/reflection** - trainees should demonstrate the ability to reflect on their discussion and their practice using a critical and evaluative stance taking into account varied standpoints evidenced in the literature base, then to draw conclusions from these reflections.
- **Sourcing** - trainees must demonstrate the depth and breadth of their reading, use a variety of literature to support their writing, show ability evaluate sources and use APA referencing protocols appropriately.

Marking is numerical against the University-wide marking criteria for Level 6 (degree level) and Level 7 (postgraduate level) assessments using the College of Life and Environmental Science (CLES) notched marking scheme, see https://cedar.exeter.ac.uk/iapt/iapt/marking/.

Submission methods

The table below offers an overview of the submission process, please see the text below for further details.

Assignment	Method of Submission	Required:
Live Tapes	**Submitted via secure form by 11 am** ***(or NHS portal by explicit agreement only)*** Trainees submit the components of their submission via the secure, form (or NHS portal) in accordance with service policies*[1]	• Recording of session e.g. mp3 or .wav file • Recording of any verbal consent file e.g. mp3, .wav Electronic copies of: • Signed Coversheet pdf*[2] • Consent form*[3]
Clinical Practice Outcomes	**Submitted via Ebart by 11am**	• Signed Outcomes*[4]
Written Work (essay, reflective commentary)	**Submitted via Ebart by 11am** Trainees MUST put their student number into the header or footer, but NOT their name (so it can be blind marked)	• Word processed written work, e.g. .pdf • Signed Coversheet pdf*[2]
Presentations	1. **Consent file and narrated PowerPoint submitted via secure form by 11 am.**	• Presentation file (e.g. Microsoft Powerpoint file) • Consent file (form or audio file)
*[1] It is **each trainee's** responsibility to ensure they adhere to their service policies, so discuss this in advance of the submission deadline. *[2] Hand sign and scan these documents, or use the remote signing procedure as detailed in the main document above. *[3] Submit the correct consent format dependant on whether remote or in-clinic. *[4] Submit a scanned version of the original hard copy **signed by trainee and supervisor**, or use the remote signing procedure as detailed in the main document above.		

Submitting through Ebart

The link to submit assignments through Ebart is on the Assessments tile on ELE. Click on the appropriate link to go to the Ebart submission page.

If trainees submit work and realise they have made a mistake, it is possible to correct it and re-upload another version unlimited times before the deadline.

Trainees should allow a good amount of time to upload work to Ebart prior to the deadline – IT Helpdesk suggest handing work in a minimum of three hours prior to deadlines so if something goes wrong there is time to speak to the IT Helpdesk for assistance. **Computer failure/technical problems are not an acceptable reason for Mitigation.**

Passing or failing assessments

For each assessment, two attempts are allowed.

Passing an assessment and grade boundaries

For all clinical practice assessments an overall mark of at least 50% must be achieved and all compulsory sections must pass with at least 50%, including the risk assessment which is an auto-fail section. This applies to both PGCert and GradCert routes. Marks below these levels will be deemed fails.

For all academic assessments trainees following the PGCert award must pass with a mark of at least 50% and those following the GradCert award must pass with a mark of at least 40%. Marks below these levels will be deemed fails.

Pass marks are as follows:

1. **Clinical assessments**: 50% and above
2. **Academic assessments (PGCert)**: 50% and above
3. **Academic assessments (GradCert)**: 40% and above
4. **Clinical Outcomes Documents**: Pass or Fail

Failing an assessment

Failing a first attempt

If a first attempt at an assessment fails, the following applies:

- **Trainees can contact the teaching team for detailed feedback** (this is strongly advised).
- **For Module 1 and Module 2 clinical assessments trainees will also be invited to an optional (but strongly recommended) Skills Top-Up Day** at the University to help practice specific areas of development needed to pass.
- **A resubmission/resit date will be agreed** usually within 4 weeks of receiving notification of results (or 4 weeks from the Skills Top-Up Day for the Module 1 clinical assessment and 6 weeks from the top-up day for the Module 2 clinical assessment).
- **Marks will be capped** at a maximum 50% for second attempts of clinical assessments, and for academic assessments at 50% for postgraduate routes and 40% for degree routes.
- **In addition, marks for the whole module will be capped at the bare pass mark.**

Failing a second attempt

If a second attempt fails, the following applies:

1. **For academic assessment fails, a PGCert (postgraduate route) trainee may be allowed to continue training by transferring to the GradCert (degree-level route)** where their attempt has received a mark of 40-49% (i.e. within GradCert pass boundaries).
2. **In all other cases, a second attempt fail constitutes a fail in the module and therefore overall fail of the programme.** Registration as a trainee of the University is terminated. Dependent on service policy, this may also mean termination of the trainee's employment.

Late/non submissions

If trainees are experiencing difficulties in submitting assignments on time, **they are strongly advised to speak to their personal tutor** who will be able to offer support and discuss ways forward.

Penalties for late or non-submission without a valid mitigation are as follows:

First submissions

- **Late submission within 24 hours.** If an assignment is submitted late but within an hour of the deadline, 5 marks will be deducted. If an assignment is submitted up to 24 hours after the deadline without approved mitigation, **marks will be capped for this assignment at the bare pass mark** (50% for clinical assessments, for academic assessments 50% for PGCert and 40% for GradCert). Second attempts are still allowed if this attempt fails.
- **Late submission beyond 24 hours.** Work submitted more than 24 hours beyond a submission date without approved mitigation will receive a mark of zero. Second attempts are still allowed. **Marks for the whole module are capped at the bare pass mark.**

- **Non submissions.** These are marked at 0%. A second attempt is still allowed. **Marks for the whole module are capped at the bare pass mark.**

Second submissions

1. **Late or non-submissions for second attempts without approved mitigation result in a mark of zero for the whole module and therefore a programme fail.** There is no 24 hour grace period. Training is terminated and the trainee's University registration is ended. The trainee's service employment may also end, but this is dependent on their employment contract conditions.

Formatting work

All written assessments (case studies, reflective commentaries etc.) should be word-processed with the following conventions:

1. Use 1.5 line spacing on A4 paper.
2. Use a font size of 12 pt.
3. Use only Times New Roman, Arial or Calibri.
4. Margins: 30mm on the left-hand side, 20mm on the right-hand side and 20mm for top/bottom margins.
5. All pages (including appendices etc.) should be numbered consecutively in one sequence starting with the title page as 1.
6. Include the student number in the header but trainees should **NOT** include their name anywhere on the assignment, as this will prevent work being blind-marked.

Word count guidance

Please note that any words over the word count will not be marked.

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The following content is **not** included in a final word count:

7. Title
8. Reference list
9. Appendices
10. Words used in tables, graphs and other forms of data presentation (including titles of figures)

The following content **is** included in a final word count:

11. Main body of text
12. In-text quotations
13. In-text references
14. Section headings
15. Footnotes containing large amounts of text (unless indicated otherwise by module convenor)

Citing and referencing

We require in-text citations and a reference list (not a bibliography).

Psychology has adopted the American Psychological Association (APA) conventions as the standard for citations and references. References must therefore be completed using the precise details for APA style. We use the standard of 'a publishable article' and expect citations and references to adhere to that standard. The information given here is based on the latest edition of the Publication Manual of the APA. We would encourage trainees to consult these guidelines and copies are kept in the library or can be obtained online at www.apastyle.org and links to online training are on ELE. There are many web sites providing summaries of the APA Style Guide (a Google search will identify these).

The main conventions are as follows:

Journal Articles
A typical citation would be (Ablon & Jones, 1999) and the reference would appear as:

Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, *67*, 6-7.

Another example would be:

Kasen, S., Cohen, P., Skodol, A. E., Johnson, J. G., Smailes, E., & Brook, J. S. (2001). Childhood depression and adult personality disorder - Alternative pathways of continuity. *Archives of General Psychiatry*, *58*, 231-236.

Books
A typical citation would be (Bateman, Brown, & Pedder, 2000) and the reference would appear as:

Bateman, A., Brown, D., & Pedder, J. (2000). *An introduction to psychotherapy* (3rd ed.). London: Routledge.

Chapters in a Book
If you have read a chapter in an edited book you would put the following citation in the text: (Aveline, 2006). In the reference section you would list it as:

Aveline, M., Strauss, B., & Stiles, W. B. (2005). Psychotherapy research. In G. Gabbard, J. S. Beck, & J. Holmes (Eds.), *Oxford textbook of psychotherapy* (pp. 449-462). Oxford: Oxford University Press.

Citations in the Main Text
Citing in text means referring to author(s) with the dates (e.g., Eells, 1997) so that the reader can then go to the References and find them in more detail.

Eells, T. D. (1997). *Handbook of psychotherapy case formulation*. New York: Guilford Press.

Reference citations for two or more works within the same parentheses. List two or more works by different authors who are cited within the same parentheses in alphabetical order by the first author's surname. Separate the citations with semicolons. For example: Several studies (Balda, 1980; Kamil, 1988; Pepperberg & Funk, 1990). Exception: You may separate a major citation from other citations within parentheses by inserting a phrase such as see also, before the first of the remaining citations, which should be in alphabetical order. For example: (Minor, 2001; see also Adams, 1999; Storandt, 1997).

There are many different instances of citing and referencing (e.g. internet resources, personal communication, conference papers, case examples, and you are advised to consult the Publication Manual for these.

Plagiarism and academic misconduct

Plagiarism and academic misconduct is a growing problem in all sectors of education, and the number of reported cases in UK universities has risen dramatically in recent years.

Plagiarism and academic or clinical misconduct are serious breaches of professional ethics. Trainees can fail the programme, be expelled from University or even be prevented from pursuing a career as a PWP.

Plagiarism and academic misconduct are defined as follows:

- **Unauthorised collusion**, i.e. either aiding or obtaining aid from another candidate, or any other person, where such aid is not explicitly required and/or declared;
- **Acting dishonestly in any way**, whether before, during or after an examination or other assessment so as to either obtain or offer to others an unfair advantage in that examination or assessment;
- **Deliberate plagiarism** (see below for definition of plagiarism);
- **Misrepresentation of clinical practice** (for example, in a case report or live patient recording)

Plagiarism

The act of presenting someone else's words or ideas, whether published or not, without proper acknowledgement is called plagiarism. There are three main types of plagiarism, which could occur within all modules of assessment:

1. **Direct copying of text, or illustrations** from a book, article, fellow trainee's essay, handout, thesis, web page or other source without proper acknowledgement. *NB: this can occur unintentionally by failing to use quote marks accurately when quoting from a source.*
2. **Claiming individual ideas derived from a book, article etc. as one's own**, and incorporating them into one's work without acknowledging the source of those ideas. This includes paraphrasing a source, or altering the material taken from the source so it appears to be one's own work.
3. **Overly depending on the work of one or more others without proper acknowledgement** of the source, by constructing an essay, project etc. by extracting large sections of text from another source, and merely linking these together with a few of one's own sentences.

Plagiarism and academic misconduct of any kind are highly serious, and there can be far reaching consequences.

In addition to ensuring you only ever submit your own work based on your own genuine clinical and theoretical practice we would strongly recommend you work through the online resource about Understanding Plagiarism on ELE to clarify the differences between academic honesty and plagiarism, and to identify ways in which you can directly or inadvertently plagiarise.

If you are in any doubt at all or are in anyway unsure how to submit work of clinical and academic honesty please contact your personal tutor.

4. **The re-submission or re-use of the trainee's own work in another assignment** whether this was submitted at the University of Exeter or any other academic institution worldwide. (This is not intended to prevent a student from developing an academic idea over the period of a course, for example stating an argument in an essay for a particular module and then developing this argument in a dissertation, but to prevent the counting of credit twice for the same piece of work. However, this operates at the discretion of the Panel considering the offence.)

Appendix 4: Gaining patient consent and obtaining and recording live treatment recordings

Gaining consent

For any live patient recordings and for the clinical case presentation assessment in Module 3, consent must be gained from the patient. Consent forms detailing how to gain and record consent are on ELE. These differ whether gaining remotely, e.g., by telephone, or face to face in a clinic setting. Patients can consent for their sessions to be recorded (for the Module 2 assessment) or for their session information to be used for a clinical case presentation (the Module 3 assessment). Each requires a different form. For recordings, patients can consent for these to be used for assessment only or for assessment and teaching purposes.

Guidance on recording live treatment recordings

For the competency skills assessment in Module 2 (PYCM068/PYC3020), trainees must submit a recording of a 35-minute live treatment session with a patient. This is mandatory for the summative assessment and is optional, but preferred, for the formative assessment (where marks are for feedback and development only). All guidance for the assessments and recordings is on ELE.

Recordings must be clearly audible and of a complete support session with a Step 2 appropriate patient, for a Step 2 appropriate probable diagnosis and with a Step 2 appropriate intervention.

Recorded patient sessions are highly confidential materials and as such should be treated with the highest standards of Information Governance. Each workplace has its own policies and procedures for gaining consent, recording, storing and transporting recorded material. It is of paramount importance that trainees ensure they understand and adhere to these policies. If in any doubt trainees should consult their clinical supervisor/clinical lead/Information Governance Officer.

Recording equipment and file formats

As part of the requirement to support trainees during training, employing services should provide trainees with the necessary equipment to record sessions in audio or video. Recording equipment should only be used that meets service Information Governance policy standards and **under no circumstances should trainees use personal devices to record patient sessions.** Please ensure that the recordings are saved as standard audio file types, eg .wav, .mp3 etc.

Confidentiality

As far as possible trainees **should avoid identifying a patient by their full name or in any other way on the recording** (See Appendix 7). Consent forms, cover sheets and sound files must all be stored as separate files. Do not include the patient name or any patient identifiable information in any of the filenames.

Obtaining and submitting consent for recording

Prior to making any recordings for University assessment purposes, consent must be gained from the patient to record the session for assessment and optionally teaching purposes. The University protocol for gaining and storing consent is as follows. **It is strongly recommended that trainees request consent for and record as many of their sessions as possible**. This gives the best options for selecting an appropriate recording for assessment, and additionally reflectively listening to sessions

alone or with a supervisor is an excellent way of improving practice, and standard within psychological therapy practices.

Recording a face-to-face in-clinic session

- **Prior to the session, explain the request to record the session**, describing the key information included on the 'In-clinic Consent for Recording Sessions' form (see ELE). Patients can consent to their information being used for assessment only, or for assessment and teaching.
- **If in agreement, ask the patient to sign the relevant part(s) of the form**. This should be hand signed by the patient before the session is started.
- **When you are ready to begin the session itself, start recording. Read out and ask your patient to confirm the Ongoing Statement of Consent.** If 'Yes', keep the recording running and continue with your session as usual. **It is vital that the verbal continuation consent given by the patient is clearly audible at the start of the recorded session.** Unless teaching staff hear this, they cannot mark the recording. If 'No', stop the recording.
- **At the end of the session the trainee should fully complete all other form details** required.
- **For subsequent sessions, repeat step 3 above.**
- **Scan a copy of the completed form and submit alongside the recording and associated cover sheet**. It is good practice to offer a copy of the form to the patient and service policy may also require you to upload a copy to the patient's clinical notes.

Recording remote sessions

- **Prior to the first recorded session, do not start recording but explain the request to record**, as detailed in the 'Remote Consent for Recording Sessions' form (see ELE). Patients can consent to their recordings being used for assessment only, or for assessment and teaching.
- **If the patient is in agreement, start recording. Read out and ask your patient to confirm whether they agree to the relevant parts of the Statement of Verbal Consent** on the form.
- **Stop recording.** You have now created a short audio consent file.
- **When you are ready to begin the session itself, start recording. Read out and ask your patient to confirm the Ongoing Statement of Consent.** If 'Yes', keep the recording running and continue with your session as usual. **It is vital that this ongoing statement of consent by the patient is clearly audible at the start of the recorded session.** Unless teaching staff hear this, they cannot mark the recording. If 'No', stop recording.
- **For subsequent sessions, repeat step 4 above.**
- **Complete, sign and scan the second page of the consent form.** Offer a copy to the patient and service policy may require that you also upload a copy to the patient's clinical notes.
- **Submit the scanned document along with your recording, original audio consent file and associated cover sheet**.

Failure to record consent

No session will begin to be marked until the appropriate fully completed consent is submitted and ongoing consent can clearly be heard on the recording. **Failure to obtain written or recorded patient consent as indicated above will result in the recorded session not being marked, with a first attempt 'Fail' most likely being recorded**, and the service supervisor being advised.

Storage and transportation of recordings

When transporting the recording and any associated cover sheets and consent forms, trainees must adhere to service policies. Recordings, cover sheets and consent forms must ONLY be stored and transported on secure, encrypted devices, in keeping with service policies.

How recordings are stored after submission

The programme timetable clearly identifies when and where recordings are submitted. Once accepted by programme staff, the following apply:

1. On submission, files are stored with the trainee's name, date of submission and details of the assessment (e.g. PYCM067). There should be no other identifiable information.
2. Recordings are transferred to the University's secure drive for IAPT LI by the IAPT LI Course Administrator. Access is restricted to the Programme Administrator, Programme Lead, IT Lead and designated markers only.
3. The markers consist of the IAPT LI teaching team and Programme Lead and for some submissions, the Programme Director and External Examiner. All staff are responsible for adhering to the Data Protection Act, Information Governance and University of Exeter policies and procedures.
4. Markers will access the recordings in a private and appropriate working space to maintain confidentiality.

All recordings are stored on the University's secure drive for IAPT LI as follows:

- Recordings will be stored securely for up to 6 years from the date of submission, after which they will be securely destroyed.
- Exceptions are where consent for use for training purposes has been given by the client and trainee has been given. Recordings are therefore kept on an ongoing basis for training purposes on University of Exeter LICBT courses, and deleted once no longer required.
- No identifiable client information is stored with the recordings.

Any failure in the process outlined above will be highlighted to the Programme Lead and the trainee in the first instance, followed by the trainee's manager. Where there is a continual failure to follow the agreed process, this will be escalated to the Caldicott Guardian or person responsible for Data Protection at each organisation so they may undertake a review.

Appendix 5: Mitigation and Interruption

Mitigation

If short term adverse circumstances in the workplace or in a trainee's personal life are impacting their ability to submit an assignment of appropriate quality on time, trainees may make a mitigation request for these circumstances to be taken into account and the type of consideration being requested, e.g., an extended deadline. Once the request is submitted, decisions are made by a Mitigation Committee which is separate from the teaching staff. Confidentiality rules apply, information will only be shared with the programme team if necessary and wherever possible this will be agreed with the trainee first.

Mitigation procedures

Applications for mitigation will not always be accepted and **we would encourage trainees to speak to their tutor prior to submitting a request**. This page gives examples of acceptable reasons for mitigation: Annex F - Mitigation - Teaching Quality Assurance Manual - University of Exeter

The process for Mitigation is as follows:

i. **Speak to your tutor to discuss your concerns** (optional but encouraged).

ii. **Download the Mitigation form from ELE.**

iii. **Complete and sign your own section and ask your workplace supervisor to complete and sign their section.** NB: if waiting for a workplace supervisor to sign the form would cause a delay in submitting the form beyond the deadline outlined below, then trainees should submit the form with their section completed only, and then follow up as soon as possible with their workplace supervisor's part. Supervisors may 'sign' by typing their name however they must also then send a duplicate copy of the mitigation form to CEDAR-mitigations@exeter.ac.uk as verification.

iv. **Submit your form any time before and no later than 24 hours after the submission deadline** of the assignment you wish to mitigate, by emailing CEDAR-mitigations@exeter.ac.uk (if supervisors are signing remotely they must also email a copy of the completed form to this address). Requests submitted after this time will not be considered except in the most extreme of circumstances. You may optionally wish to submit work or attend an assessment as 'insurance', in case your mitigation request is unsuccessful.

v. **You may need to include evidence for your mitigation request**. If you are unable to provide the evidence at the time of submitting your form, you have up to 10 working days after the assignment deadline to provide this.

vi. **Your form and evidence will be reviewed by the Mitigation Committee** and their decision will be communicated via the Course Administrator.

vii. **If your mitigation request is accepted, a new submission deadline is agreed (or other consideration as indicated by the evidence**). Any work submitted that is no longer relevant will not be marked.

viii. **If your mitigation request is late or rejected, any work you have submitted will be marked as usual**. If you have not submitted work, late and non-submission rules apply (see Appendix 3).

Mitigation duration

There are set durations for mitigation requests, depending on the assignment being submitted.

- Students can request a 72-hour evidence-free extensions for submissions via the eBART system (e.g. essay or outcome document). Please note this is only available for submissions made via eBART and is limited to 4 occasions in a 12-month period.
- Applications for mitigation of academic assignments (essay or exam) are 2 weeks for the first mitigation request, then an additional 2 weeks for the second mitigation request. Third mitigation requests are exceptional and are decided by the programme lead.
- Applications for mitigation of clinical assignments (competency assessment, outcome documents or presentation) are 2 weeks for the first mitigation request, then an additional 4 weeks for the second mitigation request. Third mitigation requests are exceptional and are decided by the programme lead.
- If the proposed submission date on your mitigation request does not match the durations outlined above, then the mitigation team will amend these.

Interruption

Whilst Mitigation is for short-term adverse circumstances, if a trainee is experiencing longer term (6-8 weeks or more) circumstances that make continuing with the course or submitting assessments of an appropriate quality difficult, they may be able to Interrupt, i.e. pause their studies and resume again at a later date. Interruption is a more flexible process for longer term, ongoing difficult circumstances as trainees may request Interruption without knowing a specific date of their return. Interruption is generally for periods of between 2 months and 1 year, although in exceptional circumstances a second year may be agreed.

The process for Interruption is as follows:

i. **Trainees should have an initial conversation with their personal tutor to see if Interruption is a practical option**, and similarly with their service. Service protocols may differ from University procedures, so trainees should ensure this is a viable option with their service.

ii. **If Interruption is indicated, trainees should send an email to LI-IAPT@exeter.ac.uk** requesting Interruption. They will be contacted by the mitigation admin team and supported to fill out a brief form outlining reasons for the request. NB trainees do not have to disclose extensive details of their adverse circumstances, but enough information that those reviewing the request can make an appropriate decision. For example, if a trainee has been signed off sick by their doctor, they can state this but are not obliged to detail the nature of the illness. Trainees will be asked for a date they expect to return to work, however this date can be changed at any time as new information arises or circumstances change.

iii. **The request is forwarded to the Programme Lead and a member of the senior programme staff, who make a joint decision** as to whether to agree Interruption.

iv. **If Interruption is agreed, training is suspended**.

v. **Nothing further occurs until the trainee is able to return to work. The preliminary date for return can be changed as circumstances resolve or continue.** When the trainee is ready to return, the trainee's academic tutor and workplace supervisor liaise together with the

trainee to agree a return schedule. If the trainee had not completed all taught days by the time of Interruption, they will be able to join a future cohort at the same point in the timetable at which they Interrupted (or earlier by agreement). New deadlines for assignment submissions are agreed that take into account the time needed for the trainee to rebuild an appropriate caseload etc.

If any trainee is experiencing ongoing adverse circumstances that affect their ability to engage with the course and produce work of an appropriate quality, we would strongly advise a discussion with their academic tutor to find a supportive way forward.

Appendix 6: Further educational and emotional support

Emotional and wellbeing support

Any form of professional training is potentially stressful. We recognise that the three components of the course: University attendance, clinical practice and independent study may be difficult to balance, and the nature of the work itself can be very demanding.

Within the 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 clinical supervisors. However, we recognise that the programme team and supervisors cannot necessarily provide all the support that may be required.

Other sources of support:

- **Academic Personal Tutor:**
  The academic personal tutor is there to support trainees if they begin to experience difficulties of any kind: personal, academic or otherwise that impact on their training. In the event of significant difficulties that may impede a trainee's ability to study, the academic personal tutor can liaise with the practice-based clinical supervisor to discuss a supportive way forward. This can be far better than a trainee trying to 'keep going' when they are unable to produce work of an appropriate quality that may then result in an assignment, or even programme, fail.

- **Wellbeing Services:**
  The University Wellbeing Services offer free and confidential support for personal problems, emotional difficulties and difficulties with mental health, including 1-1 CBT and counselling as well as more general support, advice and signposting. It is available to all students of Exeter University including trainees. An initial telephone appointment is offered and from there an advisor will help work out the best route of support. Appointments are available by telephoning **01392 724381** or emailing wellbeing@exeter.ac.uk.

  You can read more or book an appointment online here: https://www.exeter.ac.uk/wellbeing/

Support with additional learning needs, disabilities and health conditions

The University AccessAbility team offers support to students with disabilities, physical or mental health conditions and learning or literacy difficulties – or any circumstance that may impact negatively on a trainee's ability to engage with study and meet assessment requirements. The service endeavours to provide facilities and equipment suited to people's individual needs https://www.exeter.ac.uk/students/wellbeing/support/

Following an assessment with the AccessAbility team, if recommendations are made to support the trainee with their learning these will be documented in an Individual Learning Plan (ILP) which programme staff can then use to make reasonable adjustments to the course or assessments. These could include a range of adjustments such as extra time in exams or separate rooms, course materials and lecture slides given out early or on coloured paper, additional time for academic assignments or anything else the team assess as appropriate. Without a documented ILP, the teaching team are unable to make any changes.

Any trainee who could benefit from an ILP is advised to contact the AccessAbility team as soon as possible - even before the course starts - if adaptations could be helpful.

Library facilities and services

The main library facilities are at the University of Exeter Streatham Campus. The library catalogue, including access to electronic journals, and facilities for reserving and renewing books are also available online www.exeter.ac.uk/library.

Library support is organised by subject, and this is the specific page for Psychology students: https://libguides.exeter.ac.uk/psychology. As well as access to all the Psychology texts, databases and resources, the library offers highly helpful online tutorials, links and information, plus 1-1 support if needed around about the following:

1. how (and where) to effectively search for articles, research, books and papers
2. how to evaluate source materials and how to reference them
3. how to understand different academic materials, e.g., statistics, reports, systematic reviews, policies, guidelines etc
4. where to find statistics

Access to external libraries and inter-library loans

Trainees can also access other higher education libraries via SCONUL (an arrangement between many higher education institutions) and are entitled to Inter-Library Loans.

More information can be found on the University Library website at www.exeter.ac.uk/library, or direct from SCONUL- www.sconul.ac.uk/sconul-access .

Study Skills Service

The Study Skills Service offers confidential help to any student who would like to improve their academic study skills. The Study Skills Advisors can help with the following:

5. reading effectively
6. selecting reading from book lists
7. planning and writing assignments or essays
8. taking useful notes
9. revising for exams
10. organising your time
11. generally evaluating your study skills

This service is available to all students of the University including trainees, who can and do consult the Study Skills Advisors. Help is available throughout each term and during part of each vacation - see www.exeter.ac.uk/student-engagement-skills.

This support can be highly beneficial for anyone, especially if a trainee has not worked at post-graduate level before.

English Language Skills Development

The University of Exeter offers courses, workshops and tutorials that support the English language development of students whose first language is not English. This provision helps students to improve and develop their academic English and literacy skills for academic study, and to build communicative and intercultural competence for life in the UK.

Courses and workshops include Subject Specific Academic English, General Academic English and Social and Cultural English. They cover:

- Academic writing
- Presentations skills
- Language development and grammar
- Oral Communication
- Pronunciation
- Language for employability
- Intercultural communication
- One-to-one tutorial support

More information can be found on the English Language Skills Development website. Please click here.

Appendix 7: Confidentiality

Working within IAPT necessarily involves working with patients around distressing, sensitive and difficult issues. As practitioners, we are given the power to influence the lives of patients who may be very vulnerable and this requires a high degree of responsibility in respecting confidentiality and being fully aware of information governance. It is also a job that requires emotional resilience, self-awareness and self-care.

Patient confidentiality

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.

When sharing information about patients or cases, trainees and staff alike must do so:

- **in a manner most likely to protect the identity of the patients, both directly and indirectly.** This means not disclosing any directly identifying information, such as names, identifying details of their contact with the service e.g., dates/times, the name of the service, clinic or location they attended etc. In addition, no details should be disclosed that are so specific about the patient or their family that they could pinpoint who the patient is. Examples are: names of family members; GP; home, school or workplace locations; specific job; unusual health conditions; unusual hobbies or interests etc.
- **in a manner and setting which is respectful,** for example not using inappropriate or caricaturising illustrations, captions or representations etc.
- **in a manner which honours the limits of confidentiality,** explained previously to a patient.
- **with an understanding that no member of the group will disclose any information** about such patients outside the sessions.

Trainee confidentiality

It is recognised that we all have life experiences and relationships that have shaped who we are and that we can all be emotionally affected by the work we do. It is for this reason that the programme promotes reflective practice, to ensure that we are mindful of the way our own experiences and assumptions about the world, people and relationships may influence our therapeutic practice.

We would like to promote an ethos which allows trainees the opportunity to reflect openly and honestly on the challenges of their role. This means that trainees may sometimes share personal information about themselves with staff and each other. Trainees can expect that colleagues and staff members will be thoughtful and sensitive about their right to confidentiality. As a staff team, we also have to balance this with the need to ensure that we are protecting the interests of potential patients; and to ensure that trainees are able to provide appropriate clinical interventions. For this reason, we provide the following information about confidentiality of trainees:

1. **The details of any personal material remains confidential within the context in which it is shared.** 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.

2. **The only exception is if there are concerns about an individual's safety** (child or adult). In such cases trainees should consult a member of the programme team, and when possible, inform the person concerned that they are doing this and explain why.

3. **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/supervisor as identified). This will routinely include sharing trainees' marks for the assessments within the programme and sharing an overview of the trainees' progress. Trainees will have consented to having this information shared as part of the application form.

4. **Personal matters affecting training can be kept confidential within or from the programme team**. Where a trainee shares personal details regarding circumstances affecting their training or ability to provide appropriate patient care, there should be a discussion about how best and with whom to share concerns. Although 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 will be done in a way which keeps the specific details of trainees' circumstances confidential, even between members of the teaching team if the trainee desires. If necessary, a confidentiality agreement can be drawn up between the trainee and appropriate staff/supervisors.

5. **If a trainee discloses information indicating personal risk of harm to self or others, it is necessary to inform the trainee's service and/or their GP**, in accordance with standard mental health practice. Trainees will have consented to this as part of the application form. Where risk is a concern, the teaching team will always, where possible, seek to inform others with the trainee's full knowledge.

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, gender reassignment, age, race and ethnicity, disability, marriage and civil partnership, pregnancy and maternity, religion and belief, sexual orientation, 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.
- **Remember you are the "expert" about your own life** – any questions or suggestions from others may be rejected as inappropriate.

Supplementary guidance on the use of Social Media

All of the above applies as much to social media as to any other mode of communication. The British Psychological Society (BPS) acknowledges that members are using social networking sites to communicate with friends, family, professionals and clients. Page 19 of the BPS Practice Guidelines (Third Edition) provides practical advice for using social networking sites responsibly.

Appendix 8: Campus and Washington Singer services

The University campus

The campus is compact and well signposted. Click here for a map. Key buildings include:

- The Forum (for Student Information Desk, cafes and restaurants, non-academic enquiries & the Library)
- Devonshire House (café, shops, Student Union bar etc.)
- Reed Hall Mews (Student Health Centre)
- Northcote House houses the University's administration
- The Sports Hall & open-air swimming pool adjacent to Cornwall House (open end of May to middle of September) and an indoor pool at St Luke's College.

Parking

The University encourages sustainable transport. However, we recognise that for many students travelling by car is the only practical option. **Parking is very restricted** on campus, so it is strongly advised to read the University's web pages about parking on campus.

Access to buildings

Washington Singer Laboratories and the adjacent Sir Henry Welcome Building are home to the CEDAR programmes. Washington Singer hours of access are:

- Reception opening hours are 9am - 4.45pm term time.
- Open 24/7 with swipe card access

IT facilities

There are numerous desktop computers with scanning and printing facilities available for trainees use within Washington Singer. Ask at reception for details of how to use your university card for printing etc. The University has many additional IT facilities. Please see the following links for more information: Exeter IT

Bikes

The University of Exeter encourages a green transport scheme. There are bike racks at the front of Washington Singer Laboratories.

Showers

There are showers available in both the ground floor male and female toilets, that are free to use.

Refreshment facilities

A boiling water tap and microwave are available for student use in the Lea Hub on the ground floor. Coffee and snack vending machine facilities are available in the building.

There are numerous shops, eat-in and take away food and drink outlets right across the University available for trainee use. Please see here for full details:
http://www.exeter.ac.uk/campusservices/eatandshop/

Appendix 9: Risk Assessment

Risk Assessment - Assessment

1. All introductions and questions should be stated clearly and without euphemisms or apologies.
2. There must be no leading or assumptions, and no double questions.
3. Any positive, vague or ambiguous answers must be funnelled to gain clear, accurate details.
4. The following must be asked as a minimum, service policy may dictate additional details should be asked or given.

Current Suicide	**Separately** ask about: **1.** Thoughts **2.** Plans **3.** Actions *NB if asking about 'intent' also ask about Thoughts, Plans and Actions*
Past Suicide	**Separately** ask about: **4.** Thoughts **5.** Actions
Protective factors	Ask clearly about protective factors, explaining what protective factors are as needed. Funnel to gain any details if needed.
Current Self-Harm	**Separately** ask about: **6.** Thoughts **7.** Actions *NB if asking about 'intent' also ask about Thoughts and Actions* *If needed, explain questions are about harming oneself in <u>any</u> way, to distinguish from suicide attempts or only overt means such as cutting, burning etc*
Past Self-Harm	Ask about: **8.** Actions
Risk to Others	Clearly ask if the patient feels they may pose a risk of harm in **<u>any</u>** way to **<u>anyone</u>** else. *NB harm can take many forms: physical, verbal, emotional, psychological, financial etc.*
Risk from Others	Clearly ask if the patient feels they may be at risk of harm in **<u>any</u>** way from **<u>anyone</u>** else. *NB harm can take many forms: physical, verbal, emotional, psychological, financial etc.*
Self-neglect	Clearly ask if the patient is not looking after themselves in any way which may be harmful e.g. (but not limited to) not washing themselves or their clothes/bedclothes, not eating or drinking well enough, using harmful substances, not taking medication or getting medical help etc.
Dependents	Clearly ask if there is anyone who depends on the patient for their care in any way, adult or child, directly or indirectly.
Neglect of Others	Clearly and separately ask about: **9.** Neglect of any identified dependents (adults or children) **10.** Anyone else the patient may feel they are neglecting

IN ALL CASES, IF RISK IS IDENTIFIED PWPS <u>MUST PRIORITISE</u> FOLLOWING SERVICE PROCEDURES TO ENSURE PATIENT AND/OR OTHERS ARE SAFEGUARDED.

Risk Assessment - Treatment

5. For each item, previously understood information should be reflected back and then the patient asked if there are any changes.
6. There must be no leading or assumptions, and no double questions.
7. Any changes or any vague or ambiguous answers must be funnelled to gain clear, accurate details.
8. The following must be asked as a minimum, service policy may dictate additional details should be asked or given. Trainees will not be marked down for this, but it is not required.

<table>
<tr><td>Current Suicide</td><td colspan="2">If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:
11. Thoughts
12. Plans
13. Actions
If no risk was previously identified Thoughts, Plans and Actions can be reflected back together e.g., “With regards to suicide, last time we met you told me you weren’t experiencing any thoughts of wanting to end your life, hadn’t made any plans and hadn’t taken any actions towards ending your life – has anything changed?”</td></tr>
<tr><td>Protective factors</td><td colspan="2">Reflect back previously understood protective factors and ask if there have been any changes.</td></tr>
<tr><td>Current Self-Harm</td><td colspan="2">If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:
14. Thoughts
15. Actions
If no risk was previously identified Thoughts and Actions can be reflected back together e.g., “With regards to any kind of self-harm, last time we met you told me you weren’t experiencing any thoughts of hurting yourself and hadn’t taken any actions towards self-harm in any way – has anything changed?”</td></tr>
<tr><td>Risk to Others</td><td>Reflect back previously understood risk status and ask if there have been any changes.
NB harm can take many forms: physical, verbal, emotional, psychological, financial etc.</td><td rowspan="2">If no risk was previously indicated Harm to and from others can be reflected back together, e.g. “Last time you told me you didn’t feel you posed a risk of harm to anyone, and that no one was posing any risk of any kind to you – has anything changed?</td></tr>
<tr><td>Risk from Others</td><td>Reflect back previously understood risk status and ask if there have been any changes.
NB harm can take many forms: physical, verbal, emotional, psychological, financial etc.</td></tr>
<tr><td>Dependents
Neglect of Dependents</td><td colspan="2">Reflect back previously understood dependents/lack of dependents and ask if there have been any changes. If dependents, then ensure neglect of dependents is reflected and checked.</td></tr>
<tr><td>Self-neglect</td><td>Reflect back previously understood risk status and ask if there have been any changes.</td><td rowspan="2">If no neglect to self or others was previously indicated Self-neglect and Neglect of Others can be reflected back together, e.g. “Last time you told me you didn’t feel you were neglecting yourself, or anyone else who may depend on you in any way – has anything changed?</td></tr>
<tr><td>Neglect of Others</td><td>Even if no dependents, still check neglect to anyone else. Reflect back previously understood neglect/lack of neglect and ask if there have been any changes.</td></tr>
</table>

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