Marking Clinical Reports

Table of Contents

Marking procedure for all clinical reports

Each report is marked by a single marker, who does not know the candidate's identity. A sample of at least 10% of reports is reviewed by a moderating marker, to ensure fairness and consistency in the way that marks have been applied. The moderating marker is usually the lead marker for the set of clinical reports being marked.

The moderation sample contains:

1. All reports given a fail mark by the first marker
2. A selection of examples of "typical" passes and stipulated revisions
3. A selection of "borderline" marking examples (for example, stipulated revisions that were close to being awarded a pass, or vice versa).

In any rare instances where the moderating marker considers that there is a problem with the way marks have been applied, they will liaise with the Deputy Chair of the Board of Examiners who will give directions on appropriate action to be taken. Similarly, if the lead marker first-marks any reports and assigns them a "fail" mark, they will liaise with the Deputy Chair of the Board of Examiners to arrange moderation.

Moderating markers will not add additional comments to any mark sheets, and all candidates will receive marks and feedback from their first marker only. Moderators will log their process in a separate spreadsheet, and do not complete additional forms.

Marking categories

There are three possible marking categories:

- Pass
- Stipulated revisions (two months)
- Fail

Further details of the criteria for each marking category are set out in Section 25 of the course handbook.

Stipulated revisions will be required when there are issues or concerns that need to be addressed before the report can be of a passing standard. Often these will relate to the way the work is conceptualised or reported, and/or where an essential component of the report is missing or underdeveloped (as outlined in the marking guidance). Minor typographical and formatting issues are not a basis for stipulated revisions, and further guidance on this is available below.

The fail category is used when the report, as a whole, falls seriously short of expected professional or academic standards. Problems may include work that raises major ethical problems, a clearly inappropriate clinical approach to the work, or a confused or incoherent approach to reporting.

A failed report will first be reviewed by the moderating marker, and the fail will also go for moderation to the Chair or Deputy Chair of the Exam Board. If the fail would lead to failure of the course, then the Chair or Deputy Chair of the Exam Board may also consult with the Exam Board. All failed reports are sent once a year to an external examiner, who gives a general assessment about the marking standards to help the Department to calibrate the threshold for passing. In the case of a first failed report, a new report, usually based on a different piece of clinical work, will need to be submitted.

Resubmissions

Stipulated revisions (two months): Trainees submit the revised submission (resubmission) via Moodle. The resubmission **must** include:

- A written statement which provides a clear account of all the changes that have been made, cross-referring to the points on the mark sheet, ensuring that all points on the mark sheet are addressed. This should be included at the beginning of the revised submission, so the trainee is only uploading one document.
- The resubmission, showing changes from the original in 'track changes' (so that the examiner can see where changes from the original submission have been made).

As above, the written statement and resubmission should be uploaded as ONE document because Moodle cannot accept multiple uploads from the same candidate.

Resubmissions will be marked as soon as possible, and typically within a four-week timeframe.

The administrative team will alert the marker that a revision has been submitted and requires marking, and the marker will mark the resubmission. If it is judged to reach passing standard, no other marker will be involved. If there are still problems with the work, the moderating marker will also assess it.

Where revisions set out in the original marking have not been addressed or new major concerns are raised that mean the revised report is not of a pass standard, the resubmitted report will be given a fail.

There are two possible outcomes on a resubmission:

- Pass
- Fail

Marking guidance for Clinical Reports

When completing the mark sheet, markers should follow the marking guidance below.

Trainees and markers are advised to consult the Course Handbook, Section 21 for detailed guidance on the expectations for each of the clinical report formats. The guidance below applies generally across clinical reports, but markers should also be mindful that some optional report formats may vary in terms of their requirements. For example, Optional Report 7: "A Report of a Consultation with Experts by Experience/Carers" or 8: "A report of a piece of 'leadership' work", would not require the inclusion of an individualised client formulation and other contents would be applicable. For this reason, the handbook should always be consulted alongside this more general marking guidance document.

All reports should demonstrate ethical and competent clinical work, informed by appropriate psychological theory, along with a capacity to reflect at an appropriate level on process issues, on relevant cultural and contextual factors, and on clinical, professional or organisational issues that arose.

At a minimum, each report would be expected to contain the following elements. Markers should ensure that reports are appropriate in terms of content and structure, but should not necessarily insist that particular elements are contained within particular sections of the report, as long as overall readability and conceptual clarity are maintained.

1. **Introduction**

All reports should orient the reader by introducing the clinical and conceptual issues with which the report is concerned.

2. **Cultural and contextual considerations**

Whether in the introduction or elsewhere, all reports should include an appropriately reflective and developed description of relevant contextual and cultural factors. This does not necessarily need to include the clinician's own identity or cultural background, especially given that trainees may be conscious of disclosing personally identifying information within an anonymised marking structure.

In reports describing assessment or intervention work with a client, at a minimum the client's cultural background should be situated and linked with reflections on implications for formulation and/or intervention. These reflections may come later in the report. In reports describing consultation, leadership or systems-level work, relevant cultural and contextual considerations should be identified and linked with the approach taken.

3. **Formulation**

As above, report formats vary in their requirements and both markers and trainees should consult the course handbook for detailed guidance regarding the specific expectation for the type of clinical report under consideration.

However as a general principle, all clinical reports should contain a formulation, meaning that a conceptualisation of the piece of work is presented, linked with relevant

psychological theory. Trainees will often need to go beyond course teaching and undertake independent reading to develop this thinking.

Formulations should be written in full text; while a diagrammatic formulation may also be included, this should not replace a written formulation.

Reports of client-facing work such as an assessment or intervention should include a written formulation, linked with relevant psychological theory, demonstrating how the presenting problem/s have been conceptualised. Reports of consultation, leadership or other systems-level work may not include a traditional formulation, but should include at some stage a written explanation of how the piece of work has been conceptualised, drawing on relevant psychological theory.

4. Reflections

All clinical reports should be reflective in tone throughout. The reflections section **must reflect on points of learning** and how the trainee would do things differently. These may refer to the following, but this list is not prescriptive or exhaustive:

- Reflections on outcomes
- Cultural and contextual factors
- Alternative ways the presenting issue could be conceptualised or treated
- How supervision supported learning or guided the piece of work
- Reflection on relationships (including therapeutic process issues)
- Broader implications for the model or evidence base

It is not required or expected that a particular reflective model or approach is used to structure this section; however, there should be evidence (whether in a specific paragraph or throughout the report) that the trainee has reflected to an appropriate level on specific points.

In the reflections section, it may be appropriate to bring in other models or theories, besides the main theoretical orientation that has been used to conceptualise and guide the piece of work. However, the choice to draw on another model should be explained and cited. For example, a report on a CBT intervention could conclude with reflections on transference and countertransference, accompanied by a citation to literature that applies these frameworks to CBT intervention within a cognitive-behavioural framework. In this example, if psychodynamic literature had been cited and there was therefore an apparent lack of conceptual coherence to the report, this would become a point of feedback.

Typographical, referencing and formatting issues

A good standard of writing is expected, and it is not the job of the marker to act as copy-editors, although it is good practice to draw issues to the trainee's attention.

Minor typographical, formatting and referencing issues should not usually form the basis of stipulated revisions, and should not in themselves be a barrier to a report being passed. Examples of minor issues would be relatively isolated (i.e., non-systematic) occurrences, which do not substantially affect the comprehensibility or quality of the report.

Where minor issues are identified, these should be highlighted in the "recommendations and future learning" section of the mark sheet.

Stipulated revisions **should** be given in relation to sustained or major writing or formatting issues. Examples of major issues would be a failure to use the correct APA formatting style throughout a report; sustained inappropriate use of language (e.g., language that is not sufficiently respectful or person-centred); or sustained and frequent misspellings or grammatical errors that affect comprehensibility. One-off or infrequent examples of the above should be added instead to the recommendations section as above.

In cases where the general writing style is below the expected academic standard, or the level of errors is high, this should be clearly indicated on the mark sheet. This can be done by using the checkbox on the mark sheet provided, indicating that the trainee should discuss support around academic writing with their course tutor.

Guidance on marking resubmissions

As above, resubmissions can only be given a "pass" or "fail" grade. In cases where stipulated revisions have not been satisfactorily addressed, including cases where sustained typographical, formatting or referencing errors that had been stipulated have not been remedied, the report will usually be given a "fail" and passed to the moderating marker for review.

Following passing a resubmission, any remaining feedback should be advisory and entered into the "Recommendations and future learning" box on the marker sheet.

Providing feedback

Style of feedback

Markers should hold in mind that trainees are likely to have a great personal investment in the piece of clinical work they are reporting, and the tone of the feedback can therefore affect how it is received and used. Feedback should be fair, accurate, constructively critical and contribute to learning; and it should also be delivered in an encouraging and supportive tone.

While undertaking a busy, anonymous marking load it could be possible to overlook how early in their careers trainees are (particularly for the compulsory reports 1 and 2), and how

personal the feedback can feel. We therefore recommend markers take the tone of a supervisor, giving supportive supervision to a trainee.

Structure of feedback

Mark sheets should be between 1 to 1.5 pages in length. They should be structured in the following way:

i) General comments

The marker may wish to begin with a brief, concise summary of their overall response to the report, highlighting any themes relating to strengths and constructive feedback.

ii) Strengths

Markers should ensure that prior to delivering structured feedback, they highlight genuine strengths of the report. Even a report given a fail grade will have demonstrated some strengths that the trainee can build on for their next attempt.

iii) Stipulated revisions (if applicable)

This should contain **bullet-pointed** items linked to relevant page numbers. Points should be **clear, concise and concrete**, and it should be clear what the trainee needs to do to meet the marker's requirements.

iv) Reasons for fail grade (if applicable)

This should contain **bullet-pointed** reasons for the report being given a fail grade. These should be linked to, or followed by, a **clear, concise and concrete** set of recommendations for how the trainee could seek to address the limitations in a future report. As above, the tone should be constructive, supportive and encouraging.

v) Recommendations and future learning.

Markers should use this section to provide the trainee with the benefit of their clinical and academic expertise, rather than incorporating such comments into the text around the stipulated revisions. This section will also be helpful for trainees given straight pass or fail grades. As above, this should be delivered in the tone of a supportive, encouraging supervisor.

Markers should use this section for ideas that would have improved the report in their view, but which are not sufficiently "objective" for them to be stipulated as requirements, or which are recommendations for clinical practice. Markers should also use this section for more "minor" considerations for trainees to take forward for future reports. Examples of such feedback would include:

- Using a particular reflective model to structure the reflections section

- Using a particular, favoured theory to add to the formulation
- Re-thinking the clinical approach taken, or adding to the intervention

As a general rule, markers should include a piece of feedback as a recommendation rather than a stipulated revision when it is likely that another marker with a different clinical background or orientation would not have raised the same issue (for example, recommending a specific model or theory is applied).

Feeding back on concerns about the clinical approach taken

Markers should be mindful that at the point of marking, the piece of work reported is likely to have been completed, and to have been in line with clinical practice in the placement context. Where concerns about the clinical approach are raised, trainees are therefore understandably likely to counter that it is too late, had been agreed by their supervisor and/or that this is the treatment model used in their placement.

For this reason, it is helpful firstly to distinguish between major and minor concerns about the clinical approach taken. Where there are substantial concerns about the suitability, professionalism or ethics of the approach taken, markers should consult the handbook marking guidance and consider whether the report should therefore be failed. Where concerns are more minor and the report will pass or receive stipulated revisions, markers should either:

- Clearly stipulate that the required revision relates to asking for **further reflection** on the possible limitations of their approach (and why); OR
- Include feedback and suggestions for further thought in the "recommendations and further learning" section rather than the stipulated revision section.

Appendix 1: Marker Sheet – Pass

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

■ Pass

☐ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Recommendations and future learning:

Appendix 2: Marker Sheet – Stipulated Revisions

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

☐ Pass

■ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Stipulated revisions:

Recommendations and future learning:

Appendix 3: Marker Sheet - Fail

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

☐ Pass

☐ Stipulated revisions (2 months)

■ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Reasons for fail grade:

Recommendations and future learning:

Appendix 4: Example completed marker sheet

Final Marker Sheet

Example Marker 1

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT 1 – 2023 INTAKE

Trainee ID Number: XXXXXX

☐ Pass

■ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

This was a well-written first clinical report, describing a complex piece of engagement work and a thorough assessment of a client's presenting difficulties relating to OCD and perfectionism. The reporting was clear, but could benefit from a more concise description of the history of Ms A's treatment and compulsive behaviours, with a more developed formulation linked to psychological theory. There is also a need to clarify an aspect of risk assessment.

Strengths

This was an engaging report, which described what sounds like a sensitive and careful assessment. Ms A's personal history, cultural context and values were clearly described, accompanied by reflections on cultural humility and the role of supervision in building engagement. The final reflections on the limitations in the service context regarding length of assessment were appropriate and well-developed. The writing style throughout was clear and

reflective in tone, and there was a clear demonstration of a compassionate, open stance towards Ms A's feedback on the assessment process. Overall, this sounds like a successful assessment and a strong piece of clinical work – well done.

Stipulated revisions:

- The list of past treatments Ms A received over the past 25 years is very detailed and potentially identifying (p1). Please condense this into 2 or 3 summary sentences instead.
- The list of compulsive behaviours and their change over time is extensive (p2). It would be helpful to make this section more concise by reporting the key presenting behaviours you identified together, and clarifying that this has changed over time with one or two examples.
- Alongside the above, the formulation paragraph is relatively brief (p4). You need to explain the model of OCD you are drawing on, linked with relevant psychological theory and citations. Previously you had noted some thoughts relating to personal responsibility (p3). You need to ensure you include in your formulation how you are linking thoughts, behaviours and emotions, and your conception of the maintenance cycle.
- In your helpful section on identifying strengths and protective factors, you mention that Ms A's relationship with her partner had improved following high expressed emotion and anger/conflict in the past (p4). You need to clarify how you assessed historical/current risk in relation to this disclosure.

Recommendations and future learning:

I was struck by the positive relationship that you developed with Ms A, such that she was able to attend in-person sessions with you despite having worries about leaving her home. It sounds like the careful engagement work by telephone and letter was helpful towards facilitating this. I also wondered if you might reflect a little more in future on the power dynamics within clinical work, and whether in retrospect Ms A might have been working hard to be a "good client" (rather like being a "good mother", "good daughter" p.3).

I noted that you described Ms A's distress about breaking her routines (p2) and around strong smells (p2). There seemed to be a strong sensory component to some of the compulsions. You also described her struggling to make friends and fit in, at school and work (p1). I wonder if you or Ms A considered whether autistic traits could be playing any role in this, and if it could have been helpful to consider a brief autism screening tool?

Overall, this was a good report of a thoughtful, careful assessment, well done. I look forward to reading your revised report in due course.