



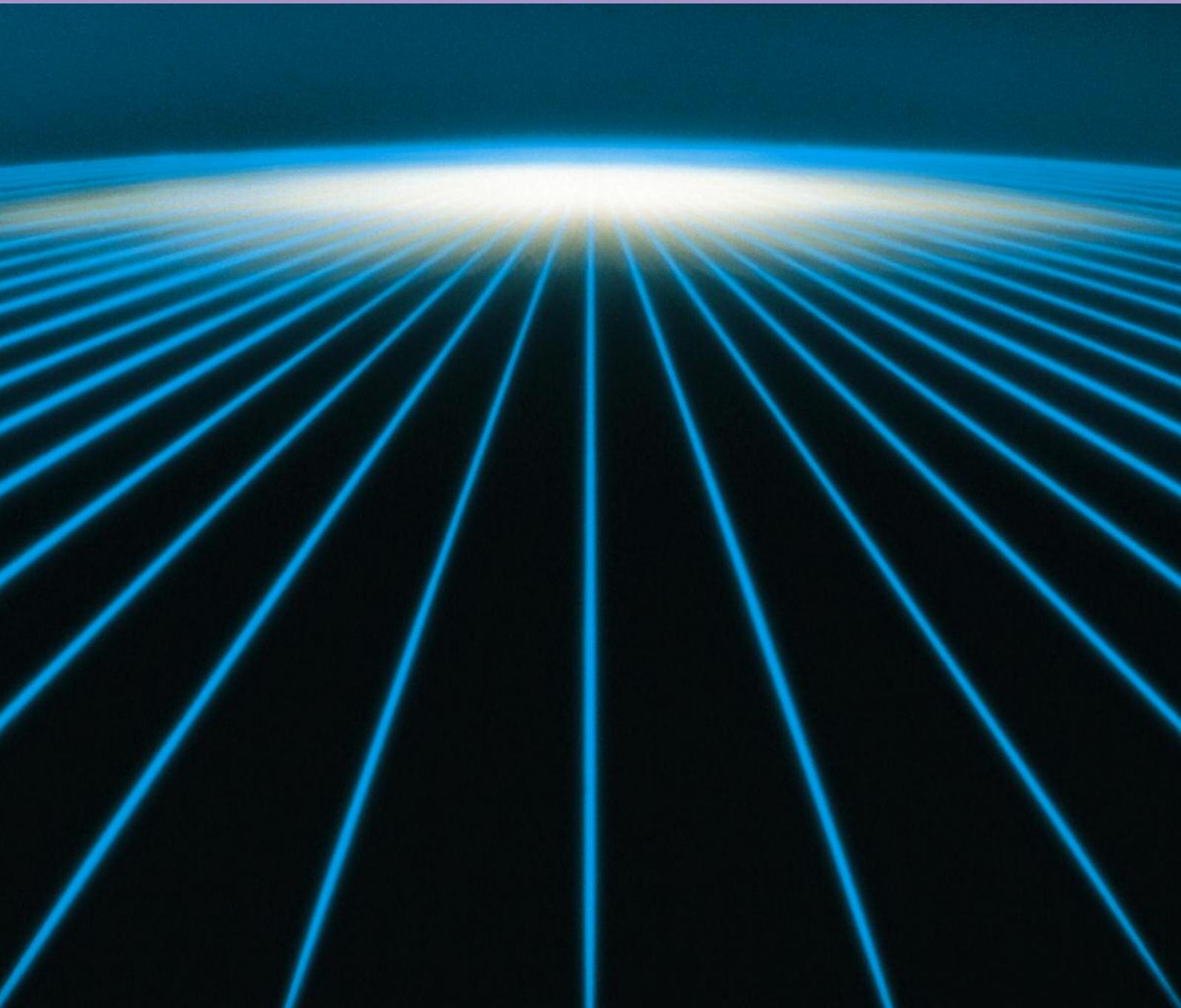
The British  
Psychological Society



Division of  
Clinical Psychology

# Guidelines on Activity for Clinical Psychologists

*Relevant factors and the function and utility of job plans*



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# Contents

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Recommendations .....	2
Summary Statement .....	3
1. Introduction.....	4
2. Clarifying some aspects of the work .....	5
2.1 Terminology	
2.2 Length of client contacts	
2.3 Non face-to-face aspects of client work	
2.4 Travel time	
2.5 Supervision and CPD	
2.6 Part-time workers and those in split posts	
3. The value and role of job plans .....	8
3.1 Working out a job plan	
3.2 Example job plan for a Band 8a Clinical Psychologist within a community mental health team for older adults	
3.3 Example job plan for a Band 8b Clinical Psychologist in a service for adults of working age in secondary mental health	
3.4 Example job plan for a Band 8c or 8d Clinical Psychologist working in a child, adolescent and family service in secondary care	
3.5 Example job plan for a Band 9 Clinical Psychologist	
4. Targets for client activity .....	14
5. Balance of direct clinical to indirect clinical activity or non client related activity...	14
6. Group work versus individual work .....	14
7. Caseload .....	15
8. Additional factors .....	16
(a) Generic team/service activity/duty	
(b) Care co-ordination roles	
(c) Waiting times and waiting lists	
(d) Trainees	
9. Disagreements about clinical activity.....	18
References .....	19
Appendix .....	20
Contributors .....	23

## Recommendations

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1. That all clinical psychologists have a job plan that is reviewed at least annually and agreed jointly with the post holder, their manager and with input from a more senior clinical psychologist.
2. That any job plan addresses and incorporates the full range of work that will be undertaken, including team meetings and indirect work such as supervision and support to others, professional activities such as CPD and personal supervision, and any additional responsibilities.
3. That 'proxy contacts' are accepted where there is significant work through family, carers and other staff members and adopted as part of activity recording.
4. That referrals are addressed by the whole team or jointly with the team manager in order to ensure appropriate prioritisation and to assist the direction of the psychologists use of time.
5. That trainees' caseloads be included in that of the supervisor and that the supervisors' clinical activity be reduced by the equivalent supervision time.

## Summary statement

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The Division of Clinical Psychology does not have a formal policy on caseload numbers or time distribution between the various spheres of professional activity. The principal reason for this is that all posts are different in their composition, objectives and management arrangements, and to provide benchmark recommendations would restrict post holders ability and capacity to develop posts in line with the changing needs of services.

However, the Division of Clinical Psychology does advise members to ensure that all professional aspects of a post receive attention and are fully represented in the post holder's job description and personal development plan. Consequently, giving and receiving supervision, providing consultancy and teaching, and engaging in service related research should be adequately represented in weekly or monthly job plans, as well as core clinical activities and administrative tasks. There may also be a need to factor in travel time for some posts which serve a large geographical area or where there are a large number of visits to other sites to see clients.

Any local agreements on the percentage of time spent in each activity should be reviewed at least annually as part of the local appraisal process and be informed by service objectives and the individual's development needs and competencies.

This document:

- clarifies some aspect of the practise of clinical psychology;
- outlines the range of areas of work that will come under the remit of a clinical psychologist;
- makes recommendations about how a local arrangement might be best developed;
- may help in finding innovative solutions to provide a cost effective, well focused and quality service.

It also provides examples of job plans for different grades, although, given the range of specialist areas of work and variation in roles, these should be viewed as illustrative only.

# 1. Introduction

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The purpose of this document is to provide information and guidance to underpin discussions about the clinical activity of clinical psychologists.

It is intended to outline for clinical psychologists standards and expectations for activity and to assist managers, team members and other colleagues to understand the nature and scope of clinical psychologists' work. The document aims to:

- describe the type and range of work conducted by clinical psychologists;
- explain some of the broader aspects of clinical psychologists' work that affect clinical activity;
- clarify some of the issues that may occur when setting targets for clinical activity;
- set out an effective process for reaching working arrangements in order to ensure that clinical services are provided in the appropriate way within a clinical context.

In addition it may also:

- Demonstrate to managers and commissioners who are not familiar with the work that psychologists do, the range of work/activity that can be expected from a clinical psychologist at a specific grade and why, say, a clinical psychologist in a Band 8c or 8d post might take on less direct clinical work than someone in a Band 7 or 8a position. It will help to orientate them to the skills and competencies a psychologist brings to an organisation at different grades.
- Help managers to understand more clearly the range of work psychologists do and why they do what they do, and help begin the dialogue about choices about what they receive.
- Be used as an important 'support tool' for determining what might be expected from a psychology service.

It needs to be stressed that the range and type of work of clinical psychologists is very wide, spanning the more intensive high volume activity that might occur within an IAPT service within primary care to a specialist neuropsychology assessment service where the emphasis will be on thorough and time consuming assessments for a small number of individuals.

This document should be read in conjunction with the *Core Purpose and Philosophy of the Profession* (BPS, 2011a), *Good Practice Guidelines for Clinical Psychology Services* (BPS, 2011b), *Guidelines on CPD for Clinical Psychologists* (BPS, 2011c), *New Ways of Working for Clinical Psychologists* (BPS, 2007) and the *Leadership Development Framework* (2010). Individual Faculties, areas such as The Faculty for Children, Young People & Their Families and The Faculty for Learning Disabilities, have produced more specific guidance on core competencies. The NICE guidelines give specific recommendations for psychological interventions for certain problem areas (although they do not specify the details).

This guidance addresses:

- clinical contacts;
- balance of direct clinical to non-client related activity;
- caseload;
- care co-ordination roles.

## 2. Clarifying some aspects of the work

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### 2.1 Terminology

A full-time clinical psychologist will work 37.5 hours per week under the NHS Agenda for Change. For people working part-time, this would apply on a pro rata basis.

When psychologists chunk their clinical time they tend to talk in ‘sessions’, each of half a day, and thus it is common to talk about doing ‘eight sessions of clinical work’ per week, rather than, as with professions such as physiotherapy, individual client contacts. This can be confusing and care should be taken to avoid ambiguity and misunderstanding.

### 2.2 Length of client contacts

These vary widely and need to be understood in terms of the type of work and the purpose of the intervention and thus may need local agreement. Electronic health records record each contact for face-to-face activity for individuals (including carers); they may not incorporate in data reports the length of each contact.

For instance, at one extreme a developmental assessment for a child with suspected autism may require them to be seen for one and a half to two hours at a time while a range of tests are administered, or a neuropsychological assessment for a person after a stroke may require three hours. At the other extreme, a brief consultation within a diabetes multidisciplinary clinic might be 20 minutes. These would both be recorded as one contact on many systems even though the duration is markedly different.

The most usual duration of an intervention is one hour (therapeutic hours – 50 minutes of direct client contact and 10 minutes for preparation and/or recording). Follow-up sessions might be 30 minutes or may still be the full hour.

### 2.3 Non face-to-face aspects of client work

***Recommendation: That ‘proxy contacts’ are accepted where there is significant work through family, carers and other staff members, and adopted as part of activity recording***

In some areas of work there may be considerable preparation time where the psychologist carries out consultation with colleagues within the clinical team and may see the individual client for a relatively brief face-to-face intervention. This is not well reflected in electronic health records where the recording is usually only of face to face contact or carer contact. In many services the intervention might be wholly indirect and carried out through other staff. Examples of this might be an assessment for a child with development delay (where the psychologist would talk with school staff, colleagues in medical services and other therapists) or when working to reduce challenging behaviour within a care setting for someone with learning disabilities or dementia.

The concept of proxy contacts is a useful way of reframing indirect work that is an agreed concept in some areas of work. Proxy contacts are commonly used in children’s services, but have also been used in Learning Disability services, and a case can be made for them being used more in adult and older adult services too. It must be understood that there is a distinction between proxy contacts and people who assist in psychologists’ work by providing information (e.g. as part of an assessment or in reviewing an intervention). Proxy contacts do what a clinical

psychologist might do, but at the request and under the direction of the psychologist. The idea is that one is assessing, intervening or treating the individual by working through someone else (e.g. a family member or paid carer in recording behavioural interventions). It could include the direction under supervision of other staff delivering basic level psychological interventions (e.g. supporting a community nurse in helping a client with managing anxiety or anger).

In addition, where the work is in highly complex areas there could be a considerable commitment to reading about technical aspects of the work and writing individualised formulations and detailed care plans for the individual. An example might be an assessment within a specialist trauma service for a person without English as a first language from a country where the cultural aspects might be a crucial factor to incorporate and necessitate considerable research. This might include working through an interpreter, which requires significantly more time (*Guidelines on Working with Interpreters*; BPS, 2011). Again, this time will not be reflected in day-to-day activity recording. It may be legitimate to collect this information through an audit to inform managers and supervisors of the range of activity undertaken.

In terms of service planning, there are several methods of calculating the time requirements of the various elements of a psychologist's job plan (Newton, 2011; Huey, 2012 – [www.bps.org.uk/system/files/Public%20files/activity\\_for\\_clinical\\_psychologists\\_-\\_guidelines\\_-\\_accompanying\\_documents\\_3.zip](http://www.bps.org.uk/system/files/Public%20files/activity_for_clinical_psychologists_-_guidelines_-_accompanying_documents_3.zip)). This is useful for purposes such as agreeing workloads or targets, prioritising tasks, service planning, and informing managers or commissioners about the likely productivity of a service that has identified tasks and a set staff group. This method allows estimation of time requirements for tasks that range from the simple to the complex. Complex tasks – such as working with a person with dementia and challenging behaviour in a residential setting – can be broken down into smaller elements to improve the accuracy of estimation.

## 2.4 Travel time

This issue is obviously not specific to clinical psychology but, with the move towards more community working, travel time can be significant.

Where clinical psychologists work on different sites within a working day, this may impact on their use of time.

In addition, where there is a high amount of home visits or visits to see clients on particular sites (such as a community resource centre), this may add significantly to the time taken to complete the clinical contact, adding between 50 and 100 per cent extra time (or even 200 per cent in rural areas) to the actual clinical intervention. Local agreement should be sought to recognise the implications for levels of clinical activity.

Clinicians and services should optimise travel arrangements wherever possible.

## 2.5 Supervision and CPD

All clinical psychologists are required to undertake supervision and CPD – this is identified by the Department of Health (DoH, 1998), the Society (BPS, 2008) and the Health Professions Council (HPC, 2008, 2009a, 2009b). The HPC requires time spent on CPD to be recorded and this could be audited in the future. The Society's Division of Clinical Psychology (DCP) provides guidance on supervision (BPS, 2006 and in development) and CPD (BPS, 2011).

Supervision will take several forms: managerial supervision is provided by the line manager, who may not be a clinical psychologist; clinical supervision addresses clinical competencies and is provided by someone with expertise within the model of working (who may not be a clinical psychologist). There will also be professional supervision received from a more senior clinical psychologist.

The DCP recommends that a full-time worker should have a minimum of 10 days per year study leave, pro rata for part time workers (BPS, 2011c).

For CPD, there are a range of ways in which this may be addressed. Within some posts CPD is provided as a core part of the job (such as for an IAPT High Intensity Worker); other times there may be a formally allocated amount of time within the job plan for CPD to be undertaken. This latter arrangement is more common in junior grades, but would be expected for all staff.

Sometimes the psychologist is, with agreement from all, undertaking a course requiring a substantial time commitment. For instance, a course might require attendance one day per week for academic teaching with a further half day on supervised clinical work. Where this is agreed to come out of the normal working week, this time would be identified within the job plan.

## 2.6 Part-time workers and those in split posts

A high proportion of the clinical psychology workforce work part-time and there are also people working a few sessions a week. Some people may work in a split post where they have two different managers and relate to two different services. It is particularly important in these situations to provide a job plan, for two reasons:

Firstly, all the areas identified within a job plan need to be addressed in discussions about workload, etc. – a person working four sessions/two days per week will still require supervision and access to CPD rather than being viewed as a resource for two days of direct clinical provision. Even the need to free up time to provide some staff training to colleagues within the service would need to have time identified for it, without putting undue pressure on the staff member.

Secondly, a psychologist working part-time in a service may be faced with dilemmas about the use of their time that it would be better to share with managers and supervisors and agree how to deal with them. For instance someone working 0.5 wte within a Child & Adolescence Tier 3 service might be unclear whether they should regularly attend the whole of the weekly referral allocation meeting, taking up two hours of their time, or attend less frequently or attend for part of the time or as requested by the team manager.

### Case Study

Marie worked two days a week in a pain clinic where her time was fully committed in team meetings, and individual and group client work. This work was also at a distance from other psychologists for supervision and CPD. It was agreed between Marie, her manager and psychologist supervisor that she would have one session per month to include supervision and attendance at the psychology CPD event. No client work was booked in for this session.

## 3. The value and role of job plans

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**Recommendation:** *That all clinical psychologists have a job plan that is reviewed at least annually and agreed jointly with the post holder and their manager with input from a more senior clinical psychologist.*

The most effective means to clarify the clinical activity is to work it out as part of a job plan (Department of Health, 2004). This could be best done between the individual, the service manager and the professional supervisor. Sometimes the staff member provides a record of all activity over a time period (say a month) to inform the meeting. Trafford Healthcare NHS Trust (Huey, 2010) has a detailed system for describing the range of activities undertaken by psychologists and Greater Manchester West Mental Health NHS Foundation Trust has a system for recording work activity in preparation for a developmental review (Greater Manchester, 2010 – [http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/guidelines-on-activity-fr-clinical-psychologists\\$.cfm](http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/guidelines-on-activity-fr-clinical-psychologists$.cfm)).

A job plan should be devised after reference to:

- the job description (describing the range of clinical duties to be performed);
- the person specification for the post (identifying the level of competency expected).

And from the development review:

- the individual's objectives (these would outline the priorities set from the organisation for use of time);
- their Personal Development Plan, which should identify training needs and plans for the individual.

### 3.1 Working out a job plan

**Recommendation:** *That any job plan addresses and incorporated the full range of work that will be undertaken, including team meeting and indirect work such as supervision and support to others, professional activities such as CPD and personal supervision, and any additional responsibilities.*

Consideration would be given to time required for the following eight areas of work (different systems might address these differently or use a different method of categorisation, but all areas should potentially be included).

#### *Clinical*

1. Attendance at regular meetings such as team/service clinical and business meetings. Where the person is in split posts or covers several teams, they may not be able to attend each one or may only attend part, so some indication of frequency/attendance would be useful.
2. Activity relevant to direct face-to-face work with individuals such as assessment and interventions. This area should also include clinical administrative time, completing electronic health records, report writing, etc., and proxy contacts (see recommendation).
3. Other direct clinical activity such as: running groups or providing consultation to (or supervision with) other staff about their clients; and face-to-face work with carers, parents, partner, etc. (for which there will be identified service users).

4. Supervision of trainee psychologists.
5. Non-clinical support activity such as running a reflective practice group for ward staff, supervising other members of the team, providing some local team training, carrying out an audit, doing duty, and clinical supervision of psychology staff.
6. Additional responsibilities – activities and roles related to professional supervision and line management, service delivery, governance and service development where this is formally agreed with managers. Clinical and professional supervision of qualified psychology staff should come under this area, as could work in staff training and development, research and development, and audit or outcome measurement (this section could be broken into different headings where this is a major component of work).
7. Time identified for own clinical, management and professional supervision.
8. Allocated regular time for CPD activity.

There are a range of approaches to structuring work plans and in some organisations this may be done centrally, so this structure needs to be seen as providing an illustrative way of meeting the needs of clinical psychologists.

One important distinction is how much is 'loaded' onto clinical activity and how much is identified as 'non-clinical'. There are pros and cons to either approach. Some of this may relate to how the service operates or how activity is commissioned (e.g. costed by number of contacts or by case).

It can be argued that, for instance, supervision of colleagues and trainees is a form of clinical activity in that it impacts directly onto client care. On the other hand, it could be that it is valuable to reflect accurately that this can be a substantial and cost effective use of time for a clinical psychologist and thus should be identified separately.

In addition, there may be an issue related to pension entitlement for some – for example, for those employed under special conditions (e.g. Mental Health Officer status) – who would need to be careful that their proportion of clinical activity does not drop below a certain level if they wish to retain this status.

In some systems where the individual staff member has a specified management or professional role, these sessions are taken out of the job planning in relation to the proportion of client work. So, for instance, where the psychologist is a full-time employee, but within this works two days a week in a research position or in a training role within the service, their job plan should be based on being available for three days or 0.6 wte.

The Royal College of Psychiatrists' (Department of Health, 2010) approach to job planning is widely recommended and utilised.

The following examples separate out the eight components to illustrate the range of work carried out and the proportion of time that may apply for each activity. The ratio of clinical to non-clinical activity is based on a narrower definition of clinical.

These examples are all on the assumption of full-time worker (1.0 wte) and are for illustrative purposes only, although a recent survey based on these categories did validate some aspects of the approach (Shenoy & de Villiers, 2011).

### 3.2 Example job plan for a Band 8a Clinical Psychologist within a community mental health team for older adults

For a full-time Band 8a Clinical Psychologist the breakdown of time shown below would be common.

This reflects a 60:40 ratio of direct clinical to non-clinical activity.

Category of activity	Time allocation	Comments
1. Attendance at team meeting	1 session	1 session per week (plus admin time, including preparation of materials)
2. Direct face-to-face work with individuals (including new assessment and treatment cases)	5 sessions	1 session Memory Clinic
3. Other direct clinical activity	0.5 session	Running Relapse Prevention Group for depression (6–8 attendees)
4. Supervision of trainee psychologists	0.5 session	Trainees carry out client work and support the work of the qualified staff member
5. Non-direct clinical support	1 session	Providing supervision to assistant psychologists and community psychiatric nurses; Auditing team referrals against NICE guidance
6. Additional responsibilities	Ad hoc	Occasional attendance at meetings
7. Own supervision	0.5 sessions	Clinical and managerial supervision
8. CPD activity	1 session	Advanced CBT training

### 3.3 Example job plan for a Band 8b Clinical Psychologist in a service for adults of working age in secondary mental health

As mentioned earlier, the activities of a clinical psychologist on any particular grade will depend on the actual job and the nature of the duties. However, in general, the more senior the grade the higher the ratio of non-direct to direct clinical activity.

Thus a Grade 8b Clinical Psychologist might have a job plan as shown below.

This reflects a 50:50 ratio of direct clinical to non clinical activity.

Category of activity	Time allocation	Comments
1. Attendance at team meeting.	1 session	1 afternoon per week plus admin time
2. Direct face-to-face work with individuals (including new assessment and treatment cases)	3 sessions	1 session working in an inpatient ward providing staff training and consultation about individual service users; 1 session supervising colleagues within the team and providing clinical supervision for clinical psychologists; 1 session complex cases 'clinic'
3. Other direct clinical activity	0.5 session	Running a self-management group for bipolar clients
4. Supervision of trainee psychologists (2)	1 session	Trainees carry out client work and support the work of the qualified staff member
5. Non-direct clinical support	2 sessions	Supervising colleagues in team. Providing training to staff on an in-patient ward; Offering consultation within the ward; Clinical supervision of clinical psychologists
6. Additional responsibilities	1.75 sessions	Providing professional supervision and consultation to 7/ 8a psychologists in the service; Overseeing referral allocations; Chairing local audit group; Attending service meetings
7. Own supervision	0.25 session	Clinical and managerial supervision
8. CPD activity	No designated time	Agreed ad hoc

### 3.4 Example job plan for a Band 8c or 8d Clinical Psychologist in a child, adolescent and family service in secondary care

A Band 8c/8d Clinical Psychologist might have the job plan shown below.

This reflects a 40:60 ratio of clinical to non clinical activity.

Category of activity	Time allocation	Comments
1. Organising and attending clinical team meetings	1 session	Chairing clinical team meetings
2. Direct face-to-face work with individuals	2 sessions	Includes new assessment and treatment cases (one session neurodevelopmental assessment meeting)
3. Other direct clinical activity	1 session	Fortnightly consultation sessions with home visitors; Overseeing family therapy clinic; Ad hoc consultations with other teams
4. Supervision of trainee psychologists (2)	0.5 session	Trainees carry out clinical work and support the work of the qualified staff member
5. Non direct clinical support	2 sessions	Clinical psychology professional supervision of grade 8b clinical psychologists and professional development work
6. Additional responsibilities	3 sessions	1 session service development work (autism development); 1 day per month staff training, plus preparation; Attendance at service meetings, including chairing Clinical Governance meetings
7. Own supervision	0.5 session	Own clinical and managerial supervision plus administrative time
8. CPD activity	None allocated	Addressed as part of 6

### 3.5 Example job plan for a Band 9 Clinical Psychologist

A Band 9 Clinical Psychologist might have the following job plan. They would often maintain a small area of clinical work.

This reflects a 10:90 ratio of clinical to non-clinical activity.

Category of activity	Time allocation	Comments
1. Organising and attending team meetings	0.5 session	Chairing psychology management meetings plus associated admin
2. Direct face to face work with individuals	1 session	Includes new assessment and treatment cases
3. Non-direct clinical support	3 sessions	Clinical Psychology professional supervision of 8ds and psychology professional development work
4. Additional responsibilities	5 sessions	Attendance at Trust Executive meetings; Chairs Trust Psychological Therapies committee; 2 sessions service development work
5. Own supervision	0.5 session	Own clinical and managerial supervision plus administrative time
6. CPD activity	None allocated	

## 4. Targets for client activity

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There are various ways of measuring clinical activity, and one is the number of client contacts per week – which could be expressed as an expected number of direct contacts (for instance, 10 face-to-face contacts within a week). Where there is a high amount of indirect or liaison work or lengthy assessment, it may be more representative to state, for instance, 20 contact hours per week for a full-time worker.

There are other approaches such as ‘packages of care’ where the specification is that a service/clinician will see a certain number of cases with the expectation of set activity within this; for instance, a service providing NICE interventions may contract to see 6,000 clients per year, each having on average 10 contacts. Or a third sector learning disability service may be commissioned to see 40 cases of challenging behaviour, each requiring very high amounts of clinical activity from the clinical psychologist and other members of the multi-disciplinary team.

If one focused on clinical contacts, the numbers would depend on the area of work. Within primary care, a higher number of contact hours might be anticipated. For instance, four per half day session providing Step 3 CBT for depression or anxiety. In secondary mental health, contact hours may be 1–3 per session, depending on the amount of preparation, liaison and travel required. In more specialist areas, one contact per session would be anticipated if, say, carrying out a complex forensic intervention.

Agreement in this area is best worked out with the relevant manager or commissioner and a senior psychologist, where there can be realistic negotiation about what service is required (and how best to provide this) with an appropriate currency for the activity and activity levels agreed. There are two examples of methodologies available to achieve this; one for a general service (Newton, 2011) and another within a learning disability service for people with challenging behaviour (Turton, 2011 – [http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/guidelines-on-activity-fr-clinical-psychologists\\$.cfm](http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/guidelines-on-activity-fr-clinical-psychologists$.cfm)).

## 5. Balance of direct clinical to indirect clinical activity and non-client related activity

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It is common for junior staff to carry out more direct clinical activity relative to more senior staff. However, this would depend on the type of job and should be specified within a job plan, although it would be expected that most staff would work towards increasing the proportion of consultation provided compared to direct clinical activity over their time in post. For instance, in a new service for challenging behaviour within dementia, the 8b Clinical Psychologist deliberately took on a high amount of clinical work initially as a way of modelling to the others in the team, and as time passed and skills developed, gradually moved to a more consultative role. This was agreed with and monitored by the team manager.

## 6. Group work versus individual work

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Providing a service through group work can have many benefits for clients; it assists with normalising their situation through contact with others, providing from others examples

of how to deal with difficulties, as well as the indirect benefits of increased social contacts. Ultimately, there should be an evidence base for the clinical utility of groups compared to individual interventions. It should be recognised that some clients do not want group provision.

Whether groups are more cost effective in the use of clinicians' time is a more mixed picture. If a group requires two people to run it, plus time to prepare beforehand and debrief afterwards, as well as individual assessment appointments and post group follow ups, then the putative savings can disappear.

## 7. Caseload

In a similar fashion to the other areas, it is not considered appropriate to specify what the caseload for any individual practitioner might be. This will depend on the balance of individual and group work, the number of assessments to ongoing therapy cases held by the staff member and the duration of interventions. The issue here is about capacity which will depend on the mode of delivery of work (group/individual/telephone, etc.), frequency of contacts and length of episode of care (if specified by the treatment or the service – e.g. a neuropsychological assessment might be up to five contacts, CBT intervention 12–16 contacts). The introduction of care pathways and Payment by Results has led to much clearer parameters for expected activity and there may be locally agreed parameters for this.

A clinical psychologist in a health setting (for instance, a pain clinic) might see a very high number of people for brief consultations but have a only very small caseload at any particular time. A colleague working in a community mental health team with a focus on group work might hold a caseload of a large number of people.

There may of course be a mix of types of work, which might need some kind of matrix to help the psychologist maintain a balance and throughput.

### Case studies

*Case Study 1:* Bob worked in an independent hospital where service users commonly stay for 6–8 weeks. He sees all new admissions for an assessment and then provides twice weekly interventions for the majority (80 per cent) of people. As people live a distance away there is no expectation of regular follow up when discharged, but he provides 15 minute phone contacts weekly for a longer-term period.

*Case Study 2:* Jill works in a service for trauma. She assesses one or two new referrals a month. Clients normally stay in therapy for a year and then have face-to-face follow up for another year, once a month for an hour. She takes a new therapy case on only when a space is due to become available within her caseload.

*Case Study 3:* Mina works in clinical health in a regional centre where much of her clinical input is brief consultations within medical clinics. In a week she might work in the pain clinic or the diabetes clinic and see eight clients for 30 minute one-off consultations. She also runs a weekly long-term drop in mindfulness group for people with pain, cancer and other conditions, where she might have 12–15 people attending.

Managing a caseload is a skill developed over time and with experience; it includes a triage function (identifying those meeting the criteria for the service and those not), signposting to alternative services, decisions about group versus individual interventions, length of interventions, and managing discharges. In some services this is highly structured; in others there is no specific guidance for the local clinician, and in new services this may be part of the development of the service. NICE guidelines provide guidance for recommended interventions and the care pathways approach as it develops will provide more explicit options within the provision of care. The job planning meeting may be a good place to initiate discussion about this if it appears to be problematic – see the Appendix for an example.

Within this there is also a governance function for managers and supervisors in relation both to the safe delivery of the service and the well-being and effectiveness of the clinician. A caseload should not be so large that the clinical psychologist cannot keep track of all clients on the caseload and it is not good or safe practise to have large caseloads of people who are seen at long intervals (Department of Health, 2010).

## **8. Additional factors**

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### **(a) Generic team/service activity/duty**

There are a range of activities within a team or service and it may be expected that the clinical psychologist should undertake these. This may include carrying out generic first assessments, which means that they would then not be free to carry out the psychological work.

Many services require the clinical psychologist to undertake ‘duty’, where they will be available for phone queries, referrals and emergency action as part of the provision within the team. They would thus not be able to book in clients for this time.

There are many advantages in taking on this work: it helps the psychologist be aware of the realities of the range of work within a service and it supports the authenticity of their role within the team. However it should be recognised that the clinical psychologist at Band 7/8a or 8b will be an expensive resource to use in this way, and it is recommended that, where there is a local arrangement to use the clinical psychology resource in this way, this should be on an occasional basis rather than a regular weekly commitment.

### **(b) Care co-ordination roles**

A similar argument is made for clinical psychologists taking on this role as for the above. It can be entirely appropriate for clients where there is a strong psychological aspect to the clinical need to have the psychologist as their care co-ordinator. It is not a good use of an expensive specialist resource if they are required to be a generic care co-ordinator, carry out commissioning of social care packages or undertake so much of this activity that they are not able to reach their own clinical targets.

This is a difficult area to make any specific recommendations as the definitions of levels of Care Programme Approach have altered and local implementation is variable.

## **(c) Waiting times and waiting lists**

*Recommendation 1: That referrals are addressed with the whole team or jointly with the team manager to ensure appropriate prioritisation and to assist the direction of the psychologists' use of time.*

*Recommendation 2: That in management supervision the referrals and waiting list are reviewed on at least a monthly basis between the clinical psychologist and their line manager. The professional supervisor may also be able to assist in this process.*

Waiting time for first appointment or for treatment to commence can be a concern. Historically, there were long waits for clinical psychology services, demonstrating an imbalance between supply and demand, but this can feel worrying and burdensome for the individual staff member who may feel personally responsible for dealing with them.

Increasingly however, given Payment by Results and the focus on outcomes and service user experience, waiting lists are not viewed as acceptable, and where this might arise is viewed as an organisational problem rather than one for the individual to resolve in isolation.

There may at times be very good reasons for having a waiting list; for instance, when waiting for new trainees to start or when planning to set up a group when sufficient people have been referred. In general though, to have a large waiting list with no ongoing review, where people wait for months before being seen at all, is not considered good practice as it will lead to clients becoming disillusioned and likely not to engage, or to deteriorate and then become more urgent.

It is more useful to see the referrals and waiting times as something jointly managed between the individual staff member and their team/service manager and, where appropriate, shared within the whole team. This allows for prioritisation and review of the need for the clinical psychology service. This process may highlight inappropriate referral patterns or a misunderstanding of the role of psychology. It may lead to innovative ways of addressing the problem; for instance consultation with the referrer may obviate the need for a referral to the clinical psychologist by replacing it with regular consultations, or it might be possible to supervise another member of the team in providing the intervention (BPS, 2007).

Reviewing the referrals and waiting times with the whole team on a regular basis can be valuable as individual team members can take responsibility for prioritising those clients in higher need or deciding that others may not require the service at this point in time.

## **(d) Trainees**

*Recommendation: That the trainees' caseload should be included in that of the supervisor and that the supervisors' clinical activity be reduced by the equivalent supervision time.*

Currently, most clinical psychologists will take trainees on a regular basis and in some settings more than one.

Trainees are normally on doctoral level training, paid up to Band 6, and come with high levels of experience and expertise. They make a contribution to the provision of a service, carry out work with service users, and can bring innovation and creativity to the service in return for placement supervision. Trainee psychologists supplement the work of the

qualified member of staff, in return for supervision. They are not clinically autonomous and work under the direction of their supervisor.

Trainees' caseload should be included in that of the supervisor and this balances out the time required for supervision. Supervision time should be included in the direct clinical activity component for the clinical time, thus reflecting reduced face-to-face activity for the supervisor.

## 9. Disagreements about clinical activity

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It is to be hoped that this guidance will help to reduce disagreements about clinical activity.

The team/service manager has a legitimate right to specify what needs to be addressed in terms of organisational priorities and may be under pressure to meet particular targets, which may be set by external commissioners.

The staff member, supported by their professional supervisor, contributes an understanding of the clinical provisions, expected standards of delivery, and the range of methods of service delivery.

This could clearly cause tension, but should also allow for creative resolution where the needs of the service are met without overburdening the individual practitioner. For instance, concern about waiting times for assessment could be resolved by providing joint assessments with a team colleague to exclude inappropriate referrals.

It should be possible to reach an agreement, but where there are ongoing disputes the professional supervisor or a more senior psychologist in the service could advise, or a senior practitioner from another trust or the specific faculty could be asked to give their opinion.

Two examples are provided in the appendix.

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# Appendix

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## Example 1

An 8a Clinical Psychologist worked in an adult mental health community mental health team (CMHT) and was well regarded for the quality and outcomes of her clinical work within the team.

However, the team manager was becoming extremely concerned about the high number of referrals and the slow response to them. He was not keen on there being a waiting list, but was aware that there was a 'virtual' waiting list of people waiting for a first appointment.

In team meetings it was common for people to ask when someone would be seen and the psychologist felt under pressure and had taken this to her professional supervisor for advice.

The team manager and professional supervisor made contact and felt a three way meeting might be helpful.

They looked at the whole process of managing the psychology referrals. It was evident that:

### *1 Referral patterns*

Junior doctors referred more than the consultants. Less experienced community psychiatric nurses (CPNs) also referred more frequently.

These referrals were more likely to be inappropriate, often asking for support of counselling, referring people who had not responded to therapy previously, or referring people for no clear reason.

#### *Outcome*

It was agreed that the psychologist would work out an information sheet for criteria for referral, covering the types of problems and what could be offered.

It was also agreed that the consultants would confirm the appropriateness of referrals from junior doctors and the team manager for CPNs.

### *2 Psychology provision*

The psychologist always provided an individual assessment and sometimes several appointments before deciding whether to offer therapy.

#### *Outcome*

It was suggested that the psychologist could either meet with the client jointly with the referrer for a more informal assessment or conduct the assessment joint with the CPNs. This allowed a quicker response and it was easier to decide on the appropriateness of the referral.

It was also suggested that the psychologist could provide supervision to CPNs for some client work for staff that had had some CBT training.

It was recognised that this was a learning experience for the psychologist, so training courses were identified for this and this was addressed within supervision.

### ***3 Psychologist's way of working***

The professional supervisor noted that the psychologist liked to completely discharge people before offering appointments to new clients. She would build in a week to finish off reports and administration and then set up new appointments.

#### ***Outcome***

The professional supervisor pointed out that this was inefficient in use of time and allowed delays to build up (for instance, if dates could not be agreed for first appointments). She and the team manager were both firmly convinced that as people came up for discharge, appointments for new clients should be made without delay with due recognition of the need for time to ensure final written work was completed. It was agreed that this should be piloted over three months and then reviewed.

The professional supervisor also suggested looking at the local work on care pathways to help inform thinking about how clinical work is viewed within a systems framework as part of CPD.

### **Example 2**

A newly appointed Band 7 Clinical Psychologist worked in an adult mental health CMHT, having taken over from someone at a more senior level (8b) who had retired.

The team was very pleased to welcome the new member of staff and appreciated the new ideas and skills they brought to the team. However, they were concerned that a high level of referrals was being rejected as not appropriate without being seen. In addition, frequently after the psychology assessment the decision was given that the service users were not suitable for psychological therapy. The psychologist worked with a small caseload and was seen as over protective of her time in taking on other aspects of work.

In clinical supervision the psychologist talked about being overwhelmed by the workload and feeling that the team were totally unrealistic about the workload. She also complained that the team manager was already asking her to close a complex case after seeing them for just a few weeks.

After four months in post, the team manager, professional supervisor and psychologist held a three way meeting to establish a job plan and agree parameters of work.

They started by looking at the use of time over an average week, identifying set activities. The professional supervisor pointed out that as a newly qualified psychologist at Band 7 there was a need for time for CPD and also more time for clinical preparation. She also pointed out that there would be no trainees within the service for a period of time. The three of them agreed the amount of time available for the clinical service. They also looked at the whole process of managing the psychology referrals.

It was evident that the team were accustomed to referring a wide range of people without always identifying a specific need. The previous psychologist was happy to work with a broad remit.

The supervisor and psychologist emphasised the importance of working to the NICE guidelines. When this was done it was clear that some people could be referred back to primary care services and others would not be deemed appropriate for a NICE compliant intervention. The team however, valued the broader work for other clients and wished this to continue.

## *Outcome*

It was agreed that the psychologist would present to the team the NICE guidance on the main clinical areas and use this to decide with colleagues if referrals should be sent to primary care or taken on within the team.

The psychologist had identified set sessions providing psychological therapy under the NICE guidelines within their job plan.

There was also agreement that a proportion of clinical time within the job plan should be for more complex client work, either seeing clients face-to-face or providing consultations to the care co-ordinator.

This latter area was identified as a development need for the psychologist who had only done this in her last placement. A more experienced colleague agreed to mentor her contributors.

## Contributors

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