

PGCert/GradCert Psychological Therapies (Low Intensity Cognitive Behavioural Therapies)

Course Handbook Cohort 35

March 2024

Teaching Team: LI_tutor-support@exeter.ac.uk

Programme Administrator: LI-IAPT@exeter.ac.uk

ELE Cohort 35 homepage: <https://ele.exeter.ac.uk/course/view.php?id=17235>



University
of Exeter

Cedar

Table of Contents

How to use this handbook	4
Supervisor notes	4
Protection of dignity at work and study	4
Cedar Equity, Diversity & Inclusion Statement	5
Course contacts	6
Communication	6
Contacting us	6
Course overview	8
Key facts about the course	8
Course content, assessments and passing or failing the course	11
The role of the clinical supervisor	13
Specific roles of the clinical supervisor	13
Module 1: Engagement and assessment of patients with common mental health problems ..	15
Learning objectives	15
Key topics covered	15
Module 1 Assessments	17
Module 1 Clinical assessment	17
Module 1 Academic assessment	17
Module 1 Clinical Outcomes Document	18
Supervisor notes	21
Module 2: Evidence-based Low Intensity treatment for common mental health disorders ..	23
Learning objectives	23
Key topics covered	23
Module 2 Assessments	24
Module 2 Clinical assessment	24
Formative clinical assessment	26
Module 2 Academic assessment	26
Module 2 Clinical Outcomes Document	27
Supervisor notes	31
Module 3: Values, diversity and context	34
Learning objectives	34
Key topics covered	34
Module 3 Assessments	35
Module 3 Clinical assessment	35

Module 3 Academic assessment	36
Module 3 Clinical Outcomes Document	37
Supervisor notes.....	40
Appendices.....	43
Appendix 1: Timetable, locations and teaching and learning methods.....	43
Locations	43
Teaching and learning methods	43
Self-Practice, Self-Reflection (SP/SR)	44
Appendix 2: Passing or failing the course and appeals	46
Passing the course and final awards	46
Module weighting	46
Final award calculation:.....	46
Receiving certificates	47
Graduation	47
Failing the course.....	47
Appeals	48
Appendix 3: Assignment guidance and submission	49
Specific assignment guidance.....	49
Assignment marking schemes	49
Clinical assessment marking schemes.....	49
Academic assessment marking schemes	49
Submission methods	51
Submitting through ELE.....	51
Passing or failing assessments.....	52
Passing an assessment and grade boundaries	52
Failing an assessment	52
Late/non submissions.....	53
First submissions	53
Second submissions	53
Formatting work	53
Word count guidance.....	54
Citing and referencing	54
Plagiarism and academic misconduct	54
Appendix 4: Gaining patient consent and obtaining and recording live treatment recordings	57

Gaining consent.....	57
Guidance on recording live treatment sessions.....	57
Recording equipment and file formats.....	57
Confidentiality.....	58
Obtaining and submitting consent for recording	58
Recording a face-to-face in-clinic session	58
Recording remote sessions.....	58
Failure to record consent	59
Storage and transportation of recordings	59
How recordings are stored after submission.....	59
Appendix 5: Mitigation and Interruption	61
Mitigation.....	61
Mitigation procedures	61
Mitigation duration.....	62
Interruption.....	62
Appendix 6: Further educational and emotional support	64
Wellbeing support	64
Support with additional learning needs, disabilities and health conditions.....	65
Library facilities and services	65
Access to external libraries and inter-library loans	65
Study Zone Service	66
Appendix 7: Confidentiality and ground rules	67
Patient confidentiality.....	67
Trainee confidentiality.....	67
Ground rules for groups, tutorials and supervision.....	68
Supplementary guidance on the use of Social Media.....	69
Appendix 8: Risk Assessment	70
Risk Assessment at assessment	70
Risk Assessment at treatment	71

How to use this handbook

Ensure you have used the course 'Quick Start and How-to Guide' to get up and running for Day 1. 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:

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

To navigate the handbook, you can press Ctrl + Click on the headings on the Table of Contents page to take you to that specific section. Alternatively, you can use Ctrl + F to search within the document, e.g. "module 1 assessments".

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.

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/>

Cedar Equity, Diversity & Inclusion Statement

It is our intention within Cedar that trainees from all diverse backgrounds and perspectives be well served by our training courses, that trainees' learning needs be addressed both in and out of teaching sessions, and that the diversity that trainees bring to their learning environment be viewed as a resource, strength and benefit. It is our intention to present materials and activities that are respectful of diversity. This includes, but is not limited to, gender and gender identity, sexuality, disability, age, socioeconomic status, ethnicity, religion, race, and culture. Your suggestions are at all times invited, encouraged and appreciated. We encourage you to let us know ways to improve the effectiveness of the course for you personally or for other trainees or student groups. In addition, if any of our training sessions conflict with your religious events, or if you have a disability or other condition necessitating accommodation, please let us know so that we can make the necessary arrangements for you in line with your professional body/ national curriculum requirements.

Our goal within Cedar as a learning community is to create a safe learning environment that fosters open and honest dialogue. We are all expected to contribute to creating a respectful, welcoming, and inclusive environment within which any form of discrimination will not be tolerated. To this end, classroom discussions should always be conducted in a way that shows respect and dignity to all members of the class. Moreover, disagreements should be pursued without personal attack and aggression, and instead, should be handled with care, consideration and a non-judgmental stance. This will allow for rigorous intellectual engagement and a deeper learning experience for all.

(Statement adapted from the University of Iowa, College of Education and Yale University - Dr. Carolyn Roberts, Assistant Professor, History of Science & History of Medicine, and African American Studies)

At Cedar, in our training of psychological professionals, we are committed to progressing and embedding the principles of equity, diversity and inclusion into all areas of our training courses, and are active in our endorsement of the Psychological Professions Network Equity, Diversity, and Inclusion Position Statement which can be read here:

<https://www.ppn.nhs.uk/resources/ppn-publications/462-ppn-equity-diversity-and-inclusion-position-statement-v1-0-october-2023/file>




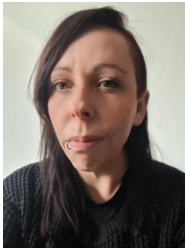


Course contacts













Communication

For day-to-day communication we use trainees' University of Exeter email addresses, so it is essential that trainees check this email address regularly or set up forwarding to their main email address. Trainees must use their university email to contact tutors and programme team members, rather than service or personal accounts.

Contacting us

- **The Teaching Team (LI_tutor-support@exeter.ac.uk):** email us at any time to ask questions or get support around the training, teaching content or assessments, or to let us know about planned or sudden absences, difficulties with accessing links or materials, etc.
- **The Programme Administrator (LI-IAPT@exeter.ac.uk):** will be able to answer information about course procedures and protocols, e.g., attendance, submission, mitigations etc.

<p>Professor Paul Farrand Co-Director of Low Intensity CBT Training</p> <p><u>P.A.Farrand@exeter.ac.uk</u></p>		<p>Liz Kell Co-Director of Low Intensity CBT Training</p> <p><u>L.Kell@exeter.ac.uk</u></p>	
<p>Sarah McGahey Programme Lead (PGCert), Senior Lecturer</p> <p><u>S.McGahey@exeter.ac.uk</u></p>		<p>Dona-Marie Anderson Programme Lead (PWP Apprenticeship), Senior Lecturer</p> <p><u>D.Anderson4@exeter.ac.uk</u></p>	
<p>Laura Blaken Programme Administrator (PGCert)</p> <p><u>LI-IAPT@exeter.ac.uk</u></p>		<p>Senga Clarke-Côté Lecturer</p> <p><u>S.Clarke-Cote@exeter.ac.uk</u></p>	

<p>Michaela Newton Lecturer</p> <p><u>M.Newton2@exeter.ac.uk</u></p>		<p>Rose Wysocka Lecturer</p> <p><u>R.Wysocka@exeter.ac.uk</u></p>	
<p>Megan Whitworth Lecturer</p> <p><u>M.Whitworth@exeter.ac.uk</u></p>		<p>Grace Riley Associate Lecturer</p> <p><u>GR383@exeter.ac.uk</u></p>	
<p>Natasha Page Associate Lecturer</p> <p><u>N.A.Page@exeter.ac.uk</u></p>		<p>Tamsin Hayes Associate Lecturer</p> <p><u>T.Hayes@exeter.ac.uk</u></p>	
<p>Manraj Singh Baring Associate Lecturer</p> <p><u>M.S.Baring@exeter.ac.uk</u></p>		<p>Helena Carter Associate Lecturer</p> <p><u>HC770@exeter.ac.uk</u></p>	
<p>Yahya Delair Associate Lecturer</p> <p><u>Y.Delair@exeter.ac.uk</u></p>		<p>Amber Ford Associate Lecturer</p> <p><u>A.Ford2@exeter.ac.uk</u></p>	
<p>Laura Makem Associate Lecturer</p> <p><u>lm877@exeter.ac.uk</u></p>		<p>Lucy Howl Associate Lecturer</p> <p><u>lh812@exeter.ac.uk</u></p>	

Course overview

The course follows the **National Curriculum for the Education of Psychological Wellbeing Practitioners** (updated April 2023) see:

<https://healtheducationengland.sharepoint.com/:w:/g/Comms/Digital/EX6iEBwa8SJHmVrhOQRYOqUB3FBI00m7lZHPEDb5yIAaPA?rttime=bm1EY-CY20g>) 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 practices may differ, but this national curriculum and the assessment and treatment protocols taught are based on the evidence of what constitutes effective, safe, patient-centred assessment and treatment as part of the NHS Talking Therapies (formerly known as 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 NHS Talking Therapies 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 NHS Talking Therapies 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 (pass mark is 50%), however for academic assignments the pass mark for GradCert is 40% and the pass mark for PGCert 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 NHS Talking Therapies service.
- **The course consists of 3 modules, across 30 taught days** (teaching theory and clinical skills) **and 15 University directed study days** (directed study, roleplay, Self-Practice/Self Reflection, problem-based learning etc). The service should also facilitate 10 self-directed study days in addition to this. **Each module has 3 assessments:** one clinical, one academic and one service based. **All trainees will need to undertake additional private study, for example for assessment preparation, exam revision, further reading etc, which could be completed in the evenings or at weekends.**
- **Teaching locations:** Locations for each taught session are detailed on the Timetable ([Appendix 1](#)). Sessions will be delivered through blended learning, comprising a mixture of remote and in-person teaching. Remote sessions run from **9am – 5pm**, with half an hour to prepare from 9am, and then the scheduled activities 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. In-person teaching sessions will run from **10am- 4.30pm** with a minimum of 45 minutes allocated for a lunch break, plus two 15-minute breaks.

- **ELE:** All timetables, day schedules, course materials and resources are on the course intranet ELE (Exeter Learning Environment). Each trainee has a unique log in to this protected area.
- **Attendance & absence:** Attendance is expected to be 100% in line with national NHS Talking Therapies 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. 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 and their service.** It is not possible to 'make up' for absence, but trainees are expected to catch up on all missed material before the next teaching day. **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 is 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 and Wellbeing services – 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 looking favourably on extension to deadline requests and extended examination times) that the teaching team can make, but only where there is a documented ILP in place advising such.
- **Liaison with managers/supervisors/clinical leads:** Academic tutors routinely discuss marks, performance and any difficulties with service supervisors/clinical leads. At the end of Modules 1 and 2 feedback calls between trainees, tutors, and service supervisors are offered to discuss the 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 act within the Codes of Practice and Professional Conduct as defined by their service and a professional and/or accreditation body. The latest Codes of Practice and Professional Conduct can be found under the 'How the Course Works' tile on ELE. Additionally, the University has a responsibility to ensure trainees are 'fit to practise'. Concerns around a trainee's fitness to practise may arise when a trainee:
 - disregards the Codes of Practice and Conduct
 - demonstrates a lack of insight/awareness
 - fails to remediate (following support)
 - disregards probity and honesty (misconduct)
 - fails to appropriately manage a health condition/demonstrates a lack of insight into the impact of this on those around them

Further information about this and the Fitness To Practise procedure can be found on ELE ('Course Information' tile).

- **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** (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: Worry Management; Cognitive Restructuring (with or without Behavioural Experiments); Exposure & Habituation or Exposure and Response Prevention; and Behavioural Activation.

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 pass mark. Failure of a second attempt results in failure of the programme and termination from the course. (See [Appendix 3](#))

Failing the course: Failure of a second attempt at an 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](#))

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 (for second attempts this will result in failure of the course). Extensions of any kind cannot be granted except by formal Mitigation request (see below). **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 will be released on ELE 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 complete the course without shadowing, observing, practising and working under competent supervision by a fully trained practitioner within a fully functioning NHS Talking Therapies 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 roleplay; 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; case management supervision; facilitating clinical skills supervision; reviewing trainee reflections 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:

- **Be familiar with the course structure, timetable, key clinical competencies, assessment dates and marking schemes** and refer to programme materials and academic staff as much as necessary to fill any gaps in current knowledge.
- **Negotiate, sign and date a supervision contract** clarifying boundaries and responsibilities of the supervisor and supervisee.
- **Facilitate ongoing opportunities and experience for the trainee to develop appropriate competence in clinical skills** across face-to-face, telephone, video, email/text, 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 roleplay or actual patient contact with Step 2-appropriate patients, as appropriate to trainees' developing skills.
- **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.
- **Carry out observation of a trainee's work and competence directly and indirectly** - initially through roleplay and then through direct shadowing of assessments and treatments, reviewing tapes of sessions, reading and reviewing case notes, trainee referrals etc.
- **Facilitate, monitor and develop trainee skills in case management supervision and clinical skills supervision** in line with NHS Talking Therapies and PWP national curriculum guidelines.

- **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 roleplay then through live or recorded sessions.
- **Review and practice-mark treatment formative and summative tapes prior to submission**, identify any development needs, 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.
- **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.
- **Where necessary raise issues around a trainee's progress** with appropriate members of staff, both within the service and the University.
- **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.
- **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.
- **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 request an extension if not met):
 - 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).
 - a minimum of **20 hours of clinical skills supervision**
 - a minimum of **20 hours of case management supervision**
- **Monitor through supervision the trainee's delivery of a complete treatment protocol** with at least one patient for each of the following interventions:
 - **Behavioural Activation**
 - **Worry Management** (including Worry Postponement or Problem Solving)
 - **Cognitive Restructuring** (with or without Behavioural Experiments)
 - **Exposure and Habituation** or **Exposure and Response Prevention**

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

Learning objectives

This module covers the Learning Outcomes for Module 1 from **the National Curriculum for the Education of Psychological Wellbeing Practitioners** (updated April 2023) see: <https://healtheducationengland.sharepoint.com/:w:/g/Comms/Digital/EX6iEBwa8SJHmVrhOQRY0qUB3FBI00m7IZHPEDb5yIAaPA?rttime=bm1EY-CY20g>

Overall, trainees will develop 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 NHS Talking Therapies 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**
 - **Body Dysmorphic Disorder** (*not treated at Step 2*)
 - **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 through the teaching days, study days and service days with other conditions that they may encounter and need to recognise within Step 2 assessments such as Bipolar Disorder, psychosis, eating disorders, Chronic Fatigue, MUS, personality disorders etc. This is something services should support through in-service training.)

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
 - **NHS Talking Therapies Risk Assessment** (See [Appendix 8](#))
 - **General information gathering** (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
 - **Ending:** problem statement, next contact etc
- 6. Common factor skills** (empathy, non-judgment, funnelling, collaboration, reflection, summarising, timing)
- 7. Medication support**
- 8. Clinical decision making** for appropriate disorders for Step 2 and Step 3, see Table 1

Table 1

Disorder	Step 2 Intervention Taught (for Mild to Moderately Severe Presentations)
Depression	Behavioural Activation (with or without physical activity). Alternatively, CR (with or without Behavioural Experiments)
GAD	Worry Management (including Worry Postponement or Problem Solving)
Panic Disorder	Cognitive Restructuring (with or without Behavioural Experiments)
Agoraphobia and Specific Phobias	Exposure & Habituation
OCD	Exposure and Response Prevention
PTSD	No current Step 2 intervention, step 3 indicated
Social Phobia	No current Step 2 intervention, step 3 indicated
Health Anxiety	No current Step 2 intervention, step 3 indicated
Body Dysmorphic Disorder	No current Step 2 intervention, step 3 indicated

Module 1 Assessments

Module 1 Clinical assessment

- **Roleplay with an actor simulating a 45 minute Step 2 PWP assessment** according to National Curriculum Guidelines.
- **Submission** - live roleplay on the day of assessment via video call. Roleplays are video recorded 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. (See [Appendix 8](#))
 - **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 ELE and copied to designated service supervisors.
- **In the event of failure**, trainees will receive detailed feedback and be invited to attend a Skills Day.
- **Reassessment:** 4 weeks from the Skills Day. Marks for reassessments are capped at 50%, and the overall module mark is also capped at the 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 the link on ELE by no later than 11 am on the date of assessment.

- **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](#)), focussing 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:** Looking for clear familiarity with and understanding of the key topics and issues covered to date,
 - **Theory into practice:** 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 ELE and copied to designated service supervisors.
- **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 pass mark.

Module 1 Clinical Outcomes Document

- The Clinical Outcomes Document is a working document, which means trainees will add to it as they expand their competencies and build on their clinical hours over the course of the training. There are 3 submissions throughout the course corresponding to the 3 modules, but trainees will use the same document each time. This means they can add to what they have already recorded, and easily keep track of their clinical hours. By the end of the programme (and by the Module 3 Clinical Outcome Document deadline), trainees should have a fully completed 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. Trainees can find 'plain English' explanations of these competencies in the Clinical Outcomes Document Guidance, available on ELE.

1. **Demonstrate competency in undertaking and recording a range of assessment formats.** This should include both triage within an NHS Talking Therapies service and problem focused assessments.
 2. **Demonstrate experience and competence in the assessment and correct identification of presenting problems across a range of problem descriptors** including depression and two or more anxiety disorders.
 3. **Demonstrate the common factor competencies necessary to engage patients** across the range of assessment formats.
 4. **Demonstrate understanding of the complexity of mental health difficulties,** to conceptualise comorbidity of mental disorders and prioritise the appropriate primary problem in the context of both physical and mental health comorbidity.
 5. **Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record keeping systems.**
 6. **Demonstrate competence in identifying patients at assessment who do not fit the criteria for treatment at Step 2** (e.g. those with PTSD, social anxiety disorder or severe mental health problems) and facilitate appropriate stepping up or onward referral.
- **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.
 - **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/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 the link on ELE by no later than 11 am on the deadline date.

If **hand signing**, you can still type into the document but will need to print it out, hand sign it, and then the trainee will scan the document and submit via the link on ELE.

If **digitally signing**, the supervisor/s must type the name or insert an e-signature. The trainee will then need to submit the 'signed' document via the link on ELE.

Additionally, the supervisor will need to email LI-IAPT@exeter.ac.uk from their work email with the same completed document attached, by the deadline. If they are happy to sign off your Outcome Document they should include the following statement in their email: ***"I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email"***. If the supervisor is not signing off an element of the Outcome Document as the trainee has not yet demonstrated the ability to meet a certain area, the supervisor should include a statement in the email saying ***"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 outcome where supervisor is not yet happy to sign trainee off] for [module and outcome number, e.g. Module 2, outcome 1.]"***

If there is a mix of both hand and digital signatures, you must follow the digital signing procedure above.

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 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 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 pass mark.

- **Reassessment:** 4 weeks from the feedback being given (or as agreed in discussions).

Supervisor 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 roleplay practice, the majority of trainees find translating this into effective, real-world clinical practice difficult. Observation of all trainees assessments until successful completion of the Module 1 Competency Assessment is the best way to ensure patient safety, adequate clinical standards, and staff wellbeing. Trainees would benefit from building their assessment caseloads very gradually whilst receiving routine support and immediate supervision for each session until their skills have fully 'bedded down', which may take some weeks. Many trainees find developing their PWP assessment skills, supervision skills and clinical note taking skills – alongside their University training and assignments – stressful and may need close monitoring and assistance.

2. Additional roleplay

Trainees are given roleplay opportunities within University taught and study days, but without further roleplay opportunities within service will find it difficult to achieve competency. Trainees would benefit from a wide range of roleplay 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. Roleplays 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 PWP's 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 outlined in [Appendix 8](#). 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 outlined in [Appendix 8](#).

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 PWP's. Trainees should be able to give clear, normalising explanations of common mental health conditions, their related CBT 'vicious cycles' and how CBT 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. 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 compulsory sections in the competency assessment within time is a common way for trainees to fail. Facilitating trainees to practise full roleplays 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

Learning objectives

This module covers the Learning Outcomes for Module 2 from **the National Curriculum for the Education of Psychological Wellbeing Practitioners** (updated April 2023) see: <https://healtheducationengland.sharepoint.com/:w:/g/Comms/Digital/EX6iEBwa8SJHmVrhOQRYOqUB3FBI00m7lZHPEDb5yIAaPA?rtime=bm1EY-CY20g>

Overall, trainees will develop 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, video, email/text, 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; NHS Talking Therapies 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 can be found in [Appendix 4](#).
 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
 - Exposure & Response Prevention
 - Promoting good sleep
 - 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, video, email/interactive text, face-to-face and cCBT and group working:** an introduction to delivering patient sessions across a variety of modes
 6. **Promoting good sleep:** including sleep hygiene
 7. **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, complete 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. The complete recording of the whole session must be submitted, without pausing within the session or editing after the session.
- **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. The 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).

Note the following essential submission criteria:

1. **All submissions must be accompanied by appropriate patient consent.** 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.
2. **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.
3. **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 e.g. 'firstname_lastnamerecording.wav', 'firstname_lastnameverbalconsent.wav'
4. **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.
5. **Where remote working prevents printing and hand signing of the cover sheet, use the following remote sign off process:**
 - a) 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 the secure form on ELE as described above.
 - b) **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.

- **The submission will be marked** using the Competency Assessment Treatment Marking Scheme, which can be found on ELE.
- **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:
 1. **Risk Assessment is an auto-fail section**, i.e. failing the risk assessment means failing the whole assessment. See [Appendix 8](#).
 2. **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 ELE and copied to designated service supervisors.
- **In the event of failure** trainees receive detailed feedback and can attend a Skills Day.
- **Reassessment:** 6 weeks from the Skills Day. Marks for reassessment are capped at 50%, and the whole module is capped at the pass mark.

Formative clinical assessment

There is a formative version of this clinical assessment several weeks prior to the summative, which is marked but only for feedback and development purposes. Detailed feedback is provided to trainees through a telephone 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 roleplay based on a scenario provided by the University.

All details for submission are as for the summative, except in cases of a roleplay 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 university directed days can be tested. Trainees are encouraged to revise intervention protocols, key literature and evidence base etc that are referred to directly on teaching PowerPoint slides or on associated UDD homework sheets. Note: Content may include some elements that were raised in Module 1 that are built upon in module 2 e.g. funnelling, COM-B, risk etc.
- **Submission:** 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 ELE and copied to designated service supervisors.
- **In the event of failure**, a trainee should contact the teaching team for further support.
- **Reassessment:** 4 weeks from the date results are provided. Second attempts are capped at the pass mark. The overall mark for the module is also capped at the pass mark.

Module 2 Clinical Outcomes Document

- The Clinical Outcomes Document is a working document, which means trainees will add to it as they expand their competencies and build on their clinical hours over the course of the training. There are 3 submissions throughout the course corresponding to the 3 modules, but trainees will use the same document each time. This means they can add to what they have already recorded, and easily keep track of their clinical hours. By the end of the programme (and by the Module 3 Clinical Outcome Document deadline), trainees should have a fully completed 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. Trainees can find 'plain English' explanations of these competencies in the Clinical Outcomes Document Guidance, available on ELE.
 1. **Demonstrate 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 descriptors including depression and two or more anxiety disorders, and across all modes of intervention (in person, telephone, video platform).
 2. **Demonstrate an understanding of problems that should not be treated at Step 2**, and where and how appropriate treatment should be accessed for these.
 3. **Demonstrates the ability to use common factor competencies to manage emotional distress and maintain therapeutic alliances** to support patients using LI interventions.

4. **Demonstrate competence in delivering low-intensity interventions using a range of methods including one-to-one treatment** (in person, via video consultation, via telephone, interactive text or computerised cognitive behavioural therapy (cCBT)) and where possible guided self-help groups (in person and via video).
 5. **Demonstrate competence in selecting and revising mode of delivery**, as necessary on an ongoing basis depending on patient choice, suitability, etc.
 6. **Demonstrate knowledge and understanding to map core skills into text-based interventions.**
 7. **Demonstrate high quality clinical note keeping and effective use of clinical outcome measures to shape and adapt low intensity interventions.**
- **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.
 - **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 Postponement or Problem Solving); Exposure & Habituation or Exposure and Response Prevention; 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, and telephone/face-to-face/video/computerised/text-based treatment sessions. A maximum of 10 treatment hours can come from facilitation of groups. Calculate group contact time by length of group session divided by no 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 the link on ELE by no later than 11 am on the deadline date.

If **hand signing**, you can still type into the document but will need to print it out, hand sign it, and then the trainee will scan the document and submit via the link on ELE.

If **digitally signing**, the supervisor/s must type the name or insert an e-signature. The trainee will then need to submit the ‘signed’ document via the link on ELE.

Additionally, the supervisor will need to email LI-IAPT@exeter.ac.uk from their work email with the same completed document attached, by the deadline. If they are happy to sign off your Outcome Document they should include the following statement in their email: ***"I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email"***. If the supervisor is not signing off an element of the Outcome Document as the trainee has not yet demonstrated the ability to meet a certain area, the supervisor should include a statement in the email saying ***"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 outcome where supervisor is not yet happy to sign trainee off] for [module and outcome number, e.g. Module 2, outcome 1.]"***

If there is a mix of both hand and digital signatures, you must follow the digital signing procedure above.

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 pass mark.
- **Reassessment:** 4 weeks from the feedback being given (or as agreed in discussions).

Supervisor notes

1. Monitoring and managing trainee caseloads

Many trainees report Module 2 as the most stressful time on the course as they are 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 PWP's 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 roleplay

Roleplay is an essential clinical learning tool throughout this module and alongside patient contact. Trainees are given roleplay opportunities within University taught and study days, but are unlikely to achieve competency without further roleplay opportunity within service. Rather than just roleplaying with their fellow service trainees, they would benefit from a wide range of roleplay partners, particularly appropriately trained and qualified staff (e.g. recently qualified PWP's, Senior PWP's, PWP's with supervisory training etc). Familiarity with the course requirements, particularly the marking scheme, is highly beneficial for this to be most effective. Roleplays 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 which must be on an intervention-related step (i.e. not just reading, goals, vicious cycle etc), check and supplement the patient's understanding of the intervention rationale and steps, troubleshoot any difficulties 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 8](#)). 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 NHS Talking Therapies 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.

7. Information Gathering: Intervention

Essential skills to develop to support this section are: ability to explore the patient's barriers regarding completing the home practice, ability to explore any benefit that the patient is experiencing from the home practice; ability to explore any difficulties the patient has experienced from the home practice; and crucially, ability to understand if the home practice step has been completed in line with the intervention protocols. A strong understanding of the intervention rationale and protocols is essential to guide your questioning in this section. 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 redressing 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 roleplays in order to learn how to become more efficient, effective and succinct without sacrificing interpersonal skills is therefore very helpful.

9. **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

Learning objectives

This module covers the Learning Outcomes for Module 3 from **the National Curriculum for the Education of Psychological Wellbeing Practitioners** (updated April 2023) see: <https://healtheducationengland.sharepoint.com/:w:/g/Comms/Digital/EX6iEBwa8SJHmVrhOQRyOqUB3FBI00m7lZHPEDb5yIAaPA?rtime=bm1EY-CY20g>

Overall, trainees will develop the knowledge and competencies to:

- **Operate as an inclusive, anti-discriminatory and anti-racist practitioner, recognising, valuing and respecting diversity, recognising own response to difference 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

1. **Case management and clinical skills supervision within NHS Talking Therapies and the specific competencies needed for effective Step 2 working** (actual teaching takes place during Module 2)
2. **Diversity and inclusion within NHS Talking Therapies** – the core principles of recognising, valuing and adapting for diversity, recognising one’s own response to difference and ensuring equality of access and outcomes for all groups and individuals, with a particular emphasis on under-represented groups.
3. **Adapting practice to accommodate diverse needs** including adaptations for: physical needs (LTCs); diverse cultures and communities; the use of interpreters; older adults; sensory needs; learning difficulties and disabilities.
4. **Power** - recognising power imbalances and ways to minimise negative impacts.
5. **Motivational interviewing:** introduction to an evidence-based clinical approach to increasing positive behavioural change through focussing on eliciting patients’ own reasons for change.
6. **Employment, social inclusion and signposting** to support wider work, social and economic needs.
7. **High Intensity treatment** - understanding stepping up and different modalities of treatment at Step 3.
8. **PWP ongoing development** - an introduction to the opportunities 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 (with consent), 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. 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 NHS Talking Therapies 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 [Appendix 3](#)). Marks are awarded according to:

1. **Structure & organisation 10%**
 2. **Delivery & timing 10%**
 3. **Knowledge & understanding 30%**
 4. **Theory into practice 40%**
 5. **Use of source materials 10%**
 6. **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 request 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 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 above 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 the link on ELE by no later than 11 am on the day of assessment. 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 ELE and copied to designated service supervisors.
- **In the event of failure**, trainees should contact the teaching team to receive detailed feedback.
- **Reassessment:** 4 weeks from the date results were provided. Second attempts are capped at the pass mark. The overall mark for the module is also capped at the pass mark.

Module 3 Clinical Outcomes Document

- The Clinical Outcomes Document is a working document, which means trainees will add to it as they expand their competencies and build on their clinical hours over the course of the training. There are 3 submissions throughout the course corresponding to the 3 modules, but trainees will use the same document each time. This means they can add to what they have already recorded, and easily keep track of their clinical hours. By the end of the programme (and by the Module 3 Clinical Outcome Document deadline), trainees should have a fully completed document.

- The document (see ELE) provides 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. Trainees can find ‘plain English’ explanations of these competencies in the Clinical Outcomes Document Guidance, available on ELE.
1. **Demonstrates the ability to engage with people from diverse demographic, social and cultural backgrounds in assessment and delivery of low-intensity interventions.** This could include adaptations to practice in line with positive practice guides, using interpretation services or self-help materials for people who are deaf or whose first language is not English, and/or adapting self-help materials for people with learning or literacy difficulties including as a result of cognitive or neurological conditions.
 2. **Demonstrates the ability to effectively manage a large caseload efficiently and safely,** including step-up within NHS Talking Therapies, onward referral to employment support and signposted services, or other referral beyond NHS Talking Therapies.
 3. **Demonstrates the ability to use supervision to the benefit of effective case management and clinical skills development.** This should include:
 - a) **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.
 - b) **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.
 - **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 Postponement or Problem Solving); Exposure & Habituation or Exposure and Response Prevention, Cognitive Restructuring (with or without Behavioural Experiments).
 - **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, and telephone/face-to-

face/video/computerised/text-based treatment sessions. A maximum of 10 treatment hours can come from facilitation of groups. Calculate group contact time by length of group session divided by no 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 the link on ELE by no later than 11 am on the deadline date.

If **hand signing**, you can still type into the document but will need to print it out, hand sign it, and then the trainee will scan the document and submit via the link on ELE.

If **digitally signing**, the supervisor/s must type the name or insert an e-signature. The trainee will then need to submit the 'signed' document via the link on ELE.

Additionally, the supervisor will need to email LI-IAPT@exeter.ac.uk from their work email with the same completed document attached, by the deadline. If they are happy to sign off your Outcome Document they should include the following statement in their email: ***"I can confirm that I am signing off all elements of the module outcome document for [trainee name], as attached to this email"***. If the supervisor is not signing off an element of the Outcome Document as the trainee has not yet demonstrated the ability to meet a certain area, the supervisor should include a statement in the email saying ***"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 outcome where supervisor is not yet happy to sign trainee off] for [module and outcome number, e.g. Module 2, outcome 1.]"***

If there is a mix of both hand and digital signatures, you must follow the digital signing procedure above.

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 notes

1. Additional roleplay, practise, shadowing and observation

Trainees are given roleplay 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 roleplaying 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.

2. 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; 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.

3. 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 evidence-based 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.

4. 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.

5. 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.

6. 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.

7. 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.

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.

All remote sessions run from **9am – 5pm**, with half an hour to prepare from 9am, and then the scheduled activities 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. In-person teaching sessions run from **10am-4.30pm**, with minimum of 45 minutes allocated for a lunch break, plus two 15-minute breaks. Sessions will either be held in Bristol, Exeter or London depending on trainee location, it is important that trainees consistently attend lectures in their agreed location and do not change throughout the duration of the course.

Locations

Bristol Trainees:

- Lower Hall, St Michael's Centre, Bristol
- Vassal Centre, Bristol

Exeter Trainees:

- Washington Singer Building, University of Exeter

London Trainees:

- Richbell House, London
- LSE Centre Building, London
- Location TBC

Teaching and learning methods

The course is taught across 30 taught days and 15 University Directed study Days (UDDs). However additional private study is needed for assignment preparation, revision, further reading etc, which trainees will need to ensure they are factoring into their own time. To partially assist with this, there are also an additional 10 independent study days, to be taken as agreed between yourself and your service.

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
- Roleplay, 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, roleplaying, 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 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, certificates will be sent to the trainee's 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 programme administrators 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, 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 attending and then completing the course.

Trainees should also note that both the NHS Talking Therapies National Team and NHS England (NHSE), which funds training places for PWP's, have a national policy of not providing a second training place if a trainee fails the course, 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 (and the supervisor Sharepoint page). 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 annotated mark schemes with additional notes on the requirements of individual components) can be found on ELE (or the supervisor Sharepoint page). 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.

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 <http://tinyurl.com/CLES-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 on ELE by 11 am (or NHS portal by explicit agreement only) in accordance with service policies ¹	<ul style="list-style-type: none"> Recording of session e.g. mp3 or .wav file Recording of any verbal consent file e.g. mp3, .wav Electronic copies of: <ul style="list-style-type: none"> Signed Coversheet² Consent form³
Clinical Practice Outcomes	Submitted via the link on ELE by 11am	<ul style="list-style-type: none"> Signed Outcomes Document uploaded as a Microsoft Word document or PDF⁴
Written Work (essay, reflective commentary)	Submitted via the link on ELE by 11am Trainees MUST put their student number into the header or footer, but NOT their name (so it can be blind marked)	<ul style="list-style-type: none"> Word processed written work, e.g. PDF or Microsoft Word Document
Presentations	Submitted via the secure form on ELE by 11am	<ul style="list-style-type: none"> Presentation file (e.g. Microsoft Powerpoint file) Consent file (form or audio file)
<p>¹ It is each trainee's responsibility to ensure they adhere to their service policies, so discuss this in advance of the submission deadline.</p> <p>² Hand sign and scan these documents, or use the remote signing procedure as detailed in the main document above.</p> <p>³ Submit the correct consent format dependant on whether remote or in-clinic.</p> <p>⁴ Consult the hand/digital signing procedure detailed in the document above.</p>		

Submitting through ELE

The link to submit assignments is available through Assessments tile on ELE. Click on the appropriate link to go to the 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. **It is the trainee's responsibility to ensure they are uploading the correct version.**

Trainees should allow a good amount of time to upload their work 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:

- **Clinical assessments:** 50% and above
- **Academic assessments (PGCert):** 50% and above
- **Academic assessments (GradCert):** 40% and above
- **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 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 Day for the Module 1 clinical assessment and 6 weeks from the Skills Day for the Module 2 clinical assessment).
- **Marks for resubmissions will be capped** at a maximum 50% for second attempts of clinical assessments, and for academic assessments at 50% for postgraduate routes (PGCert) and 40% for degree (GradCert) routes.
- In addition, **marks for the whole module will be capped at the pass mark.**

Failing a second attempt

If a second attempt fails, the following applies:

- **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).
- **In all other cases a second attempt fail constitutes a fail of 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

1. **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 for this assignment will be capped at the pass mark** (for clinical assessments this is 50%, for academic assessments this is 50% for PGCert and 40% for GradCert). Second attempts are still allowed if this attempt fails.
2. **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 pass mark.**
3. **Non submissions.** These are marked at 0%. A second attempt is still allowed. **Marks for the whole module are capped at the pass mark.**
4. **EXCEPTIONS: There is no late period for first submissions that have received an extension from the original deadline.** In these cases, if the submission is not made before the extended deadline, it is considered a non-submission, and is treated as above.

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 (essays, reflective commentaries etc) should be word-processed with the following conventions:

- Use 1.5 line spacing on A4 paper.
- Use a font size of 12 pt.
- Use only Times New Roman, Arial or Calibri.
- Margins: 30mm on the left-hand side, 20mm on the right-hand side and 20mm for top/bottom margins.
- All pages (including appendices etc) should be numbered consecutively in one sequence starting with the title page as 1.
- 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.

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

- Title
- Reference list
- Appendices
- 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:

- Main body of text
- In text quotations
- In text references
- Section headings
- 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: <https://apastyle.apa.org/> Further support regarding citation can be found on ELE.

Plagiarism and academic misconduct

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.

Detailed information regarding the University's policy on Academic conduct and practice, including the consequences arising from academic offences, can be found in the **Teaching Quality Insurance Manual**: <https://as.exeter.ac.uk/academic-policy-standards/tqa-manual/aph/managingacademicmisconduct/>

An academic 'offence' is defined as an act or failure to act that if undetected gives, or aims to give, an advantage over other students, or any behaviour which may deceive those setting, administering and marking a piece of work. Academic offences can take a number of forms including but not limited to:

- **Plagiarism**, i.e. the act of representing work or ideas as one's own without appropriate acknowledgement or referencing. For instance:

- **Direct copying** of text, or illustrations, from a book, article, fellow student's essay, handout, thesis, web page, AI-generated content, or other source without proper acknowledgement.
 - **Claiming individual ideas derived from a book, article etc. as one's own**, and incorporating them into one's work without properly acknowledging the source of those ideas. This includes, among many other things, insufficiently paraphrasing a source, or altering the material taken from the source so it appears to be one's own work, or mirroring the structure of the argument of another writer without correct attribution.
 - **Overly depending on the work of others** by constructing a significant part of an assessment by extracting large sections of text from another source.
 - **Self-plagiarism:** the re-submission or re-use of the student's own work in another assignment whether this was submitted at the University of Exeter or any other academic institution worldwide without citing the previous work. (This is not intended to prevent a student from developing an academic idea over the course of their studies, 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, or sections of work, however this operates at the discretion of the Panel considering the offence).
- **Collusion**, i.e. the unauthorised working with another person, whether in person or via electronic device, on a piece of work, which is then submitted as part of an assessment, without acknowledgement of the other's contribution.
 - **Coercion**, this is where a student puts pressure on another student or member of staff to act in a particular way, or attempts to do so, with the intention of gaining an academic advantage. Where this is initially investigated as collusion it will be possible for the outcomes and penalties applied to differ between the parties involved. It is also possible for an outcome to be reached for one party ahead of the final outcome for the student alleged to have coerced another.
 - **The use or possession of unauthorised books, notes, software, electronic devices or other materials in an examination or assessment** (unless specifically permitted. This includes material obtained from essay sites, also known as 'Essay Mills').
 - **Obtaining or sharing an examination paper or assessment question ahead of its authorised release.** Or obtaining or sharing another student's answer to an examination paper.
 - **Attempting to impersonate or impersonation of another individual**, due to be sitting a specific assessment.
 - **Fabrication**, i.e. the creation of false data or other aspects of research or assessed work, including but not limited to documentation and participant consent forms with the intention of deceiving the marker. The inclusion of fabricated references.
 - **Falsification**, i.e. the inappropriate manipulations and/or selection of data imagery and/or consents with the intention of deceiving the marker.
 - **Misrepresentation** including, but not limited to, misrepresenting data, or misrepresenting the work of someone else, or from an AI-generated source, as your

own, in whole or in part. For example: disguising the authorship of the work through the use of electronic devices to conceal the extent to which the work is not the student's own; using source material originally in another language and translating this into English without attributing the work to the original author, or using synonyms throughout copied material; copying another's bibliography and referencing, implying the research completed is the student's own. This may also include the presence of hidden characters (white text) within the work which may have been included to manipulate the word count, to avoid source matches or to otherwise mislead the marker. Note, evidence of an attempt to disguise any of the forms of plagiarism listed above (which might involve the use of paraphrasing systems or translation systems, or a translator or third party who acts as more than a proof-reader under the University's regulations) will normally be treated more severely than plagiarism alone.

- **Contract Cheating** involving a student requesting a third-party to complete an assessment, or part of an assessment, on their behalf, which may or may not involve a commercial transaction. This can include arranging for another student or individual to complete an assessment, paying a company to provide an assignment or using artificial intelligence or chatbots to complete all or part of an assessment.

In addition to ensuring trainees only ever submit their own work based on their own genuine clinical and theoretical practice, trainees are required to 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 trainees are in any doubt at all or are in anyway unsure how to submit work of clinical and academic honesty, they are advised to contact the teaching team.

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

Gaining consent

For any live 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 (or the supervisor Sharepoint Page). 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 sessions

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, e.g. .wav, .mp3 etc.

Confidentiality

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

1. **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 additionally for assessment and teaching.
2. **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.
3. **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.
4. **At the end of the session the trainee should fully complete all other form details** required.
5. **For subsequent sessions, repeat step 3 above.**
6. **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

1. **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 additionally for assessment and teaching.

2. **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.
3. **Stop recording.** You have now created a short audio consent file.
4. **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.
5. **For subsequent sessions, repeat step 4 above.**
6. **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.
7. **Submit the scanned document along with your recording, original audio consent file and associated cover sheet.**

Failure to record consent

No session will be marked without the appropriate fully completed consent being 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.

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.

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 by the Course Administrator. Access is restricted to the Programme Administrator, Programme Lead, IT Lead and designated Markers only.
3. The markers consist of the 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 as follows:

1. Recordings will be stored securely for up to 6 years from the date of submission, after which they will be securely destroyed.
2. 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.
3. No identifiable client information is stored with the recordings.

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. Advice from the Mitigation Committee is for trainees to work to their new requested deadline after they have submitted the mitigation form.

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: <https://as.exeter.ac.uk/academic-policy-standards/tqa-manual/aph/annex-f/>.

The process for Mitigation is as follows:

1. **Speak to your personal tutor to discuss your concerns** (optional but encouraged)
2. **Download the Mitigation form from ELE**
3. **Complete and sign your own section, clearly outlining the circumstances impacting your opportunity to meet the deadline to provide rationale for the request. 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 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.
4. **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 remote signing 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.
5. **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.
6. **Your form and evidence will be reviewed by the Mitigation Committee** and their decision will be communicated via the Course Administrator

7. **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.
8. **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 using the submission links on ELE (e.g. essay or outcome document). Please note this is only available for non-clinical submissions (essays and outcomes documents) 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 more flexible in duration and should be discussed with the personal tutor.
- 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 more flexible in duration and should be discussed with the personal tutor.
- If the proposed submission date on a trainees 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. The interruption period is for a minimum of 3 months and can extend to 1 year, although in exceptional circumstances a 2nd year may be agreed.

The process for Interruption is as follows:

1. **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 sure ensure this is a viable option with their service.
2. **If Interruption is indicated, trainees should send an email to LI-IAPT@exeter.ac.uk** requesting Interruption. They will be contacted by the 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 training/work. As this date approaches, they will be contacted by the University Student Information Desk to confirm they wish to return to study. The interruption period can be extended at this time if circumstances are still not favourable for return.

- 3. 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.
- 4. If Interruption is agreed, training is suspended.**
- 5. Nothing further occurs until the trainee is able to return to work. Trainees cannot log patient or supervision hours during the interrupted period, or submit clinical recordings or case presentations on patients seen during this period. 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

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.

- **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 personal academic 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 email wellbeing@exeter.ac.uk.

Further information regarding wellbeing or booking appointment online here:

<https://www.exeter.ac.uk/wellbeing/>

- **Education Welfare Team (Peter Chalk Hub)**

Any trainee who is finding that life circumstances, mental wellbeing or physical wellbeing is impacting on their ability to manage their training without feeling overwhelmed can refer to the Education Welfare Team. This team can help trainees to navigate the support on offer, including study skills, organisation and time management, Wellbeing support, mitigations, interruptions and much more. Please refer to the Peter Chalk Hub. For more information click here:

<https://www.exeter.ac.uk/students/wellbeing/talk/welfare/>

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 www.exeter.ac.uk/accessability.

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 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 are highly helpful online tutorials, links and information, plus 1-1 support if needed around about the following:

- how (and where) to effectively search for articles, research, books and papers
- how to evaluate source materials and how to reference them
- how to understand different academic materials, eg statistics, reports, systematic reviews, policies, guidelines etc
- 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 Zone Service

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

- reading effectively
- selecting reading from book lists
- planning and writing assignments or essays
- taking useful notes
- revising for exams
- organising your time
- 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: [Drop-ins | Study Zone | University of Exeter](#).

You can also access digital skills support through the Study Zone – see [Study Zone Digital](#)

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

Further information and support around study skills can be found on the Wellbeing and Study Support tile on ELE.

Appendix 7: Confidentiality and ground rules

Working within NHS Talking Therapies 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:

- i. **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.
- ii. **in a manner and setting which is respectful**, for example not using inappropriate or caricaturising illustrations, captions or representations etc.
- iii. **in a manner which honours the limits of confidentiality**, explained previously to a patient.
- iv. **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:

- i. **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.
- ii. **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.
- iii. **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.
- iv. **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 trainee's circumstances confidential, even between members of the teaching team if the trainee desires. Information will only be shared with service supervisors on a need-to-know basis to support the trainee in their training.
- v. **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

- **Be punctual** - the timetable is tight, delays starting tasks or arriving on group or roleplay meeting links can lead others to waiting around and losing the opportunity to learn/practice skills.
- **Communicate** - if something comes up and you are suddenly unable to attend/take part, tell the course team via the shared teaching team inbox AND let your small group or roleplay colleagues know.
- **Have the resources and technology to take part in all sessions** - you need a working microphone, video camera, speakers and a good internet connection. You'll also need to log on with your Exeter logon (not your work one) to MS Teams to be able to fully access meetings etc. Contact us if you have problems.
- **Contribute** - tutorials, group discussions and tasks don't work well if people don't speak up and participate. Your cohort peers will be at a wide range of stages in their PWP journey. There is so much we can learn from each other and by sparking discussion and sharing

between us. We know it can be anxiety provoking to speak, and some people find speaking over MS Teams/video technology particularly hard, but the more you do, the easier it gets.

- **Take part** - role plays and small group tasks work best when everyone takes them seriously; you compromise your own and others' learning if you don't engage with the tasks as intended.
- **Be respectful** - respect and value that staff and peers may have other viewpoints, experiences and opinions than yours, and keep discussions polite and constructive. Sharing and understanding different perspectives is central to rounded learning and gaining new insights.
- **No question is silly** - please ask, everyone will learn.
- **Ensure confidentiality** - when discussing patients or colleagues.

Linking in with our Equality, Diversity, & Inclusion Statement, the University have also created a list of **ground rules for 'good talk'**. The rules ensure that we strive to overcome historical and divisive biases, treat each other respectfully, and aim to promote a safe atmosphere for open discussion. The document also contains helpful discussion tools to support conversations with others, such as how to apologise properly and how to 'call someone out'. Further details can be found under the Course Information tile on ELE.

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) Ethics Committee acknowledges that members are using social networking sites to communicate with friends, family, professionals and clients. The Ethics Committee has created a [guidance document](#) in line with the Society's Code of Ethics and Conduct that provides practical advice for using social networking sites responsibly.

Appendix 8: Risk Assessment

Risk Assessment at assessment

- All introductions and questions should be stated clearly and without euphemisms or apologies. There must be no leading or assumptions, and no double questions.
- Any positive, vague or ambiguous answers must be funnelled to gain clear, accurate details.
- The following must be asked as a minimum, service policy may dictate additional details should be asked or given.
- **In all cases, if risk is identified, PWP's must prioritise following service procedures to ensure patient and/or others are safeguarded.**

Current Suicide	<p>Separately ask about:</p> <ul style="list-style-type: none"> • Thoughts • Plans • Actions <p><i>NB if asking about 'intent' <u>also</u> ask about Thoughts, Plans and Actions</i></p>
Past Suicide	<p>Separately ask about:</p> <ul style="list-style-type: none"> • Thoughts • 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	<p>Separately ask about:</p> <ul style="list-style-type: none"> • Thoughts • Actions <p><i>NB if asking about 'intent' <u>also</u> ask about Thoughts and Actions</i> <i>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</i></p>
Past Self-Harm	Ask about: <ul style="list-style-type: none"> • Actions
Risk to Others	Clearly ask if the patient feels they may pose a risk of harm in any way to anyone else. <i>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</i>
Risk from Others	Clearly ask if the patient feels they may be at risk of harm in any way from anyone else. <i>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</i>
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 Neglect of Dependents	Clearly ask if there is anyone who depends on the patient for their care in any way, adult or child, directly or indirectly. If dependents , check Neglect of any identified dependents (adults or children).
Neglect of Others	Clearly and <u>separately</u> ask about: <ul style="list-style-type: none"> • Anyone else the patient may feel they are neglecting (even if no dependents are disclosed)

The risk assessment should then be summarised, checking this is correct and if the patient wishes to add anything. Appropriate safety planning should be completed with the patient.

Risk Assessment at treatment

- For each item, previously understood information should be reflected back and then the patient asked if there are any changes. There must be no leading or assumptions, and no double questions.
- Any changes or vague/ambiguous answers must be funnelled to gain clear, accurate details.
- The following must be asked as a minimum, service policy may dictate additional details should be asked or given.
- **In all cases, if risk is identified, PWP's must prioritise following service procedures to ensure patient and/or others are safeguarded.**

Current Suicide	<p>If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:</p> <ul style="list-style-type: none"> • Thoughts • Plans • Actions <p>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?”</p>
Protective factors	Reflect back previously understood protective factors and ask if there have been any changes.
Current Self-Harm	<p>If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:</p> <ul style="list-style-type: none"> • Thoughts • Actions <p>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 self-harm and hadn’t taken any actions towards self-harm in any way – has anything changed?”</p>
Risk to Others	<p>Reflect back previously understood risk status and ask if there have been any changes.</p> <p><i>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</i></p>
Risk from Others	<p>Reflect back previously understood risk status and ask if there have been any changes.</p> <p><i>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</i></p>
	<p>If no risk to/from others 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?”</p>
Dependents Neglect of Dependents	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 <u>separately</u> .
Self-neglect	Reflect back previously understood risk status and ask if there have been any changes.
Neglect of Others	<p>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.</p>
	<p>If no neglect to self/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 in any way – has anything changed?”</p>

The risk assessment should then be summarised, checking this is correct and if the patient wishes to add anything. Appropriate safety planning should be reviewed with the patient.