Nottingham Trent University
Psychology

Defining "Clinical Responsibility" and Clinical Supervision Requirements for Clinical Associates in Psychology (CAPs) in the Occupational Standard

28th May 2024

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This paper has been produced for consideration by the Clinical Associate in Psychology Trailblazer meeting on 4th June 2024. It solely represents the views of the author, and is intended as an initial starting point for consideration in discussion amongst attendees – it is not intended as a position paper for the trailblazer to adopt, nor does it hold any status as an output representing the trailblazer itself.

Summary

There are two elements of wording in the current occupational standard that pose potential barriers to employer uptake of CAPs in their workforce, and one of which also does not hold any clearly defined meaning (and therefore, arguably, benefit) through its inclusion. This paper outlines the case for removing the wording about "overall responsibility" for CAP practice, along with aligning the supervision frequency to the BPS registration standards (and clarifying who may provide this supervision) and lobbying for a minor change in wording to BPS registration information. It is proposed that these changes will support the trailblazer in promoting CAPs to the wider workforce through making it easier for employers to conceptualise the level of support required.

Context

With CAPs still a relatively new workforce and employed in only a section of the potential employers that they could be, a challenge facing those of us who seek to increase the workforce continues to be the ways in which we articulate to potential employers what value CAPs can bring to the services. In doing so, we draw from a range of sources – not least is the trailblazer's own frequently asked questions document, but alongside this we may point employers to the IfATE occupational standards[i] as the definitive outline of a CAP in practice. These standards were written by this trailblazer, and any changes remain the trailblazer responsibility, in collaboration with IfATE.

In using these standards to understand how CAPs fit into their existing workforce planning, an occasionally reported concern is regarding the level of support required by CAPs upon qualification. In this context, potential employers will notice two specific phrases in the standard that can pose a barrier:

1. "[CAPs] provide a range of psychological treatments working within their scope of practice, whilst the supervising HCPC registered practitioner psychologist retains overall clinical responsibility for their work"
2. "…meeting their clinical psychology supervisor on a weekly basis in accordance with British Psychological Society (BPS) standards for accredited practice."

This first set of wording can raise concerns for employers; in particular, the implication taken from this wording can be seen to imply firstly, that CAPs will require such high oversight as to not provide sufficient intended workload relief for their practitioner psychologists, and secondly, that individual clinicians who supervise CAPs will be opening themselves up to litigation in the event of clinical errors by a CAP. Anecdotally, this particular element does seem to be a frequent point of concern for those of us seeking to encourage uptake of the CAP role by employers, and so it is important to ensure that we understand what is meant by it.

Clinical Responsibility for CAPs' Work – The Case in Current Practice

It is surprisingly hard to find a definition of *Clinical Responsibility* in the public domain amongst guidelines or legislation of relevance to CAP employers. HCPC standards of conduct[ii], proficiency[iii] and education[iv] do not specifically reference this term for practitioner psychologist standards, and the term does not appear in the BPS accreditation standards for CAPs[v] or clinical psychologists[vi].

In terms of understanding how responsibility for practice works during training, the closest we come to seeing one professional take responsibility for another is in the phrase

> *"Placements must have a primary supervisor who is a registered practitioner psychologist and has overall responsibility for supervision of the trainee's placement experience"*

within the CAP accreditation standards, whilst in the ClinPsy accreditation standards we see

> "*All clinical supervisors must be fully aware of their responsibilities. No placement should be arranged unless the supervisor has indicated her or his willingness to provide full supervision and take responsibility for the trainee.*"

This is followed later in both standards by acknowledging *that*

> *"Systems for trainee support should empower learners to take personal control of their own development, by providing opportunities for the exercise of choice, decision-making, and responsibility within a supportive environment, in order to promote the development of autonomous learning.*"

Finally, the BPS criteria[vii] for entry onto the CAP register specify a frequency of clinical supervision, CPD, and continued operation within scope of practice. In summary, the core professional standards and guidelines recognise a responsibility for clinical supervision as a vehicle for supporting CAPs to operate within their own arena of responsibility, but do not define any process whereby a practitioner psychologist is individually responsible for the clinical decision-making of CAPs at the level of direct clinical practice.

If we look more broadly than psychology, we find General Medical Council guidance[viii] regarding shared care in the prescription of medication. Medical doctors are directed to take clinical responsibility for only delegating tasks to individuals who they are confident have the skills to perform said tasks. However, there remains the clarity that the clinical responsibility is in the act of delegation, not in maintaining ongoing clinical responsibility for the decisions made by that individual, whilst the individual taking the delegation is expected to take responsibility for deciding themselves whether they have the competence to perform the task.

An occasional justification for the inclusion of phraseology regarding clinical responsibility is made in regard to the worst-case scenario; the death of a service user receiving care from a CAP, with the resultant inquest in a coroner's court and the idea that a CAP should not sit alone in such circumstances. However, there are clear principles whereby this sentiment is not meaningfully met through the inclusion of being within the "overall clinical responsibility" of a practitioner psychologist. Firstly, inquest guidelines[ix] are clear that coroners "cannot blame individuals or organisations or find them responsible for the death"; secondly, in understanding the behaviour and decisions of individuals, there is no principle for indicating that any individual's decision can be considered the responsibility of another, more senior professional; thirdly, the practitioner psychologist will be expected to account for the nature of clinical supervision provide, as they would be for any professional they are allocated to clinical supervision; and finally, whenever individual professionals are expected to attend a coroner's court, there is no barrier to them being accompanied and supported by colleagues. In summary, the phrase regarding "overall clinical responsibility" would have no meaningful application in law, and nor is it necessary for CAPs to be supported should they find themselves in these situations.

Our final reference document in considering CAP clinical responsibility is in the NHS Job Evaluation Handbook[x] - whilst there is not yet a national CAP job profile, all CAPs in the NHS will have their posts evaluated using this process, and so we need to understand how that might be impacted or relevant to the question of whether someone else retains overall clinical responsibility for the CAP's work. To do so, we can look at Factor 6 (Responsibilities for patient client care); we can note here that

there is no wording about providing care that is someone else's responsibility. Up to level four, individuals might be carrying out work decided by others (e.g. level 4a "includes carrying out programmes of care, therapy or treatment determined by others"), but even here there is no indication that the work itself is entirely the overall responsibility of another. Furthermore, it is reasonable to suggest (based primarily of the duties that CAPs are trained to deliver according to the occupational standard) that most people would agree to place CAPs at least at level 5, where they are developing packages of care rather than implementing others' packages. A final note on this document is that when we consider the practitioner psychologists themselves and their own job evaluations, Factor 9 (Responsibilities for human resources) does not at any point make reference to taking clinical responsibility for another professional's actions.

An Alternative Means of Articulating CAPs' Autonomy and Responsibility

The occupational standard already contains many statements that demonstrate the appropriate level of expectation to be placed upon CAPs. In the opening statement, CAPs are "able to practice autonomously with appropriate support, working within their scope of practice, under the supervision of an appropriately registered HCPC practitioner psychologist." In more detail later, CAPs

> *will be responsible for providing psychological assessment and interventions within their scope of practice across a range of service settings, such as in the workplace, community, hospital, or prison and including individual or group settings. Scope of practice is determined by a range of factors and defines the procedures, actions and processes that a CAP is qualified to deliver.*

Arguably, the determinants here around the balance between autonomy and scope of practice are appropriately captured in these two statements. As such, the phrase in question could be changed from:

> *- provide a range of psychological treatments working within their scope of practice, whilst the supervising HCPC registered practitioner psychologist retains overall clinical responsibility for their work*

to

> *- provide a range of psychological treatments working within their scope of practice,*
>
> *- engage in clinical supervision as determined by the BPS standards of registration*

This simple change would not risk any sense of leaving CAPs at risk of working beyond their capabilities, but would allow employers a stronger sense of the true independence and autonomy of CAPs; importantly, it would also help CAPs to feel respected in their own right, based on the training they will have undertaken to get to this point.

A second suggestion is that in the standard, there are two references to the following:

> *report to a HCPC registered practitioner psychologist in terms of psychological assessment, formulation and intervention.*

This phrase also carries ambiguity, in that "reports to… in terms of" carries the implication that each instance of assessment, formulation, and intervention will be directly discussed with the practitioner psychologist. In practice, this is not necessary for an autonomous professional, but the spirit of the principle that CAPs are less qualified than practitioner psychologists and will continue to need that level of expertise to conduct their work effectively could be captured in

> *Conducts psychological assessment, formulation and intervention under the clinical supervision of an HCPC registered practitioner psychologist [or an appropriate alternative – see below].*

A final suggestion in regard to clinical responsibility is that the BPS registration website does refer to CAPs as "semi-autonomous", whilst the occupational standards refer to CAPs as "autonomous". The "semi-autonomous" phrase was removed from the standards previously in recognition that it did not match the reality of a qualified CAP's work, and it would be helpful if the trailblazer could take a position now to request that the BPS also changes the wording in the registration documents so that the two are more fully aligned in this regard of clinical responsibility.

Clinical Supervision of CAPs

There are currently some elements of confusion in a comparison between the occupational standards for CAPs and the BPS registration requirements.

In training: The BPS accreditation documents state that “Placements must have a primary supervisor who is a registered practitioner psychologist and has overall responsibility for supervision of the trainee’s placement experience” whilst “trainees may receive supervision on placement from other supplementary clinical or practice supervisors. These supervisors must be appropriately qualified, but may be registered in a different domain of psychology, or may be an experienced qualified associate psychologist or a qualified member of another profession” and that “trainees should have a least one hour of formal supervision per week or equivalent”.

Post qualification: The BPS register states that CAPs require fortnightly supervision by an HCPC registered practitioner psychologist; whilst the occupational standard refers to "supervision by an HCPC registered clinical psychologist”, and also still “meeting their clinical psychology supervisor on a weekly basis in accordance with British Psychological Society (BPS) standards for accredited practice.”

In summary, whilst training CAPs require an hour weekly, but this can be delivered by an appropriate supervisor provided a practitioner psychologist has oversight of the process. Once qualified, the registration requires fortnightly supervision but the occupational standard implies weekly supervision, and in both cases supervision can now only be with a practitioner psychologist. This can mean that a service might have supervision capacity to train a CAP but not then employ them post-qualification, where one would rightly expect this to occur in reverse.

An Alternative Means of Articulating CAPs’ Supervision

It is suggested that now we have BPS registration live, the occupational standards should remove specifiers regarding frequency or profession of clinical supervisor, so that there is a single reference point (the BPS register) where these specific requirements can be found.

Alongside, it is proposed that the trailblazer makes the case to the BPS that their registration documents need to be aligned with the principles of the training accreditation, so that registration now requires oversight of clinical supervision by a practitioner psychologist, and at least fortnightly supervision by an appropriately qualified individual in agreement between the CAP and the psychologist.

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[i] https://www.instituteforapprenticeships.org/apprenticeship-standards/clinical-associate-in-psychology-cap-integrated-degree-v1-0
[ii] https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
[iii] https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/
[iv] https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-education-and-training.pdf?v=637660865080000000
[v] https://cms.bps.org.uk/sites/default/files/2022-07/Associate%20Psychologists%20-%20Standards%20for%20Accreditation.pdf
[vi] https://cms.bps.org.uk/sites/default/files/2022-07/Clinical%20Accreditation%20Handbook%202019.pdf
[vii] https://www.bps.org.uk/wider-psychological-workforce
[viii] https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care
[ix] https://assets.publishing.service.gov.uk/media/5e258ec240f0b62c52248094/guide-to-coroner-services-bereaved-people-jan-2020.pdf
[x] https://www.nhsemployers.org/publications/nhs-job-evaluation-handbook