

# Standards for Doctoral programmes in Clinical Psychology



The British  
Psychological Society  
Partnership & Accreditation

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## Introduction

In 2012, the Partnership and Accreditation Committee (PAC) commenced a process of review in collaboration with its postgraduate Training Committees, Divisions, providers of accredited programmes and other relevant stakeholders. The purpose of the review was twofold:

1. To inform and influence a review of the Standards of Proficiency for practitioner psychologists being undertaken by the Health and Care Professions Council (HCPC) which is due to be completed in 2014/15. The Standards of Proficiency are the threshold standards necessary for safe and effective practice, and individuals need to have achieved the Standards of Proficiency in order to register to practise.
2. To ensure that the Society's own standards reflect contemporary theory and practice, enabling accredited programmes and the Society's own qualifications to develop psychologists who will be fit for purpose for the future. As such, these reflect the highest level professional standards, promoted by the Society through the award of Chartered Psychologist status.

In reviewing our standards for accreditation, the Partnership and Accreditation Committee was keen to create flexibility for programmes to develop distinctive identities, by making the most of particular strengths around research and practice shared by their staff team, or those that are reflected in the strategic priorities of their Department or University.

## Our standards for Doctoral programmes in Clinical Psychology

Our standards are organised around nine overarching areas, and have been derived following extensive consultation between the Society and education providers; these comprise our *programme standards*, and must be achieved by all accredited programmes. Each overarching standard is followed by a rationale for its inclusion, together with an outline of the factors that education providers might wish to consider in confirming their achievement of each standard.

The information provided is not intended to prescribe a particular approach to meeting our standards; rather it is intended to reflect the likely areas of interest for visiting teams or reviewers when exploring achievement of the standards with education providers, students/trainees, employers, and other stakeholders. During partnership visits, the questions that visiting teams will ask will be designed specifically to give education providers every opportunity to confirm their achievement of the standards.

Some of our nine overarching standards are complemented by a series of further standards that are of specific relevance to Doctoral programmes in Clinical Psychology. These represent the benchmark level of quality that the Society expects all accredited programmes of this kind to attain. However, we recognise that different programmes will aim to meet these standards in different ways and our overall approach is to encourage flexibility in the methods used in meeting the standards.

Overall, our standards are designed to support education providers offering programmes of training leading to eligibility for Chartered Membership of the Society (CPsychol) and full membership of the Division of Clinical Psychology. Such programmes will seek to prepare trainees for professional practice as a Clinical Psychologist. Practitioner psychologists are statutorily regulated by the Health and Care Professions Council (HCPC), and it is a legal requirement that anyone who wishes to practise using a title protected by the Health Professions Order 2001 (e.g. Clinical Psychologist) is on the HCPC's Register. As such, programmes will need to seek approval from the Health and Care Professions Council. The information contained within this document is also intended to inform that process.

Our standards framework is organised as follows:



## Preface

The statements in this document form a policy statement by the Society on what programmes should achieve and, therefore, the requirements for those who seek Chartered Membership of the Society and full membership of the Division of Clinical Psychology. Programmes should also note the following:

1. The aim of this document is to specify the standards that programmes should achieve. It is not the Society's intention to reduce the diversity between programmes or impair their flexibility to respond to local and changing circumstances. Related to this, the standards often reference indicative, rather than prescriptive, criteria to facilitate this. It is important to emphasise that while the Society expects that the required standards are met, a key emphasis in this document is that wherever possible, the Society does not wish to be prescriptive in how these standards are achieved.
2. Accredited programmes will also need to be approved by the Health and Care Professions Council (HCPC). The HCPC's role is to assure threshold levels of quality, by ensuring that graduates of approved programmes meet the Standards of Proficiency. The Society's accreditation process is designed to work beyond those quality thresholds by promoting quality enhancement.
3. In reading this document, it is essential to recognise that although the various aspects of working as a competent clinical psychologist are described separately, it is the combination and integration of these components that are particularly important. This is true for both the required outcomes of training and for the process of training.
4. In meeting the requirements of a professional training in clinical psychology, programmes should be sufficiently flexible in content and structure to adapt readily to current and future needs and to the emergence of new knowledge in clinical psychology and related fields. They should also play a major part in the identification of such needs and the development of innovative practices. Programmes should refer to the standards and guidelines which are identified and revised from time to time by the Division of Clinical Psychology's Faculties and Special Interest Groups (SIGs) for guidance in relation to the knowledge and skills required for work with specific populations and groups.
5. Programmes will need to work collaboratively with relevant external stakeholders and especially commissioners to identify and negotiate any particular skill sets they may wish to prioritise, and how the standards outlined in this document might best be implemented locally.
6. Education providers may offer two or more programmes in the same branch of applied psychology, and these will be considered as separate programmes.
7. The current accreditation criteria have been informed by a number of contemporaneous guidelines and strategy documents. These have included Divisional and Society guidance in relation to knowledge and skills required for work with a wide range of specific populations, the leadership development framework, the Good Practice Guidelines series including those related to formulation, psychological health and well-being, connecting communities, code of conduct and ethical guidelines for practice and research and working in teams ([www.bpsshop.org.uk](http://www.bpsshop.org.uk)). These guidelines are free to Divisional members.

8. In addition to Society guidelines, these accreditation standards have been informed by:
- Evidence based practice guidelines such as those as disseminated in NICE / SIGN guidelines on what works for whom ([www.nice.org.uk](http://www.nice.org.uk); [www.sign.ac.uk](http://www.sign.ac.uk)). The Society notes, however, that this guidance is designed to inform, not replace, clinical decision making and such guidance should not be applied in any formulaic fashion – especially pertinent when dealing with the complexity and co-morbidity for which training needs to prepare clinical psychologists. The Society recognises that programmes may wish to be informed by other knowledge bases when developing their curricula – especially where guidelines such as NICE have not been sufficiently developed for given populations or services (e.g. interventions with people with intellectual disability).
  - National strategies and policy initiatives related to psychological health and well-being. Specific examples are not referenced as rapid change is a feature herein. However, current themes, across the four nations, relate to an increased emphasis on mental health, psychological well-being, the talking therapies, improving access, redesign of services, stepped care interventions, diversification of healthcare providers, secondary prevention, psychological interventions in physical healthcare etc. This list is not exhaustive but reflects the contemporaneous influences which have informed the standards review.

## Acknowledgements

In preparing the current review of our accreditation criteria the Committee for Training in Clinical Psychology was mindful that current standards represent an evolution of such over a great many decades. The values, ethos and tenets which underpin our standards reflect the foresight, intellectual rigor, work and commitment to the profession of clinical psychology of a great many people from our community both current and historical. At this juncture we wish to pay particular tribute to three directors of training programmes who had started this most recent process with us - *Malcolm Adams*, *Andrew Cuthbertson* and *Mark Rapley*. We will remember and thank them for their wisdom, vision and creativity.

## Programme standard 1: Learning, research and practice

### The programme must reflect contemporary learning, research and practice in psychology

- The programme must be able to document its intended learning outcomes, the ways in which these reflect the relevant domain-specific requirements, the learning and teaching strategies that will be used to support students' achievement of the learning outcomes, and the assessment strategies that will enable students to demonstrate those achievements.
- Students' successful fulfilment of the programme's requirements must be marked by the conferment of a named HE award at the appropriate level.
- Education providers will normally demonstrate their achievement of this standard through production of a programme specification.
- Whilst programme specifications are a standard feature of quality monitoring for education providers, inclusion of this standard here offers an opportunity for the Society to identify innovative and creative practice in relation to teaching, learning and assessment.

### A Required Core Competencies

The HCPC's Standard of Education and Training (SET) 1 specifies the threshold level of qualification for entry to their Register as: **Professional doctorate for clinical psychologists.**

*Doctoral programmes that are able to demonstrate that their graduates achieve the relevant Standards of Proficiency can demonstrate their fulfillment of SET1.*

#### 1. Core training of the Clinical Psychologist – a statement of intent

Clinical psychology is a postgraduate, doctoral, three year training programme which promotes transferable knowledge and competencies relevant to working across a very wide range of health and social care programmes and presentations. These include, for example, services for children, adults, older adults, families, people with developmental and intellectual disability, mild – severe mental health difficulties, physical health presentations, chronic conditions and other groups and presentations which may have been included in a specific training pathway. This is in contrast to multiple, often sub-doctoral, programmes which prepare graduates for work with only circumscribed groups, presentations or models of therapy. As well as safeguarding and improving quality of service provision, the cost-efficiency for commissioning of training is evident.

Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and well-being, minimise exclusion and inequalities and enable service users to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure.

The evidence base tells us that different interventions work for different presentations and groups. It also tells us about the central importance of non-specific therapist factors in outcomes. Moreover, service users often present with complex and co-morbid presentations which require multimodal interventions. NICE guidance increasingly highlights the need to tailor a range of psychological interventions to complex presentations and the specifics of service user contexts. A defining feature of the clinical psychologist is the capacity to draw from, and utilise, different models of therapy, and evidence based interventions, as appropriate to the needs and choices of the service user. The clinical psychologist is not a uni-modal therapist, although by the end of training specific competencies will be professionally accredited by the Society through programme accreditation, within cognitive-behaviour (and one other) model of psychological intervention (which will vary, depending on the training pathway pursued). Many will develop further particular expertise in specific therapies.

The evidence base highlights the relevance of psychological processes, support and interventions across a great many healthcare presentations. Clinical psychologists are trained not just to deliver interventions, but to also promote psychological mindedness and skills in other health, educational and social care providers.

### **Clinical psychologists as reflective scientist practitioners**

Clinical psychology is one of the applications of psychological science to help address human problems. Clinical psychologists have been trained not only to be critical consumers of research, and ever emerging knowledge bases, but to contribute to this knowledge base through research, with relevant skills benchmarked at doctoral level. Clinical psychology has a prominent history of developing, evaluating and refining psychological interventions which are often then promulgated across the skill base of other professions and practitioners.

Complementing this capacity to draw critically from the evidence base to inform their work, clinical psychologists embrace an ethos of practice based evidence. A critical evaluative stance pervades practice which includes utilising an outcomes framework, informed by well-being and recovery principles, as well as the values and goals of the service user. Clinical Psychologists will often lead on developing systems of practice based evidence within services.

Reflective practice is also promoted through an effective use of supervision and collaboration with service users and other colleagues in setting goals and monitoring progress. Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development.

### **Clinical psychology in practice**

Clinical psychologists work with individuals, couples, families and groups and at the organisational and community level. They work in specialist and generic services which increasingly are accessed by groups historically considered as “specialist”. They work across a diversity of health and social care providers (e.g. NHS, social care, third sector and independent providers and education) and in a variety of settings including in-patient and community, primary, secondary and tertiary care and with all age

groups and presentations as noted above.

### **Overview of the accreditation standards**

The standards outlined in this document highlight the training requirements necessary for enabling the graduate clinical psychologist to practice as described in this statement of intent. Whilst the Standards of Proficiency, regulated by the HCPC, assure quality thresholds for safe practice, the accreditation standards outlined here are designed to promote quality enhancement. Graduates of accredited programmes who have attained these enhanced standards will be eligible for Chartered status through full divisional membership of the Division of Clinical Psychology.

The key features of the new accreditation standards include:

- Emphasis on over-arching competencies to deliver tailored, multi-modal and often complex, psychological interventions across a range of ages, presentation configurations and service delivery systems and which are informed by knowledge and skills from across formal psychological therapies and other evidence bases.
- Increased credibility that specific knowledge and skills sets, which contribute to the above, have been obtained through transparent benchmarking of work against competence frameworks adapted and appropriate to the age, presentation or specialism to which such are applied.
- Delivering a curriculum which is contemporaneous, relevant to current healthcare exigencies and informed by the evidence base and social contexts.
- Incorporating systematic approaches to *in vivo* assessment to further quality assure competence development.
- Deepening collaborative practices with service users and carers (including in ways informed by DCP good practice guidance on the involvement of service users and carers in clinical psychology training).
- Greater emphasis on skills of indirect influence and leadership in bringing psychological mindedness to services.



## 2. Required learning outcomes for accredited doctorates in Clinical Psychology

- 2.1. Clinical psychology programmes will vary in the emphases they place on work with particular clinical groups, therapeutic modalities, curriculum content, non-therapy skills, training methods etc. This is healthy and promotes diversity and richness within the profession. It ensures programmes can be responsive to regional and national priorities, opens up opportunities for some programmes to coordinate and complement their efforts and offers prospective applicants choice of programmes which best suit their own preferences, learning style and goals. Similarly, trainee clinical psychologists within programmes may follow a range of training pathways depending on practice placement experiences, research undertaken, optional modules chosen etc. Thus whilst all graduates will demonstrate core standards of proficiency, with transferability demonstrated across the range of clients and services as specified below, some variation in individual strengths and competencies will be both inevitable and desirable.

This context means that whilst the BPS will accredit programmes as meeting the standards required for their graduates to be eligible for Chartered status, it will be incumbent on programmes to validate the specific portfolio of skills and competencies of graduates in a way which is transparent to employers and commissioners of services. Whilst programmes are free to develop their own portfolio format, examples of how this might look are contained in Appendix 1. These examples should be seen as indicative, rather than prescriptive.

- 2.2. Overarching goals, outcomes, ethos and values for all programmes include the following:

### **By the end of their programme, trainees will have:**

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological well-being through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.
2. The skills, knowledge and values to develop *working alliances* with clients, including individuals, carers and/or services, in order to carry out *psychological assessment*, develop a *formulation* based on psychological theories and knowledge, carry out *psychological interventions*, *evaluate* their work and *communicate effectively* with clients, referrers and others, orally, electronically and in writing.
3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.
4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.
5. Clinical and research skills that demonstrate work with clients and systems based on a *reflective scientist-practitioner* model that incorporates a cycle of assessment, formulation,



intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.

6. The skills, knowledge and values to work effectively with *systems* relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.
7. The skills, knowledge and values to work in a range of *indirect ways* to improve psychological aspects of health and healthcare. This includes leadership skills and competencies in *consultancy, supervision, teaching and training*, working collaboratively and *influencing psychological mindedness and practices of teams*.
8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.
9. A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.
10. High level skills in managing a *personal learning agenda* and self-care, in *critical reflection* and *self-awareness* that enable transfer of knowledge and skills to new settings and problems and professional standards of behavior as might be expected by the public, employers and colleagues.

NINE core competencies are defined as follows:

### **2.2.1. Generalisable meta-competencies**

1. Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.
2. Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations.
3. Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.
4. Being familiar with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision making without being formulaic in application.
5. Complementing evidence based practice with an ethos of practice based evidence where processes, outcomes, progress and needs are critically and reflectively

evaluated.

6. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.
7. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.
8. Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.
9. Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity, and working as a reflective practitioner within ethical and professional practice frameworks.

### **2.2.2. Psychological assessment**

1. Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.
2. Ability to choose, use and interpret a broad range of assessment methods appropriate:
  - to the client and service delivery system in which the assessment takes place; *and*
  - to the type of intervention which is likely to be required.
3. Assessment procedures in which competence is demonstrated will include:
  - performance based psychometric measures (e.g. of cognition and development);
  - self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours);
  - systematic interviewing procedures;
  - other structured methods of assessment (e.g. observation, or gathering information from others); *and*
  - assessment of social context and organisations.
4. Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.
5. Conducting appropriate risk assessment and using this to guide practice.

### 2.2.3. Psychological formulation

1. Using assessment to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors.
2. Constructing formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.
3. Constructing formulations utilising theoretical frameworks with an integrative, multi-model, perspective as appropriate and adapted to circumstance and context.
4. Developing a formulation through a shared understanding of its personal meaning with the client(s) and / or team in a way which helps the client better understand their experience.
5. Capacity to develop a formulation collaboratively with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.
6. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.
7. Ensuring that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.
8. Using formulations to guide appropriate interventions if appropriate.
9. Reflecting on and revising formulations in the light of on-going feedback and intervention.
10. Leading on the implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services.

#### 2.2.4. Psychological intervention

1. On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with:
  - individuals
  - couples, families or groups
  - services / organisations
2. Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.
3. Ability to implement therapeutic interventions based on knowledge and practice in *at least two* evidence-based models of formal psychological interventions, of which one must be cognitive-behaviour therapy. Model specific therapeutic skills must be evidenced against a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.
4. In addition, however, the ability to utilise multi-model interventions, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.
5. Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and well-being.
6. Conducting interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals.
7. Having an awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.
8. Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives.
9. Implementing interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.
10. Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to clients and carers.

### **2.2.5. Evaluation**

1. Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).
2. Devising innovative evaluative procedures where appropriate.
3. Capacity to utilise supervision effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.
4. Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.
5. Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.
6. Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

### **2.2.6. Research**

1. Being a critical and effective consumer, interpreter and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.
2. Conceptualising, designing and conducting independent, original and translational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and merit publication including: identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis (both quantitative and qualitative), reporting outcomes and identifying appropriate pathways for dissemination.
3. Understanding the need and value of undertaking translational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.
4. The capacity to conduct service evaluation, small N, pilot and feasibility studies and other research which is consistent with the values of both evidence based practice and practice based evidence.
5. Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups

etc.) and within the ethical and governance frameworks of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

#### **2.2.7. Personal and professional skills and values**

1. Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.
2. Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.
3. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices.
4. Understanding the impact of one's own value base upon clinical practice.
5. Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.
6. Capacity to adapt to, and comply with, the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.
7. Managing own personal learning needs and developing strategies for meeting these. Using supervision to reflect on practice, and making appropriate use of feedback received.
8. Developing strategies to handle the emotional and physical impact of practice and seeking appropriate support when necessary, with good awareness of boundary issues.
9. Developing resilience but also the capacity to recognize when own fitness to practice is compromised and take steps to manage this risk as appropriate.
10. Working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

#### **2.2.8. Communication and teaching**

1. Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).
2. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.
3. Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).
4. Understanding of the supervision process for both supervisee and supervisor roles.
5. Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.
6. Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof.
7. Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

#### **2.2.9. Organisational and systemic influence and leadership**

1. Awareness of the legislative and national planning contexts for service delivery and clinical practice.
2. Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.
3. Providing supervision at an appropriate level within own sphere of competence.
4. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.
5. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.



6. Working with users and carers to facilitate their involvement in service planning and delivery.
7. Understanding of change processes in service delivery systems.
8. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.
9. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

### 3. The structure of training

- 3.1. It is essential that programmes provide a holistic experience of training that enables trainees to develop an integrated set of learning outcomes.
- 3.2. Programmes should provide a balanced and developmental set of academic, research and clinical experiences throughout training. The academic component needs to provide an integrated curriculum supporting the clinical and research training. The research training needs to be carefully planned and have sufficient time devoted to it to enable trainees to conduct research at a postgraduate level and to be in a position to contribute to the knowledge base of the profession.
- 3.3. Supervised practice needs to be gained across the range of clients, therapy and intervention modalities and settings as outlined below (section C.1). Clinical experience will be gained in service delivery systems that offer a coherent clinical context. This can include settings defined for the purposes of training by one, or a combination of, factor(s) including the population (e.g. child, adult, older people), special needs (e.g. intellectual disability, serious mental health problems, health-related problems, substance abuse), psychological interventions (e.g. model of therapy) or service delivery contexts (e.g. primary, secondary and tertiary care, in-patient, out-patient, community, third sector, leadership, consultancy or inter-professional working).
- 3.4. A hallmark and strength of clinical psychology training is that generalisable and transferrable skills and competencies are developed. This is evidenced by demonstration of the core competencies outlined in 2.2 above and across the settings outlined in C.1 below. However, it would be impossible to demonstrate these competencies across ALL such settings, and combination of settings, and thus, once again, these are indicative rather than prescriptive. Moreover, programmes generally, and individual trainees specifically, will vary in emphases and strengths. A sufficient range of experience must be attained, however, to evidence this transferability in practice. Thus, the *specific* settings, population and interventions in which competencies have been demonstrated must be monitored and available within a training portfolio (see Appendix 1 for an example of how such a portfolio might look).

- 3.5. It is important to recognise that the scope of clinical psychology is so great that initial training provides a foundation for the range of skills and knowledge demonstrated by the profession. Further skills and knowledge will need to be acquired through continuing professional development appropriate to the specific employment pathways taken by newly qualified psychologists.
- 3.6. Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the health and social care sectors. These requirements will be shaped in part by national policies and service frameworks, as well as by evidence of recruitment problems in specialties or regions. National standards as set out by the *Division of Clinical Psychology's* Faculties and Special Interest Groups should guide training patterns for each cohort of trainees and programmes should consult with these and other local stakeholders to ensure that – across the trainee cohort – there is optimum, effective and efficient use of all available placements.
- 3.7. Of the total programme time (exclusive of annual leave), at least fifty per cent must be allocated to supervised clinical experience. In addition, at least ten per cent must be available to trainees for self-directed study throughout the programme. Of the remaining time there must be an appropriate balance between research activity and learning and teaching, to ensure that the guidance outlined in section B can be met.

## **B The curriculum and research**

*This part of our standards relates to section 4 of the HCPC's Standards of Education and Training, which focuses on the ways in which those completing a programme develop the required professional skills and knowledge, and are fit to practise. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

### **1. Programme specification**

- 1.1. Programmes must have a clear programme specification that provides a concise description of the intended learning outcomes of the programme, and which helps trainees to understand the teaching and learning methods that enable the learning outcomes to be achieved, and the assessment methods that enable achievement to be demonstrated. The programme specification should include the competencies outlined in this document, though there will be a range of acceptable ways to promote these competencies.
- 1.2. Programmes must have a statement of orientation and values that underlie the programme specification.
- 1.3. The programme specification should be widely discussed and accepted by the major stakeholders in the programme. This will probably be achieved through the various committees and management structures that have been set up to plan, organise and monitor the programme. The content and organisation of the programme must reflect the orientations and values and the programme specification, which will need to be reviewed regularly.
- 1.4. As well as statements of orientation, values and learning outcomes, the programme specification should give sufficient attention to the content of the curriculum, teaching and

assessment methods and quality assurance practices to be transparent to applicants, stakeholders and governing authorities.

- 1.5. Each programme must be able to highlight its own particular strengths in order to communicate these to both prospective candidates and the profession as a whole. These strengths might be related to (a) teaching and practice with a particular client group or in a particular clinical setting, (b) teaching and implementation of a particular conceptual model, (c) a discrete area of clinical research or perhaps (d) general all round strength.

## **2. Curriculum**

- 2.1. Programmes should have an academic syllabus and a coherent plan for organising and presenting the material to be covered. The academic syllabus and plan will reflect the programme specification and will be designed to help trainees achieve the learning outcomes set out in A.2. The content of curricula should reflect relevant and up to date psychological knowledge and skills, ensuring that contemporary psychological practice and research is promoted. Programmes should be able to demonstrate how the syllabus has been informed by general and specific guidance such as: DCP policy (including Faculty good practice guidelines); recognised practice guidance such as NICE/SIGN where this exists, and other sources relevant to the practice of clinical psychology and its advancing knowledge base.
- 2.2. It is recognised that programmes may legitimately vary in their curricular emphases, taxonomical system and language for defining presentations. Programmes should be mindful of the DCP position statement regarding limitations in “diagnostic” frameworks and this may inform language and taxonomy. However, to a greater or lesser degree the indicative areas of curriculum content specified in this document, have been informed by commonly used taxonomies as understood not only by the profession, but by service users, carers, commissioners, colleagues and other stakeholders.
- 2.3. Indicative content for a clinical psychology curriculum should reflect a broad range of conditions and interventions that includes the following:
  - 2.3.1. A satisfactory introductory programme that addresses practical issues and is geared to familiarising the trainee with skills in engaging clients, working collaboratively, assessment methods, including interviewing, observational techniques and psychometric assessment.
  - 2.3.2. Clinical psychology in context including our history and the evolution of healthcare systems in the UK.
  - 2.3.3. Knowledge and theories related to the psychological needs and problems of a range of client groups across the life-span and relevant to clinical psychology. In practice this should relate to:
    - common mental health presentations (e.g. anxiety presentations and depression);
    - severe and enduring mental health presentations (e.g. hearing voices, psychosis, complex trauma);

- physical health presentations and issues related to adjustment and coping across the life-span;
- presentations of infancy and childhood (e.g. infant mental health, developmental, social, adjustment to adversity, physical health presentations, looked after children, conduct and mood difficulties);
- presentations of older adulthood (e.g. related to developmental changes and psychosocial adaptation, losses to cognitive functioning);
- neurological presentations of adult and childhood;
- presentations of those with physical and intellectual disability;
- specialist clinical presentations which could present across the life span and in combination with other presentations such as substance misuse, addictive behaviours, eating disorders, personality disorders and forensic presentations.

In practice trainees will often work with complex and co-morbid presentations and thus will be required to synthesise the relevance of any single presentation knowledge base for transtheoretical application.

- 2.3.4. Substantial teaching on the theory and practice of psychological assessment methods, including the interpretation of findings and the formulation of clinical problems. There should be explicit consideration of the relationship between assessment, formulation, intervention and evaluation. This should be in relation to service users across the age range, with the range of presentations and as underpinned by the different therapeutic modalities as specified in C.1 below.
- 2.3.5. Understanding of the theoretical and evidence bases related to commonly used psychometric assessments. Psychometric theory and approaches to understanding assessment findings including statistical and clinical significance should be understood.
- 2.3.6. Substantial coverage of formal systems of psychological interventions and this must include more than one orientation and approach. Content should include the philosophical and theoretical bases of therapies, their practical application to various client groups, and their current empirical status. Consideration should be given to the evidence base of what works for whom and when it is appropriate to draw from different knowledge bases, especially in work with complex and co-morbid presentations.
- 2.3.7. Opportunities for learning about professional and organisational issues. This should include the organisation of health and social care services and the profession, and the work of related professions and agencies. The Society's *Code of Ethics and Conduct* should be covered together with emergent ethical competence frameworks for applied psychology, as well as the impact of major legislative frameworks, statutory regulation, and other significant developments affecting the profession.
- 2.3.8. Issues concerning the influences of society, cultural and other areas of diversity should be integrated throughout the academic programme, demonstrating the relevance to

clinical practice. Values related to an ethos of critical community psychology, recovery and well-being should inform appropriate aspects of the curriculum.

- 2.3.9. Non-therapy skills such as exerting influence and leadership, critical self-awareness, communication and teaching, models of consultancy, multidisciplinary working and group and organisational processes.
- 2.3.10. Programmes should be responsive to new developments and areas of concern within the profession and aim to incorporate learning opportunities in such areas within the programme as and when appropriate.
- 2.4. The plan for delivering the academic syllabus must ensure that trainees receive adequate preparation for their clinical placements and that there are adequate links between the taught material and contemporaneous placements. This will mean that the plan takes account of the likelihood that trainees in the same cohort will be working in different clinical specialties at any one time.
- 2.5. Programmes should provide substantial learning opportunities that use a range of educational methods, adapting the style of these to the stage a trainee has reached. In general, methods should be used which require substantial trainee participation.
- 2.6. The majority of the learning opportunities should be provided by clinically qualified psychologists. However, service users and carers should inform and participate in the delivery of the curriculum. Teaching by other psychologists and professionals is to be encouraged as is engagement with inter-professional learning.

### **3. Research**

- 3.1. Programmes must have an explicit and written statement of aims and objectives for a programme of research training throughout the programme. This should be developed in discussion with supervisors and should include the aim of encouraging clinical research during placements. Where appropriate, collaborative research should be encouraged.
- 3.2. Programmes should provide sound teaching and training in research methodology. This will include: (a) formal teaching of research design and methods including small N designs, pilot and feasibility studies and those methods, both quantitative and qualitative, that are most useful in the conduct of applicable clinical research including service evaluation; (b) ethical issues in research; (c) statistical analysis including both exploratory and hypothesis testing methods; (d) critical appraisal of published research including systematic reviews and (e) supervised research work involving not only a major project but also some smaller scale service related research or research related to professional issues.
- 3.3. Trainees must complete at least one formally assessed smaller scale project involving the use of audit, service development, service evaluation or applied research methods related to service delivery or professional issues.
- 3.4. During the programme trainees must undertake an independent research project that requires them to conceptualise, design, carry out and communicate the results of research that is

relevant to clinical psychology theory and practice. Research methodologies and traditions are not prescribed and programmes and examiners should take an inclusive approach to acceptable products. However, this research should be at doctoral level, merit publication through a peer-reviewed process and contribute to the knowledge base related to clinical psychology.

- 3.5. All research projects must demonstrate that they conform to the appropriate relevant ethics and governance procedures and to the Society's guidelines on the conduct of research.
- 3.6. Trainees must have access to computer facilities for data analysis and have adequate training in their use, including guidance on data protection and confidentiality.
- 3.7. Each trainee must have a research supervisor who is competent in research supervision. The Programme Director or research coordinator must be responsible for approving the allocation of research supervisors. Supervisory loads must be monitored and be such that adequate supervision is provided to trainees. There should be a research agreement between supervisor and trainee that covers matters such as a schedule of regular supervision meetings and progress reviews, written feedback on drafts and a timetable for the project.
- 3.8. Great care must be taken to allow trainees to plan and organise their research project in good time, such that there is the opportunity to complete it successfully. Time must be set aside early on in the programme for discussion of the proposed project. Regular monitoring of trainees' progress and the quality of the research must be carried out throughout the programme.
- 3.9. Programmes must be sensitive to the problems that may arise in carrying out applied research. Care must be taken to anticipate common difficulties and take preventative action.
- 3.10. The research curriculum must be designed to promote post-qualification practice that includes research activity through conducting and facilitating research, and applying research to inform practice.

## C Supervised Practice

*This part of our standards relates to Section 5 of the HCPC's Standards of Education and Training, which focuses on programmes' practice placements. For Society-accredited Doctoral programmes in Clinical Psychology, supervision is defined as a personal interaction between the trainee clinical psychologist and their supervisor for the purpose of addressing the trainee's needs and performance in relation to the requirements of the accredited programme. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

### 1. Clinical experience and skills

- 1.1. The learning outcomes described above need to be demonstrated with a *range* of clients and across a *range* of settings. In keeping with the spirit of these standards, these outcomes are not defined prescriptively, and there are multiple pathways through which these goals may be achieved. The range of service user presentations and settings is outlined below and these experiences should be supported by the curriculum exposure as outlined in B.2 above to promote the competencies defined in A.2.
- 1.2. **Service Users:** A fundamental principle is that trainees work with clients across the lifespan, such that they see a range of service users whose difficulties are representative of problems across all stages of development. These include:
  - a wide breadth of presentations – from acute to enduring and from mild to severe;
  - problems ranging from those with mainly biological and/or neuropsychological causation to those emanating mainly from psychosocial factors;
  - problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions;
  - service users with significant levels of challenging behaviour;
  - service users across a range of levels of intellectual functioning over a range of ages, specifically to include experience with individuals with developmental intellectual disability and acquired cognitive impairment;
  - service users whose disability makes it difficult for them to communicate;
  - where service users include carers and families;
  - service users from a range of backgrounds reflecting the demographic characteristics of the population. Trainees will need to understand the impact of difference and diversity on people's lives (including sexuality, disability, ethnicity, culture, faith, cohort differences of age, socio-economic status), and their implications for working practices.
- 1.3. **Service delivery systems:** Trainees should have experience of working across a range of healthcare systems and providers. These could be largely within the NHS but may also involve work within third sector, social care, and independent providers encompassing primary and community care, secondary care and in-patient or other residential facilities. The extent to which such placements are used will be dependent on local circumstances.



1.4. **Modes and type of work:** Trainees should:

- undertake assessment, formulation and intervention both directly and indirectly (e.g. through staff, carers and consulting with other professionals delivering care and intervention);
  - this work should be underpinned by *at least two* evidence-based models of formal psychological intervention, one of which must be cognitive-behaviour therapy;
  - however, trainees must be able to work with complexity and co-morbidity and thus draw from knowledge bases across models of therapy, and evidence bases for different interventions and approaches, when appropriate to the needs and choices of the service user;
  - work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;
  - be critical of their own approach, and aware of how to practise in the absence of reliable evidence, as well as being able to contribute from their work to the evidence base.
- 1.5. Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken.
- 1.6. The national standards as set out by the *Division of Clinical Psychology's* Faculties and Special Interest Groups should provide reference information for supervised practice commensurate with competence in a given area of work. Based on this reference information programmes will develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. The degree to which programmes privilege particular faculty guidance is one way in which specific programme strengths and identity will emerge.
- 1.7. The length of time in a placement, the number of, and the length of time involved with, service users must be sufficient to allow this. An adequate balance of time must be allocated across services and client groups, and optimum use made of available placements, so that the required range of experience across the lifespan may be gained.
- 1.8. The programme of supervised clinical experience needs to be planned for each trainee in order to ensure that all trainees will gain required experience. The Programme Director or Clinical coordinator is responsible for monitoring each individual plan and making adjustments as necessary so that any gaps or problems can be identified early and resolved later in training. The main requirement is that over the period of the programme trainees must gain the range of experience noted above, rather than spending specified lengths of time in particular placements. Flexibility in placement planning is needed to ensure this. Trainees must be fully involved in monitoring their individual plan.
- 1.9. Programmes should ensure that within clinical placements trainees have experience of working with other professions, and that the opportunities for inter-professional learning are maximised.

- 1.10. Trainees must keep a portfolio of their clinical experience to enable their training plan to be monitored and to evidence the range of presentations, service delivery systems, modes of working etc. in which competencies have been accrued.
- 1.11. The portfolio must clearly summarise the experiences and work undertaken within a given placement setting and cumulatively across training. Whilst it is expected that the competencies outlined in section A.2 related to the transferrable skills of assessment, formulation, intervention and evaluation will be integral to most placements, the specific service user presentations, service settings and modes of working will vary and need to be defined and summarised in a readily accessible and transparent way. Whilst a template example is presented in Appendix 1, programmes are encouraged to develop their own portfolio system.
- 1.12. In addition, programmes must operationalise their requirements for trainees to demonstrate competence in the two specific models of psychological therapy required (one of which must be cognitive behaviour therapy) in a credible and robust way. The Society recognises that there is no patent on defining these and that individual training programmes and trainees will vary in the breadth and level of competence promoted. However, the Society will accredit programmes in so far as they have operationalised their own minimum standards for individual validation. These should be benchmarked against recognised criteria, where these exist, such as those formulated by the Society's *Centre for Outcomes Research and Effectiveness* (CORE) – [www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm). However, programmes may adapt these, or indeed use other credible competence frameworks, which best capture the application of CBT and other therapies to specific ages, populations and presentations. A template example of how these might look is presented in Appendix 1.
- 1.13. Similar requirements for test competencies should be operationalised as outlined in D.3.2 below.

## **2. Clinical supervision**

- 2.1. Programmes must have access to an adequate number of appropriately qualified and experienced placement supervisors.
- 2.2. Trainees will have a co-ordinating placement tutor or supervisor who is a qualified clinical psychologist. The identification of a co-ordinating tutor or supervisor is intended to ensure that the trainee participates in supervision with an appropriately qualified psychologist for the majority of their training. The co-ordinating supervisor may be a member of the programme team.
- 2.3. In addition, trainees will have clinical or practice supervisors. These supervisors must be appropriately qualified, but may be registered in a different domain of psychology, or be a member of another profession:
  - a) Psychologists providing supervision to trainees on accredited programmes must be registered with the Health and Care Professions Council.
  - b) Members of other professions who are providing supervision to trainees on accredited programmes should normally be registered with an appropriate professional or statutory body.

The nature of supervision provided will depend on the organisational context in which the placement takes place and may range from supervision of specific case work to supervision of the whole placement experience. It is for programmes to ensure that all supervisors, based on their training, experience and CPD, have the appropriate competencies to be offering the particular services in which they are supervising the trainee.

- 2.4. All supervisors are expected to have completed training in supervision as recognised by the Society or provided by the education provider.
- 2.5. All clinical supervisors must be fully aware of their responsibilities. No placement should be arranged unless the supervisor has indicated her or his willingness to provide full supervision and take responsibility for the trainee. The programme must have written guidelines on clinical supervision, or, alternatively, utilise the Society's guidelines, which are available at [www.bps.org.uk/accreditationdownloads](http://www.bps.org.uk/accreditationdownloads). The guidelines on supervision must be circulated to all supervisors.
- 2.6. A variety of supervisory arrangements is acceptable. These include trainee to supervisor ratios of 1:1 and 2:1 and various forms of team supervision for groups of trainees. The programme must ensure:
  - 2.6.1. that each trainee has a named supervisor who is responsible for the co-ordination of their supervision and who formally assesses the trainee in consultation with the other supervisor(s) involved; *and*
  - 2.6.2. that individual supervision provides opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as on-going case work.
- 2.7. Supervision in all placements must meet the following standards:
  - 2.7.1. The general aims of the placement should be established prior to or at the very beginning of the placement.
  - 2.7.2. A written placement contract should be drawn up towards the start of the placement.
  - 2.7.3. There must be a formal, scheduled supervision meeting each week that must be of at least an hour's duration.
  - 2.7.4. The trainee must have an appropriate amount of individual supervision in addition to any group supervision.
  - 2.7.5. Total 'contact' time between supervisor(s) and trainee(s) must be at least three hours per week.
  - 2.7.6. There must be a formal, interim review of the trainee's progress in the placement, and of the experience provided.
  - 2.7.7. Full written feedback should be given on the trainee's performance on placements.
  - 2.7.8. The trainee must see and comment on the full report.

- 2.7.9. Trainees must have the opportunity to observe the work of their supervisors; supervisors must observe the work of trainees.
- 2.7.10. Supervisors should be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work.
- 2.7.11. Supervisors should closely monitor and help develop trainees' communications (oral and written) and non-therapy skills as defined above.
- 2.8. There must be a formal process whereby the programme team monitors the clinical experience of trainees and the supervision provided, and helps to resolve any problems that may have arisen. This process must be timed such that if there are problems there will be still be time available in the placement to overcome the problems, if this is feasible. The process must include the opportunity for a member of the programme team to hold discussions in private with the trainee and supervisor individually prior to a joint discussion. A written record of the monitoring and any action plan agreed must be held on file.
- 2.9. Regular workshops on supervisory skills and other training events for supervisors must be organised by the programme to ensure effective supervision. Supervisors should attend workshops and training events periodically. Programmes must ensure that the training events offered meet the needs of both new supervisors and more experienced colleagues. Suggested learning objectives for introductory supervisor training are provided at [www.bps.org.uk/accreditationdownloads](http://www.bps.org.uk/accreditationdownloads).
- 2.10. Trainees must have the opportunity to provide feedback on the adequacy of placements and supervision, and programmes should ensure that it is possible to change important aspects of placements that are found to be unsatisfactory.
- 2.11. Programmes must have a formal, documented audit process for clinical placements and supervision in partnership with Heads of Service and supervisors. The Programme Board/Training Committee must have mechanisms for considering the outcomes of each audit, and procedures for seeking to overcome any problems that are identified.

### **3. Critical evidence based practice**

- 3.1. During the periods when trainees are on clinical placements, supervisors should guide trainees to read relevant literature and use their knowledge of the literature to inform their clinical work, particularly formulation of clinical problems.
- 3.2. It is important that supervisors and programme staff keep abreast of theoretical, research and evidence based guidance in their fields of work, and participate in continuing professional development. It is important that trainees are encouraged to develop a critically reflective stance to the evidence base and do not seek to apply it in a reductionistic and formulaic fashion.
- 3.3. During the academic programme, teachers should be encouraged to use clinical material of their own and of the trainees as a means of elucidating theoretical and research issues.
- 3.4. Programmes must consider how they integrate theory and practice throughout the clinical training programme. This should include consideration of issues such as the use of academic

knowledge on placement, the use of clinical examples in teaching and how the academic programme as a whole relates to the clinical experience.

- 3.5. Since trainees may not all follow the same pathway through training, programmes should have a system for monitoring the level of integration that is achieved between academic teaching and placement training and for developing an action plan to deal with problems.

## **D Assessment and transparency of specific competencies**

*This part of our standards relates to section 6 of the HCPC's Standards of Education and Training, which outlines the standards that programmes need to meet in relation to assessment. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

### **1. Regulations**

- 1.1. Programmes must have a clear set of published regulations relating to assessment which are readily accessible and understood by applicants, trainees, staff, supervisors and internal and external examiners. The criteria for passing or failing the programme must be explicit, together with any fall-back awards criteria. These regulations and assessment criteria must relate clearly to the programme's learning outcomes.
- 1.2. Any APL (Accreditation of Prior Learning) regulations should make clear that relevant learning has to take place after eligibility for the Graduate Basis for Chartered Membership of the Society (GBC) has been attained. Regardless of university regulations pertaining to APL, programmes must show how they satisfy themselves that the trainee still meets the learning outcomes outlined in A.2 and as specified in the HCPC standards of proficiency.
- 1.3. Programmes should have effective systems in place in order to quality assure, ratify or mediate assessment decisions. This typically involves systems of internal moderation, external examiner review of standards and failure decisions and an exam board which can oversee and, where appropriate, make decisions on pass / fail recommendations.
- 1.4. Programmes must provide written guidelines on criteria for failure in the assessment of all components of the programme. The criteria must be clearly related to the programme's required learning outcomes. In general, the whole period of training should comprise work that is of an acceptable standard. If a trainee has failed an assessment of competence, but been allowed to continue in training, then there must be a clear mechanism for extending the period of training, if necessary, to ensure that there is an opportunity for acceptable standards of practice to be reached and for core competencies to be acquired.
- 1.5. Assessments must give appropriate weighting to professional competence. The Programme Director(s) must take responsibility for ensuring that there are adequate procedures to ensure that trainees who are incompetent or whose behaviour is unethical do not obtain a qualification in clinical psychology. There must also be mechanisms to ensure that such trainees should be identified as early as possible in the programme, and are not allowed to continue if remedial action is ineffective. These procedures should, as far as possible, be consistent across those used by the University and trainees' employers.

- 1.6. Mechanisms should exist to consider requests for reasonable adjustments and the relevance of extenuating circumstances with respect to decisions about student progression. However, these should not compromise assessment decisions regarding attainment of learning outcomes.
- 1.7. Programmes must have an explicit appeals procedure, consistent with University and employers' procedures, for considering formal appeals from trainees who fail to satisfy the examiners. Trainees should be made aware of these at the beginning of the programme.

## **2. Assessment procedures**

- 2.1. Assessment practices should be fair and appropriately valid and reliable. Assessment should be undertaken only by appropriately qualified staff, who have been adequately trained and briefed.
- 2.2. Trainees should be given feedback and assessment decisions in a timely manner which allows remedial action and change to take place.
- 2.3. Programmes should use a range of assessment methods, formative and summative, as appropriate to assessing the learning outcomes related to academic knowledge, clinical practice, research competencies and personal and professional development.
- 2.4. In addition to methods of assessment of clinical skills which are based on how the trainee disseminates their work orally and in writing, systematic assessment tools must be in place for evaluating trainees' clinical competencies *in vivo*. This means that, as part of the assessment of trainees' competence, they should be observed, and the outcome of that observation should contribute to the overall assessment process –either discretely or as part of a larger assessment unit (e.g. placement ratings). Programmes may choose observational assessment tools or protocols that are most appropriate for their context. How these are applied may also vary and some possible examples of application are provided below. :
  - supervisor or programme staff observation and assessment of clinical practice (e.g. psychometric and other approaches to assessment, intervention);
  - supervisor or programme staff observation of simulations related to the above (e.g. role plays involving service users, colleagues or actors);
  - supervisor or programme staff assessment of recordings of practice (audio or video) and/or transcriptions of the same.
  - supervisor or programme staff observation and assessment of non-therapy skills (e.g. performance in multidisciplinary team, presentations, training).
- 2.5. In addition to observation and assessment by supervisors or programme staff, programmes are also encouraged to work with service user and carer colleagues to design ways in which their feedback may be incorporated into the assessment process.

### 3. Transparency in validating specific competencies

The hallmark features of training in clinical psychology have been highlighted in A.1. These include the capacity to draw from knowledge across the evidence bases of psychological therapies and interventions of what works for whom, and applying that in a critical way to common, as well as complex and co-morbid presentations. The ability to draw across knowledge of different models is key to being able to select the best intervention(s) for the client but this should not be taken to imply that uni-model interventions cannot offer the best approach for a particular client. However, it does indicate that clinical psychologists need to be able to conceptualise in both a uni-model and a multi-model way. The capacity to transfer these competencies across specialisms and populations, service delivery systems and across the life-span is a defining feature of clinical psychology training. Moreover, the research skills to be effective consumers, but also contributors to the knowledge base, are emphasised. Procedures to achieve these doctoral level competencies underpin current accreditation criteria to confer Chartered status with full Divisional membership.

However, the Society recognizes that some specific employment competencies, which whilst encompassed in clinical psychology training and accreditation criteria, are not unique to the training of clinical psychologists. In particular these include competence to deliver specific therapies (i.e. cognitive behaviour therapy plus one other) and test competencies.

3.1. Consequently, and in order to facilitate employer and commissioner appreciation of these specific competencies programmes should benchmark their curriculum and placement provision against a competence framework in whichever formal models of psychological intervention they are including in relation to the criteria outlined in A.2.2.4 and C.1.4 above.

3.1.1. It should be clear from this exercise that programmes have in place an academic curriculum, placement and supervisory resources required to meet a given competence framework for all trainees, in terms of CBT. Similarly, curriculum, placement and supervisory resources should be in place for the second model of psychological intervention, which will either be agreed by the programme for all trainees, or selected by the trainee in a specific training pathway (thus the second model may vary across trainees within a single programme).

3.1.2. The Society recognizes that therapy competence frameworks may be operationalised and defined in different ways. The Society would encourage using the competence frameworks developed by the *BPS Centre for Outcomes Research and Effectiveness* (CORE) – [www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm) as a starting point. These may be utilised as they stand, or programmes may *adapt* these to make them more relevant to applying (for example) CBT to work outside adult mental health (e.g. with children, people with an intellectual disability, people who hear voices, older adults etc.). The same principle is relevant to the other therapy frameworks. The generic competencies within each competence framework are key here, though programmes are free to formulate competence frameworks for specific presentations if, for example, that is consistent with how they choose to market and define themselves. Programmes may utilise other competence frameworks where appropriate to the skills they say their trainee(s) are competent within. The key principle is that programmes utilise a credible competence framework to quality assure trainee work against. The Society will accredit programmes where this is the case, although the more widely



accepted a competence framework is, the more credible these learning outcomes are likely to be in the employment and commissioning market.

- 3.1.3. The Society will accredit a programme as having the required curriculum, placement and supervisory resources required to enable trainees to meet these competencies in principle should the trainee choose a particular placement pathway to obtain these. It should be noted that the Society does not require supervisors to be “accredited” by any other professional body to supervise specific therapies, though this may of course be the case. Rather, it is the capacity to utilise specific therapy interventions in the practice of clinical psychology which is key and we would expect programmes to have in place ways of identifying supervisors and placements where this is the case.
- 3.1.4. It will thus be incumbent on programmes to have in place monitoring and assessment systems to validate the attainment of competencies in their trainees as specific intervention subsets are likely to vary depending on programme emphases and indeed the placement pathway pursued by individual trainees. In addition to the programme benchmarking the curriculum, trainees are thus required to keep portfolios of clinical experience, certified by their supervisors, which attests to the achievement of given competencies within a competence framework (e.g. use of behavioural activation, circular questioning, guided discovery, working with transference etc.) across clinical activities. These could be obtained in many placement settings and with varied populations and should not necessarily be required within a uni-modal CBT, or psychodynamic, or systemic placement etc. – although again this would also be satisfactory. A template example of how such a system might look in the clinical practice portfolio is outlined in Appendix 1.
- 3.2. Similar principles should operate in accreditation of a programmes capacity to promote test competencies. The fundamental feature of the competencies defined in A.2.2.2 and A.2.2.5 above is that trainees should be able to *choose, use and interpret* tests and test results. The curriculum and placement experiences should clearly highlight how these competencies are promoted. Programmes may find the DCP publication on test standards in clinical psychology training (2009) and the more recent competence framework developed by the Division of Neuropsychology (2012) useful in guiding thinking here. Similarly, the clinical portfolio should make clear in which tests (performance and paper and pencil psychometrics) the trainee has experience. Sufficient exposure should be attained to allow generalisability to be inferred and some, at least formative, *in vivo* assessment should pertain here.

**In subsequent standards those which are generic across accredited postgraduate programmes are bullet pointed within the shaded box. Those specific to *Doctorates in Clinical Psychology* are subsequently numbered.**

## Programme standard 2: Working ethically

**The programme must include teaching on the Society's *Code of Ethics and Conduct*, and evaluation of students' understanding of working ethically, as appropriate to the level of study.<sup>1</sup>**

The inclusion of this standard reflects the particular importance of ethics and ethical practice to psychologists.

The Society's *Code of Ethics and Conduct* and supplementary ethical guidelines provide clear ethical principles, values and standards to guide and support psychologists' decisions in the difficult and challenging situations they may face. Further information can be found at [www.bps.org.uk/ethics](http://www.bps.org.uk/ethics).

In addition to providing teaching on the Society's *Code of Ethics and Conduct* and relevant supplementary ethical guidelines, Masters and Doctoral programmes are also expected to make students aware of the Health and Care Professions Council's *Guidance on Conduct and Ethics for Students*.

All accredited programmes are expected to include formal teaching on ethics, and should be able to demonstrate how working ethically is integral to all aspects of their provision, including research (as outlined below), and placement activities (where applicable).

Students need to understand the ethical frameworks that apply to their research, and how to engage with these, as well as understanding the ethical implications of the research that they encounter and working with people more generally.

Programmes should also seek to foster appropriate understanding of and competencies in ethical decision-making and practice, both at the general level and specific to the sorts of situations and contexts that applied psychologists face in their work, at the appropriate level.

In evaluating students' understanding of working ethically, education providers should have in place mechanisms for identifying and dealing with academic and professional misconduct, as appropriate to the programme(s) offered. The programme should consider the ways in which these mechanisms are publicised to students.

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<sup>1</sup> The Society's Ethics Committee is undertaking work on the development of a framework for the specification of ethical competencies, and how these may be taught and assessed at different levels of study. Its aim will be to provide guidance for psychology educators and professional psychology programmes in due course, and, once available, programmes will be encouraged to adopt that framework as appropriate to their provision.

## Programme standard 3: Selection and entry

**The programme must apply appropriate selection and entry criteria that are consistent with promoting equality of opportunity and access to psychology to as diverse a range of applicants as possible.**

- Education providers have certain obligations in relation to equality of opportunity and access in relation to UK legislation and the requirements of the Office for Fair Access ([www.offa.org.uk](http://www.offa.org.uk)), or equivalent.
- The Society is interested in the ways in which education providers implement their equality and diversity policies for the benefit of prospective and current psychology students/trainees.
- This standard is included because it is particularly important that those progressing to undertake professional training in psychology, and therefore those moving into employment as psychologists, reflect the demographics of the populations with whom they will be working.
- Similarly, the Society is keen to promote diversity in psychology students progressing towards careers as academics or researchers.
- Overall, it is important that psychological knowledge and expertise is reflected across a diverse range of people, and that this diversity is ultimately reflected throughout the Society's membership.

*This part of our standards relates to section 2 of the HCPC's Standards of Education and Training, which outlines the standards that programmes need to meet in relation to their selection and admission procedures. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

1. The Society normally expects entrants to accredited Doctoral programmes to be eligible for the Graduate Basis for Chartered Membership (GBC). Programmes may also accept applicants who do are not eligible for GBC, provided they have a clear rationale for doing so, and are able to put in place any additional support required by such applicants. This may include support to get up to speed on relevant aspects of psychological theory and research. Programmes may choose to retain eligibility for the GBC as a minimum entry requirement should they so wish.
2. Programmes must provide clear information to students indicating that, in order to be eligible for Chartered Membership of the Society and full Division membership, they will need to have completed a programme granting eligibility for the GBC prior to commencing Doctoral training.
3. Programmes may operate procedures for the accreditation of prior learning (APL) or existing competence (AEC) against the learning outcomes of the accredited award. These procedures should ensure that any exemptions are granted on the basis of learning undertaken or competence gained following the trainee's achievement of eligibility for the GBC.
4. Both teaching staff and clinical supervisors must be fully involved in the selection of trainees. There must be opportunities for short-listed applicants to meet existing trainees.
5. Trainees should normally be paid on Agenda for Change terms and conditions or equivalent. Where this is not the case, funding bodies need to ensure that the pay of trainees is sufficient to enable them

to meet training requirements, and the Programme Board/Committee must regularly review the situation.

6. Programmes should take active steps, including outreach activity, to widen access to entry to the profession of clinical psychology, aiming for diversity within trainee cohorts, and must produce documentary evidence of these strategies. Programmes must periodically review their entry requirements and the ways in which potential to achieve competence is assessed at selection, to ensure that these are consistent with the overall aim of widening access to the profession, and are not discriminatory.
7. The Programme Director(s) must ensure that any additional honorary contracts that are required for trainees above and beyond their contracts of employment are in place at the appropriate juncture. This may include, for example, contracts that are required if trainees are undertaking clinical placements or research outside of their employing Trust, but will be dependent upon local circumstances. Trainees who are not NHS employees must hold honorary contracts or a letter of access with the appropriate NHS Provider, issued before they take up their appointments, and with other agencies where applicable.

## Programme standard 4: Society membership

**The programme must provide students with information on gaining membership of the Society at the appropriate level.**

- This standard is included because it is important that education providers communicate the benefits of completing an accredited programme to their students.
- Programmes should familiarise students with the distinct role of the Society as the professional body and the Health and Care Professions Council as the statutory regulator for practitioner psychologists in the UK. The Society's role is to develop and support the discipline of psychology, and to disseminate psychological knowledge to the public and policy makers. Belonging to the Society is an integral part of being a psychologist. It recognises graduates' qualifications and reflects their aspiration to represent the highest possible professional standards. Programmes are encouraged to share the benefits of belonging to the Society with their students and trainees, for example by including the information provided on pages 6 and 7 in student handbooks.
- Completion of an accredited programme offers graduates a clear route to Society membership at the appropriate level, and therefore access to the full range of membership benefits, including a variety of services, publications, conferences, training and networking opportunities. Society membership also presents graduates with opportunities for developing and influencing the profession as leaders in their field in the future. For more information on the benefits of Society membership, see [www.bps.org.uk/membership/benefits](http://www.bps.org.uk/membership/benefits).

## Programme standard 5: Personal and professional development

**The programme must be able to articulate a strategy for supporting students' development as psychologists, in a way that is appropriate to their level of study.**

- The programme must have in place mechanisms for the support of students' personal and/or professional development, as appropriate.
- This standard is included because close attention to students' personal and professional development is key to their employability. Education providers may link with local and/or national employers in a variety of ways, and the Society is keen to develop its understanding of these approaches through partnership visits.
- Psychology graduates should explicitly understand how their training equips them with transferrable skills that are of value to employers.
- In particular, providers of postgraduate professional training programmes should consider the ways in which their students are supported in developing an identity as practitioner psychologists of the future, and be able to outline the resources that are allocated to leading and co-ordinating this aspect of their provision.
- Postgraduate programmes should also pay particular attention to professional development where students on accredited programmes are taught alongside other student groups (for example, those that do not hold eligibility for the GBC, or other professional groups).
- Opportunities for interdisciplinary working can enrich the learning experience, however, and where these exist education providers should clearly outline their availability for the benefit of students. The Society does not advocate a particular approach to programme delivery, and interdisciplinary or inter-professional learning may be more or less appropriate depending upon the organisational context within which the programme is operating. However, the Society is keen to collate clearer information on the range of approaches that are taken to learning and teaching through exploration and enquiry with education providers at partnership visits.

*This part of our standards does not relate directly to the HCPC's Standards of Education and Training. However, the steps outlined below will have a positive impact on the learning experience of trainee clinical psychologists.*

1. Programmes must have a system for monitoring trainees' progress on an annual basis in clinical, academic and research work and in developing professional roles, that is consistent with relevant NHS recruitment and performance management policies and procedures (see [www.bps.org.uk/accreditationdownloads](http://www.bps.org.uk/accreditationdownloads) for an indication of the ways in which these standards relate to the Knowledge and Skills Framework). This monitoring should look at a trainee's work as a whole and lead to guidance on future development, including both specific goals and career guidance. There must be shared documentation for recording this information that demonstrates that each aspect of the trainee's progress, as outlined above, is explicitly and consistently considered.

2. Education providers should ensure that detailed and up to date records on student progress are kept. Throughout a programme of study, students should receive prompt and helpful feedback about their performance and progress in relation to assessment criteria so that they can appropriately direct their subsequent learning activities.
3. Programmes should ensure that trainees monitor and review their own progress and develop skills in self-reflection and critical reflection on practice.
4. Programmes must have mechanisms for helping trainees to manage their own personal learning needs and to develop strategies for meeting these. This will include using supervision to reflect on practice, and making appropriate use of feedback received.
5. Programmes must have plans for enabling trainees to understand the impact of difference and diversity on people's lives and its implications for working practices.
6. Programmes must have arrangements for ensuring that trainees with special needs are supported in undertaking the requirements of the programme.
7. Programmes should ensure that trainees develop strategies to handle the emotional and physical impact of their own practice and to seek appropriate support when necessary, with good awareness of boundary issues. However, trainees should also have the capacity to monitor their own fitness to practice, recognise when this is compromised, and take steps to manage this risk as appropriate.
8. Programme Directors, Tutors and Supervisors should be alert to personal issues that bear on a trainee's professional performance and academic achievement, and which often arise from the stresses of taking part in a clinical training programme. Programmes must make provision for such matters to be discussed with trainees routinely, and have in place written procedures on the systems that provide opportunities for such discussions. Trainees must have access to a range of support mechanisms including those available outside the programme team.
9. Trainees who experience stress or psychological disturbance should be given assistance in obtaining appropriate help.
10. Programmes must have a written policy on health and safety matters and ensure that this is brought to the attention of trainees, and that adequate training is provided. This policy will need to draw attention to the various health and safety policies that will be applicable to trainees; e.g. those of the programme base, the trainees' employer(s) and the organisations within which clinical placements are undertaken.
11. Trainees should have the capacity to adapt to, and comply with, the policies and practices of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.
12. Towards the end of their training, trainees should be helped to identify their continuing professional development needs. In particular, programmes must ensure that issues relating to the transition from trainee to qualified clinical psychologist are explicitly addressed.

## Programme standard 6: Staffing

**The education provider must have appropriate human resources in place to support the effective delivery of the programme. Specifically, postgraduate programmes should normally operate a minimum staff student ratio of 1:10, although there are specific instances where variance from this standard is appropriate and acceptable.**

- This standard is included as contact with and support from sufficient numbers of appropriately qualified staff will contribute significantly to the quality of the overall experience of psychology students.
- Education providers should provide a calculation of their current staff student ratio in the evidence they submit in support of an application for accreditation, or in advance of a paper-based review or partnership visit.
- There are key roles and functions that the Society considers are essential to the effective and efficient delivery of an accredited programme. Programmes must therefore have sufficient staff with enough time allocated to carry out tasks that are normally associated with: management; teaching; organising, co-ordinating and monitoring placements (if appropriate); training and supporting supervisors or other assessors; research supervision; marking; providing personal support to students; supporting their professional development; and liaising with employers, visiting speakers and other external stakeholders.
- All programmes must pay particular attention to ensuring that staffing levels are such that trainees receive research supervision at a level consistent with the programme's aims and that research supervision loads for staff are appropriate to enable them to provide adequate supervision at the required level.
- Where staff have other duties (e.g. other teaching or practice commitments) these must be taken into account in setting staffing levels and must be such that they do not interfere with the execution of the major responsibility of programme delivery.
- Programmes with small cohort sizes are likely to require an enhanced staff student ratio in order to be able to fulfil the key roles and functions required above.
- Programmes must have access to sufficient administrative, administrative, technical or other learning support staff to support their effective delivery. However, the contributions made by such staff, and those of visiting lecturers and supervisors of trainees' professional practice, should not normally be included in any calculation of staff student ratio.

*This part of our standards relates to section 3 of the HCPC's Standards of Education and Training, which outlines the standards that programmes need to meet in relation to their management, and the resources that should be available to staff, trainees and others contributing to the programme. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

1. Programmes must have adequate staffing to provide effective training that reflects this guidance. This means sufficient staff with enough time allocated to carry out the required tasks: management; teaching; organising, coordinating and monitoring clinical placements; training and supporting



supervisors; research supervision; assessment and monitoring of trainees; and liaison with other agency staff. In particular, staffing levels must be such that trainees receive research supervision at a level consistent with the programme's aims and that research supervision loads for staff are appropriate to enable them to provide adequate supervision at the required level. The Programme Director(s) should ensure that the academic, clinical and research components of the programme are appropriately coordinated. Where staff have other duties (e.g. undergraduate teaching or clinical commitments) these must be taken into account in setting staffing levels and must be such that they do not interfere with the execution of the major responsibility of programme delivery.

2. The programme team (Programme Director(s) and those staff with a major commitment to the programme) must have an adequate range of skills and experience in order to fulfill the tasks identified in 6.1. The selection of staff must ensure that an appropriate balance is maintained in terms of staffing resources for the various components of the programme.
3. Staff are entitled to expect an institutional culture which values and rewards professionalism and scholarship, and which provides access to development opportunities which assist them in their support for trainee learning. Institutions should support initial and continuing professional development for all staff, and encourage self-evaluation as an essential element of reflective professional practice.
4. All core members of programme teams are expected to undertake continuing professional development that is relevant to their role within the institution and, where appropriate, to their professional practice as a clinical psychologist. It is expected that this would include undertaking relevant research and other scholarly activity, and attendance at relevant conferences. Opportunities for development should be available to all staff who are engaged in, or are supporting, teaching, research and scholarship. Additionally, the programme team should be involved in regular work which has relevance to the programme.
5. Where staff external to the core team contribute to the programme, the nature and level of their involvements should be clearly stated. This refers both to other academic staff and contributors from external organisations. The nature and level of involvement of staff who are part-time or visiting also need to be clearly specified.
6. The programme must be able to demonstrate that it has access to sufficient administrative and clerical support to support its effective delivery.

## Programme standard 7: Leadership and co-ordination

**The education provider must appoint an appropriately qualified and experienced director or co-ordinator for the programme.**

- The leadership and co-ordination of the programme is central to shaping students' experience of psychology and their development as psychologists.
- For postgraduate programmes, the Director should be either a Chartered Psychologist holding full membership of the Division within whose domain the programme falls, or otherwise appropriately qualified and experienced (for example, registered with the Health and Care Professions Council, or eligible for Chartered Psychologist status and membership of the relevant Division).
- The Programme Director must normally have appropriate academic, professional practice, research and managerial skills, in addition to prior knowledge and experience of training in the relevant area of applied psychology.
- The skills required will differ according to the nature of the accredited programme. Programmes offering underpinning knowledge and/or research (stage one of the requirements for Chartered Psychologist status) must normally be managed by an individual with clear academic and/or research expertise; the management of programmes providing full training from GBC to eligibility for registration as a Chartered Psychologist (stage two and integrated Doctoral programmes), or other training with a substantial focus on professional practice (educational psychology programmes in Scotland) will also require appropriate professional practice skills and experience.
- Where appropriate, Programme Directors may also be supported in aspects of their role by colleagues with complementary skills and experience to their own. Education providers may wish to consider the roles that other programme team members may take in relation to the leadership and co-ordination of the programme as part of their staff development strategy, particularly in connection with longer-term succession planning or to support the development of leadership potential.
- The Programme Director must be of an appropriately senior academic status within the education provider, such that the Society may be confident that they can take overall responsibility for, or make a significant contribution to, the programme's day-to-day management and strategic direction.

*This part of our standards complements section 3 of the HCPC's Standards of Education and Training, which includes HCPC's requirements in relation to the directorship of the programme. Accredited programmes are expected to meet the additional standard below:*

1. Programmes must be managed and organized by a Programme Director who meets the Society's expectations, who has the programme as his/her major commitment, and is free to devote sufficient time to ensure its effective and efficient running. Additionally, the Programme Director must have sufficient time to conduct research, knowledge transfer, consultancy/organisational and/or clinical work; normally this will be at least one day per week.

## Programme standard 8: Physical resources

**The education provider must have appropriate physical resources in place to support the effective delivery of the programme.**

- This standard is included because the student experience must be underpinned by access to physical resources that are appropriate to the psychology programme(s) offered by the education provider.
- The availability of appropriate resources is key to the delivery of psychology as a science, with associated levels of practical work culminating in students' completion of individual research at the appropriate level.
- Physical resources will normally include teaching, tutorial and laboratory space, learning resources (such as texts and journals, available in hard copy and/or electronically, computing facilities), psychological testing materials, specialist equipment supporting psychological research, software supporting data collection and analysis in psychology research, and other IT facilities.
- Education providers should consider how students are advised of the physical and learning resources to which they have access.

*This part of our standards complements section 3 of the HCPC's Standards of Education and Training, which includes HCPC's requirements in relation to the physical resources and facilities underpinning programmes. Accredited programmes are expected to meet the additional standard below:*

1. When trainees are on clinical placements they must have access to (at least) a shared office and telephone. There must be adequate arrangements for secretarial and IT support for their placement work, and trainees must be given guidance on the facilities available.

## Programme standard 9: Quality management

**The education provider's quality management systems must make regular provision for the periodic review of the validity and relevance of the programme, such that it continues to reflect our standards.**

- This standard is included because *accreditation through partnership* relies upon education providers having in place robust quality management mechanisms that facilitate self-evaluation against the programme standards, and the domain-specific standards that apply to the programme(s) in question.
- The Society recognises education providers' quality management mechanisms as a reliable source of evidence of continued achievement of the standards.
- Whatever the mechanisms that are in place, they should provide for periodic review of the programme's aims and intended learning outcomes and content, the strategies associated with programme delivery, and the assessment methods that are used to evaluate students' achievement of the learning outcomes. Overall, they should ensure that the programme continues to reflect contemporary learning, research and practice in psychology.
- Students should have the opportunity to provide feedback via the quality management mechanisms that are in place. Programmes should identify ways in which any difficulties identified may be satisfactorily resolved, and changes to current systems and practices made where appropriate.
- Programmes should also consider the ways in which employer feedback might be harnessed.
- Programmes will appoint appropriate External Examiner(s) whose expertise will be of relevance to the breadth and depth of provision being offered.
- External peer review offers a valuable perspective upon the ways in which the programme compares to others of a similar nature nationally. With this in mind, enabling the Society to have sight of External Examiners' reports, and the programme's response to these, allows our reviewers to gain insight into the extent to which the education provider's quality management mechanisms function effectively for the benefit of students, and the discipline as a whole.

*This part of our standards relates to section 3 of the HCPC's Standards of Education and Training, which includes HCPC's requirements in relation to programme management, and to section 6, which relates to assessment. In addition to HCPC's requirements, accredited programmes must meet the standards outlined below:*

## **Programme management: organisation and governance**

1. The overall organisation of the programme (for both full-time and part-time programmes) must ensure the effective planning, delivery and monitoring of the programme. Whatever the structure, it must be sufficiently clear to work effectively.
2. There must be a clear channel of accountability for the work of the Director(s), acceptable to both the academic institution and psychologists within local health and social care providers. A programme based in a University must be regarded as a collaborative enterprise with the NHS, other healthcare providers, the services associated with the programme and other relevant stakeholders.
3. The programme must have a Programme Board/Training Committee on which the Director(s), teaching staff, clinical supervisors, relevant DCP subsystems, heads of services, trainees, purchasers of training and service users are represented in a way that reflects the joint enterprise upon which the programme is based. The Programme Board/Committee must have a written constitution and terms of reference. It must ensure that the interests of the different stakeholder groups are respected; it must be involved with the overall policy of the programme and the long-term objectives, and should oversee the work of the programme team and any sub-committee structure. It must be acceptable to the different groups involved in the programme and have wide support.
4. Programmes must work collaboratively with service users, carers and community representatives to identify and implement strategies for the active participation of these stakeholders in the programme. These strategies, and the practical support available to implement them, must be acceptable to the different groups involved in the programme and have wide support.
5. Programmes will normally be associated with a particular geographical area and it is expected that the major part of the funding, teaching and placement resources required by the programme will be provided from that area. Development of any new programme or a major change in any existing programme (which could affect other existing programmes) must be made in consultation with other programmes and local psychologists within the area to avoid impairing the viability of existing programmes. Such consultation must be undertaken from the earliest stage of programme development.
6. Funding arrangements must be clear and transparent. Programmes must have sufficient 'core' funding, such that there is normally an agreed minimum number of funded places in order to ensure stability and predictability in planning the programme. The budget must include funding adequate for agreed expenditure. The budget should be held by the Programme Director(s), or if there are other arrangements they must be clear and acceptable to the Programme Director(s), Programme Board/Committee and purchasers. The programme must have a financial plan detailing the funding available and how resources are/will be allocated. When a programme is expanding it is essential that the necessary additional resources required are identified and agreed with the purchasers before new trainees are accepted on to the programme. Similarly, any contraction of a programme must be managed in a clear and transparent way.
7. Regular reviews, informed by appropriate external benchmarks, should be undertaken to monitor the effectiveness of learning, teaching and assessment strategies. Through evaluation of the impact of its policies and practices, an education provider should seek to implement continuing improvement of the learning environment, the educational opportunities available to its trainees, and the quality and academic standards of learning in the education it provides.

8. Each programme must be able to identify its own limitations and to indicate how it hopes to rectify these. This might include any limitations in providing learning and placement experiences with particular client groups or in particular clinical or service settings, and should indicate the likely impact of this for prospective trainees, commissioners and employers.

### **External examination**

9. External Examiners of programmes should normally be qualified clinical psychologists. Where programmes make use of more than one External Examiner, they must ensure that an External Examiner with responsibility for maintaining an overview of the programme in question is identified and appointed. Programmes must make explicit the nature of the External Examiners' role and duties. Policies and procedures for the nomination and appointment of External Examiners must be explicit, and clear and transparent criteria for the appointment of an individual who is not a clinical psychologist must be in place (for example, for the individual external examination of trainees' research theses). External Examiners must be provided with adequate information to support their role.