The British Psychological Society

hcpc health & care professions council

CPD Profile –Clinical psychology manager

1.1 Full name: Clinical psychology manager

1.2 Profession: Clinical Psychologist

1.3 Registration number:

2. Summary of recent work experience/practice

I work full time in a Learning Disabilities Directorate in a large mental health trust. I am Head of Service and manage an overall staff team of ten psychologists. In addition to this, I am Clinical Director of the Directorate which employs over 300 staff and manages a range of services.

I have three key responsibilities:

- To practice as a consultant clinical psychologist with complex cases, specialising in forensic work; this is for two–three days per week.
- To provide overall management (including professional issues) to the Psychology Service within the Directorate, directly line manage the two 8c posts (who, in turn manages the other grades of staff) and oversee the strategy and direction of the development of the service.
- To provide overall clinical leadership to the directorate, taking a lead role in clinical governance.

My line manager is an Executive Member of the Trust Board and I liaise on a regular basis with other heads of psychology within the Trust regarding professional issues.

I have worked in the NHS in various capacities over a 20-year career and have been in my current post for the past two years.

Total words: 189 (Max. 500)

3. Personal Statement

Standard 1: A registrant must maintain a continuous and up-to-date and accurate record of their CPD activity

I keep a continuous and up-to-date continuing professional development (CPD) log, using the format developed by the British Psychological Society (BPS), and have been completing such a log for the past four years. I update this each time I attend relevant training and also use a specific CPD notebook to take notes during all CPD activity and I often reflect on my learning during such activity. I may reflect further as I put into place new learning. I store this log on my work computer and submit it as part of my Personal Development Plan with my line manager.

Evidence 1 of this CPD profile contains the information from my CPD log for the period under review together with supporting evidence.

Standard 2: A registrant must identify that their CPD activities are a mixture of learning activities relevant to current or future practice

Each year I plan my CPD activity based on my agreed objectives from my Personal Development Plan which is reviewed with my line manager (Evidence 2). These incorporate ongoing responsibilities and new developments which I am expected to lead on for the service. Therefore my CPD activity is geared towards:

a) ensuring I am keeping up-to-date with current developments in my fields of clinical expertise;

b) and keeping up to date with professional issues and new government guidelines etc which affect our services.

My CPD is agreed annually during my appraisals with my line manager and specific training is agreed as well as ad-hoc learning.

I have undertaken a mixture of activities to meet the Health and Care Professions Council (HCPC) CPD requirements, which include formal and informal learning. Examples of my activities include: reading journals and other publications, discussions with colleagues and attendance at various conferences and events. All of my CPD activity is relevant to both current and future practice.

Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery

Standard 4. A registrant must seek to ensure that their CPD benefits the service user

The examples below demonstrate how my CPD activity has contributed to my practice and how the service user has benefited from my professional

development. Evidence 1 of this CPD profile contains a complete list of my CPD activity during the period under review.

Journal club
I chair a journal club within my psychology service and as a team we monitor the major journals for our areas of practice and also the allied publications from other relevant organisations. This keeps us all up-to-date on the latest clinical approaches in our area. An example of this is a recent journal article we read which was about identifying the effect on the mental health of siblings who have a relative with an autism spectrum disorder (ASD), which was relevant to our service development work (Abstract Evidence 3). In the discussion we explored the impact on siblings of having a relative with ASD and this made me aware that I did not always cover this as part of my assessment of the home situation with clients. I have since then highlighted this within my own practice. I can think of one case where not just did I receive feedback of the benefit to the sister of the client, it also resulted in her assisting him more in social interactions. This article was a major factor in proposing having a support group for siblings as part of the Asperger's development work in our service.

Clinical and professional updates
I am also a member of the Learning Disabilities Management Faculty of the BPS and monitor emails relating to professional and clinical issues in our field.

One email to exemplify this was from a psychologist working within a private organisation for people with learning difficulties with challenging behaviour where she felt that she was required to carry out work that was not of the expected standards of ethics nor the most up-to-date in terms of practice. The email discussion identified a wider range of issues in relation to clinical supervision and access to professional support. The issue of how one raises issues of professional and ethical concern was considered by all contributors. This made me think about how this was implemented within my wider organisation. I arranged for a discussion on this topic within the clinical governance meeting in my Trust which led to identifying further guidance to be shared with staff; this will hopefully lead to better service user experience within the service.

Personal practice – expert witness
I have attended training this year on writing court reports and appearing in court as an expert witness (Evidence 4). Soon after this training I prepared a court report for a client with learning disabilities and appeared as an expert witness before a judge and jury. My report covered neuropsychological assessment focusing on understanding and information processing, memory; mental capacity aspects, in particular the ability to weigh evidence, and the role of suggestibility and social desirability in affecting judgement (Evidence 5).

My main learning from this was in report writing; it resulted in me spending more time on clarifying how I was answering the questions required for the court rather

than just stating my findings; It also made me realise and work on providing clear justification for any judgements made throughout the reports. This helped me when I was in court to express my opinions more clearly and concisely and then be more confident in answering questions about it.

The benefits of this for service users would be that they received a more skilled and sensitive assessment which was presented to the courts in a more effective way to enable my professional judgement to be better heard. This had a direct impact on the service user as from my report and testimony it was deemed by the jury that he was not fit to plead to the charges and through the direction of the judge he was referred for further intervention and support. As an additional benefit of this learning I am also now able to provide supervision and training to other psychologists who do this work plus offer a wider consultation role within my service.

Personal Practice – autistic spectrum disorders (ASD)
As a service, we have received increasing number of referrals for people on the autistic spectrum who may or may not have Asperger Syndrome. I have joined a working party within the Trust to look at what services might be required for this client group and have undertaken specialist training to use the Diagnostic Interview for Social and Communication Disorders (DISCO) (Evidence 4). This information is fed back to the working party and we are about to submit a proposal for a multidisciplinary support team.

The DISCO training taught me to understand the particular role that neuro-psychological assessment plays in providing evidence for the diagnosis of ASD by learning how to identify and interpret the profiles that people with ASD would display. I also learnt the structure of the developmental history that is a crucial part of the assessment.

I have used the DISCO approach with the service users and their families to provide a historical basis for differential diagnosis. Thus far I have identified five individuals who meet the diagnostic category for Asperger Syndrome and would benefit from services to provide skills training (social skills, problems solving and managing emotions) and access to specialist support – for instance vocational services.

Management responsibilities
In terms of my management responsibilities, I have received further training this year relating to using the Knowledge and Skills Framework (KSF) within Personal Development Planning and this has assisted me in my staff appraisals (Evidence 6). I have also cascaded the training to my managers within our team. What was particularly useful was to learn about different ways of eliciting the evidence for the KSF dimensions– for instance to ask staff to take one clinical activity and use this to provide evidence for all dimensions – this seemed to be easier for some

staff to identify how their work contributed to quality or equality and diversity. This was particularly helpful for managers who were working with less qualified staff.

Clinical supervision
I have undertaken peer group supervision for clinical work throughout the year on a monthly basis with my two senior colleagues. At each session, each of us presents a case, and we advise each other, making reference to the literature, our own practice based evidence, and information from other training courses. For example, one of my peers is formally trained in cognitive analytic therapy (CAT) and will provide additional thoughts on formulation and clinical interventions which all three of us find helpful. At the end of each session we engage in a joint reflection on the session and build this into our respective CPD log books (Evidence 7). On example of the value of this was a recent case of mine which I was approaching from a primarily cognitive behavioural therapy (CBT) perspective; reflections within the group provided me with both the CAT aspect but also more psychodynamic and system features, which led to a more complex formulation and more individualised intervention (Evidence 8).

Total Words: 1500
Max Words (1500)

4. Summary of supporting evidence submitted.

Evidence Number	Description	No of pages	HCPC CPD standards
1	CPD log incorporating development needs and descriptions of activities undertaken to meet these needs together with reflections on learning. Covers a total of 80 hours of CPD activity	15	1, 2 & 4
2	Personal Development Plan: incorporates objectives for the year, progress on last year's objectives, learning and development needs (referring to the separate log book) and mandatory training need and attendance.	10	2, 3 & 4
3	Abstract of journal article	1	2 , 3 & 4
4	Certificate of attendance on Expert Witness courses and Diagnostic assessment course	3 Certificates 3 pages	2 & 3
5	Summary of expert witness report (redacted)	2	2 & 3
6	Certificate of Attendance	1	3
7	Sample pages of notes from CPD notebook with column for reflections	3 sample pages	2, 3 & 4
8	Example of complex formulation (redacted)	1	3 and 4