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Guidance for employing practitioner psychologists in physical healthcare settings

GUIDANCE

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This guidance was developed by the Division of Clinical Psychology Workforce and Training Committee, Physical Health Task and Finish Group 2023

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Introduction

Purpose and scope of this guidance

This document is a guide for those commissioning or employing practitioner psychologists to deliver services to people with acute physical health concerns, injuries, or long-term conditions in healthcare settings.

The guidance is also for practitioner psychologists working within Clinical Health Psychology Services, in the above contexts.

An update to the document Clinical Health Psychologists in the NHS (BPS, 2008)[1], its recommendations relate to current NHS services and are informed by current professional practice so the guidance should be periodically updated.

1. Section one – Context and background: Why do we need this guidance now

Strategic planning and healthcare policy

Across the UK, all four nations advocate integrated psychological and physical healthcare, viewing this as key to good service delivery. This is reflected in the strategic documents referenced below[2]. Psychology service provision is increasingly viewed as a core component of the multidisciplinary approach to health conditions, integrated into medical care pathways. Condition specific guidance (e.g. Diabetes, Cancer, Stroke, ICU, HIV, Long-Covid disease, Cardiology, and others), also calls for integrated psychological and physical healthcare provision[3]. Likewise, the physical health needs of those presenting with mental health issues is increasingly being addressed.

The arguments for integration are based on research evidence[4] but also the potential cost benefit to the NHS[5]. The financial cost to the NHS of not integrating care was calculated to be more than £11 billion in a report by the Kings Fund 2016. With the strategic drivers identified above, it is not surprising that there has been an expansion of psychology posts in health[6], and it is likely the demand for psychology in physical healthcare will continue to grow.

The strategic direction is for the healthcare system to move towards a new standard of integrated and holistic care, alongside a need to move towards a more pro-active healthcare approach where health promotion and illness prevention are increasingly systemised as health enablers. This will require input across all levels of care from public health to primary care and beyond.

Psychologists can contribute to support the broader healthcare approach now mandated. Incorporating evidence based psychological theory and practice into the care pathway, can support levels of psychological adjustment, symptom coping and condition management. As part of an MDT approach this can improve health trajectory, health related quality of life and unplanned healthcare activity. The ultimate system transformation ambition must be for all patients living with physical health conditions, especially long-term conditions, to have timely access to appropriate psychological support including input to their MDT medical care and rehabilitation whatever the disease or injury and wherever this is needed.

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When commissioning psychology input to physical health it is important to recognise that as well as similarities, there are specific differences in this work from traditional mental health, therapies, or counselling roles. Examples will be offered to illustrate this. Commissioning for such posts needs to ensure the clinical/practitioner psychologists providing the work are supported by adequate supervision, CPD and governance arrangements to support the range of their work in physical health.

Why is this expansion of psychology in physical healthcare happening now?

There are five main reasons.

Firstly, there is good evidence for the clinical and cost benefit of psychological interventions in healthcare. Examples are provided in the strategic documents referenced.

Secondly, advances in our scientific understanding of how the body and mind work together require we think differently about our models of physical and mental health[4]. Health service and commissioning structures often still separate mental and physical health. This can perpetuate dualistic thinking and impede integrated care.

Thirdly patients and their families request it.

'I think speaking to a psychologist would have really helped me to come to terms with my diagnosis. I was so young. I felt so horrified to have a disease and relied on my parents to explain things and reassure me. I had to have injections weekly, I felt different and didn't want to speak to anyone at school about it. I had an incidence of alopecia (hair loss) due to stress and this was particularly upsetting. Speaking to someone who understands mental and physical health would have been helpful'.

Fourthly health inequalities research demonstrates the need to address integrating care. Examples include those with intellectual disability, a group who experience significant health inequalities and continue to die prematurely. Compared with the general population, it has been established that people with a learning disability were three to four times as likely to die from an avoidable medical cause of death[7]. Life expectancy can be reduced by decades. The figures for those with long term mental health problems show a similar pattern.

Finally, healthcare staff recognise that integrating psychology effectively into medical pathways, benefits patients and families as well as supporting healthcare professionals themselves to deliver the psychological care integral to their roles as part of good medical care. It can additionally assist healthcare staff to manage the emotional demands of their roles[8].

Workforce and service developments

Much of the growth of psychological provision in physical health has been organic, strategically uncoordinated, responding to local demand, often starting with local funding, or arising from successful pilot studies. This has led to inequity of access to psychology services in physical health across the UK. This strategically un-coordinated approach to psychology service development is ripe for review. Furthermore, within psychology workforce planning, the workforce growth in this area could benefit from comprehensive review and planning of workforce needs to include training, recruitment, induction, and governance.

Recent surveys of clinical psychologists in Physical Health (2023 and 2015)[6] demonstrate that psychology in healthcare settings is now one of the most rapidly developing specialisms within Clinical Psychology. The surveys evidence that clinical psychology remains the predominant

psychological workforce specialism within healthcare, but other practitioner psychologists[9] are increasingly employed and include Health Psychologists and Counselling Psychologists.

Advertised posts are usually open to any practitioner psychologist able to meet the person specification and who can demonstrate the competences to deliver the job description. The current guidance is extended to all practitioner psychologists for this reason.

As this work has developed, service descriptors continue to evolve... Currently it appears that 'Clinical Health Psychology' which is the term most commonly used in recent workforce surveys (2008, 2015) may be the most common but other service descriptors are used. As the work develops an agreed service area descriptor may be helpful to increase its visibility for those developing Healthcare strategy and commissioning as well as communication about the work[(10)].

The Health Professions Council (HPC), which preceded the current Health and Care Professions Council (HCPC), was given statutory responsibility for the regulation of practitioner psychologists from July 2009. Practitioner psychologists working in Clinical Health Psychology services are bound by HCPC regulations in terms of the protected titles used since 2009. Clinical Health Psychologist is not a protected title.[(9)]

The BPS survey of posts 2023, and recent issues raised by psychologists within the British Psychological Society, suggest guidance in specific areas is needed:

1. While psychology in physical healthcare grows, psychologists nonetheless remain a small professional group in the physical health workforce compared to nursing, medicine, and the Allied Health Professionals (AHP). Some employers may not have directly employed psychologists before and there are some services employing lone psychologists. Up to a fifth of posts in the most recent workforce survey (2023) were lone practitioners.

   Guidance will be offered here to support the design of job descriptions and job plans, as well as appropriate grading structures and governance. In promoting good governance and support for the psychologist, this is likely to ensure beneficial impact for patients, colleagues, and the organisation. Staff retention is more likely as is the most effective use of resources.

2. Practitioner psychologists in physical healthcare usually have roles that are overlapping but different to their roles in mental health. It is essential for those commissioning services to understand the differences. This will avoid gaps or duplication in commissioning, (e.g. as happened previously in some cases with IAPT* Long Term Conditions funding) (*IAPT is now known as NHS Talking Therapies for Anxiety and Depression). This guidance will describe some of the roles practitioner psychologists provide in healthcare, illustrating specific health related aspects of the role which extend beyond mental health assessment and therapy.

'At 18 I had to make a big decision about whether to have major jaw surgery. My chin had receded due to rheumatoid arthritis. I felt incredibly insecure about this leading me to struggle with self esteem and social anxiety. I was referred to NHS Talking therapies however we did not touch upon my history of rheumatoid arthritis and how this affected my mental health. It was definitely my mental health issues leading to my decision to go through with surgery. Speaking to a psychologist at the hospital would have really helped me to go through the options and understand better what was happening. This feels important to enable informed consent.'

3. In highlighting these areas of difference, the guidance will assist employers to ensure that induction, CPD, supervision and appraisal are appropriate to this broader role.

4. There has been an increase in demand for psychologists to offer staff support within physical health settings. This provision can be in specific staff wellbeing provision or alongside occupational health services; however, it is also often included in the generic job description around support for multidisciplinary teamwork. Similarities and differences between these two roles should be understood and the differences made clear to ensure appropriate boundaries are maintained.

5. Surveys show a mixed pattern of employment structures e.g. some NHS Acute Trusts employing their own psychologists and others having contractual agreements to employ psychologists from Mental Health Trusts. The guidance will highlight some advantages and disadvantages of each model anticipating that in future, as the workforce grows, more Acute Trusts will seek to establish their own psychology structures as already happens in many larger acute hospitals Trusts. In Scotland, Wales and Northern Ireland commissioning is undertaken via Health Boards and this will be included when looking at advantages and disadvantages.

   Service models will be discussed. Certain clinical areas attract funding more readily than others and to ensure equity of access for smaller clinical specialties a case for generic psychology roles in health will be presented.

'*The data from the survey of posts in Clinical Health Psychology show some clinical areas do not receive psychology input. Why are only certain conditions getting psychological input?'*

6. Outcomes evaluation, to include both Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS), is important in this developing area of work. Recent surveys show that reporting of outcomes is widespread but not universal. Outcomes evaluation should be routine and where meaningful, the inclusion of measures relating to physical health outcomes and evidence for cost-effectiveness is also recommended.

2. Section two – What can a practitioner psychologist working in physical health provide?

The nature of the work and the role of the practitioner psychologist

Clinical Health psychology is a specialism within psychology. It is rooted in a strong scientific evidence base and encompasses a breadth of inputs to support optimal healthcare provision and improve clinical outcomes. It aims to provide 'Psychologically Informed Care Pathways', (including Psychologically Informed Environments and Trauma Informed Care). It may offer certain inputs to achieve this. These will include providing specialist needs assessment, care planning and delivery of interventions usually within a multidisciplinary care context, to affect positive change for patients who may be facing distressing and chronic physical complaints or illness or brain changes following illness or injury). Optimised medical care and treatment outcomes are achieved by interventions which improve medical engagement, function, coping, condition management, and which work to reduce disability, and improve health-related quality of life.

Health conditions are best understood as biopsychosocial phenomena, where multiple factors interplay and affect physical illness and the individual experience of it. There is a close and dynamic relationship between physical health, psycho-social experience, and mental health. This can present complex clinical management challenges in medical care particularly in long term conditions and where multimorbidity presents. These inter-relationships need to be taken into consideration and managed effectively. Experienced practitioner psychologists in this field are experts in considering the interplay between thoughts, emotions, behaviours, social relationships, and health as well as the implications of health conditions in risk assessment.

In the NHS, Clinical Health Psychology Services[10] are provided to patients of all ages and in a range of inpatient and outpatient settings including critical care and specialist units. Services may be provided at all stages of an illness, from inpatient work close to a crisis, e.g. following a road traffic accident, diagnosis of a new condition or life-threatening illness, to the longer-term management of chronic conditions where anxiety, depression or other mental health or social/socioeconomic issues may feature impacting on treatment complexity. Services may contribute to palliative and end of life care. Psychologists may be required to work with those who present with health problems and intellectual disability, neuropsychological impairment, or dementia.

How Psychologists contribute to supporting other healthcare staff

In addition to offering training, psychologists working in physical health, will support colleagues from other professions who deliver psychological care to patients in the contexts of their own roles. Examples might include supporting a medical team managing a patient who has a co-morbid mental health problem, or supporting other healthcare professionals around the reasonable adjustments that they might make to their practice to make their care more accessible to patients with other needs e.g. people with intellectual disabilities. This is a routine part of the work of a psychologist in physical health and while it may be termed 'consultation' or 'supervision of psychological work', it does not replace nor conflict with the profession-specific supervision the nurse, doctor or AHP will receive and should not be confused with this.

Psychologists may also be asked to support a team, or an individual team member, to manage the emotional impact of their professional work and the psychologist may offer reflective practice or consultation to staff. They may teach coping strategies. They will be careful not to

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blur professional boundaries by engaging in complex mental health assessment or therapeutic intervention with a team member or colleague who may need a mental health intervention. Should that need be identified, they would refer them to an appropriate service.

The roles of a practitioner psychologist in physical health will encompass but are not limited to the following:

Assessment: Practitioner psychologists working in a clinical health psychology context, will come with a variety of skills, providing specialised biopsychosocial assessments and formulation. Where possible the assessment will also suggest interventions to achieve optimal outcomes. While assessment in physical health may overlap with the assessment conducted in a mental health setting there is likely to be a particular physical health focus, for example to assess suitability for a surgical procedure (e.g. prophylactic surgery, renal transplant, amputation, or bariatric surgery; for assessment of prehabilitation needs before surgery (to help improve outcome for the patients; for assessing motivational or adjustment blocks that may otherwise impede coping and recovery (in the face of chronic illness struggles); or for identication of rehabilitation needs. Needs assessment to inform optimal rehabilitation planning following illness or injury will also be a common theme. Illness prevention may be a focus where health related behaviours may be identified as areas for intervention either to prevent a health problem occurring or prevent deterioration in an existing health problem.

'I feel that speaking with a psychologist to assist lifestyle changes and maintain health would be really positive. Working with a psychologist to help make changes and exploring any barriers to this could be especially useful to ensure quality of life despite a long term condition.'

Interventions: Beyond assessment, practitioner psychologists can provide patient and family therapeutic or other psychologically informed interventions, either as psychological input or part of the multidisciplinary team (MDT) intervention. The breadth and varied goals of these interventions have already been outlined and further detail is given below in the section on job planning.

Interface with other providers and the development of clinical pathways: Practitioner psychologists, specialising in physical healthcare, frequently interface with a wider local system or network of mental health and emotional support services, including, at times, community and third sector support services. These activities are undertaken alongside psychological assessment and/or interventions.

Training, research and service evaluation: Staff training activities and service development work including service evaluation and research are an important part of the role and aim to improve psychologically informed care offered to patients.

It can be seen from the above, that in addition to bringing an understanding of mental health issues, psychological contributions to healthcare offer significant added value, where psychological wellbeing and psychological coping exist as key modifiable factors which can have a profoundly influential role on illness risk, development, experience, and trajectory.

The next section on job planning describes some of these roles and others in more detail.

3 Section three – Job planning and grading

Establishing a post or re-grading an existing post

When developing a new practitioner psychologist role in physical health or evaluating an existing one up to band 8b, it is strongly recommended that commissioners or organisations should obtain advice from a psychologist at consultant level to design the job description, the person specification, to advise on grading and to support the interview process.

For appointments at band 8c and above, which are consultant level posts, in accordance with professional guidance, the post and appointment should be externally validated. The British Psychological Society Division of Clinical Psychologists and Association of Clinical Psychologists UK can provide an external expert assessor who will have been trained to support design of the job description, advise on the recruitment process and they can attend as a member of the interview panel[11]. It is also strongly recommended that the interview panel includes at least one practitioner psychologist with several years clinical experience and management experience working in Clinical Health psychology settings, ideally at band 8d or above. It should not be assumed without evidence that an external assessor or consultant psychologist working in mental health but without clinical experience in health can provide this.

Generic information to support design of the job description and job plan:

Professional guidance on Job Planning for Practitioner Psychologists in Health and Social Care has been published[12].

A full-time member of staff is usually contracted to provide 37.5 hours each week. This work is normally carried out over ten sessions of 3.75 hours. For part-time staff these hours and sessions are calculated on a pro rata basis.

Guidance on grading can be found in the updated guidance referred to above[12].

The job description will reflect duties encompassing direct clinical care (DCC), specified supporting professional activities (SPA) and other activities such as additional NHS responsibilities (ANR) and externally funded duties (ED). The balance of DCC to SPA and other responsibilities depends upon grade and the nature of the post. Job planning is essential to create clear, realistic expectations of the balance of DCC to other activities.

1. **Direct clinical care (DCC)**
   This may be with patients individually or with families or in groups. This activity can be face-to-face, via telephone or video link and generally has a focus on assessment and formulation, intervention, and outcome evaluation. DCC also includes record keeping, clinical letter & report writing, clinically related MDT meetings and clinical supervision about the individual, family, or group (where the practitioner is the supervisor). In some instances, this may include clinical consultation about the patient rather than direct therapeutic contact with the patient.

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Examples of DCC in physical health include:

a. Enabling patients to come to terms with or adjust to their diagnosis, illness, and treatment.

Improving the uptake of medical treatment and adherence to complex treatment regimes. This may include the management of side effects.

'I always found it hard to take medication due to the distressing side effects of nausea. I would work myself up and feel sick even before taking them almost experiencing a phobic response so I would sometimes skip them for weeks. Working through that with a professional would have been helpful to my physical and mental health.'

b. Enabling patients to reduce psychological distress where this is interfering with treatment and recovery from treatment.

c. Assisting patients and health care professionals in decision making about treatment including the cessation of treatment

d. Prehabilitation (patient physical, psychological, and social optimisation)[3]

e. Rehabilitation; planning and intervention

f. Helping to reduce unwanted side effects of a treatment (e.g. pain and nausea)

g. Assisting patients to make lifestyle changes that maintain and improve health.

2. **Working in teams**
   This may include supervision of psychological work carried out by other professionals and joint clinical work with other professionals. e.g. communication of complex or emotive information including end of life, resourcing health care professionals to support patients having to make complex treatment decisions or stopping treatment.

3. **Working to support healthcare teams with the emotional impact of their work**
   This has already been outlined, including reflective practice, but may also include organisational staff wellbeing work such as leading 'Schwartz Rounds', supervision of Mental Health First Aiders and supporting teams after critical incidents e.g. unexpected death of a child patient or treating a colleague with terminal illness. Psychologists may be asked to support HR and occupational health services in their organisational policies around psychological aspects of staff wellbeing.

4. **Clinical consultancy and project/programme design work**
   This work is aimed at groups of patients or programmes of care rather than specific registered patients. In addition to work on wards or with teams, this could include work with community groups and organisations supporting patients, including third sector. It may include working into care homes to improve the quality of care, meeting with school nurses, schools, children's centre staff to provide a psychological perspective on psychologically informed approaches and psychologically informed environments.

5. **Preventative and public health work**
   Here the aim is to improve the wellbeing of the population or subgroups of the population.

6. **Teaching, training and supervision**

These three activities can be provided to the psychologist's own profession and trainees but also to other psychological professions and members of the multidisciplinary teams.

While all practitioner psychologists are involved in leadership activities, the following activities form a larger part of senior and consultant practitioner psychologist roles.

7. **Service and organisational development**
   This work involves contributions to the organisation, planning and management of multidisciplinary services, the provision of advice to staff (individuals and teams/groups including clinical and professional advisory forums) designed to enhance the delivery and development of services.

8. **Systems and higher-level working**
   Influencing, developing, and optimising pathways of care, including care-pathway re-design, to achieve improved service delivery and clinical outcome; at local, regional, or national levels. This may include activities such as the creation of new pathways of care, with commissioning or clinical partners, or co-production of new services with non-NHS parties, (e.g. third sector organisations), to improve patient care.

9. **Governance and management of services and staff**
   This work involves the direct management of individual staff, groups, meetings of staff and the associated services, in a way that provides leadership and governance for those services. This includes MDT meetings which focus on business and team development activities. This may be at Clinical Service, Directorate or Trust level, to develop policies, procedures or interventions that enhance the quality of psychological and physical care given to patients. Another example is the development of new psychological services, based on interpretation and implementation of recommendations of government directives and policies which affect the quality of psychological care which health care professionals provide, e.g. communication skills training, management of staff work-related stress. Such lines of work often include working with national health policy makers and with bodies setting best-practice guidance.

   This area of activity includes providing management and case load supervision. It will also include work connected with inspection visits (e.g. CQC) and HR related activities (e.g. recruitment, retention, and staff experience).

10. **Research, service evaluation, quality improvement activity and audit**
    This involves the systematic collection, analysis and reporting about data concerned with therapeutic activities or services including clinical outcomes and cost benefits . These activities directly or indirectly benefit patients.

    Practitioner psychologists routinely develop innovative approaches to patient care and use research methodology to evaluate the effectiveness of interventions.

Additional NHS responsibilities (ANR) and externally funded duties (ED)
This usually refers to wider system work and is most likely featured in job descriptions at higher grades. Examples might include contribution to NICE guidance and national expert reference groups, a paid or voluntary role for a professional body, work with practice and policy networks, policy and service development work at ICS level and NHS working groups at regional or national level. Contributions to parliamentary work such as All-Party Parliamentary Groups (APPG) on health issues is another example.

These roles do not always come with specific funding therefore should be built into the role of senior psychology posts where relevant. Organisations should recognise that this is a core part of a senior psychologist's role that brings benefits to the organisation as well as the CPD for the practitioner, through establishing professional networks and cross organisational learning.

Supporting professional activities

Job plans for psychologists in physical health need to provide time for Supportive Professional Activity (SPA). Continuing Professional Development, (CPD), is part of this and references activities to ensure the professional remains up to date and able to deliver high quality services. CPD is mandated by the regulator (Health Care Professions Council). Examples include, mandatory training, conference and workshops, accredited programmes and receiving supervision/ mentoring/coaching.

4. Section four – Funding and employment structures

There are a variety of organisational arrangements under which practitioner psychologists may be employed in physical health. They may be directly employed by Acute or Specialist Hospital Trusts, Mental Health Trusts, by Primary Care Networks or by other Primary Care providers). They may also be employed under a Service Level Agreement (SLA) by a larger Psychology Service within an NHS Trust or organisation; third sector (which may be a pump priming temporary approach), or within a private company, which may be an NHS provider. Some clinical health/ practitioner psychologists may also be employed by local borough councils, social services, or housing associations.

Services may be organised within specific conditions e.g. diabetes, breast cancer, cystic fibrosis, stroke, or around clinical pathways which address a variety of health conditions and diagnoses e.g. haematology, chronic pain, cardiovascular or respiratory disease, chronic fatigue, or brain injury. Some services have a general waiting list for a wide range of physical health conditions.

Budgets may be centralised or may be managed within each clinical service directorate/team. The 2023 survey of CHP posts reported that 28% covered some generic work with most posts working into clinical specialisms.

The clinical specialism model has its strengths as it allows for the development of specialist knowledge in what are often highly complex conditions however it can limit the recognition that transdiagnostic work is often beneficial and necessary especially as many patients will present with co-morbidity or multi-morbidities.

Commissioning needs to consider how smaller clinical groups can access psychological input where this may be of benefit. Generic Clinical Health Psychology roles could play a part however the Psychologist would need time to develop expertise in more than one specialty and have adequate CPD and supervision in place to cover different areas of work.

Table 1: Some advantages and disadvantages of employment structures for Psychologists working in physical health.

EMPLOYMENT STRUCTURE	CONSIDERATIONS
Direct employment in acute or specialist trust	+ One management structure simplifying relationships, potential to reduce management costs, and facilitate a consistent approach across service areas. + Psychologist may be able to offer wider role to the trust outside of a clinical specialism. + Professional management and some clinical supervision may be provided 'in-house'. + Direct employment may increase visibility of the psychology professionals and integration of psychological work within the organisation. – Trusts new to employing Psychologists may need to source guidance and supervision independently – Small services such as psychology may not have high level representation within the Trust impacting on their effectiveness

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EMPLOYMENT STRUCTURE	CONSIDERATIONS
Employed under service level agreement from Mental Health Trust	+ Mental Health Trusts have extensive knowledge and experience of managing mental health professionals and their governance structures. + For lone-psychologists, a Mental Health Trust can provide links with psychology colleagues potentially reducing professional isolation. – Mental Health Trust overheads usually charged on top of the overheads already incurred . In some instances this cost may be balanced by the benefits listed above or economies of scale. – Mental health trusts do not necessary offer the physical health expertise needed or understand the systems the psychologist works within. – Possibility of service culture conflict
Health board model/ other devolved nation model	+ Part of larger Board/Trust psychology structure within organization with existing or agreed governance standards. + Usually greater opportunities for psychology supervision, to support CPD trainee placements and offer career progression within Board/ Trust thus supporting staff retention. + Supports more holistic and coordinated care where patients have complex significant mental and physical health needs. + Centrally agreed funding allocated to Board /Trust supporting consistency of approach as well as opportunity to meet local health system needs. – May have to compete with mental health services. – Standards /structures for mental health services may not be applicable in a physical health context. – Allocation of funding needs to consider population size and demography across trusts.

Establishing Services; a comment on 'Pilot' services

The absence of strategic development and consequently little designated funding for psychological services in physical heath, means that trying to establish new psychology services has sometimes led to charitable, 'transformational 'or other forms of temporary funding being sourced for 'pilot services'. These, usually short-term services, are set up to demonstrate clinical and cost benefit and create a business case for permanent posts.

This guidance recommends that this practice should be discouraged where there is already evidence of clinical and cost benefit to draw upon. The time taken to set up temporary services, to recruit and train staff, to create clinical pathways and evaluate outcomes, often from a small number of referrals and sub optimal support structures such as admin support and accommodation, is not generally a good use of resources and may not provide valid conditions to evaluate outcome. Such approaches also risk failure of test of concept where successful recruitment or service model implementation may be undermined by time-limited funding.

It is recommended pilots have a place only where permanent funding has already been identified and agreed, should the service meet clear criteria for continuation at the end of the pilot period.

5. Section five – Minimum service requirements to support the role of a practitioner psychologist

Clinical Governance Requirements

The psychological care team, within any hospital, organisation, health system, setting or network must be embedded within the necessary clinical governance framework. Here service clinical leadership, service management, staff clinical supervision and oversight of clinical delivery planning (and of risk assessment and risk management where needed), can be provided and assured.

Necessary clinical governance of the psychological workforce will thus require Consultant level practitioner psychologist leadership, alongside a suitably planned skill mix and grade mix of practitioner psychologists and other psychological professionals. The Service should be guided and informed by practice guidelines sensitive to the needs of the patient/client group and life-stage for example the specific BPS guidance on psychological services for Children and Young people with Physical Health Needs[13].

Clinical Governance Framework: Principles to be followed.

- The practitioner psychologist should be HCPC registered, and registration checked annually at appraisal.
- There should be a designated Consultant Lead Psychologist/ Head of Specialty for Clinical Health Psychology or Clinical Neuropsychology and, where services are directly managed within the Board/Trust in which services are provided, a designated Board/Trust Head of Service for Clinical Health Psychology with allocated time to fulfil this role.
- The psychology head of service should report to a board level manager.
- Regular professional supervision from an appropriately experienced psychologist with experience of clinical health psychology work, should be provided to fulfil clinical governance requirements. In small services, or in Mental Health Trusts it may be necessary to purchase this supervision externally.
- There should be a clear and shared understanding of the different roles and responsibilities of the line manager (who may not always be a psychologist), the professional lead and the clinical supervisor.
- The practitioner psychologist's annual performance review should be carried out from within the profession as would responsibility for approving Continuing Professional Development activities. It can be helpful in annual review to involve both line management and lines of professional accountability, where these are separate, to maintain clarity about objectives for the role and consensus about the support needed for the individual and their role.
- Smaller sites may combine resources to create one clinical post, but travel time across units should be factored in.
- The service may be supported by non-qualified staff such as Assistant Psychologists who must be supervised by a qualified and HCPC registered , clinical or other practitioner psychologist.

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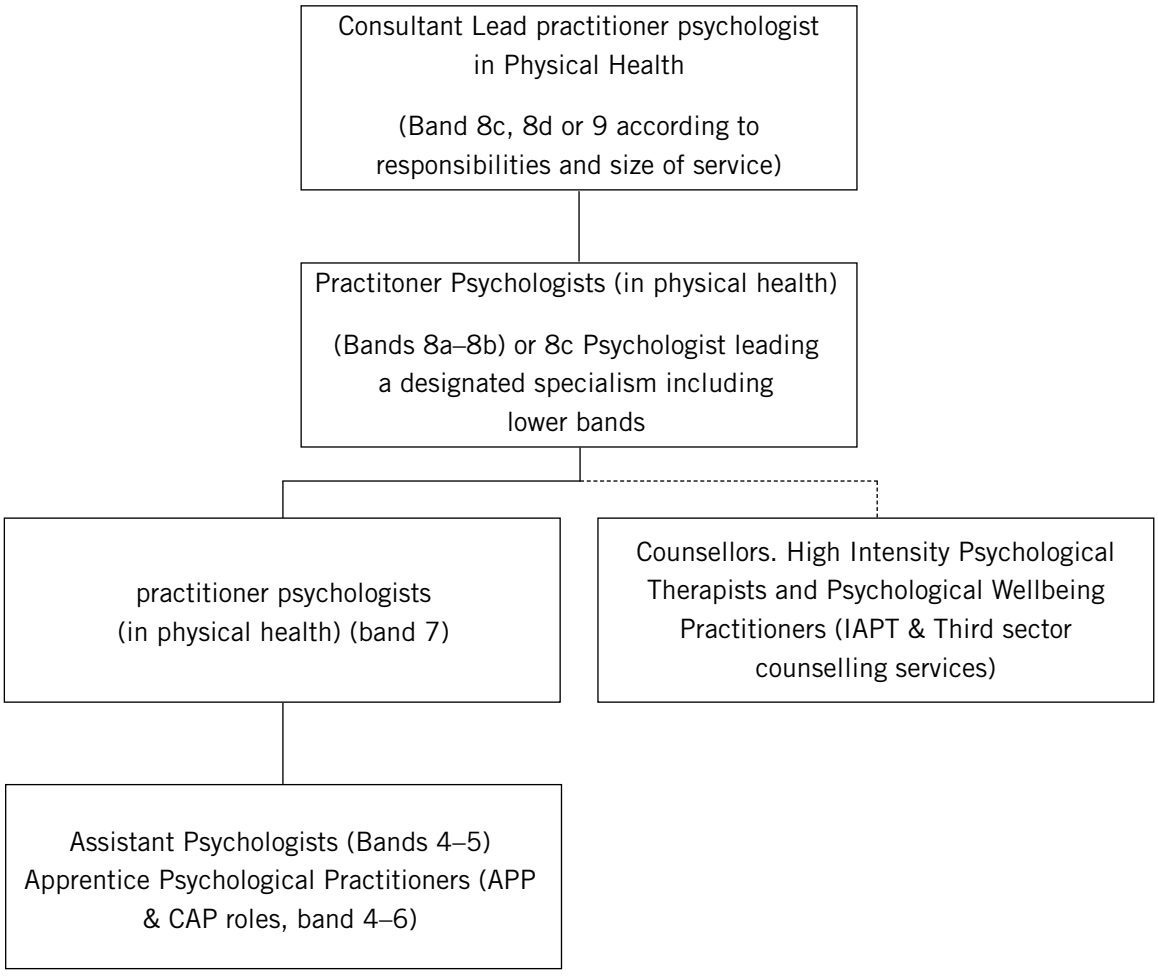
- Clinical Associates in Psychology/Applied Psychology, (CAP England, CAAP Scotland) have qualifications to deliver a range of psychological interventions under the supervision of a practitioner psychologist. There are variations between the roles in Scotland and England and the supervisory requirements. In Scotland the supervisory requirement for CAAPs is fortnightly supervision with a Clinical psychologist for full time staff. For CAPs in England weekly supervision with an HCPC registered practioner psychologist is required.
- Psychological Wellbeing Practitioners are qualified staff who deliver low intensity interventions within their scope of practice and may hold a caseload. There are specific supervision requirements for the role which can be provided by experienced mental health practitioners who have attended the relevant supervision training for PWPs.
- Ideally junior staff should not be employed without an on-site qualified practitioner psychologist to supervise them.
- The practitioner psychologist requires access to a bookable private room on site for conducting sessions with relatives, outpatients, and staff.
- Where the practitioner psychologist is employed in a service they should have accommodation in an office on the same site as the clinical area, ideally within the footprint of the service.
- The practitioner psychologist should have access to lockable storage for clinical notes, or an alternative confidential electronic system.
- Patient experience and clinical outcome measures (PREMS and PROMS) should be routinely collected, audited and used for service improvement.

Table 2: Example of a Psychology Service Professional Governance Structure



As identified earlier, some practitioner psychologists work as lone practitioners within a medical team or pathway which is not connected to a wider psychology team or department. It is recommended that such posts are embedded within a strong governance framework which supports their work in physical health through clear and regular managerial support, as well as professional and clinical supervision to provide expertise around the psychological and health aspects of the role. Where there is not a local Clinical Health Psychology service to link with or any regional professional support, the same professional and clinical governance requirements should look to be met through national connectivity solutions, potentially through remote support solutions that may be enabled by online technologies.

6. Section six – Concluding comments

This document has been produced to provide clear recommendations on the role of practitioner psychologists in enhancing physical healthcare outcomes and on the organisational requirements for supporting safe and effective care. This guidance is expected to be refreshed by 2028 in accordance with the expanding clinical evidence base, and onward NHS modernisation.

https://doi.org/10.53841/bpsrep.2024.inf362.6

References and notes

[1] **Previous DCP Guidance**

DCP Briefing Paper No. 27: Clinical Health Psychologists in the NHS. Division of Clinical Psychology 2008 DOI: https://doi.org/10.53841/bpsrep.2008.inf120

[2] **National Strategic documents highlighting the value of integrating physical health and mental health**

a. England:

i. The NHS Five year Forward View https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

ii. England NHS Long Term plan https://www.longtermplan.nhs.uk/online-version/overview-and-summary/

b. Scotland

i. Scotland- mental health strategy parity of esteem Mental Health Strategy 2017–2027 https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/7/

ii. https://www.nes.scot.nhs.uk/media/fqgjnlo5/psychological_interventions_in_physical_health_care_the_need_and_the_economic_case.pdf

c. Northern Ireland Mental Health Strategy 2021–2023

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mhs-strategy-2021-2031.pdf see actions: 7,20,21,22

d. Wales

https://www.gov.wales/sites/default/files/publications/2019-04/together-for-mental-health-summary.pdf

[3] **Examples of condition-specific guidance calling for more integration**

Intensive Care includes cost benefit analysis

https://ics.ac.uk/resource/integrated-practitioner-psychologists-guidance.html

Cancer

a. Cancer Scotland

https://www.gov.scot/publications/cancer-action-plan-scotland-2023-2026/pages/2/

b. Cancer Northern Ireland

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-strategy-march-2022.pdf

https://doi.org/10.53841/bpsrep.2024.inf362.7

Prehabilitation and Cancer

https://cdn.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/1532-10061/prehabilitation-for-people-with-cancer-tcm9-353994

Stroke

Recommendations for integrated community stroke services,BPS.

Accident and Emergency

www.tnlcommunityfund.org.uk/media/insights/documents/Creating-Better-Mental-Health-Pathways-The-Aintree-AE-Medical-Psychology-Service-model.pdf?mtime=20220606165818&focal=none

Cardiology rehab

https://cms.bps.org.uk/sites/default/files/2022-09/Meeting%20psychological%20and%20psychosocial%20needs%20in%20cardiac%20rehabilitation.pdf

Other generic examples can be found here:

https://www.bps.org.uk/member-networks/dcp-faculty-clinical-health-psychology

Diabetes

https://www.diabetes.org.uk/resources-s3/2019-03/0506%20Diabetes%20UK%20Australian%20Handbook_P4_FINAL_1.pdf

HIV

BHIVA. British HIV Association Standards of care for people living with HIV 2018. April 2018.

http://www.bhiva.org/standards-of-care-2018.aspx

Surgery

https://www.cpoc.org.uk/sites/cpoc/files/documents/2021-06/Preoperative%20assessment%20and%20optimisation%20guidance.pdf

[4] **Research base: Integrating physical and psychological healthcare examples:**

i. Doan, T., Ha, V., Strazdins, L. et al. Healthy minds live in healthy bodies – Effect of physical health on mental health: Evidence from Australian longitudinal data. Curr Psychol (2022). https://doi.org/10.1007/s12144-022-03053-7

ii. Persistent Pain as example: Central sensitization, chronic pain, and other symptoms: Better understanding, better management. Mary M. Volcheck, MSN, RN, Stephanie M. Graham, RN, Kevin C. Fleming, MD, Arya B. Mohabbat, MD and Connie A. Luedtke, RN, PMGT-BCCleveland *Clinic Journal of Medicine April 2023, 90* (4) 245–254; DOI: https://doi.org/10.3949/ccjm.90a.22019

iii. Psychoneuroimmunology :Bower, Julienne & Kuhlman, Kate. (2023). Psychoneuroimmunology: An Introduction to Immune-to-Brain Communication and Its Implications for Clinical Psychology. *Annual Review of Clinical Psychology. 19*. https://doi.org/10.1146/annurev-clinpsy-080621-045153.

iv. Gut-microbiome: https://journals.physiology.org/doi/full/10.1152/physrev.00018.2018 More than a gut feeling Professor John F. Cryan address to the annual conference of the British Psychological Society's Psychobiology Section. 27 November 2018 https://www.bps.org.uk/psychologist/more-gut-feeling

[5] **Systematic reviews of clinical and cost benefit**

i. Niklas et al 2022 ps://rdcu.be/cVanc

ii. Naylor, C. et al Kings Fund 2016 https://www.kingsfund.org.uk/publications/physical-and-mental-health

[6] **BPS DCP Survey of Psychology Posts in Physical Health 2023**
British Psychological Society (2024). *Survey of clinical psychology and practitioner psychology posts in physical health care 2022*. Leicester: The British Psychological Society.

[7] **Intellectual disability Health inequities**

The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: A population-based study Heslop. P., Blair. P.S., et al https://doi.org/10.1016/S0140-6736(13)62026-7

[8] **Healthcare staff and emotional impact of their work:**

Surgeons example

https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/supporting-surgeons-after-adverseevents/guide/

ICU example

Wade D, Georgieva M, Gunnewicht H, Finnigan J, MacCallum N. Delivery of a psychological intervention to assess and reduce workplace stress among intensive care staff. *Journal of the Intensive Care Society. 2021; 22* (1):52–59. https://doi.org/10.1177/1751143719884855

[9] **Practitioner psychologist definition from UK professional standards authority for health and social care**

https://www.professionalstandards.org.uk/check-practitioners/practitioner/practitioner-psychologist

'Practitioner psychologist is a protected title. They can work in a variety of areas of psychology, including clinical, counselling, education, forensic, health, occupational, sport and exercise and others. They are regulated by law and registered by the Health and Care Professions Council (HCPC)'.

[10] **Clinical health psychology services**

This was the most common service description of Psychology Services in Physical Health in the BPS DCP survey of posts in 2015–2016. Other service descriptors may be used. The CHP service descriptor, may for some people presenting with a physical health problem, help avoid the perceived stigma and barriers associated with accessing a mental health professional or intervention.

[11] **Guidance- national assessors**

a. BPS The appointment of a Consultant Psychologist

https://cms.bps.org.uk/sites/default/files/2022-06/The%20Appointment%20of%20Consultant%20Psychologists%20-%20Guidance%20on%20Using%20National%20Assessors.pdf

b. British Psychological Society Guidelines for National Assessors

https://cms.bps.org.uk/sites/default/files/2022-07/Guidelines%20for%20National%20Assessors.pdf

[12] **BPS (2023) Job planning for practitioner psychologists in the NHS and social care**

https://explore.bps.org.uk/content/report-guideline/bpsrep.2023.rep170

[13] **Children and young people with physical health needs; how psychological services contribute to the care pathway**

https://cms.bps.org.uk/sites/default/files/2022-07/Children%20and%20young%20people%20with%20physical%20health%20needs%20How%20psychological%20services%20contribute%20to%20the%20care%20pathway.pdf

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