



The
British
Psychological
Society

Guidelines for Clinical Psychology Services

July 2011

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Printed and published by the British Psychological Society.

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Incorporated by Royal Charter Registered Charity No 229642

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Foreword

This document has been produced as an updated replacement to the original Guidelines for Clinical Psychology Services Document. In an ever changing work environment the policy and technological changes of today are reflected in the document and this offers guidance on how modern Psychology services operate.

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Introduction

These *Guidelines for Clinical Psychology Services* have been produced by the British Psychological Society's Division of Clinical Psychology (DCP) to establish and disseminate national standards for clinical psychology services. The aim is to provide guidance and direction on the standards of service provision. The guidelines assimilate wider professional policy documents and may, therefore, serve as a useful glossary of professional guidelines to consider when working with/within a psychological service. As well as providing a benchmark for local services to review, the document may be used to inform communications with managers, commissioners, other professionals and service users.

The guidelines are intended for the following audiences:

- Clinical psychologists and psychology managers, to help ensure that their services meet national standards.
- Commissioners of clinical psychology services and their professional advisers, to clarify the standards that they can both expect of psychology services and which they should be supporting through their commissioning policies.

This document is intended for use across the UK as a whole. There are, however, areas in which different policy and guidance are relevant for different nations. Where this occurs it will be clearly highlighted and information and guidance as applicable to each nation provided.

Relationship with Professional Practice

These service guidelines are distinct from the British Psychological Society's *Generic Professional Practice Guidelines* (BPS, 2008a) in that they provide standards for services rather than for individual practice. They concern the generic non-clinical aspects of services rather than specific clinical interventions and procedures. Some overlap between the perceptions of professional practice and service provision, however, is inevitable and in such cases the appropriate professional documents have been referenced and should be referred to for further detail.

1. Policies and Context

1.1 Working Psychologically in Teams

Aim of the Guidance: To ensure that clinical psychologists are aware of current policy on how to effectively integrate and lead psychological services.

For full guidance on working psychologically in teams, please refer to *New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams* (Onyett, 2007).

This document was developed as part of the National Institute for Mental Health in England (NIMHE) *New Ways of Working* initiative. The document highlights ‘positive practice and guidance on effective team working for application in a variety of contexts’ and ‘aims to have some relevance to any team member wanting to work using psychological principles’. Clinical psychologists should refer to this document for guidance and information around their integration in teams.

Key recommendations from the document state:

‘Psychologists should be actively involved in the design, operation and evaluation of teams making use of appropriate research evidence (e.g. with respect to team size, composition, and process). This work should be informed by an understanding of the team’s role in the wider context of the local system of care, an understanding of how change within complex systems occurs, and awareness of forthcoming developments in new roles and work practices (e.g. increased virtual team working).

Psychologists should seek to integrate their work within teams in a way that continues to promote their unique contribution to work with service users.

Psychologists should seek to develop their role in contributing to the improved effectiveness of services through process consultancy at systems level, peer consultation and supervision, leadership, and the promotion of effective roles for users and carers. The achievement of effective person-centred planning should be a key marker for the success of this contribution.’ (Onyett, 2007, p.4)

More specifically the report states that when working in teams, psychologists should strive to:

- Play an important role in achieving improved outcomes from team working. These include helping to achieve optimal team design and operation, effective individual service planning, peer consultation processes, reflective practice, the effective involvement of users and carers, teaching, training, research, evaluation and development.
- Adopt new ways of working which will be determined by local contexts and include some new and specific challenges. It often requires that psychologists become further integrated into teams.
- Providing consultancy to organisations on organisational and systems improvement (e.g. leadership and teamwork development) but their competence and confidence to assume these roles cannot be assumed.
- Integrate into teams while retaining the unique identity and contribution (e.g. offering an authoritative and constructive counter-balance to the ‘medical model’) that psychologists can offer.

- Consider key factors from research that have been associated with effective team working, including:
 - clear and achievable objectives;
 - differentiated, diverse and clear roles;
 - a need for members to work together to achieve shared objectives;
 - the necessary authority, autonomy and resources to achieve these objectives;
 - a capacity for effective dialogue. This means effective processes for decision making, being able to engage in constructive conflict and if complex decision making is involved the team needs to be small enough (no larger than eight or nine people);
 - expectations of excellence;
 - opportunities to review what the team is trying to achieve, how it is going about it and what needs to change; and clear and effective leadership.
 - Dedicated effort is required to improve team working within local whole systems. Tried-and-tested service improvement approaches are available to support this and should be more widely applied.

Specific guidelines relating to the integration of clinical psychologists across different service contexts are covered in further detail within the document.

1.2 Professional Responsibility (HPC)

Aim of the Guidance: To ensure clinical psychologists are aware of the standards of proficiency and ethical conduct set out by the HPC regulatory body.

Clinical psychologists are currently professionally regulated by the Health Professions Council (HPC) – a regulatory body set up to protect the public through keeping a register of professionals who meet their standards in training, professional skills, behaviour and health.

It is expected that all practicing clinical psychologists will adhere to the guidelines set out in the HPC's standards of proficiency document. The standards of proficiency are the threshold standards necessary for safe and effective practice and play a key role in ensuring that registrants practise safely and effectively (HPC, 2009).

An electronic version of this document can be accessed at the following website:
www.hpc-uk.org/assets/documents/10002963SOP_Practitioner_psychologists.pdf

It is also expected that all practicing psychologists regulated by the HPC will adhere to their 'standards of conduct, performance and ethics'.

An electronic version of the 'standards of conduct, performance and ethics' can be accessed at the following website:

www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf

NB: The British Psychological Society and the Division of Clinical Psychology continue to act as the major professional body for clinical psychologists serving to support, promote, advise and help guide the direction of the profession.

1.3 Leadership in Psychological Services

Aim of the Guidance: To encourage clinical psychologists to adopt leadership roles within psychological services.

The issue of promoting positive leadership in health care is relevant for all health care professionals, including clinical psychologists. This is reflected in Government policy that calls for local and national leadership (DoH, 2009; Scottish Government, 2009) in order to effectively meet the aims of: improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health.

As part of this call for leadership within clinical psychology the DCP commissioned a working group to develop a leadership and skills framework for clinical psychology. This has recently been published (DCP, 2010) and is available at the following website: www.bpsshop.org.uk/Clinical-Psychology-Leadership-Development-Framework-P1388.aspx

The document, which is compatible with and maps across to the National Clinical Leadership Competency Framework (NLC, 2010), sets out a continuing developmental framework for leadership behaviour and seeks to outline answers to the following questions for psychologists at differing points in their career progression:

- Why do I want leadership skills?
- What combination of skills do I, as a clinical psychologist, bring to leadership?
- How am I going to develop these skills?
- What am I going to do with these skills?

This work has built upon that produced as part of the *New Ways of Working* agenda (BPS, 2007a), which widely recognises that leadership development is an essential component of psychologists work. As part of the *New Ways of Working* programme, the following document was produced: *New Ways of Working for Applied Psychologists in Health and Social Care. Organising, Managing, and Leading Psychological Service* (BPS, 2007a).

Many of the recommendations included in the *Organising, Managing, and Leading Psychological Service* document, emerged from research undertaken when constructing the *Leading Psychological Services* (DCP, 2007a) document.

1.4 Marketing Clinical Psychology Services

Aim of the Guidance: To provide clinical psychologists with guidance and recourses on how they can develop local strategies around marketing to promote the profession.

In response to the changing climate of the NHS, the DCP commissioned a project designed to provide a wider understanding of ‘customer’ (i.e. those financing services, e.g. commissioners and managers) needs and devise a marketing strategy for the profession. Findings from this project were then collated to form the document *Understanding customer needs of Clinical Psychology Services* (DCP, 2007b).

An electronic version of this document can be accessed at the following website: <http://dcp-bps.org.uk/dcp/dcp-publications>

The project gathered information through two phases. The first phase of the project involved dissemination of a 47-item questionnaire to both clinical psychologists and non-clinicians such as managers, commissioners and chief executives. The aim of this work was to gain an indication of what different groups perceived as priorities and what percentage of clinical psychologists were perceived to be delivering on these. Some of the key findings from this first stage included:

- General agreement between clinicians and non-clinicians regarding priorities in all sections with the exception of Section B (Treatment offering).
- Some indications of differences in perspectives were noted with clinicians rating clinical skills higher and non-clinicians rating access more importantly.
- Supporting other professionals and working with complex cases were agreed priorities.
- Responses suggested that there may be a lack of understanding from non-clinicians regarding certain areas, i.e. reflective practice.
- Non-clinicians generally rated the percentage of clinical psychologists delivering on these items as lower than clinicians rated. On 19 out of 47 items the difference between the two groups was statistically significantly different ($p>0.05$).

The second phase of the project involved 14 in-depth interviews being conducted with a mix of clinicians and non-clinicians. The main findings from these interviews are summarised below:

- Breadth and depth of clinical psychologists roles was highlighted. Valued roles in terms of supporting other professionals and working with complexity.
- The need to engage with all stakeholders.
- Consideration of how best to engage with and influence commissioners. Variability in terms of perception of what value the profession adds.
- Lack of clarity regarding the role of clinical psychologists, expectations of different grades and the need to clarify what exactly clinical psychologists can and can not do.
- Issues were raised regarding integration and isolation of the profession from other team members.
- Variability in terms of quality and individual capabilities.
- Issues regarding training and how prepared newly-qualified staff are to meet expectations.
- The diversity of settings in which Clinical Psychologist work and issues relating to specific specialties were also highlighted.

Having identified a variety of issues for the profession, including insight into the customer's needs and unique selling points of the profession, the project followed on with a further publication entitled *Marketing strategy resources for clinical psychologists* (DCP, 2007). This reference document collates various sources of information to provide resources for clinical psychologists looking to develop local strategies for promoting the profession.

An electronic version of this document can be accessed at the following website:

<http://dcp-bps.org.uk/dcp/dcp-publications>

Examples of marketing strategy resources available from this document include:

- Information regarding programme budgeting and marginal analysis.
- Workforce planning guidance.
- Guidance on the structure and content of bids for service developments.
- Examples of innovative practice and added value of clinical psychology.
- Information regarding how to define clinical psychology.
- Guidance on how to capture outcomes and activity recoding.
- Commissioning.

Many of the helpful tools referred to throughout the document are available in the separate 'Appendices' article which can be accessed at the following website:
<http://dcp-bps.org.uk/dcp/dcp-publications>

1.5 Ill Served Communities

Aim of the Guidance: To provide clinical psychologists with guidance on the development of productive working relationships with culturally and linguistically diverse groups of people who may access their services. This covers those from Black and Minority Ethnic Backgrounds, but also those people with a different gender or sexual orientation, older people, people with disabilities, homeless and refugee communities and other such groups who may be subject to discrimination or prejudice.

Approximately eight per cent of the population of England and Wales come from Black and other Minority Ethnic backgrounds. This figure is expected to rise to 10 to 12 per cent by 2020. At the 2001 Census, the size of the ethnic minority population in Scotland was around two per cent of the total population. Between 1991 and 2001 whilst the total population increased by 1.3 per cent the ethnic minority population increased by 62.3 per cent (Scottish Government, 2004). Psychologists need to find ways of understanding mental health publications that reflect different strengths and needs of Black and Minority Ethnic (BME) service users and their carers.

Psychological service managers and other health managers need to develop services based on *DIVERSITY* as a basic principle that recognises:

- D – Different**
- I – Individuals**
- V – Valuing**
- E – Each other**
- R – Regardless of**
- S – Skin**
- I – Intellect**
- T – Talent**
- Y – Years**

Psychologists need to ensure that services are offered in non-stigmatising, non-institutional settings in the community, including the Voluntary Sector, and that diversity and difference are positively valued. Psychologists also need to develop cultural competencies in knowledge skills and attitudes that question the stereotyped views and beliefs many hold about racially and culturally different clients. This may include questioning the use of traditional

mainstream psychological practice, against racist and prejudice beliefs and xenophobic conditioning. As part of a caring role, psychologists need to help BME individuals with emotional and mental difficulties, to find their way back to meaningful existence, relationships, and restored identities. Psychologists should also try to assist BME people to work through the damaging experiences of racism, discrimination and disadvantage.

Psychologists need to show a genuine willingness and desire to learn about other cultures and their diverse variants relating to perceptions of psychological care, mental health and mental well-being. They need to take a holistic view within a person-centred approach, which considers a person's religious, cultural and spiritual beliefs regarding their definition of mental health and mental well-being. To ensure that psychologists practice helps benefit the BME service user, psychologists need to undertake race equality impact assessments and see how policies and procedures employed by their services directly impact on the BME service user (e.g. the Mental Health Act 2007 compulsory sections which transfer people directly into mental health in-patient units or forensic services rather than treating them by primary care health services).

Psychologists need to move away from the status quo where in culture, race and ethnicity becomes the problem. Within the *NHS Knowledge and Skills Framework* (NHS KSF) (DoH, 2004b), diversity is recognised as one of the six core dimensions that NHS staffs must develop core skills and competence in. This is mirrored in Scotland, as part of the Scottish Government's *Better Health, Better Care* Action Plan, which indicates six dimensions necessary for the improvement of patient care. One of these is for care to be '*Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.*' (Scottish Government, 2007)

All practicing psychologists must, therefore, develop productive working relationships with culturally and linguistically diverse groups of people by:

- Avoiding different types of biases and finding new ways (verbally and non-verbally) to build rapport and respect.
- Using and working with trained interpreters in assessment, formulation and intervention work as well as research work.
- Re-assessing and re-interpreting the word culture and incorporating ethnic identity (including its fine gradations, region, class and generation), which can impact on the process and outcome of therapy.
- Acknowledging their own ethnocentricity and hostility to people who are 'different'. Psychologists need to acknowledge that people can change – irrespective of their differences and psychological distress.
- Re-looking at current models of mental health, which traditionally reflect Western constructions of mental health. Psychologists should incorporate other world views of psychological and mental well-being.

Full details of the NHS KSF documentation are available at the following website:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843

Full details of the *Better Health, Better Care* document are available at the following website:

www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf

1.6 Assistant Psychologists and Trainee Psychologists

Aim of the Guidance: To ensure that appropriate governance arrangements are in place for assistant psychologists and trainee clinical psychologists.

Assistant Psychologists

Clinical psychologists must ensure that they adhere to the Society's (2007) *Guidelines for the Employment of Assistant Psychologists*, an electronic version of which can be accessed at the following website:

<http://dcp-bps.org.uk/dcp/dcp-publications>

Trainee Clinical Psychologists

1. Trainees will be aware of and abide by the Division of Clinical Psychology's *Professional Practice Guidelines* and the HPC's *Standards of Conduct, Performance and Ethics*.
2. Trainees will inform clients of their training status, the length of their placement in the service and explain that they are being supervised by a psychologist whom they should name.
3. Trainees' competence will be monitored by direct and/or indirect observation by the placement supervisor and, where applicable, relevant others working in the service.
4. When case material is used in teaching sessions or for assignments, tutors and trainees will adhere to confidentiality sections so that client personal details remain anonymous.
5. Trainees will receive supervision in line with CTCP supervision guidelines (BPS, 2002a), and
6. BPS (2010) *Standards for Doctoral Programmes in Clinical Psychology – Section 5 'Supervised Practice'*
7. Supervisors will normally have had at least two years' post-qualification experience after registering as a Practitioner Clinical Psychologist with the HPC. They will have attended at least one workshop on supervision provided by an HPC-approved Doctoral Clinical psychology programme, prior to taking on a trainee.
8. Supervisors should meet the criteria to join the Society's Register of Applied Psychology Practice Supervisors:
www.bps.org.uk/what-we-do/developing-profession/register-applied-psychology-practice-supervisors-rapps-register-app
9. Supervisors will arrange for additional supervision from another psychologist if the needs of supervision exceed their current abilities in line with the DCP's (2006) *Policy Document on Continued Supervision*.
10. Supervisors, course tutors and trainees will recognise the importance of personal development and will help trainees to identify such issues.
11. If personal therapy is needed by a trainee, the supervisor or course tutor will facilitate access to a suitable therapist. In no circumstances should the supervisor take on that role themselves
12. Supervisors will adhere to the HPC's *Standards of Proficiency*.
13. Supervisors will adhere to the HPC's *Standards of Conduct, Performance and Ethics*.

Section 8 of the HPC's *Standards of Conduct, Performance and Ethics* applies to the supervision of both assistant psychologists and trainee clinical psychologists:

You must effectively supervise tasks you have asked other people to carry out.

People who consult you or receive treatment or services from you are entitled to assume that a person with appropriate knowledge and skills will carry out their treatment or provide services. Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice. You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely and effectively, you must not force them to carry out the task anyway. If their refusal raises a disciplinary or training issue, you must deal with that separately, but you should not put the safety of the service user in danger.'

2. Law and Policies

2.1 The Mental Health Act – England & Wales

Aim of the Guidance: To provide a summary of changes in the Mental Health Act that are directly relevant to clinical psychology and signpost key documentation.

In recent years the Mental Health Act 2007 (MHA 2007) has amended the Mental Health Act 1983. The MHA 2007 also amends the Mental Capacity Act 2005 (MCA 2005). Both amendments have implications for clinical psychologists.

The MHA 2007 introduced two new roles of approved clinicians (AC) and responsible clinicians (RC) that might be filled by a number of mental health professionals, including chartered psychologists. ACs who are allocated to appropriate patients as RCs, will undertake the majority of the functions previously performed by Responsible Medical Officers (RMOs).

In response to these changes the Society has produced supplementary guidance to that provided in the revised *Code of Practice for the Mental Health Act 1983* (CoP; Department of Health, 2008a) for psychologist ACs concerning aspects of the operation and implementation of the Act that are particularly relevant to the practice of psychologists.

It is expected that AC clinical psychologists acting as RCs will be informed by Society guidance and adhere to any Governmental guidance policy in their practice, for example, *Code of Practice for the Mental Health Act 1983* (CoP; Department of Health, 2008a) and the *Reference Guide to the Mental Health Act 1983* (Department of Health, 2008b).

2.2 The Mental Capacity Act – England and Wales

Aim of the Guidance: To familiarise clinical psychologists with the Mental Capacity Act and how it relates to everyday practice.

The Mental Capacity Act 2005 (MCA) introduced a new framework for decision-making for those aged 16 and over who are deemed unable to make decisions for themselves. It established a number of key principles, as well as defining a functional approach to the assessment of capacity. The Act also set up a new Court of Protection with new powers, a new Public Guardian; advocacy for those who do not have someone who can speak for them; a framework for advance decisions; and parameters for research. There is a *Code of Practice* to support the Act (Department of Health, 2007).

The Society has published guidance for psychologists around the assessment of capacity. This is accessible from the following website:

www.bps.org.uk/publications/policy-guidelines/practice-guidelines-policy-documents/practice-guidelines-policy-docum

The Society and the Department of Health have compiled guidance around Best Interests decision making (BPS and Department of Health, 2007). At present this is not available as a free download but can be purchased via the Society's website. In addition, the Society, in conjunction with the Social Care Institute for Excellence, has published an Audit Tool for Mental Capacity Assessments, which can be accessed at the following website:

www.bps.org.uk/publications/policy-guidelines/practice-guidelines-policy-documents/practice-guidelines-policy-docum

In 2009 the Deprivation of Liberty (DoL) safeguards amended the MCA. The safeguards provide protection for people who do not have capacity to decide about their care or treatment and are deprived of their liberty to protect them from harm, but are not covered by the MHA safeguards. The DoL safeguards are supported by a *Code of Practice* (Department of Health, 2008c).

Psychologists can act as Best Interests Assessors for the DoL safeguards if they have practiced for two years post-qualification. Approved training is also required before a Best Interests Assessor begins work. Such courses are provided locally.

2.3 Mental Health (Care and Treatment) (Scotland) Act 2003

The NHS in Scotland was formed by legislation – the NHS (Scotland) Act 1947 – which made it a separate body from the NHS in England and Wales. This has meant that the NHS in Scotland has developed independently and the Department of Health has no jurisdiction over it. In 1999, devolution created the Scottish Parliament creating scope for further divergence in the in areas of health, including mental health.

Since the enactment of the Mental Health (Scotland) Act in 1984 (the 1984 Act) legislation has been introduced in a piecemeal fashion to make provision for areas not covered or not adequately covered by the 1984 Act.

The 2003 Act makes provision for an ‘approved medical practitioner’ and a ‘designated medical practitioner.’ An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under Section 22 of the 2003 Act by an NHS Board or the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder.

Designated medical practitioners are those The Mental Welfare Commission consider to have the qualification and experience to discharge the functions conferred on designated medical practitioners by virtue of this Act. A designated medical practitioner may:

- Interview a patient at any reasonable time and require any such interview to be conducted in private;
- Carry out a medical examination of a patient in private at any reasonable time; and
- Require any person holding medical records of a patient to produce such records for inspection by the designated medical practitioner.

The Bill gives a provision of a *Code of Practice* to be drawn up by Scottish Ministers giving guidance to any persons discharging the functions of this act. Full details of the *Code of Practice* can be accessed at the following website:

www.legislation.gov.uk/asp/2003/13/part/18/crossheading/code-of-practice

2.4 Adults with Incapacity (Scotland) Act 2000

Aim of the Guidance: To familiarise clinical psychologists with the Adults with Incapacity Act and how it relates to everyday practice.

The Adults with Incapacity (Scotland) Act 2000 provides a framework for helping adults who lack the capacity to make decisions for themselves due to mental disorder. The Act is wide ranging in scope defining the role of the Public Guardian; continuing and welfare powers of attorney; management of accounts; the provision of authority to medical practitioners to treat adults with incapacity.

There is a *Code of Practice* included in the Act. Full details of this *Code of Practice* can be accessed at the following website:

www.legislation.gov.uk/asp/2000/4/part/1/crossheading/codes-of-practice

3. Clinical Work and Case Management

3.1 Record Keeping

Aim of the Guidance: To ensure that a clear and accurate record of each client's presenting problem, referral, psychological intervention process, outcome and risk issues are kept.

Specific guidance around good record keeping has been detailed within the Society's document: *Record Keeping: Guidance on Good Practice* (BPS, 2008b).

An electronic version of this document can be accessed at the following website:
<http://dcp.bps.org.uk/dcp/dcp-publications>

This document replaces the DCP publication, *Clinical Psychology and Case Notes: Guidance on Good Practice*, published by the Society in 2000, and provides guidance on good practice through addressing frequently asked questions around record keeping. As well as answering frequently asked questions the document also provides basic guidelines for record keeping, as detailed below.

Summary of basic record keeping standards:

1. Use paper provided by the organisation (e.g. Clinical Notes sheets and CPA paperwork).
2. Always write in black ink.
3. Do not leave spaces between lines or entries.
4. Sign and date alterations and keep the original intact (do not erase).
5. Record the date and time of the session, who was present, where it took place and as a minimum key points discussed and outcomes and action plans.
6. Write your name, sign, date and time the entries.
7. Always write up notes on the same day or the day after.
8. Avoid taking client files (or copies) 'off service premises' or home in order to write up in own time.
9. Send letters out within a week.
10. Keep anonymised notes of clinical supervision sessions to the same standards as client records and store securely.
11. Destroy recordings (audio, visual, digital) when they have been listened to/watched or otherwise achieved their purpose.
12. Give back work that belongs to the client (materials they have produced for your work together whether writing, artistic creations, etc.) before discharge.
13. Carry out all the duties and requirements for CPA paperwork if acting as Care Co-ordinator.
14. Remember that records written in the context of NHS employment are NHS property and do not belong to the person who wrote them.

Electronic record keeping

Electronic records are replacing, and will ultimately replace, all paper records in mental health services. The entire record will be electronic, already a reality in some services. Clinical notes, incoming and outgoing correspondence and documents, test forms and the like will all be included. (BPS, 2008c)

In light of a number of enquires to the DCP seeking guidance around the introduction of computerised record systems in their services, the Society have produced the following document: *Clinical Psychologists and Electronic Records: The New Reality* (BPS, 2008a).

An electronic version of this document can be accessed at the following website:
www.bps.org.uk/clinical-psychology-forum-no-183-march-2008-p684.aspx

This document, compiled based on the authors' (Berger & Skinner) experience, seeks to give guidance and support around the differing types of record systems (Electronic Patient Record (EPR) and The Summary Care Record (SCR)) currently in place across the NHS. Information is provided about current and future developments and their likely impact on clients, practitioners and services.

It is expected that clinical psychologists will take account of both sets of guidelines and integrate recommendations from these in line with local service record keeping policy.

3.2 Working with Vulnerable Client Groups

Aim of the Guidance: To familiarise clinical psychologists with guidance and legislation around working with vulnerable groups.

England & Wales

Children and Young People

Clinical psychologists have responsibilities to help to protect children and young people from abuse, harm and neglect. *Working Together to Safeguard Children* (Department of Children, Schools and Families, 2010) sets out how individuals and organisations should work together to safeguard and promote the welfare of children. Professional responsibilities for psychologists are outlined in the Society's *Child Protection Position Paper* which can be accessed at the website below. The document also highlights the unique contribution that psychologists can make to professional responses to child protection: www.bps.org.uk/publications/policy-guidelines/practice-guidelines-policy-documents/practice-guidelines-policy-docum

Vulnerable Adults

A vulnerable adult is defined in *No Secrets* (Department of Health/Home Office, 2000) as a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or her self, or unable to protect him or her self against significant harm or exploitation'. Clinical psychologists have a responsibility to be aware of the guidance and how to deal with concerns about vulnerable adults who lack capacity to make decisions, and vulnerable adults who may be subject to neglect or abuse.

The Office of the Public Guardian has published a protocol for the protection of Vulnerable Adults and details how the Courts, The Office of the Public Guardian and Local Authorities work together. This is accessible at:
www.publicguardian.gov.uk/docs/joint-working-protocol1-1208.pdf

Locally, the way in which Adult Protection/Safeguarding arrangements are made by Local Authorities will vary. However, the arrangements will be multi-agency in nature and will detail protocols with key stages for the investigation of reported concerns. Each Local Authority website has details about how to report concerns.

Scotland

Protection of Vulnerable Groups (Scotland) Act 2007

The Protection of Vulnerable Groups (Scotland) Act 2007 was passed in March 2007. The Act was based on a recommendation from the Bichard Inquiry (2004) in relation to England and Wales which was set up to look at failings in child protection following the deaths of two schoolgirls in 2003. Although the Act was aimed at England and Wales, Scottish Ministers felt it was important to take forward recommendations from the inquiry.

The Act makes provision for two lists – a Children’s List and an Adults List. If an individual were to be on either list it would prevent them from working with the relevant group. The Lists are continually updated gathering information from various sources. The Act also created a new vetting and disclosure system for those to work with vulnerable groups (Children under 18 and ‘protected adults’).

Professional responsibilities for psychologists are outlined in the Society’s *Child Protection Position Paper* which can be accessed at the website below. The document also highlights the unique contribution that psychologists can make to professional responses to child protection:

www.bps.org.uk/publications/policy-guidelines/practice-guidelines-policy-documents/practice-guidelines-policy-docum

Clinical psychologists have a responsibility to be aware of the guidance and how to deal with concerns about vulnerable adults who lack capacity to make decisions, and vulnerable adults who may be subject to neglect or abuse.

As part of the Adults with Incapacity (Scotland) Act 2000 the Scottish Government published a *Code of Practice* for people working with vulnerable adults. This is accessible at: www.scotland.gov.uk/Topics/Justice/law/awi/010408awiwebpubs/cop

3.3 Consent

Aim of the Guidance: To ensure that issues of informed consent are routinely taken into account in clinical practice.

All applied psychologists must consider the issue of informed consent within their practice and adhere to guidelines set out by their regulatory body. Issues of informed consent should be routinely considered with regards to assessment, treatment, record keeping and when discussing the boundaries of confidentiality. Outlined within the HPC’s *Standards of Conduct, Performance and Ethics* (2009) are specific guidelines regarding the issue of obtaining informed consent from clients which state:

1. You must explain to the service user the treatment you are planning on carrying out, the risks involved and any other possible treatments.
2. You must make sure that you get their informed consent to any treatment you do carry out.

3. You must make a record of the person's decisions for treatment and pass this on to other members of the health care or social care team involved in their care.
4. In emergencies, you may not be able to explain treatment, get consent or pass on information to other members of the health care or social care team. However, you should still try to do all of these things as far as you can.
5. A person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure that they are fully aware of the risks of refusing treatment, particularly if you think that there is a significant or immediate risk to their life.
6. You must keep to your employers' procedures on consent and be aware of any guidance issued by the appropriate authority in the country you practise in.

A full electronic version of the *Standards of Conduct, Performance and Ethics* can be accessed at the following website:

www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf

The Society also provides the parameters within which professional judgements should be made regarding consent, within the *Code of Ethics and Conduct* document (BPS, 2009b, pp.12–14). It is expected that psychologists will also adhere to these guidelines as part of good practice.

A full electronic version of the *Code of Ethics and Conduct* can be accessed at the following website:

www.bps.org.uk/what-we-do/ethics-standards/ethics-standards

3.4 Working Environment

Aim of the Guidance: To provide guidance relating to the working environment and administrative support required for clinical psychologists to operate effectively and safely within a team.

Office and Equipment

It is expected that where possible clinical psychologists will have their own office space. Where it is not possible for psychologists to have their own office space they must have reliable access to desk space whenever they are in their clinical base. It is recognised that office space may be part of multi-use offices and may include the use of 'hot desk' environments at times. In all instances psychologists must have access to an internet-enabled password-protected computer, printer, telephone and lockable space for the secure storage of clinical/therapy/supervision notes, and professional books and papers. There should also be a facility for the safe removal of confidential documents, for example, shredder. These facilities should also be available for assistant psychologists and trainee psychologists, though it is accepted that they be required to share office space.

Clinical psychologists should also have direct access to psychometric test materials that form an integral part of their clinical work. Funding for such test material should be agreed with service managers, or where appropriate psychologists responsible for the directorate specific clinical psychology budget.

Any further specific equipment deemed necessary for the effective completion of a psychologist's duties, should be formally agreed during job planning/job plan review meetings with service managers.

Clinical space

Clinical psychologists should have access to adequate, private clinical space in which to carry out: psychological intervention, therapy, supervision, and consultation, in a confidential manner. This may form part of the psychologist's office space or a bookable room available to all members of the multi-disciplinary team. Access to therapeutic room space should not in any circumstances impede the delivery or privacy of psychological interventions. Space should also be available for psychologists to conduct telephone conversations in private. This is particularly important in work where there are aspects that have been deemed by the person accessing the service, or the psychologist, inappropriate to be disclosed to the rest of the team within a shared office space.

Administrative support

Secretarial support should be provided for clinical psychologists, with a dedicated administrative staff member available to type letters and reports. It is expected that assistant psychologists and trainee psychologists working with a clinical psychologist will also utilise the services of the allocated administration staff member.

Mental Health and Well-being

Psychological work can at times be difficult and stressful, it is important that the environment in which psychologists work promotes positive well-being for staff and people who access the service.

The National Institute for Clinical Excellence (NICE) has published guidelines for *Promoting Mental Well-being at Work*. The summary and full guidance documents, as well as resources are available at the following website: www.nice.org.uk/PH22

The guidance aims to promote mental well-being and healthy working conditions in all environments. The guidance particularly promotes:

- Equality, open communication, and inclusion.
- High standards for health and safety, and employee well-being.
- Consideration of flexible working, within the specific dynamics of the organisation.

It is expected that clinical psychologists become familiar with these guidelines, and champion their implementation within the psychologist's own working environment.

4. Quality Control

4.1 Capturing Outcomes (Clinical Effectiveness)

Aim of the Guidance: To promote effective provision of clinical psychological services, supported by routine assessment of progress and outcomes.

Evaluation is a 'Critical and integral part of a clinical psychologist's work' (DCP, 2001, p.4), this means both utilising established techniques and devising new ways to assess outcomes. The Society's *Generic Practice Guidelines* also state that 'All activities and interventions need to be evaluated both during their implementation and afterwards.' (BPS, 2008a, p.3)

Outcomes can be implemented at a range of levels; individual, group, service, profession, and in a variety of ways; standardised and non-standardised measures, personal narratives, formal and informal feedback, robust research and audits. There is no 'one cap fits all' when it comes to assessing clinical effectiveness. The selection of evaluation methods can be influenced by therapy/service approach, pragmatism, resources, and of course current political drivers.

Outside of standardised forms of outcome measurement, other ways of effectively considering efficacy of service provision can include process measures, service-specific assessments, qualitative and quantitative research, and feedback sessions/interviews with stakeholders.

The responsibility of clinical psychologists within this are as set out by the HPC. The HPC standards of proficiency for applied psychologists provides guidance on the competency of clinical psychologists in relation to capturing and utilising outcomes. These state that clinical psychologists should:

- be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care;
- be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user;
- recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes;
- be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately;
- be able to revise formulations in the light of ongoing intervention and when necessary reformulating the problem.

The full document can be obtained at the following website:
www.hpc-uk.org/publications/standards/index.asp?id=198

A number of papers have also been produced by the Society and the DCP to guide clinical psychologists in their use of outcome measures in practice. These include general guidance, for example, *Outcomes and Effectiveness in Clinical Psychology Practice* and guidance relating to outcomes in specific areas of practice including:

- *Measuring Outcomes Paper 1: Outcome Assessment in Routine Clinical Practice in Psychosocial Services* (BPS, 2002b).
- *Measuring Outcomes Paper 2 – Measuring Treatment Outcomes with Drug Misuse Clients* (BPS, 2004).
- *Measuring Outcomes Paper 3 – Measuring Psychosocial Treatment Outcomes with Older People* (BPS, 2006).

All of which can be found on the DCP website at:

www.dcp.bps.org.uk/dcp-publications/

In addition to the professional standards, the Scottish Government has also set HEAT targets. HEAT targets are a core set of ministerial objectives, targets and measures for the NHS in Scotland. These HEAT targets are accessible at the following website:

www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH/antidepressantprescribing

4.2 Supervision Arrangements

Aim of the Guidance: To outline the core purpose and facets of supervisory arrangements, and their role in the career of a clinical psychologist.

‘Supervision is an essential component of a psychologist’s continued development’ (DCP, 2008, p.16). The ‘essential’ status is relevant through every stage of a clinical psychologist’s career, and in relation to all aspects of their work.

Peer supervision is an important format for the supervision of clinical psychologists as it provides a network of empathic support and consideration of clinical practice. It is an adjunct to, and not replacement of, individual clinical supervision, but should still have clear processes and boundaries outlined in a supervision contract.

In 2003, the DCP published guidelines on supervision in the practice of clinical psychology, which can be obtained at the following website:

www.dcp.bps.org.uk/dcp-publications/

The document states that whilst supervision should be needs led, the minimum standard of allocation is 60 to 90 minutes to every 20 sessions worked. This is, of course, a start point, and best practice would reflect:

- Developmental/career stage;
- Whether new CPD learning is being undertaken;
- Complexity/specialised nature of work being conducted.

The guidelines advocate a functional approach to supervision, with five key components:

1. Reflection – Which should be careful and detailed.
2. Time – Ensure the allocated time fulfils needs.
3. Recognition – that supervision performs an essential clinical function.
4. Training – Formal training in supervision is a necessity.
5. Evaluation – Honest, regular feedback is important to maintain efficacy.

In a follow-up to this publication, the DCP published a document outlining the differences between clinical supervision and line management. The document can be accessed at the following website:

www.dcp.bps.org.uk/dcp-publications/

The essential differences as outlined by the document are:

Line Management: Is concerned with performance at a service and individual level. Its frequency, duration and structure can be defined by the employing organisation.

Clinical Supervision: Is focussed on personal and professional development. Selection of an appropriate supervisor is negotiable. The selected supervisor must have the appropriate expertise, and training for the supervision of clinical psychologists at the level of the supervisee.

Additional guidance on the generic application of psychological supervision can be found in pages 16 to 22 of the *Professional Practice Guidelines* (DCP, 2008). These cover the principles, nature, boundaries and responsibilities of the supervisory relationship.

In addition to this specific guidance on supervision through preceptorship from Band 7 to Band 8a can be found at the following website:

www.dcp.bps.org.uk/dcp-publications/

4.3 Continuing Professional Development (CPD)

Aim of the Guidance: To outline the current requirements for clinical psychologists undertaking continuing professional development activities.

The HPC define CPD as being ‘a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.’ (HPC, 2009)

Clinical psychologists should take responsibility for furthering their personal and professional development during the course of their employment through engaging in a range of appropriate CPD activities. Job descriptions should include time allocated to CPD activities and clinical psychologists should speak with their lead psychologist and line manager to make arrangements for implementing these activities.

HPC-registered clinical psychologists must ensure they meet the HPC’s CPD requirements.

More information can be found at: www.hpc-uk.org/registrants/cpd

The DCP has also produced in 2009 a guideline for CPD activities which can be accessed at the following website:

www.bpsshop.org.uk/Clinical-Psychology-Continuing-Professional-Development-Guidelines-P1398.aspx

5. Research and Service Development

5.1 Research

Aim of the Guidance: To provide guidance on the role of clinical psychologists in conducting ethical psychological research.

Research is a core part of clinical psychology training, particularly since it has been a doctoral level qualification. Whilst research is not a core component of every clinical psychologist's job description, it is an essential skill. Research can advance knowledge, practice, and the profession as a whole. Therefore, it is the responsibility of individuals and their services to advocate for research to be an integral part of the role of a clinical psychologist.

All research, without exception should be conducted with a strong emphasis on ethics. The Society's Working Party on Ethical Practices in Psychological Research has produced a set of minimum standards for conducting research. This document can be accessed at the following website:

www.bps.org.uk/publications/policy-guidelines/research-guidelines-policy-documents/research-guidelines-policy-docum

The guidelines hold the following minimum expectations for research:

- Ethical approval is sought for all research, without exception.
- Participants are protected at all times. This includes protection from harm, protecting dignity and rights, safeguarding anonymity and confidentiality. Adherence to the Human Rights Act is expected at all times.
- Data Protection Act guidelines should be adhered to.
- Appropriate supervision of researchers is essential, and research should be monitored for adverse effects.
- Duty of care to participants is paramount. Research should be stopped if there are concerns about the well-being of participants. Participants should be de-briefed at the end of their participation.
- Informed consent should always be sought.
- There should be no coercion.
- The right to withdraw should be maintained.
- There should be appropriate exclusion criteria.
- Additional safeguards should be explored and implemented for vulnerable people.
- Ethical treatment is also paramount in research with non-human participants.

Additional guidance is available for research with people who lack the capacity to consent to participate in research. This can be downloaded from the following website:

www.bpsshop.org.uk/Conducting-research-with-people-not-having-the-capacity-to-consent-to-their-participation-P709.aspx

Further guidance is also available for internet-based research at:

www.bps.org.uk/publications/policy-guidelines/research-guidelines-policy-documents/research-guidelines-policy-docum

5.2 Service Development

Aim of the Guidance: To assist clinical psychologists in the development of services, inform communication with managers and commissioners, and examine services within their local contextual framework. To also guide psychologists in the process of mapping services against national standards.

Key recommendations

In order to effectively develop services those psychologists in leadership and service management positions need to have a good knowledge of the other key areas described within this document and use the appropriate links to relevant national guidance and professional standards. In addition to this is essential to keep up-to-date with relevant current policy and service delivery standards and can reflect a rapidly changing landscape. Outlined below are a number of suggestions of key areas to explore when facilitating service development.

A key resource for many of these areas in England and Wales is the Department of Health website: www.dh.gov.uk/en/index.htm

Or, for Scotland, the Scottish Government ‘Mental Health in Scotland’ website: www.scotland.gov.uk/Topics/Health/health/mental-health

Knowledge of the ‘landscape’

This concerns provision of ‘value for money services’. Psychologists need to be aware of the context within which their service is delivered. It is useful to know the contractual arrangements for a service and trajectory against which services are mapped. Services should aim to deliver effective patient care within their budget without compromising service standards.

Provision and maintenance of ‘high quality’ services

Psychologists need to be aware of relevant policies and schemes that are linked to quality and outcome measurement and benchmarking. Some current examples are outlined here. The quality, innovation, productivity and prevention (QUIP) programme is an opportunity to prepare the NHS to deliver high quality care in a more difficult economic climate. A short booklet has been produced by the DoH explaining the principles of QUIP to support NHS clinicians including details of how to shape services around these particular challenges. The document is available on the DoH website in the Publications, Policy and Guidance section. A report produced by the King’s Fund, *Mental Health and the Productivity Challenge* (Naylor & Bell, 2010), provides evidence that there is scope to improve productivity in mental health care, that there are opportunities for mental health services to support productivity improvements in other areas of the NHS and in public spending more widely.

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of provider’s income conditional on quality and innovation. There are good examples available where the CQUIN schemes have worked well in Mental Health and Learning Disability environments. Some of these can be found on the NHS Institute for Innovation and Improvement website and the schemes that are successful are linked to national goals and indicators. CQUIN schemes shared by Strategic Health Authorities and

illustrative examples CQUIN schemes for acute and mental health Trusts can be found at: http://www.institute.nhs.uk/world_class_commissioning/pct-portal/cquin.html

The Care Quality Commission (CQC) regulates all health and social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisations. It also protects people detained under the Mental Health Act. The CQC makes sure that essential common quality standards are being met and has a wide range of enforcement powers to take action on behalf of people who use services if services are unacceptably poor.

Delivery of KPIs and performance against service specifications

These may be locally determined but may also be linked to QIP and CQUIN schemes. Useful links are NHS Evidence – Quality and Productivity: www.evidence.nhs.uk/qualityandproductivity

Priorities derived from the ‘NHS Operating Framework’

Psychologists and service managers need to be aware of the priorities set out in the *NHS Operating Framework* and its revision (DoH, 2009b, 2010a), the core purpose of which is the delivery of improved quality for patients. The framework is available on the DoH website. It will be influential in the development of the role of the NHS Commissioning Board and will drive quality improvement across the system.

2011/2012 will see the first year of the new Comprehensive Spending Review (CSR) period which is very challenging and focuses on delivery of £20 billion efficiency savings for re-investment in improving quality across the full CSR period.

Changes in commissioning arrangements

During 2011/2012 there will be massive changes in commissioning and changes to the whole health and social care system following on from the Coalition Government’s White paper *Equity and excellence: Liberating the NHS* (DoH, 2010b), and the related policy document *A vision for Adult Social Care: Capable Communities and Active citizens* (DoH, 2010c).

The Mental Health Strategy

It is important to have sight of the new mental health strategy. ‘No health without mental health: a cross-Government mental health outcomes strategy for people of all ages’ represents a major step forward in mainstreaming mental health and supporting the aim of achieving parity of esteem between physical and mental health. It has been produced in collaboration with many of the Department of Health’s partner organisations. It will enable more decisions about people’s mental health to be taken locally, and stresses the interconnections between mental health, housing, employment, and the criminal justice system. It can be found at the following website:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

Supporting documents including an action plan for expanding talking therapies have also been published and serve to illustrate the strategic context for provision of clinical psychology services. The documents can be accessed at the following website: www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

Commissioning at a local level

At a local level psychologists and local managers need to be aware of the changes in local commissioning arrangements and the emergence of GP Consortia commissioning and public health and well-being boards. It is important to be aware of the priorities set locally by the Joint Strategic Needs Assessment (JSNA) and the local interpretations of the *National Operating Framework*.

Most, if not all of this documentation is available through public health departments and is freely available in the public domain. It is possible to identify key gaps in services and link new services developments to local targets by referencing these materials.

Knowledge of the Commissioning Cycle and key targets for host organisations and key partners

It is helpful for psychologists to familiarise themselves with the methodology behind the Commissioning process. Information on Commissioning, Public Health Indicators NHS Comparators and the Commissioning Cycle is available at the NHS Information Centre: www.ic.nhs.uk/commissioning

Working in partnership to develop services

Innovation often requires psychologists to step out of traditional roles and work in new Partnerships with other service providers. This will involve engagement with GP Consortia Commissioners, public health and well-being boards and other Local Authority providers, Acute Trusts, and Independent and Third Sector providers.

Provision and maintenance of 'high quality' service in Scotland

At the end of 2007 the Scottish Government produced *Better Health, Better Care*. This action plan outlines the actions the Scottish Government will take to improve health.

With particular reference to mental health and well-being the action plan notes that 'We (The Scottish Government) will assess delivery, and support clinicians and service planners to tackle any inequalities in delivering care.' The Scottish Government action plan *Better Health, Better Care* can be accessed at the following website:

www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf

The Scottish Commission for the Regulation for Care (SCRC) regulates all health and social care services in Scotland, including those provided by the NHS, local authorities, private companies or voluntary organisations. The SCRC makes sure that essential common quality standards are being met and has a wide range of enforcement powers to take action on behalf of people who use services if services are unacceptably poor.

Delivery of HEAT Targets and performance against Service Specifications

HEAT targets are a core set of Ministerial objectives, targets and measures for the NHS. HEAT targets are set for a three-year period and progress towards them is measured through the Local Delivery Plan process.

Full details of HEAT Targets can be found at the following website:

www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH/antidepressantprescribing

Service management

Professional leads and managers of services need align services to the organisations business plans and engage in the process of planning. Services need to engage with an increasing number of agencies including independent and third sector providers. Services need to align to care pathways placing the user at the centre and demonstrate value for money and outcomes that are evidenced based (i.e. NICE guidance).

The DCP marketing strategy and resource can be of assistance and is available at the following website:

www.dcp.bps.org.uk/dcp-publications

Workforce planning

New Ways of Working provides guidance on the development of a modern workforce including leadership roles, working in teams, career structures and frameworks, training, and new roles. All the relevant information can be found at the following website:

www.bps.org.uk/publications/policy-guidelines/policy-and-guidelines

Services need to ensure that all qualified staff remain registered with the HPC and introduce appropriate local audits. Individual registration can be checked at the following website: www.hpc-uk.org

5.3 Key areas for audit

Aim of the Guidance: To advice on key areas of clinical psychology services that should regularly audited, to maintain high standards of professional practice.

Audit of Clinical Work and Case Management

Record Keeping

It is expected that all clinical psychology services will regularly audit clinical case records to ensure they meet the minimum standards, as listed in Section 3.1. Further items may also need to be added to record keeping audit tools to ensure they comply to service level guidance on record keeping.

Consent

All applied psychologists must consider the issue of consent within their practice and adhere to guidelines set out by their regulatory body. It is recommended that audit projects be carried out to ensure appropriate client consent is obtained and documented in accordance with recommendations outlined in the HPC's *Standards of Conduct, Performance and Ethics* (2009, p.12). A list of the minimum standards regarding consent are summarised in Section 3.3 of this document.

Working Environment

It is important to regularly monitor and audit working environment and administrative support, to ensure necessary services are provided for clinical psychologists to operate effectively and safely within a team.

Key areas of working environment that should be considered for audit include:

- Office and equipment.
- Clinical space.
- Administrative support.
- Mental health and well-being.

Full descriptions of audit standards for each aspect of the working environment are detailed in Section 3.4.

Client contacts

With an increase in policy drivers calling for cost effective services (e.g. payment by results, etc.), it is important that psychological services are able to demonstrate value for money. This can be clearly achieved through audit of direct and indirect ways of working. The DCP is soon to publish guidelines on how to describe, establish and reveal clinical activity. However, the section below also provides a brief reference tool to audit client contacts for psychologists practicing at band 7/8a per 1.0wte, across different directorates.

It is important to note that records of client contacts should also be audited in accordance with targets agreed with local line management.

Indirect ways of working

Professional policy guidelines call for effective use of clinical psychology through indirect ways of working, to increase clients' access to psychological therapies (BPS, 2007c). However, the term 'indirect work' with regards to clinical psychology can be interpreted in a number of ways depending on location. As such, there are currently no guidelines regarding recommended number of sessions that should be spent providing indirect work within services. Further guidelines on this matter will be pursued by the DCP in the near future, however, it is suggested the following areas be considered for audit during the interim:

- Supervision – of psychologists at lower banding and to other professionals.
- Consultation – to other professionals.
- Teaching – to clinical psychologists and other professionals in both academic and service contexts.
- Training – of other professionals.
- Service development/planning meetings.

It is recommended all of the above indirect ways of working, be audited in sectional or hourly time frames.

Quality and Effectiveness

Capturing outcomes (clinical effectiveness)

Outcomes should be routinely collected by clinical psychological services, at an individual, group, and service level. This is in line with expectations from the Society and the Health Professions Council. Whilst outcomes can take many forms, audits such seek to assess:

- That some form of evidence of outcomes in clinical practice and service provision is taking place routinely.
- That the form of evidence collected is appropriate to the client group, intervention, and service.
- That these outcomes are being disseminated to all stakeholders.
- Whether the form of evidence being collected requires updating.
- Whether a formal review of the service being provided is indicated from the outcomes.

Supervision arrangements

Supervision is a core requirement for the effective practice of all clinical psychologists throughout their career, regardless of the level at which they practice. Section 4.2 outlines the core requirements for supervision. In summary, key areas for audit should include:

- The time being allocated for supervision and whether this is consistent with the guidelines provided in this document, and others referred to within it.
- The person providing the supervision is of an appropriate level of experience and expertise.
- That both clinical and line management supervision is being provided.
- That the content is being appropriately recorded and agreed to by all parties involved.

Continuing Professional Development (CPD)

CPD should be a key part of clinical psychologists annual appraisals, and should feature highly throughout the career span.

Further information can be found in Section 4.3 of this document.

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