Summary of Essential (minimum) Core Clinical Competencies

All three courses in the North Thames region (RHUL, UEL, UCL) run a competency-based model of training. Trainees are allocated placements across all three years of training that will ensure they meet the minimum essential core clinical competencies outlined in the BPS accreditation criteria by the end of the course. Each trainee will therefore have a varied allocation of placements depending on their competency needs at each placement period. This contrasts to some other DClinPsy programmes where trainees complete core placements in the first two years of training followed by elective placements in the third year.

By the end of training, trainees must have developed broad competence across all the nine core competency areas, as defined below, from the BPS Accreditation Criteria (2025):

1. Generalisable meta-competencies
2. Psychological assessment
3. Psychological formulation
4. Psychological intervention
5. Evaluation
6. Research
7. Personal and professional skills and values
8. Communication and teaching
9. Organisational and systemic influence and leadership

Experience in these areas can typically be found across a range of placements and should be evidenced in your placement paperwork and clinical logs. Please see the Appendix of this document for full details of these nine core competency areas.

The BPS Accreditation criteria also set out several competencies linked to particular client groups or skills that can be met across a range of different placement settings. We have listed below the absolute minimum standards to meet these specific competencies. These do not constitute the whole range of competencies required across training but are provided to give clarity on the minimum work needed in these specific areas.

Whilst this document outlines the minimum experience required to meet these specific competencies, the expectation is that trainees seek out multiple opportunities for gaining the below competencies e.g., seeking out opportunities to gain experience in working with individuals with intellectual disabilities across both adult and child settings. Many of these competencies can be met across a variety of placements and trainees are unlikely to have full placements with all clinical client groups. Trainees are therefore encouraged to review this document with each supervisor prior to starting placement to inform discussions about what experiences it might be possible to gain within the placement. **Please see notes at the end of the document for the process to follow if trainees are aiming to gain competencies outside of the main service of the placement.

PLEASE NOTE: Trainees must complete unique pieces of work to meet each of the following specific competencies: older adult, acquired cognitive impairment, intellectual disability, neuropsychology, psychosis, neurodiversity, and challenging behaviour. Usually, these pieces of work would be with separate individuals, but the content of the work undertaken will be reviewed carefully by the course

if more than one piece of work is completed with the same individual. For example, if a trainee conducted a neuropsychological assessment with a working age adult following a stroke, the piece of work could contribute towards their acquired cognitive impairment competencies **or** their neuropsychology competencies, it could not "count" towards both. If, however, the trainee had completed the detailed neuropsychological assessment and formulation with feedback and then went on to complete an adapted piece of therapeutic work for low mood in the context of post-stroke adjustment, this could then be considered as two pieces of work, one contributing towards neuropsychology competencies and the other contributing towards acquired cognitive impairment competencies (therapeutic intervention). As noted above however, we would expect trainees to then seek out further experience with other individuals to contribute further to both these areas of competence. This ensures breadth of experience for trainees across all areas of competence, across multiple pieces of work, with a range of individuals and in various settings and contexts.

Please note: where descriptors of competencies indicate a **substantive piece of work** is required to evidence meeting the competency, **substantive work implies more than one contact**; for example, a substantive assessment might include meetings with the individual, their families/carers, their network, multiple forms of assessment, etc.

Working with Older Adults

Trainees MUST have a **minimum of 2 substantive pieces of direct work** with older adults during training. **At least one** of the 2 substantive pieces of direct work **should include intervention**. Working with older adults can include indirect work with families, networks, or staff teams, although trainees **MUST show evidence of direct work with older people** to meet the competency.

Defining Older Adults - The age criteria for access to services for older people varies - in some settings it is 65, in others 70. BPS regulations do not define this group by age (although there is a common misconception it is defined as 65+). In deciding on work which would contribute towards this competency, it is better to think in terms of life-stage rather than age. Ideally, clients would present with issues which support trainees to learn about working with people in later life. Relevant issues in later life might relate to developmental changes and psychosocial adaptation, including role changes and transitions (e.g., retirement), physical health changes, changes in cognitive functioning and progressive impairments or bereavement/loss.

Working both with People with Intellectual/Learning Disabilities and Acquired Cognitive Impairment

- Trainees MUST evidence work with individuals across a range of levels of intellectual functioning, **specifically to include experience both with individuals with intellectual disabilities *and* with individuals with acquired cognitive impairment.** Trainees MUST have a **minimum of 2 substantive pieces** of work with these client groups, ideally across the lifespan (i.e., both adult and child), who have significant impairments in their cognitive and adaptive functioning.
    - **One** must include work with individuals with **acquired cognitive impairment.** Acquired cognitive impairment might include those who have had a traumatic brain injury, stroke, diagnosis of dementia or Parkinson's disease.
    - **One** must include work with an individual with **intellectual disabilities.**
    - **At least one** of these 2 substantive pieces of direct work **should include intervention.**

Work with people whose disability makes it difficult for them to communicate

Trainees MUST evidence substantive experience of **adapting therapy and communication** for individuals with impaired communication in the context of the disability, and where appropriate their carers.

Working with People with Psychosis and/or those with distressing unusual experiences

All trainees **MUST have some exposure to work with this client group** during training, **ideally as part of direct therapeutic practice**. This might include people with a diagnosis of psychosis, bipolar disorder, or those experiencing any of the following: hearing voices, seeing visions, experiencing persecutory beliefs, or periods of confusion where they appear out of touch with reality. This should be accompanied by a level of distress and a detrimental change in functioning. This could be in the context of other diagnoses, including delirium, depression, and emotionally unstable personality disorder.

At a minimum, experiences in this area should allow the trainee to gain a sense of the clinical presentation, how services are structured to meet these clients' needs, and how communication may need to be adapted to work effectively and sensitively.

If trainees have not completed a direct therapeutic piece of work with someone with psychosis and/or with distressing unusual experiences, they should gather a range of experiences <u>across</u> training. These could include:

- Shadowing a clinician working with someone with these difficulties
- Joint/individual work with someone with these presenting difficulties
- Attending a ward round
- Group work

Neuropsychology

As a minimum, trainees **MUST have administered, interpreted and fed back the outcome and recommendations of *at least* one neuropsychological or psychometric test** that assesses cognitive, memory, or performance abilities. This can be with an adult or a child.

Trainees should gain experience of conducting an assessment which includes multiple sub-tests addressing a broad range of functions (either within one kit or choosing subtests across multiple tools/kits). An assessment should incorporate experience of conducting a clinical interview with the client, administration of standardised neuropsychological assessment materials (i.e. those with normative data), scoring the assessment, interpreting, and formulating the results, and writing up an assessment report and where possible feeding back the results. We recognise that there is variation in the assessments used by different service settings, and the selection of neuropsychological assessments will depend upon the clinical question being addressed by the assessment. It can therefore be difficult to specify particular tests that trainees should seek to gain experience of. That said, only using a screening measure, such as the Montreal Cognitive Assessment (MoCA), Mini Mental State Examination (MMSE) or the Addenbrooke's Cognitive Examination (ACE-III or ACE-R) would **not be sufficient to meet this competency requirement**.

For adults, appropriate standardised neuropsychological assessments might include the WAIS-IV, WAIS-V, WMS-IV, DKEFS, RBANS, SIB, NAB, SPANS-X, WASI-II, KBNA, Leiter-3. Similarly, in

conducting neuropsychological assessments with children, appropriate standardised neuropsychological assessments might include the WISC-V, WPPSI-IV, WIAT-III, NEPSY-II, Bayley-4, ChAMP, Leiter-3, WNVS, ADOS.

Administration and interpretation of **at least one** test **MUST be observed** by a placement supervisor or other appropriate clinician.

We strongly encourage trainees to gain a broad range of experience: across different test types, presenting difficulties and ages. We therefore encourage trainees to explore opportunities to gain such experiences across all placements. **Neuropsychology competencies include a broad-based understanding of neuropsychological assessment, formulation, *and* intervention techniques, and are more than just administering a test.** Trainees should be able to demonstrate these competencies by, for example:

- Demonstrating knowledge of neuroscience, ageing, brain pathology/injury and neurological recovery.
- Conducting clinical interviews with clients and informants to help guide assessment measure selection and hypothesising.
- Noting behavioural observations and linking these to possible neurological, cognitive, or emotional underpinnings.
- Scoring and interpreting the results of neuropsychological assessments.
- Using the results of the neuropsychological assessment in a formulation, to understand the client's neuropsychological status and facilitate their understanding and adjustment.
- Devising and delivering evidence-based psychological interventions for psychological difficulty in the context of impaired cognitive functioning, which are informed by neuropsychological assessments

Work with people who present with needs associated with neurodiversity

Trainees MUST evidence **substantive** experience of direct working with individuals who are neurodivergent e.g., individuals with ASD. This might include integrating an understanding of neurodiversity in formulation, adapting communication and intervention, or working with the network around the individual. This may be in the context of a formal diagnosis, or a suspected diagnosis.

Work relating to behaviours of distress / behaviours that challenge

This should include use of an evidenced based approach to supporting the individual based on the service context, individual client needs and the behaviours of distress / behaviours that challenge they present with. This might include functional analysis and implementation of positive behaviour support or similar approach.

Work with clients with severe & enduring mental health needs

This might include chronic / recurring / complex presentations such as chronic trauma, depression, anxiety, complex emotional and relational difficulties etc., and the difficulties having an impact on several areas of functioning.

Work with clients in an inpatient setting (health / forensic / paediatric / psychiatric / residential service)

All trainees should have some exposure to working in an inpatient setting during training. At a minimum, this contact should enable trainees to gain a sense of the environment (practicalities, roles of different professions, role of clinical psychology within the setting etc.). We strongly encourage trainees to seek out and gain a broad range of experience: across settings, client group, direct/indirect work, etc.

Work with carers, families, and wider systems

All trainees must have experience of working with carers, families, and wider systems, preferably across more than one placement context. This may be direct work e.g., delivering a family intervention, or indirectly e.g., working with other professionals to support someone in their role as carer.

Cognitive Behaviour Therapy + One Other Model of Therapy

Trainees must have **substantive** experience of Cognitive Behaviour Therapy **and** at least one other model of therapy. **Please note:** third wave approaches (e.g., ACT, DBT, CFT, MBCT, MBSR, Mindfulness etc.) are not considered as another model, these would fall under CBT competencies.

Gaining competencies in neighbouring services / teams

**As noted at the start of this document, trainees will not have placements with all client groups. To support trainees in meeting the above listed specific core essential competency requirements trainees may pick up discrete pieces of work within neighbouring services whilst on a placement. We therefore encourage trainees and supervisors to, where possible, seek out these opportunities on all placements, to support trainees gaining a breadth of experience across training. For example, a trainee on a yearlong Talking Therapies placement in the first year may deliver a group intervention in a local adult inpatient acute mental health service with a clinical psychologist based in that service. This would add breadth to their adult mental health experience and support them in gaining experience to contribute towards their inpatient competencies.

Important points to remember when exploring gaining competencies in neighbouring services / teams:

- Firstly, trainees must always first discuss in detail with their named placement supervisor the opportunities available on the placement itself, referring to this competency document. Focusing on the main placement is the priority and so exploring what is possible within it directly would be the first port of call.
- Trainees and supervisors can consider if there are any linked / related neighbouring services where experience can be gained to meet any competencies not offered by the placement.
    - If there are and the supervisor agrees it would be possible for the trainee to do work in another service alongside meeting the competencies of their placement it should be discussed how best to arrange these opportunities e.g., would the supervisor liaise with the other service in the first instance or should the trainee take the lead, etc.
    - Liaison with the other service should explore what opportunities are possible (it would help to consult this document to share what sorts of experience would help to contribute to meeting competencies)
    - The trainee to agree with the main placement supervisor and the supervisor in the linked / neighbouring service:
        - what work will be undertaken,
        - how many days / frequency of time on the neighbouring service
        - what supervision will be required to support the work and who will offer this
        - what input the supervisor in the neighbouring service will have to the MPR and EPR paperwork and meetings to reflect the work undertaken and competencies developed in the service
    - The proposed plan should then be discussed and agreed with the MPR visitor / course tutor. It should also then be noted in the placement contract and MPR/EPR paperwork.
    - If supervisor or trainee would like support or advice around this process, they should contact the trainee's course directly, who would be happy to discuss further.
    - **An example:** A trainee is on placement in a tier 2 CAMHS service. There is a linked CAMHS-Disability service. It is agreed the trainee will undertake a piece of PBS work with a family. They agree that a clinical psychologist in the CAMHS-Disability service will offer weekly 30 mins supervision across the piece of work, with the trainee using ½ a day a week to do the work across 6 weeks of the placement. This would contribute to the trainee's competencies in working with challenging behaviour and working with families / carers / wider systems. The supervisor in the CAMHS-Disability placement provided verbal feedback to the main placement supervisor about the trainee's work with them and added summary comments to the MPR-EPR paperwork regarding this piece of work, but they did not attend the MPR or EPR meetings.

APPENDIX

BPS (2025) Standards for the accreditation of Doctoral programmes in clinical psychology nine core competencies are defined as follows:

1. Generalisable Meta-Competencies

a. 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.
b. Deciding, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with service users, carers, and service systems. These skills should be supported by competencies in clinical hypothesis testing which allows evaluation of alternative, competing explanations when considered against a broad evidence and knowledge base.
c. Being able to work within an anti-racist, anti-discrimination framework. This includes being able to work in an inclusive manner with individuals and groups who represent aspects of difference in beliefs, power, and lifestyle, visible and invisible, voiced and unvoiced.
d. Being cognisant of home nation legislation in relation to mental capacity, safeguarding, and frameworks associated with compulsory detention and treatment. This includes how this legislation and related processes are related to clinical care and clinical risk assessment and management, and, more broadly, clinical assessment, formulation, intervention and evaluation.
e. Being able to engage with, contribute to and support multi-professional and multi-agency collaborative working and learning.
f. Synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.
g. Familiarity with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN. This includes the ability to utilise these frameworks in complex clinical decision-making without being formulaic in application, and in combination with clinical judgement and informed service user choice.
h. Familiarity with relevant diagnostic structures and approaches to classification. Programmes should also provide opportunities in theory and practice to critically appraise diagnostic taxonomy and classification systems.
i. Complementing evidence-based practice with an ethos of practice-based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.
j. Knowledge of opportunities and limitations of digital practice and the ability to effectively provide services (including teaching, supervision, assessment, formulation, consultation and intervention with individuals, families, groups and multi-disciplinary teams) as well as undertaking research digitally.
k. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.
l. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.
m. Ability to develop and communicate psychologically informed ideas and conclusions to other stakeholders (specialist and non-specialist), in order to influence practice and facilitate problem solving and decision making.
n. Exercising personal responsibility, integrity and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity whilst working as a reflective practitioner within ethical and professional practice frameworks.

o. Understanding and attending to planetary health in line with HCPC Standards of Proficiency and the requirement to 'understand how social, economic and environmental factors can influence a person's health and wellbeing'.

2. Psychological assessment

a. Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.
b. Ability to choose, use and interpret a broad range of assessment methods appropriate:
    i. to the client and service delivery system in which the assessment takes place; and
    ii. to the type of intervention which is likely to be required.
    iii. Assessment procedures in which competence is demonstrated will include:
    iv. detailed information gathering from individuals, couples, families, groups and services, and anyone else involved in supporting the service user,
    v. recognition of the cultural and social context of service users and carers in line with FPS4 and FPS 5, in the application, administration and interpretation of all assessment procedures,
    vi. performance based psychometric measures (e.g. of cognition, memory, development and performance),
    vii. administration and interpretation of neuropsychological and psychometric tests that assess cognitive, memory and performance abilities. This practice must be observed,
    viii. self- and other-informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours),
    ix. systematic interviewing procedures,
    x. ability to adapt an assessment to meet the cognitive and communication needs of an individual with an intellectual disability and/or Autism,
    xi. other structured methods of assessment (e.g. observation, or gathering information from others); and
    xii. assessment of social context and organisations.
c. Within the assessment process, having the ability to consider issues of relative power, social currency and the potential for the client to experience prejudice, discrimination and stigma (see FPS 6 in particular).
d. Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. reliability and validity, effect sizes, reliable change scores, sources of error and bias, base rates etc.) and utilising this knowledge to aid assessment practices and interpretations thereof. Consideration must be made of the cultural appropriateness of any assessment processes and the potential necessity for alternatives rather than adaptations.
e. Conducting appropriate risk assessments in the context of a formulation guided by the relevant evidence base and clinical theory and using this information to guide practice.
f. Capacity to provide all of the above digitally with awareness of the relevant risks and limitations.

3. Psychological formulation

a. Using an assessment to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors.
b. 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 and/ or team better understand their experience.
c. 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.

d. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.
e. Promote, undertake and co-construct formulations within teams and systems, sharing them in oral and written forms. Develop skills to lead on the implementation of formulation in services, utilising formulation to enhance teamwork, multi-professional communication, and psychological mindedness in services.
f. Within the formulation process, having the ability to consider and apply understanding of the impact of issues of relative power, social currency and the potential for individuals to experience prejudice, discrimination and stigma.
g. Recognition of the structural inequity and cultural and social context of service users in considering appropriate theories applied in the formulation in line FPS 4 and FPS 5.
h. Constructing formulations utilising relevant theoretical frameworks. These should include the ability to adopt unimodal as well as an integrative multimodal, or pluralistic perspectives, also considering transdiagnostic processes as appropriate and adapted to circumstance and context.
i. Constructing formulations of presentations which may be informed by, but which are not necessarily premised on, medical diagnostic systems. Formulations should go beyond description and classification to develop and test hypotheses, inform understanding and decision making and guide delivery of appropriate interventions.
j. An ability to develop formulations in an emergent transdiagnostic context. An awareness of the utility of formulation in understanding team and organisational responses and behaviours as part of leadership activity.
k. Ensuring that formulations are expressed in accessible language, culturally appropriate and sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.
l. Critically reflecting on and revising formulations in the light of ongoing feedback and intervention.
m. Capacity to provide all of the above digitally with awareness of the relevant risks and limitations.

4. Psychological intervention

a. On the basis of a formulation, implementing psychological 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:
    1. individuals,
    2. couples, families, or groups,
    3. services/organisations.
b. To undertake interventions which are informed by understandings of structural prejudice and stigma, power differentials and social inequity.
c. Demonstrate the capacity to understand and deliver therapeutic techniques and processes when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances, life events or trauma, homelessness, problem gambling, eating difficulties, psychosis, perinatal mental health, problematic substance use, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations, intellectual disability, physical disability and people who are neurodivergent, as well as complex and/or overlapping presentations.
d. To have the capacity to use their professional role to promote psychological wellbeing at a wider community and societal level as a psychological intervention.
e. Illustrate knowledge of and ability to use digital technologies directly and indirectly for delivering psychological interventions to individuals, families, groups or organisations. For example, offering psychological interventions by telephone and videocall and using apps.

f. Programmes must provide training in a minimum of two clinical therapy models one of which must be Cognitive Behavioural Therapy (CBT). The models chosen must provide trainees with the capacity to work with people with moderate to complex difficulties. Programmes may choose to use these models as a basis for developing secondary accreditation pathways, recognising the limits of the models and their respective evidence base.
g. Trainees must learn how to deliver psychological interventions in the absence of an appropriate evidence base, integrating psychological theory, research and principles from different perspectives to derive their intervention in such cases. They should have the knowledge of, and capacity to conduct interventions related to, primary, secondary prevention and the promotion of health and wellbeing. Attention needs to be given to:
    i. The ability to conduct interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals,
    ii. an awareness of the impact and relevance of psychopharmacological, medical and other multidisciplinary interventions,
    iii. an understanding of social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives,
    iv. knowledge and skills to implement 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; and
    v. recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to service users and carers.

5. Evaluation

a. Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values, goals and clinical indicators (such as behaviour change and change on standardised psychometric instruments). It is essential that such approaches are clinically valid and are meaningfully informed by service user experience.
b. Devising and applying innovative evaluative procedures which are clinically meaningful, valid, and which support assessment of whether an intervention has achieved its aims or objectives, or which contribute to the process of formulation and hypothesis testing.
c. During evaluation, having the ability to consider how issues of relative power, social currency experience of prejudice, discrimination and stigma influence the evaluative process.
d. Capacity to utilise supervision effectively to reflect upon personal effectiveness, and shape and change personal and organisational practice being influenced by information provided by outcomes monitoring, including in relation to unexpected or unsuccessful outcomes.
e. Capacity to use and access feedback on professional activity from other professionals and peers, e.g. reflective practice groups, placement staff groups, personal and professional development groups.
f. Knowledge of the evidence base for digital practice and digital tools for evaluating client outcomes and experiences.
g. Ability to select and use valid and appropriate digital tools for clinical outcome monitoring, service evaluation and research.
h. Understanding outcomes frameworks in wider use within national health and social care systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and using this knowledge to adopt valid and meaningful evaluative strategies.
i. Appreciation of the strengths and limitations of different evaluative strategies, informed by knowledge relating to psychometric theory, indices of change, and concepts of reliability and validity. Such knowledge should be used in particular in clinical decision making to adopt evaluative strategies which are culturally informed (see FPS 5) and clinically meaningful.

j. Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.
k. **C**apacity to disseminate the outcomes to influence practice more broadly within the team, service, organisation and more broadly as appropriate.

6. Research

a. 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.
b. Conceptualising, designing and conducting independent, original and translational and/or foundational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and which merits publication. This will include:
    1. understanding the epistemological approach and underlining assumptions,
    2. identifying research questions,
    3. demonstrating an understanding of ethical issues, choosing and undertaking appropriate research methods and analysis (both quantitative and qualitative), interpreting outcomes and
4. identifying appropriate pathways for dissemination.
c. A recognition that all research endeavours need to be meaningful and ultimately beneficial to participants and their wider communities, operating with co-production as a key principle in line with UK standards of research. Programmes should consider how to diversify and ensure inclusive and less excluding research processes which addresses the issues identified in FPS 5. This should include processes to enable marginalised/underrepresented communities and individuals to participate across the research process.
d. Understanding the need and value of undertaking translational and foundational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.
e. The capacity to review research systematically and 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.
f. Conducting research in respectful collaboration with relevant stakeholders, e.g. service users, peer researchers, 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 (see also FPS 6).

7. Personal and professional skills and values

a. A high level understanding of the application of principles of professional ethics and their application in complex clinical contexts. This should include knowledge of and evidenced adherence with relevant frameworks of professional ethics (including the BPS Code of Ethics and Conduct and the HCPC Standards of Conduct, Performance and Ethics) in all relevant clinical, professional and research settings.
b. Awareness of the principles of informed consent and shared decision making which underpins all contact with service users and research participants
c. Appreciating and attending to the inherent power imbalance between practitioners and service users and carers and how abuse of this can be minimised.
d. Understanding the impact of racism and discrimination on people's lives and actively working within an anti-racist and anti-discrimination framework (see FPS 6).
e. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices (see FPS 4 and FPS 5).
f. Understanding the impact of one's own value base, privilege and power upon clinical practice, including one's own conscious and unconscious biases and prejudices.

g. Knowledge of ethical dimensions which arise from the use of digital technologies. Awareness of one's own attitudes, skills and values regarding digital practice and the capacity to reflect on these.
h. 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.
i. Capacity to adapt to, and comply with, the policies and practices of both the employing organisations and University with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.
j. Managing own personal learning needs and developing strategies for meeting these. Utilising self-directed reflection, discussion with peers and using supervision to reflect on practice and making appropriate use of feedback received.
k. Developing strategies to handle the emotional and physical impact of practice and seeking appropriate support, when necessary, with good awareness of boundary issues.
l. Developing resilience but also the capacity to recognise when one's own fitness to study or practice is compromised and take steps to manage this risk as appropriate to ensure practise remains safe and effective.
m. Recognising and attending to the power dynamics and potential conflicts within relationships with colleagues and peers (see also FPS 2).
n. Working collaboratively and constructively with fellow psychologists, trainees and other colleagues and users of services, respecting diverse viewpoints and differences in opinion.
o. Knowledge of clinical governance, which should include assessed knowledge of the principles organisational ethics, quality control, quality assurance and quality improvement methodologies, and an understanding of how both quantitative metrics and qualitative user feedback are critical to the provision of safe services. The principles of clinical governance also need to be considered within digital practice and professional contexts in relation to digital practice, including digital record systems, risk management, clinical safety online, information storage and sharing.
p. Knowledge of research ethics and governance, which should include Health Research Authority policies regarding information governance and digital training.
q. Ability to assess capacity and obtain a client's informed consent in both a clinical and research context, an understanding of the principles of confidentiality and circumstances where this may be breached, and the ability to engage effectively with formal safeguarding procedures.

8. Communication And Teaching

a. 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).
b. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and differences in sensory processing and modes of communication.
c. Understanding the process of communicating effectively through interpreters and having an awareness of the benefits and limitations of working in this way.
d. Communicating in an inclusive, non-discriminatory manner, taking into account issues of power, privilege and difference, in line with the FPS.
e. Capacity to write detailed and, often technical, reports that clearly communicate complex information in a readable and comprehensible style relevant to a range of different audiences.
f. 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) and the medium of delivery (face-to-face, telephone or online). This should include in-person and digital training related to clinical practice and psychoeducation and awareness of both synchronous and asynchronous methods of training delivery.

g. Knowledge of how digital practice affects communication processes (e.g. turn taking and use of non-verbal information).
h. Understanding of the supervision process for both supervisee and supervisor perspectives.
i. Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.
j. Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

9. Organisational And Systemic Influence and Leadership
   a. In line with the Foundational Programme Standard, awareness of the structural inequalities within organisations and services and the capacity to address these where possible, particularly utilising anti-racist/anti-discrimination frameworks of practice.
   b. Awareness of the models of leadership and the role of leadership practice and influence on organisational culture and functioning, particularly with regards to ensuring anti-discriminatory, psychologically safe and inclusive work environments and services.
   c. Working with users and carers to facilitate their involvement in service planning and delivery.
   d. Awareness of the legislative and national planning and commissioning contexts for service delivery and clinical practice.
   e. 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.
   f. Awareness of issues in working within community and third sector settings to promote psychological thinking.
   g. Awareness of utilising systemic influence and leadership skills to promote change at a preventative stage, including within a public health setting.
   h. Ability to act as a positive role model by demonstrating an open and curious approach to the adoption of innovative digital ways of working.
   i. Providing supervision at an appropriate level for own sphere of competence.
   j. 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.
   k. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities and competencies such as being aware of and working with interpersonal processes, the need for proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.
   l. Understanding of change processes in service delivery systems.
   m. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.
   n. 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.