



General comments

Clinical Associates Psychologist Degree Apprenticeship Standard at Level 7

This initiative is welcomed and could provide an important addition to the psychological workforce and make a valuable contribution to the delivery of mental health services. There has already been a great deal of interest from service providers locally and nationally. Our comments are intended to help shape the standards so that they provide realistic expectations about the role and what can be delivered and assessed during the training period of 18 months.

We have provided very detailed feedback in the formal response with suggestions about changes to the standards and wording of the standards. We thought it would be useful to contextualise these specific comments with some more general comments.

1. There was support for many of the duties, knowledge and skills statements although they did seem too numerous and over-inclusive. This is particularly evident if compared with other apprenticeship standards at level 7 in related areas, such as the Physician Associate. For example, Physician Associate has a 36-month training, 12 duties, 27 skills, and 35 knowledge items. Bioinformatics Scientist has a 30-month training, 8 duties, and 53 knowledge, skill and behaviour items. Advanced Clinical Practitioner has a 36-month training, 8 duties, 25 skills and 25 knowledge items. In contrast, the Clinical Associate Psychologist has an 18-month training, 12 duties, 92 knowledge items, and 71 skills. This is three times the standards agreed for Physician Associates and it is difficult to understand why. This appears to create problems for the end point assessment. It is difficult to see how 163 standards can be easily assessed.

We suggest that they are reviewed and some removed or combined. We have made some specific suggestions in the detailed response.
2. The three behaviour statements repeated for each duty are positive and seem appropriate for the role.
3. It is stated in the introduction that people in these roles will be supervised by clinical psychologists. This is a very positive proposal and supports good governance and safe and effective practice. The wording in the introduction in terms of the individual's level does not reflect this arrangement, however. Neither is the need for supervision stated clearly in the actual standards themselves. This is curious, as there is such a statement in the second line of the standards for physician associates. We would suggest that the issue around the need for clinical supervision is also very pertinent to physician associates, if not more so. We therefore strongly suggest that similar wording is used to that contained in the Physician Associate Standard, that is, 'These are dependant practitioners which means they work with a clinical psychology supervisor but are able to work autonomously with appropriate support.' This wording seems to better reflect the intention in the proposal and will help considerably to securing widespread professional support.

4. It seems important to be clear which populations the apprenticeship will train CAPs to work with as the training is unlikely to cover a broad range of client groups. This has proved important in the Scottish model and is important to clarify here. The reason is that the clinical experience covered during the training will be with a particular population and the assessments and interventions used will be those with evidence for use with those populations. This is also important for the teaching element of the programme as it would be more appropriate (given the time available and the depth of coverage required) at Level 7 to focus on particular client groups (for example, Adults, Children, People with Learning Difficulties).

The introduction names different populations and service contexts but suggests that CAPS may work very broadly; later, however, it adds a line linking working in different settings to the training and supervision obtained in the apprenticeship; this seems to imply that different CAP apprenticeship training may focus on particular populations/ settings, in line with the suggestion above, but this needs to be much clearer.

5. Related to point 4, the standard often refers to a range of assessments, interventions and models without specifying what they are and this needs to be clarified. There are a number of places where CBT-based assessments and interventions are specified which is very good and clear. If the intention is to include other models or types of intervention they should be specified in the same way. Reference to knowledge of health behaviour change models does not cover this.

This is clearly important in designing, the nature of the clinical experience required during training and designing the teaching and assessments.

Most important of all this is to ensure service users receive interventions from people qualified to deliver those interventions. This is clearly a crucial issue for employers.

Conclusion

The DCP offers the above comments and the detailed feedback to help support what is considered to be a very positive initiative. We think it can make an important contribution to the development of mental health services as outlined in *Stepping Forward* and the *NHS Long Term Plan*. We would like to play an active role in helping to develop the proposal to make it a successful development.

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