

Clinical Psychology Workforce Review 2008



Clinical Psychology Workforce Review 2008



Department of
**Health, Social Services
and Public Safety**

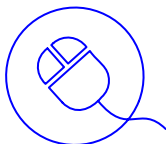
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MÁNYSTRIE O

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an Fowk Siccar**



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Executive Summary

This report sets out the second comprehensive regional review of the HSC Clinical Psychology workforce, the first having been completed in 2003. The essential aim of the review is to provide an overall assessment of the current Clinical Psychology workforce, in terms of numbers, age profile, gender profile, part-time and full-time working etc. It also provides current and projected supply and demand information for the next 5 years, together with an overview of the main issues affecting this workforce. The information provided aims to help support planning at the strategic level, and is also intended for use at organisational level. The report notes any significant changes in the workforce since the initial review.

The review was overseen by an Advisory group with representation from service providers, DHSSPS, education, commissioners, private sector and staff side. (Advisory Group members are listed in Annex C)

The content of the report includes:

- **background details relevant to the workforce;**
- **consideration of the supply and demand for clinical psychologists over the next five years;**
- **consideration of skill-mix issues and future service provision; and**
- **an exploration of the main issues impacting on the workforce.**

The statistical research indicates a gradual rise in the numbers of clinical psychologists employed in the statutory sector over the past five years, with a headcount of 164 as at the end of March 2007.

The report explores a range of issues currently impacting on the Clinical Psychology workforce.

Overall findings include:

- A need to increase the number of training places on the QUB taught doctorate programme to 13, with potential for further increases in line with service developments;
- A need to establish Clinical Psychology services in a number of areas which currently are not covered, such as care of the elderly, HIV, neurology services in addition to TBI, addictions, chronic disease management and childhood acquired brain injury;
- A need to factor appropriate psychological services into care pathways for physical illness;

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- A need to consider appropriate expansion of psychological services into community and primary care level;
- There is clear scope to develop practitioners at more junior level than Doctorate, thus developing a more tiered provision of service;
- There is a need to develop career pathways to support those entering the service at various levels, to help retain a motivated and appropriately skilled workforce into the future
- A need for a trust-level assessment of workforce needs to be carried out in line with service development planning;
- Feedback from practitioners indicates an overall job satisfaction from the professional role but a need to develop career pathways at all levels and recognise the importance of research as part of a senior professional's work.

The report concludes with recommendations for action to address main issues arising in the review.

Chapter 1

1.0 The Policy Background

1.1 DHSSPS Workforce Planning Initiative

The DHSSPS instigated its regional workforce planning initiative in summer 2001, with a key aim of providing the Department with current workforce data to inform its decision-making on the appropriate number of training places to be commissioned at the University. While this remains a key purpose, the workforce planning initiative was also designed to provide other workforce intelligence that will inform the Department and HSC about the current employment situation within the Clinical Psychology profession and the other main professional groups, highlighting issues that enhance employment prospects in the field and those which detract. By following the methodology of working alongside practitioners at different levels of experience and seniority, the information captured should be of benefit in the development of appropriate action plans to enhance recruitment to and retention within the professions. It should also give insight into issues within this, such as appropriate approaches to skill-mix, multi-professional working, and new ways of working which reflect patient needs.

The initial review provided the baseline data on the numbers of people employed in the profession, largely within the HSC, and established the main workforce profiles of age, gender, part-time to full-time ratios etc. The significance of these profiles was explored in terms of the impact on supply and demand over the 5-year span. The current report presents any subsequent changes in these profiles and analyses their potential impact on the workforce.

1.2 Current working environment

At the time of research for the review and preparation of the report, the health service has been undergoing its most fundamental re-organisation for many years. The structural re-organisation resulting from the Review of Public Administration (RPA) has established 5 Health and Social Care Trusts, replacing the former 18 Health and Social Services Trusts and additionally, the formation of Local Commissioning Groups will

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strengthen the focus on the patient being at the centre for the design of health and social care services.

While these developments are mainly organisational rather than operational the formation of local commissioning groups in particular introduces a new element within the pattern of provision of services overall, including Clinical Psychology services. From an employment perspective the larger organisations should offer greater scope for staff to gain experience in a greater range of areas of care than would have been the case in the smaller organisations. This through time should enhance scope for career path development.

1.3 Modernisation agenda

In addition to the structural changes, there is also a significant service modernisation programme underway.

Key elements that will impact on service provision are:

- the drive to place the patient at the centre of service design and delivery;
- the development of more locally available service provision; and
- the enhancement of the delivery of service through multi-professional teams.

All of these developments bring a new perspective and a challenge to traditional patterns of service delivery. They introduce the concept of provision of care outside normal working hours, and at extended hours over weekends.

The reorganisation of services offers the opportunity to establish psychological services that can achieve enhanced levels of access throughout N Ireland. The new structures emerging from RPA mean that the Trusts will be well-placed to meet the challenges posed by the national and regional agendas in areas such as the delivery of psychological therapies. One of these challenges will be improving the access to psychological interventions across the age and disability spectrums in an organised and cost-effective way. To maximise this opportunity it will be necessary to ensure that mechanisms are in place to ensure that Clinical Psychology can inform strategic planning and commissioning of services.

Future provision of psychological services taking into account the scope for greater skill-mix, is explored in greater detail later in this report.

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1.4 Productivity

Since publication of the Appleby Review¹ of the health service in N Ireland, the department has placed increasing focus on the drive to improving workforce performance and output.

The Appleby Report highlighted a gap in productivity in the health service overall in N Ireland compared to England. DHSSPS is now committed to taking forward productivity monitoring as part of a drive to raise productivity across the HSC and at the same time reduce the gap with England.

In addition to providing data for productivity monitoring purposes it is intended that the data collected from all Trusts will enable benchmarking locally and the identification of models of best practice in the areas examined.

The significance of this drive for increased productivity has also been emphasised in light of the significant investments made in pay reforms.

To take this forward, the Department has put in place productivity monitoring to cover all trusts in N Ireland. As part of this, information on a number of high level productivity indicators, such as staff sickness absence levels and staff turnover, will be published for the attention of all HSC organisations. Each organisation will be required to produce the statistics relevant to their organisation, which will then be benchmarked against all the other trusts across the region.

The monitoring system, will also facilitate cross-referencing between indicators to examine the effect each parameter has on the system overall.

It would be the aim that time released from improvements in for example working practices and skill-mix would be re-invested into the workforce thereby increasing output with no increase in workforce numbers.

While Clinical Psychologists and assistants will be included in the overall workforce statistics feeding into this monitoring work, there are at present no plans to introduce productivity targets specific for the clinical psychology profession. There are however specific targets in place for psychological services and these will be rolled out further in due course.

¹ Independent Review of Health and Social Care Services in Northern Ireland, Professor John Appleby, August 2005

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1.5 Health Policy

The Department's workforce planning is taken forward within the overall health policy context whereby the Department of Health Social Services and Public Safety works to improve the health and well-being of all the people of N Ireland through supporting the development of services that are:

- Of a high and consistent standard across the region, with resources targeted towards those most in need;
- Developed through engagement of service users, carers and the public in general;
- Continuously subject to clinical improvement in line with modern developments; and
- Constantly seeking to develop the most cost effective means of provision of care while maintaining excellence in clinical standards.

To achieve these aims the Department works in partnership with the HSC organisations responsible for the delivery of these services.

The Northern Ireland Executive, in its Programme for Government 2001-2004 identified "Working for a Healthier People" as one of its five priorities, and stated that "we will work to reduce waiting lists, implementing new management arrangements, and recruiting additional front line staff". The Department has been working in conjunction with the HSC Boards and Trusts to take this forward over the years since then. This workforce review contributes to that agenda through engaging with the service to identify how many front line staff, at what levels and with what specialist skills, will be required to achieve these aims.

The N Ireland Assembly, established in May 2007, has also committed to the ongoing development and further modernisation of health and social care in N Ireland as a key priority.

While the statutory sector provides the prime focus of this review, reference is also made to psychologists working outside that sector, largely in the private sector.

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The report presents:

- information about the current Clinical Psychology workforce;
- information on current and potential future issues impacting on the workforce of significance at both local and regional level; and
- indicative trends in the demand for clinical psychologists over the next five years.

The report concludes with a list of recommendations which seek to contribute to addressing the current and future workforce issues within the Clinical Psychology workforce.

1.6 Workforce supply and staffing

While the regional workforce planning process provides an assessment of overall need and also provides workforce intelligence regarding issues that will impact on the availability of staff into the future, it remains the responsibility of the Boards and Trusts to employ appropriate numbers of staff in line with their service delivery requirements. Ideally they are expected to draw upon the workforce data presented in these reviews to inform their recruitment and retention strategies.

Chapter 2

2.0 The Clinical Psychology workforce

2.1 The Role of the Clinical Psychologist

Clinical Psychology is a specialism within applied psychology. Clinical Psychology services aim to enable service users to have the necessary skills and abilities to cope with their emotional needs and daily lives in order to maximise psychological and physical well-being.

To assess a client, a clinical psychologist may undertake a clinical assessment using a variety of methods including psychometric tests, interviews and direct observation of behaviour. Assessment may lead to therapy, counselling or advice.

Clinical psychologists work in a variety of settings, including hospital wards, day centres, Community Mental Health Teams, HSC Trusts, primary and social care contexts and forensic settings. They work with people of all age groups, those with mild, moderate and severe mental health problems, developmental and learning disabilities, physical and sensory disability and brain injury, people with substance misuse problems and those with physical health problems, such as HIV and AIDS, cancer, heart disease, pain and diabetes. They work not just with individuals but also with couples, families and groups (e.g. therapeutic, staff and informal carers).

Clinical Psychologists often work as part of multidisciplinary teams alongside other health professionals including doctors, nurses, social workers, occupational therapists and physiotherapists, as well as educational and counselling psychologists and criminal and legal psychologists.

A key issue cited by the Advisory group was that recognition be given that Clinical Psychology impacts into every area of patient care, extending beyond mental health-related conditions into care pathways for physical illness. This is further discussed in Chapter 4.

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2.2 Clinical Psychology workforce statistics

The Human Resources Management System (HRMS) shows that there are currently 164 clinical psychologists employed in the HSC. This reflects a gradual rise in the numbers over the last 5 years, increasing by 48, which represents an increase of 41%.

The increase in whole time equivalent (WTE) over the last 5 years has been 43%. With a ratio of headcount to WTE at 1.08:1, this varies only slightly from the previous review (1.1:1 in 2003).

Numbers of clinical psychologists in the Workforce

| Year | Headcount | WTE |
|--------|-----------|--------|
| Mar-03 | 116 | 105.87 |
| Mar-04 | 127 | 119.78 |
| Mar-05 | 147 | 137.93 |
| Mar-06 | 150 | 138.99 |
| Mar-07 | 164 | 151.74 |

2.3 Assistant/trainee and Associate Clinical Psychologists

Clinical psychologists are supported in service delivery by assistant and associate clinical psychologists.

For the purposes of this review assistant and associate clinical psychologists are banded together assistant/trainee however in practice their roles are slightly different.

Assistant/trainee clinical psychologists tend to be psychology graduates employed to undertake circumscribed pieces of work. The role is considered short-term in most instances and as a pathway to obtaining places on clinical training courses. Post-holders can carry out a range of duties, from research/evaluation/audit through to undertaking assessments. The level of responsibility given to the assistant/trainee psychologist varies between Trusts. Some Trusts reported that they have developed the role such that assistants provide a significant level of service and carry significant caseloads.

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The role of Associate psychologist is usually filled by candidates with more clinical experience than the assistant psychologists and therefore associates are paid on a higher scale.

Trainee psychologists are post-associate grade, thus under Agenda for Change, assistant clinical psychologists = Band 4, associate clinical psychologist=Band 5 and trainee clinical psychologists =Band 6.

While a significant contribution to service provision is made by people working in these roles, the posts they hold are often not permanently funded and so at this point in time the roles are not established as part of a tiered service provision. This issue is further explored in consideration of skill-mix issues and future delivery of psychological services.

Numbers of assistant/trainee psychologists in the Workforce

| Year | Headcount | WTE |
|--------|-----------|-------|
| Mar-03 | 64 | 63.01 |
| Mar-04 | 72 | 71.21 |
| Mar-05 | 71 | 69.91 |
| Mar-06 | 87 | 85.07 |
| Mar-07 | 95 | 92.69 |

There has been an increase in the number (48%) of assistant/trainee clinical psychologists over the past 5 years. This skill-mix helps free up the professional to carry out the more complex procedures and assessment of required programmes of care.

2.4 Full-time and Part-time working in Clinical Psychology

The statistics show very little change in the percentages of full-time and part-time working since 2003.

| Year | Full time | Part time | | Total | |
|--------|-----------|-----------|-------|-----------|--------|
| | Headcount | Headcount | WTE | Headcount | WTE |
| Mar-03 | 89 | 27 | 16.87 | 116 | 105.87 |
| Mar-04 | 100 | 27 | 19.78 | 127 | 119.78 |
| Mar-05 | 111 | 36 | 26.93 | 147 | 137.93 |
| Mar-06 | 109 | 41 | 29.99 | 150 | 138.99 |
| Mar-07 | 122 | 42 | 29.74 | 164 | 151.74 |

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The statistics show a slight increase in part time working from 23% of the workforce in 2003 to 26% of the workforce in 2007.

Requests for flexible working arrangements can range from job-share to reduced/condensed hours, term-time working and career breaks. It has been reported in the past that staff returning after maternity leave are especially likely to request flexible working patterns.

2.5 Gender profile for Clinical Psychology

| Year | Female | | Male | | Total | |
|--------|-----------|--------|-----------|-------|-----------|--------|
| | Headcount | WTE | Headcount | WTE | Headcount | WTE |
| Mar-03 | 80 | 72.72 | 36 | 33.15 | 116 | 105.87 |
| Mar-04 | 92 | 85.65 | 35 | 34.13 | 127 | 119.78 |
| Mar-05 | 104 | 96.16 | 43 | 41.77 | 147 | 137.93 |
| Mar-06 | 107 | 97.05 | 43 | 41.94 | 150 | 138.99 |
| Mar-07 | 116 | 104.98 | 48 | 46.76 | 164 | 151.74 |

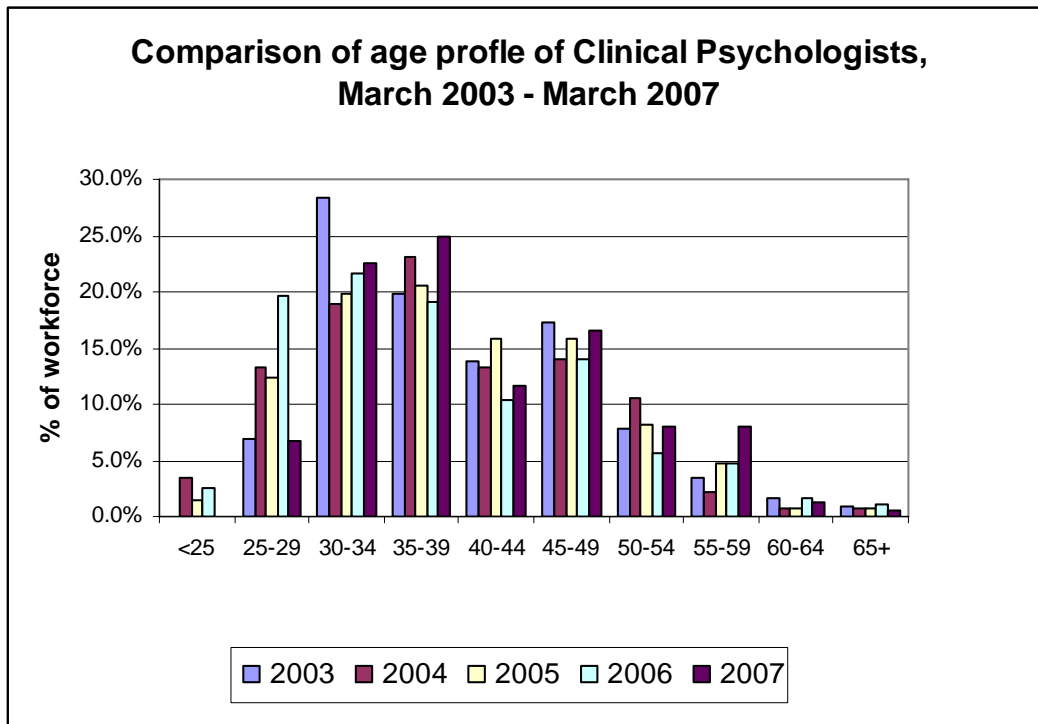
The Clinical Psychology workforce continues to be **largely female**. Current percentages are 71% female and 29% male. Whilst the number of male clinical psychologists in the workforce has increased by 12 since the last review the overall percentage of males has decreased by 2%.

2.6 Age Profile for Clinical Psychology

The Clinical Psychology workforce **is relatively young**, with 54.3% currently below 40 years old. There has been little change in the percentages aged over 50, rising from 14% in 2003 to 15% in 2007.

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Age Profile – March 2003 to March 2007



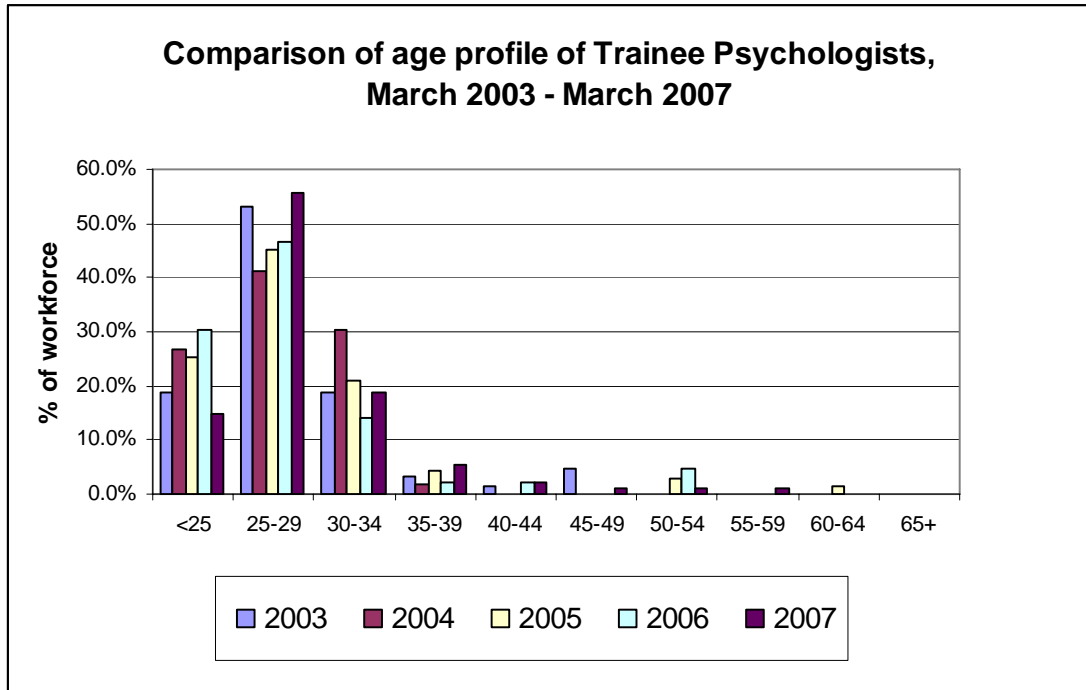
2.7 Gender Split: Assistant/trainee clinical psychologists

| Year | Female | | Male | | Total | |
|---------------|-----------|-------|-----------|-------|-----------|-------|
| | Headcount | WTE | Headcount | WTE | Headcount | WTE |
| Mar-03 | 51 | 50.01 | 13 | 13.00 | 64 | 63.01 |
| Mar-04 | 56 | 55.21 | 16 | 16.00 | 72 | 71.21 |
| Mar-05 | 57 | 55.91 | 14 | 14.00 | 71 | 69.91 |
| Mar-06 | 71 | 69.86 | 16 | 15.21 | 87 | 85.07 |
| Mar-07 | 79 | 76.69 | 16 | 16.0 | 95 | 92.69 |

Currently 83% of Assistant/Trainee Clinical Psychologists are female.

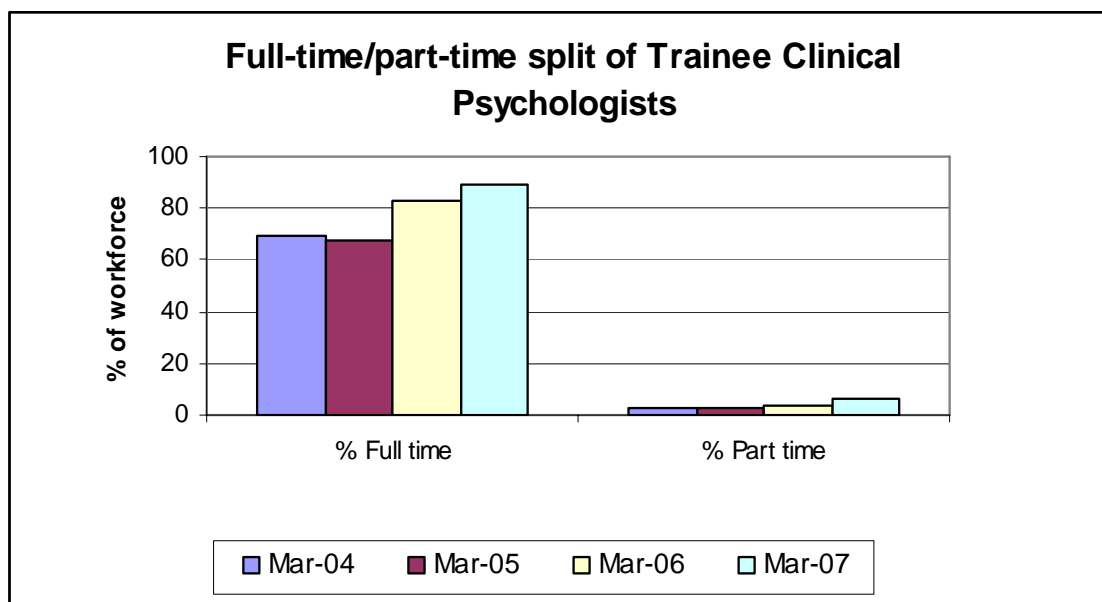
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2.8 Age Profile – March 2003 to March 2007



Currently 70.5% of Assistant/ Trainee Clinical Psychologists are aged under 30.

2.9 Full-time and Part-time Working: Assistant/trainee clinical psychologists



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Currently 93.7 % of Assistant/Trainee Psychologists work full-time.

2.10 Clinical Psychology Workforce Joiners and Leavers 2002-2007

Clinical Psychology Joiners - March 2002/03-2006/07

| | Headcount | WTE |
|---------------|------------------|------------|
| March 2002/03 | 8 | 6.95 |
| March 2003/04 | 6 | 5.45 |
| March 2004/05 | 11 | 10.24 |
| March 2005/06 | 8 | 6 |
| March 2006/07 | 9 | 8.2 |

Clinical Psychology Leavers - March 2002/03-2006/07

| | Headcount | WTE |
|---------------|------------------|------------|
| March 2002/03 | 4 | 2.76 |
| March 2003/04 | 7 | 4.15 |
| March 2004/05 | 7 | 6.71 |
| March 2005/06 | 12 | 10.54 |
| March 2006/07 | 6 | 4.73 |

Assistant/trainee Clinical Psychologist Joiners – March 2002/03-2006/07

| | Headcount | WTE |
|---------------|------------------|------------|
| March 2002/03 | 21 | 21.00 |
| March 2003/04 | 25 | 25.00 |
| March 2004/05 | 24 | 23.49 |
| March 2005/06 | 22 | 22.00 |
| March 2006/07 | 29 | 27.91 |

Assistant/trainee Clinical Psychologist Leavers – March 2002/03-2006/07

| | Headcount | WTE |
|---------------|------------------|------------|
| March 2002/03 | 6 | 6.00 |
| March 2003/04 | 10 | 10.00 |
| March 2004/05 | 13 | 13.00 |
| March 2005/06 | 7 | 7.00 |
| March 2006/07 | 12 | 11.21 |

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The Department of Health Social Services and Public Safety commissions the training of clinical psychologists at Queen's University Belfast. The commissioned numbers are determined through the Department's regional workforce planning. For this to be accurate, it is necessary for the constituent HSC organisations to assess their staffing needs to facilitate the delivery of services. This requires consideration of the impact of new services development on staffing requirements. In addition to the assessment by statutory organisations, the Department seeks to include assessment of the contribution to care provision from the private and voluntary sector, and to include consideration of the impact these sectors have on the availability of newly trained staff for employment in the HSC.

Training requirements and commissions are addressed in Chapter 4 – "Key Themes Identified".

2.11 The GB and N Ireland Context

The pattern to date shows that we very largely draw our supply of clinical psychologists from locally trained graduates, with very small numbers joining from outside the region. This pattern is also reflected in a very low attrition rate following training, with the vast majority remaining to work long-term in N Ireland.

Chapter 3

3.0 Methodology

As with the previous review, the current exercise was taken forward with the assistance of representatives, drawn from the Clinical Psychology profession in Northern Ireland.

An Advisory Group was convened involving HSC Clinical Psychology representatives from the acute, community and private sectors, and other key stakeholders from the Queen's University Belfast (QUB), Trust Human Resources and Staff Side.

The role of the Advisory Group was to:

- Inform the Department of current issues and developments since the last review impacting on the Clinical Psychology workforce.
- Provide advice on, and agree the supply and demand projections set out in the report.
- Endorse the conclusions and recommendations of the review.

Through meetings and discussions the Advisory Group provided an overall quality assurance role, ensuring the information presented in the report would give an accurate representation of the key issues of relevance to the Clinical Psychology workforce.

The methodology included the following research components:

- Focus group discussions with Clinical Psychology Department Heads

The aim of the focus groups was to

- Explore perceptions on gaps within the service provision
 - Provide best practice examples and discuss innovative ways of working
 - Discuss skill mix
 - Consider public sector versus private sector mix over the next three years
- Collection and analysis of data from a range of information sources, mainly HRMS (Human Resource

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Management System), registers of professional staff and QUB.

The Terms of Reference are detailed at Appendix B.

Chapter 4

4.0 Key Themes Identified

A number of key themes were identified after engaging with all targeted groups, individuals and organisations. This Chapter records this information, and thereby sets out a profile of current issues of significance impacting on the Clinical Psychology workforce.

Themes emerging

- **Strategies to increase the psychology workforce**
- **The role and contribution of Clinical Psychology to healthcare services**
- **Career Pathways**
- **Skill-mix and the role of the assistant**
- **“Gaps”/areas of unmet need in service provision**
- **Potential development of psychological therapies**

Each of these key themes is explored in the following sections.

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4.1 Strategies to increase the psychology workforce

4.1.1 Psychological Therapies

In considering appropriate skill mix to address patient needs into the future, the development of psychological therapies offers an important area for further development. There is considerable work ongoing in England and Scotland in relation to incorporating the development and provision of a range of therapies within appropriate pathways of care. While a policy decision has yet to be taken on psychological therapies in N Ireland, it is recognised that these offer considerable scope in provision of care especially for non-severe cases, and would merit serious consideration in developing care pathways for the future.

4.1.2 Supply and Training

Currently to be chartered for Clinical Psychology practice in the UK trainees must complete a three year post-graduate doctoral programme in Clinical Psychology, which has been professionally accredited by the British Psychological Society. Candidates who have completed training in Clinical Psychology outside the UK must undertake a 'statement of equivalence' training pathway. The Queen's University of Belfast (QUB) hosts the regional Doctorate in Clinical Psychology (D.Clin.Psych.) and is the principal training provider, with just over 80% of the practitioners in NI having trained at QUB.

The Department of Health Social Services and Public Safety is the principal funder of the D.Clin. Psych. Training, although the School of Psychology at QUB hosts the programme and contributes 1 whole time equivalent academic staff to the course team. DHSSPS funds trainee salaries, travel expenses and university fees. In addition, monies are allocated to the university to fund course staff and cover the running expenses of the programme.

At present the DHSSPS supports **11 annual training commissions**. Central commissions rose from 6 to 8 in 1998, to 9 in 2001 and to 11 in 2004. The last workforce plan in 2002 recommended a minimum of 12 training commissions per annum, and the demand for clinical psychologists indicates a continuing need to increase

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commissions to at least this level. There are currently 36 trainees on the programme across the 3 years – 33 DHSSPS commissions and 3 additional secondments from Trusts. Requests for additional secondments are common each year.

Requests for additional secondments are common each year but are currently capped due to staff to student ratios, now exceeding recommended levels. The course team have also facilitated clinical psychologists who have trained outside the UK, undertaking a statement of equivalence pathway. In the past ten years QUB staff have supported 8 additional secondments from Trusts in N Ireland and facilitated the statement of equivalence pathway for 6 non-UK trained entrants to the profession in N Ireland. The advisory group have suggested that investing in staffing resources to continue such alternative training pathways could result in significant savings on future central commissions.

Current supply is therefore: At least 11 new clinical psychologists will be entering the workforce each year.

Trainees have now been banded at Agenda for Change Band 6, which increases salaries to £24K per annum. The issue of Agenda for Change banding for tutors remains outstanding. The Department and QUB are seeking to put in place a Service Level Agreement for this training programme.

4.1.3 Service contribution of trainees

Trainee clinical psychologists are employed on career paycales and in line with this, they make a net contribution to clinical services, rising as they move through their training. Under supervision they carry a clinical caseload, provide consultancy services, carry out audits and service evaluations and engage in research partnerships with Trusts. There is scope for consideration of final year trainees to take up newly established “intern” posts on a rotational basis. This would offer opportunity to increase the workforce as well as secure a visible return on the training investment.

By the end of the D.Clin.Psych. programme trainees will have completed over 2800 hours of supervised clinical practice and will have attained a competence in at least two models of psychotherapy as applied with adults, children, people with a learning disability and an individually tailored number of other specialist populations

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– such as addiction, physical health, older adults, neurosciences, looked after children etc. A high level of proficiency in other roles and competencies of Clinical Psychology will also have been attained, for example:

- Clinical and other specialised assessments of psychological problems and processes as they relate to mental and physical health;
- Dissemination and promotion of the appropriate use of psychological approaches in healthcare – eg. through teaching, training, supervision and consultancy with other professions;
- Leading roles in research and development; and
- Organisation and service development work.

Recruitment to the D.Clin.Psych. programme has never been problematic, with currently about 16 applications for every commissioned place.

The focus group reported that more modular approaches to training would be helpful. It was suggested that modules could be used as “bolt-ons” to training to help increase experience and awareness.

The advisory group suggested a number of approaches to increase access to the profession, explored below.

4.1.4 Attrition rate

Completion rates are excellent. From 2000-2006 only 2 out of 64 students failed to successfully complete training. This equates to an attrition rate of 3%.

Employment rates for graduates of the regional D.Clin.Psych programme currently stand at 100%, reflecting an on-going demand for this group of professionals within Health and Social Care.

Retention rates are also very good. From 2000-2006 7% of centrally funded trainees broke their contract to work in NI for at least 2 years post-qualification. By 5 years post qualification the loss of graduates from 2000-2006 rose to 16% however the advisory group report that this has been more than compensated for by the recruitment of clinical psychologists trained elsewhere, these currently make up approximately 20% of the NI workforce in Clinical Psychology.

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Trust Destinations of Clinical Psychology Graduates 2000-2006

| | | | |
|----------------------------|-----|----------------------------|-----|
| Royal Hospitals | 13% | Belfast Trust | 41% |
| Belfast City Hospital | 11% | | |
| SE Belfast | 9% | | |
| NW Belfast | 6% | | |
| Greenpark | 2% | | |
| | | | |
| Down & Lisburn | 15% | South Eastern | 20% |
| Ulster Community | 5% | | |
| | | | |
| Homefirst | 17% | Northern Trust | 17% |
| | | | |
| Craigavon & Banbridge | 8% | Southern Trust | 10% |
| Armagh & Dungannon | 2% | | |
| | | | |
| Foyle | 8% | Western Trust | 10% |
| Sperrin Lakeland | 2% | | |
| | | | |
| <i>Voluntary / Charity</i> | 2% | <i>Voluntary / Charity</i> | 2% |

4.1.5 Potential options for increasing training outputs

Given the areas of unmet need in psychological services provision, and those where further development is required, it is considered that the current annual output of 11 centrally commissioned trainees will not meet workforce requirements in the next five years and beyond. In recognition of this the profession has taken forward work to examine the potential of a number of strategies to increase training outputs, provide greater skill-mix in the psychology workforce and provide alternative pathways into the profession.

4.1.6 Assistant/associate psychologists

The employment of these grades has witnessed a great expansion over the past decade. Additionally, counselling psychologists, behaviour nurse therapists and other therapists are employed within psychology services across the region. Many assistants and associates are

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employed using non-permanent under-spent money – eg from failure to recruit permanent staff, however it is clear that they are increasingly making a key contribution within psychology services. Although they are a pre-qualification grade there is clearly scope to develop established posts at those levels thus providing a greater skill-mix in psychological service delivery. It is recognised, however that provision of these supporting services is variable across the region. To develop the associated roles properly, there will need to be work taken forward to identify specific roles with clearly defined responsibilities, competences and skills and levels of supervision.

4.1.7 Increased secondments from Trusts and “statement of equivalence” pathway

As detailed above, requests for secondments are common each year. The continuation of this mechanism would enhance the supply to the workforce. It is not known however, how the rationalisation of Trusts under RPA might affect demand in this respect. Given the success of the “statement of equivalence” pathway, it would be beneficial to continue to provide this training support for those who have trained outside the UK. Both of these approaches require additional investment in staff at the university and work is ongoing to take this forward.

4.1.8 Flexible training pathways

Currently assistants and associates who have not yet begun the doctorate training programme, are attaining experience they would be required to cover on the programme, yet they do not receive accreditation for the experience gained. It is reported that there has been mixed response from psychology service managers to releasing such staff to undertake some of the academic modules of the D.Clin.Psych. programme, whilst registering and having their current clinical work assessed as contributing to the placement modules of training. If this could be managed, such a group could be completing at least one full year of the D.Clin.Psych. programme whilst employed as an associate/assistant psychologist, thus reducing later financial resources required to complete clinical training. The programme has been modularised to provide capacity to act on this in the future, but further work would need to be done on addressing logistical considerations and necessary arrangements with employing organisations. Given the

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potential time and cost saving to the training programme, this would merit further consideration.

4.1.9 Creation of a new qualification for a new grade of associate psychologist

This is currently being piloted in two regions in the UK. To take forward, it would require considerable investment in new training resources, creating a new training programme of two years duration. There is concern that people attaining this qualification would have enhanced likelihood of successfully gaining a place on the Doctorate programme, thus putting in doubt the stability of posts at this grade.

In NI, trainers and psychologists are exploring a new 1-year work/training programme leading to diploma/certificate. Whilst this could be accredited as prior learning for the doctorate its primary aim would be to increase access to psychological therapies within a stepped care model.

4.1.10 Creation of a final “intern” year in training

It has been proposed that the workforce could be expanded by at least 11 at one time if all final year trainees completed their final two placements as a one-year internship within a Trust. Under such arrangements, the internships could be filled on a rotational basis and could become established posts within Trusts. The logistics and financial implications of this would need to be explored, however it would bring with it advantages for Trusts in having a skilled trainee as a resource for a year, for the trainee in having the opportunity to consolidate experience in specialisms such as family therapy, psychodynamic therapy etc. and for DHSSPS in establishing a partnership in sharing the financial support for trainees in a year of their training. It is proposed that this option would merit further exploration.

4.1.11 Recruitment from outside N Ireland

Although historically expensive and limited in their success, it is proposed that it would be worthwhile considering recruitment drives outside N Ireland. The trend over the past ten years has shown an increase in the number of people from outside N Ireland seeking employment here hence cost-benefits are likely to show more favourable returns in the future.

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4.2 The role and contribution of Clinical Psychology to healthcare services in Northern Ireland

This was identified as being of key significance for the Clinical professional group. The focus groups and advisory groups both commented that there is a gap in understanding that Clinical Psychology is part of all programmes of care. They highlighted the fact that at present strategic direction from the Department is limited and an improvement in that respect would be necessary to develop psychological services appropriately across the spectrum of care pathways.

NICE guidelines developed for the management of physical illness now regularly refer to the psychological aspects of the illness and the requirement to refer to appropriately trained psychological therapists (*eg Nice Guidelines in Cancer, Diabetes, Obesity, Fertility, Pregnancy, Chronic Fatigue Syndrome, etc*). Similarly, national reviews such as the recent Review of Renal Services 2002, and the National Burn Care Review 2006, highlight the need for psychological interventions throughout the illness journey.

In Northern Ireland, recent service developments within some medical specialties have acknowledged the role of clinical psychologists as part of the multidisciplinary team, and the importance of attending to the psychological components of the disease process. At the last workforce plan review one third of all clinical psychologists were employed outside of traditional mental health and learning disability services, working in Adult and Child Health services, including neuropsychology.

Examples of Clinical Psychology service provision to specific healthcare specialisms in Northern Ireland are included in the table below;

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Table 1

| | |
|----------------------------------|---------------------|
| Adult neurology and neurosurgery | Metabolic services |
| Regional Intensive Care | Cardiology Services |
| Adult cancer services | ENT |
| Maternity Services | HIV/Sexual health |
| services | |
| Fertility Services | Paediatrics |
| Trauma and orthopaedics | Acquired Brain |
| Injury Rehab | |
| Chronic Pain Services | Dermatology |

(NB; service provision ranges from 0.05wte (HIV/Sexual health) to 3.0wte (Adult Cancer)

Within these area services are provided within the skills framework at the three levels of activities outlined previously. This will involve

- (a) working directly with individual patients and/or their families, enabling them to cope with and manage their illness, conducting risk assessments and treating psychological disturbances such as depression and anxiety.
- (b) promoting the psychological mindedness of the workforce by offering regular training and consultation services, eg on managing challenging behaviour on the ward, bereavement training etc, identifying depression etc.
- (c) supporting and supervising healthcare staff, either within the multidisciplinary team, or through occupational health psychology services.
- (d) leading uni- and multidisciplinary research programmes, and participating in Research Governance Committees and
- (e) working at strategic levels within Trusts eg in disaster planning and the management of emergencies and critical incidents, developing and delivering Trust Stress Management Strategies (as recommended by the Health and Safety Executive).

While clinical therapeutic service provision remains patchy, there are good examples of how Clinical Psychology services have flourished. One such example is in the area of adult cancer services. The 2003 NICE Guidelines on Supportive Cancer Care

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note that psychotherapeutic interventions meet various needs of people with cancer. There is “strong evidence” that such interventions produce significant improvements in psycho-social functioning and quality of life and some evidence on increased life expectancy. Psychological support services are also necessary for oncology staff in the prevention of burn out. The NICE guidelines express the need for more psychologists to provide level 3 and 4 care for cancer patients and carers. Already there is a special interest group for cancer in the province and a number of full-time posts have been established in cancer care in all of the Boards.

Unfortunately this development has not spread to paediatric oncology services, where currently there are no NHS funded services to children suffering from cancer. Similarly, there are major inequities of access to Clinical Psychology in, for example, services to older adults, people who have suffered stroke (children and adults) etc.

Another example of excellence demonstrates the researcher/scientist role of Clinical Psychology. A joint research initiative between the Clinical Psychology department at the Royal Hospitals, Belfast, the Paediatric Cardiology service and the Children’s heart Trust received Lottery funding of £350k to conduct a randomised clinical trial into early psychological interventions for children (infants and school-aged) with congenital heart disease. The CHIP project developed psychological interventions involving;

- (a) Parent training in problem prevention strategies;
- (b) Psychoeducation
- (c) Interventions promoting attachment and early infant development
- (d) Strategies to promote independence in a school-aged group, and
- (e) interventions to enhance family adjustment.

The results of the trial, which are currently being published (Archives of Childhood diseases in press), included improved family adjustment, reduced sickness behaviours in CHD children (ie fewer days of hospitalization, less GP visits etc), and improved neurodevelopmental outcomes in infants. This example illustrates how Clinical Psychology can add to the evidence base, not only in the area of paediatric cardiology but also to early interventions with children suffering from other chronic illnesses.

At present, the majority of psychological service provision to healthcare is provided within the acute healthcare services. It is imperative that workforce planning takes into account the

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need to expand such services at primary and community care level.

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4.3 Career Pathways

The Focus Groups were asked for their views on the current and potential future career prospects within Clinical Psychology in N Ireland.

It was reported that to date there had been limited development of a career structure for Clinical Psychology and that there is a need to look at competencies for career progression. The groups also offered the view that specialties should be consultant-led, “consultants” having 6 years experience, 3 of which must be in their chosen specialty.

The groups considered that a need exists to examine career development at both the junior and senior levels. At the junior level, assistants/trainees are reported to be well-employed at present, with extensive opportunities to gain practical experience. The scope to fully develop service at this level is however limited by the temporary basis of current funding arrangements. It was proposed that there is scope to develop and establish a staff grade psychologist.

The example of developments in Scotland was cited, whereby the assistant/trainee psychologist role has been developed as self-help support workers. This is the bottom tier of the profession, concentrating on primary care work such as triage and low level care. This was cited as worth exploring however it was also emphasised that the method of delivery would need to be safe and supervised with clear competencies at an appropriate level.

4.3.1 Senior grades

The development of senior grades was cited by the focus groups as one of the challenges facing the profession in the next 5 years. The view was given that there is not good focus on career issues at senior level, and formalisation of CPD arrangements and enhanced roles in line with the recommendations of the Bamford Review should be addressed.

The scope to develop the consultant grade was also highlighted. Increasingly this is a leadership grade and, although clinical psychologists are eligible for consultant grade 6 years after graduation, their career in those 6 years normally gives little scope to develop the skills of leadership. It was proposed that managerial and leadership skills should be better developed during the

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years before consultant grade is reached. The Principal grade was also cited as offering scope for further development. The skills of managing a multi-disciplinary team were particularly highlighted as a development need for senior staff.

The need to develop flexibility and transferable skills within the workforce was raised with the suggestion that a training package should be built into posts to support the modular approach.

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4.4 Skill-mix and the role of the assistant

Traditionally psychology services have employed psychology graduates to undertake circumscribed pieces of work. Such people have usually been employed in a context of budget surpluses arising from vacant qualified psychology posts, in-year slippage or one-off projects. Invariably the funding for such posts has been non-recurring. In addition these posts have been seen as being short-term and largely a pathway to obtaining places on clinical training courses.

In reality there is a wide range of experience gained by people holding these posts. What has been reported however, due to variations in support resources (e.g. supervision), service contexts (e.g. longterm versus ad hoc monies to employ assistants) and person specifications (e.g. training undertaken/experiences attained by assistants) is that there is a lack of consistency across the region in the range of work assistants/associates are allocated. Whilst always requiring closer supervision than post-qualification grades, assistant/associate roles vary from quite restricted collection of audit data through to undertaking circumscribed clinical assessments and interventions and carrying distinct caseloads.

Whilst there has generally been an issue of the stability of this workforce (i.e. most attain places on doctoral training programmes) there are instances where associate grades have remained in post beyond three years and where investment in CPD has occurred, the service return from them has been exceptional.

The current changes to health service delivery, and the current drivers such as economics and the drive to increase accessibility to services, dictates the need to be flexible and creative in exploring all possible options as to how psychological services can be delivered. Currently a very small percentage of all psychology graduates each year progress to ever being involved in the delivery of psychological services, hence there is significant scope to optimise the skill and knowledge of these graduates.

Whilst clinical psychologists often work in specialised and complex services across bands 7-8, it is likely that expansion of primary care, and primary care facing services, will require consequent expansion of practitioners at bands 6-7, and within this context new pre-doctoral grades (assistants/associates) could be galvanised with more formal training and evidenced competencies.

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This pattern points to a need to look at ways of employing assistants and associates in posts as Psychological Therapists, ensuring they are properly trained and supported to undertake designated tasks with specific client populations, and providing them with accredited training that would allow them to build up a portfolio for which they would get credit should they proceed to a full professional qualification, such as Clinical Psychology. Such a development could well fit in with the flexible training pathways explored above, and is additional to the establishment of permanent funding for career grade psychologists also referred to above.

4.5 Perceived 'gaps'/areas of unmet need

The focus groups reported that this was a key area for the Clinical Psychology profession. The two main areas where gaps were identified were;

- Care of the elderly
- Forensic and addictions

Other gaps highlighted were;

- HIV and sexually transmitted diseases
- Neuropsychology
- Acquired Brain Injuries (where there is no provision for children)
- Chronic Disease Management
- Autistic spectrum disorder

Adult mental health was seen as an area where it was difficult to attract people into the profession. It was also stated that learning disability has under half the recommended staffing levels. The area of physical and sensory disability was flagged up as an unknown need especially in the community.

It was also stated that the overarching framework of Clinical Psychology needs to extend beyond mental health and learning disability as NICE and other guidance emphasises the need for psychological interventions in many healthcare specialisms.

The current profile of clinical psychologists by specialism is given below:

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| Specialism | % |
|--|-----------|
| Adult Mental Health/Severe Mental Health | 25 |
| Physical Health/Neuro | 30 |
| Child Mental Health (inc: looked after Children) | 20 |
| Learning Disability | 16 |
| Various (inc. voluntary sector) | 9 |

4.5.1 Psychology in Primary Care

In 2004 the DHSSPS published a strategic framework for the development of primary health and social care over the next 20 years. The strategy envisaged maximising care and treatment in the community convenient to where people live and saw primary care providing the great majority of services. A need was highlighted for interdisciplinary team working, accessibility, responsiveness and integration of services.

One of the key objectives for the first 5 years was to develop strategies for effective community based and person-centred services for people with learning disabilities and mental illness. Given the central role of psychologists in the design and delivery of effective interventions within mental health, the profession will need to be centrally involved in plans for the development of primary care services and work will be required to determine how mental health services can be arranged within the framework of core, additional, enhanced and extended services in primary care.

It would appear at present that there is little systematic, accessible and comprehensive provision of psychological intervention within the primary care sector in N Ireland. It will be necessary for multi-disciplinary work to be taken forward to allow for the systematic application of a stepped care model of mental health delivery in primary care.

It will be necessary to develop psychological services in line with this strategic direction, and in light of the implementation of the recommendations of the Bamford report.

4.6 Potential Development of Psychological Therapies

In considering the appropriate skill-mix to address patient needs into the future, the application of psychological therapies offers an important area for further development.

4.6.1 Background

The term “psychological therapies” covers a wide range of different models, including:

- Psychodynamic;
- Cognitive behavioural; and
- Systemic approaches.

It is recognised that no one therapy is able to provide effective treatment for the full range of mental health problems experienced across the population. These therapies do however offer a range of options for treating different conditions with differing degrees of complexity. At present it is recognised that the provision of psychological therapies is patchy and there is a lack of consistency in access and provision.

Whilst the NICE evidence base for psychological therapies is at a much earlier stage of development and validation than that of psychopharmacological treatments, guidance for many mental and physical health disorders reaches consensus views about the importance of and need to incorporate, access to psychological assessment and intervention.

Moreover, for some disorders (e.g. anxiety and depression) the evidence base for psychological therapies (e.g. CBT, interpersonal psychotherapy) and their adjuncts (e.g. computerised CBT) is further advanced as both clinically effective and cost-effective and these should be noted in planning future service provision of psychological services.

4.6.2 Lord Layard Report

This report set out the economic case for investing in psychological therapies, arguing that providing quick access to such therapies could get a large number of people suffering from depression back to work. Lord Layard’s recommendation was to train additional therapists at two levels – as clinical psychologists who

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would have three years postgraduate training linked to practical NHS work, and the other half to be psychological therapists – developed through giving additional training to existing nurses, social workers, counsellors and occupational therapists working in mental health services. While this report addressed the situation in England, there are important messages for the way ahead which could equally well apply in N. Ireland.

4.6.3 Improving Access to Psychological Therapies (IAPT) – National Initiative

The Department of Health, England has established the IAPT programme, which aims to:

- Improve access and support to maintain people in work and to help them to return to work;
- Develop clinical protocols to ensure clinically effective treatments are available to people in primary and community locations;
- Develop service models for delivering integrated, stepped-care for people requiring access to psychological therapies across the spectrum of services;
- Reduce waiting lists for accessing psychological therapies;
- Develop a workforce plan for rolling-out the increases in capacity tested by the pilot sites that is sustainable, realistic and affordable.

It is also intended that the programme would assess the wider economic impact to society for providing increased access to psychological therapy services, and assemble a case for additional investment in the expansion of psychological therapies services through the roll-out of the demonstration site models.

The IAPT programme comprised of two national demonstration sites, in Newham and Doncaster, to increase access to therapy. Whilst formal evaluations have yet to be published, preliminary evidence from the two pilot sites has demonstrated increased access to

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psychological therapy and, as long as quality is evidenced, this should have positive implications for recovery and return to independent living. In May 2007 the Department of health England announced an extension of the scheme to 10 new pilots, and sought expressions of interest from Primary Care Trusts.

4.6.4 Northern Ireland Position

The Bamford Review acknowledged that psychological therapies are an important tool and should be routinely considered as an option when treating mental health problems. It is recognised that there is a need to develop a strategy to improve access to psychological therapies here. In recognition of this, the Department has commissioned a mapping of existing training in and provision of psychological therapies. As a number of voluntary and community sector groups provide “counselling”, it is recognised that accurate information on these sectors will form an essential part of the overall picture.

Plans are being developed to take forward a strategy to develop psychological therapies. It is intended that the mapping work already carried out should be used as the basis for development of the strategy. It is also proposed that the experience in the IAPT programme would be examined as part of that work.

It is proposed that the strategy would have to take into account the need for at least 3 strands of training and subsequent practice:

- General awareness of psychological therapies and their effectiveness in meeting particular needs – for front line mental health staff who could apply to some extent to their caseload but who could also recognise when they needed to refer onwards;
- Ability to deliver specific psychological therapies to more complex cases; and
- Specialist level to provide supervision and deal with the most complex cases.

From the current arrangements it is noted that a range of professionals have been trained in some of these therapies, particularly Cognitive Behavioural Therapy, but there is a lack of clarity as to whether these professionals

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are subsequently qualified to provide therapy or are qualified to a level of being able to identify when a psychology professional should be called in.

The development of clear demarcation between the different levels of therapy provision should be developed and practitioners trained to those differing levels. From a patient safety perspective it will be imperative that the same standards are applied across the region. It will likewise be necessary to ensure that care pathways are developed to mirror these levels. This type of development would free the Clinical Psychologist from cases of lesser severity which could then be addressed by appropriately trained supporting therapists, leaving them to address the needs of the more complex cases. Additionally this should shorten waiting times for treatment and avoid the risk of deterioration in health status leading to more complexity in required treatment at a later stage.

4.6.5 Current Initiatives

The Department has also provided funding for 2 local initiatives aimed at improving access to psychotherapies. The N Ireland Centre for Trauma and Transformation (NICTT) has been funded for the past 2 years to carry out a range of tasks, a key component of which was to provide training in CBT to 80 people across NI in the 2 years. It was estimated that these 80 people would then be able to deliver CBT to 2,000 clients per year. This training programme is currently under way.

Part funding has also been provided to support a pilot project set up initially by Homefirst Trust to develop computerised CBT (cCBT) at a number of primary care sites across the Northern Board and make it available to 120 new clients per year. The therapies are used in the primary care context under the supervision of a GP. This project is still running and has yet to be evaluated.

The Department also funds the Family Trauma Centre as a regional service as well as a number of voluntary organisations who provide “counselling” services.

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4.6.7 The Way Ahead

Service re-design will be key to the successful application of psychological therapies as part of the range of care provided.

It will be necessary to consider the establishment of new roles, such as formally trained psychology assistants to enhance the contribution that psychologists can make to enhancing capacity and access. To ensure safe practice it will be necessary to have clarity around organisational structures, supervisory arrangements and appropriate regulation.

To ensure optimum benefit from these developments, it will be essential that any new role is sustainable and integrates with existing and new career structures for both psychologists and other work roles within psychological therapy services. Following on from the earlier section on flexible training approaches, the new roles should also be designed to allow for transferable recognition of training and experience for those wishing to go on to enter training at Doctoral level.

It is recognised that a major piece of work is required to take this forward.

It is recommended that this should be taken forward as a high priority, and should be co-ordinated at regional level by the Department.

Chapter 5

5.0 Supply and Demand Projections

This short section addresses the projected supply of clinical psychologists to the HSC over the next 5 years. It includes consideration of the potential increase in demand based on the information currently available.

Issues impacting on supply and demand:

- Development of psychological services as part of the care pathway in managing physical illnesses
- Developing greater skill-mix within psychology
- Development of psychological therapies applications and involvement of the multi-professional team
- Geographical aspects of recruitment and retention

✚ **Psychological services in the treatment of physical illness**

As addressed previously in this report (Chapter 4 Section (ii)), the majority of psychological service provision to healthcare is provided within the acute healthcare sector. NICE guidelines developed for the management of physical illness now regularly refer to the psychological aspects of the illness and national reviews such as the Review of Renal Services in 2002 highlight the need for psychological interventions throughout the illness journey.

In light of the need to develop more fully the inclusion of psychological services as part of the care pathway in a range of physical illnesses, it is recognised that the demand for practitioners will increase. It is consequently recommended that the intake to the Doctorate training course is increased as recommended in the last workforce review. While the current report recommends considerable changes to the profile of the workforce delivering psychological services, even in light of increased assistants and other practitioners, there will be an increased need for professionally qualified supervisors to oversee the work of more junior practitioners.

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✚ Developing greater skill-mix in psychological service provision

Earlier in this report a number of developments in relation to the role and service delivery capacity of assistants/ associates, and additionally psychological therapies delivered by a range of professionals, have been cited as important areas for development. In light of these, this review recognises the need for the psychology workforce profile to change to reflect a more varied structure with people working at specific levels of expertise, providing specific aspects of care.

This review highlights the need for an increase in the number of people providing psychological services, at a range of levels.

Additionally, the review sets out the need for the development of new roles within psychology to be consistent across the region.

In light of the major changes in the profile of this workforce, it is not possible to identify the indicative number of people required. It is recommended however, that work on this area should be taken forward urgently and the workforce demand for the new differing levels of practitioner identified in line with service delivery plans across all trusts.

✚ Supervision and corporate support

A crucial factor in the implementation of new ways of delivering service is the availability of professionally qualified practitioners to ensure patient safety and the continued application of high standards of care provision. This demand will need to be built into workforce projections.

Additionally, it was reported by contributors to this review, that clinical psychologists are involved in providing training and advice to colleagues and individuals from other specialisms. This is significant in bringing a psychological approach to the health service, however to date this role has not been cited nor quantified in the activity of the profession as no patient contact is involved. It will however be necessary to include these areas of activity in workforce projections as they are vital in overall service provision.

As noted earlier in this report, there is a very low attrition rate from training of Clinical Psychologists, thus ensuring a reliable supply from training courses provided. There has been minimal variation in this pattern over many years, hence this is taken as a continuing supply element.

Chapter 6

6.0 Conclusions and Recommendations

A number of recommendations are presented here, based on the overall findings of this review. This incorporates the views of all those who contributed and the statistical research carried out.

Current commissioned numbers in training

In light of the current provision of Clinical Psychology services, and the requirements of modern service provision and development, it is concluded that there is a need to increase the annual intake to the QUB Doctorate course, as recommended in the previous workforce review. The Department has just secured funding to increase the places on the taught doctorate programme to 13. It is noted however, that there are important implications for the staff/student ratio at QUB resulting from increased commissioned numbers. Further work is therefore indicated to explore the staffing requirements in relation to this.

Recommendation 1:

Explore with QUB the feasibility and possible timing of the increase by two additional places on the Clinical Psychology taught Doctorate programme.

Skill-mix issues

While psychological services have traditionally been provided in the main by those trained to Doctorate level, there is clear scope to develop practitioners at more junior level, and to establish a wider range within the skill-mix team appropriate for this service provision. To that end it is recommended that further work is taken forward to assess the appropriate contribution to be made by existing assistant psychologists, in addition to further consideration of the potential employment of students in providing service as part of their training.

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Recommendation 2:

Work should be taken forward to identify appropriate levels of service provision/responsibility for those working at assistant level, and for students as an integral part of their training. It is recommended that this should be co-ordinated centrally by the Department, with consistency achieved across the region.

Associated with the above, it is further recommended that work should be taken forward to develop an associate practitioner programme.

✚ Career Development

While this review notes the positive message that there are no issues of concern in relation to overall recruitment to and retention within the profession, it also notes the need to develop a more tiered provision of service. It will be important to address career matters for those who do not wish to progress to Chartered level. It is also noted that currently there is limited focus on career development at the senior level and for those wishing to attain consultant level. The development of leadership/management skills, and skills in service evaluation and research have been flagged up as necessary elements within the career progression pathway in psychology.

In tandem with the development of the skill-mix team, it will be important to develop a career pathway for those people who enter the workforce at various levels, to help retain a motivated and appropriately skilled workforce into the future.

Recommendation 3:

That career development pathways giving a range of service provision opportunities, should be developed for those entering the profession at various levels, from assistant to the most senior levels.

✚ Provision of therapies by other professions

It is noted that psychologists are engaged in providing training, advice and supervisory expertise to colleagues from other professional backgrounds in multi-professional teams, alongside providing a direct service to patients with complex needs. This is a positive trend, enabling provision of service at a range of levels, enabling the psychologist to focus on complex issues, with the other practitioners working to their appropriate and supported level of competence. The implication of this supervisory work must be

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factored in to consideration of workforce needs to enable services to be delivered in this way.

Recommendation 4:

That the full range of activities is identified in developing Job Descriptions particularly taking into account both provision of support and advice at corporate level and provision of supervision of other staff, together with direct patient care.

✚ Expansion of service at community and primary care level

It is noted in this report that at present the majority of psychological service provision to healthcare is within the acute healthcare services. In line with service modernisation, it will be essential to expand such services at primary and community care level. Service reconfiguration will be key in achieving these developments.

Recommendation 5:

That a group is set up to research the scope for service reconfiguration for the expansion of psychological services to primary and community care and to produce recommendations for taking this forward.

✚ The Bamford Review of Mental Health and Learning Disability

The Minister has confirmed his commitment to implementation of the recommendations of the Bamford review, and work is now underway on the implementation programme. It is now necessary to clarify the implications of these recommendations for the provision of psychological services, both in terms of indicative staffing numbers required and modes of service delivery. The exploration earlier in this report of the potential to develop a greater skill-mix in provision of psychological services and psychological therapies is of particular relevance to the new ways of providing care as set out in the Bamford review.

Recommendation 6:

That Trusts ensure clinical psychology input to organisational planning for mental health and learning disability services, particularly in line with the Bamford recommendations. Additionally, the Department has recently commenced a review to identify the workforce implications flowing from the Bamford review. It is recommended that clinical psychology inputs to that exercise at an early stage to help inform planning of early, middle and longer-term developments and initiatives for service delivery.

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✚ Areas of unmet need/underprovision of service

Further development of the skill-mix team would help address matters such as waiting times for access to services, together with issues of under-provision of services to older adults, and services to adults and children who have suffered strokes.

Recommendation 7:

That the scope to use a greater skill-mix in delivery of services is identified as part of the planning for areas of unmet need.

✚ Strategic direction for Clinical Psychology

Contributors to this review highlighted a current lack of strategic leadership for clinical psychology. It was noted that the Special Advisory Committees (SACs) have a role to play in this regard.

Recommendation 8:

That the role of the SACs should be revisited and clarity established as to how the Department and HSC should work together to ensure the necessary strategic direction is achieved.

✚ Psychological services and care pathways for physical illness

The NICE guidelines developed for the management of physical illness now regularly refer to the psychological aspects of illness and the requirement to refer to appropriate psychological services. The extent to which these services have in practice been factored into care pathways other than Mental Health and Learning Disability have however been limited. There are some good examples where psychological services are being applied to enhance care pathways. This is however patchy and it would be beneficial to share information on these across the region to help further this approach.

This report recognises the challenge in establishing where and how psychological intervention should be factored into care pathways. It makes the recommendation that, to enable clinical psychology services to better meet the needs of the population of N Ireland:

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Recommendation 9:

- **Psychologists should have input to service development/delivery and strategic planning to identify where and how psychological intervention will bring benefit to the patient;**
- **Trusts should as part of their service delivery plans, explicitly identify how the psychological needs of their patients/clients are to be met and the workforce implications of that provision; and**
- **Areas of current underprovision or unmet need should be identified and consideration given as to how within the Trust area or on a regional basis required services might be provided.**

✚ Further development of Psychological Therapies

This offers an important area for further development to address patient needs into the future.

Recommendation 10:

- **It is recommended that development of psychological therapies is taken forward as a high priority and should be co-ordinated at regional level by the Department.**

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Appendix A: Focus Group Questions

Clinical Psychology Department Heads Focus Groups

| |
|--|
| 1. What are the current recruitment/ retention issues in the service? |
| 2. Can you identify why any difficulties identified above are happening? |
| 3. Where are there gaps in the service? (Where are the current unmet needs in service provision and at what grade?) |
| 4. What would you see as the priority areas for the development of Clinical Psychology services in the future? |
| 5. From the above, can you anticipate/identify trends where there will be future difficulties in recruiting/retaining staff? |
| 6. Can you give an indication about quality and quantity of applicants for the various grades of staff? |
| 7. What are the issues facing staff who wish to progress their career in the service? Are there "blockages" at any particular levels or in particular specialty areas? What are these? |
| 8. In general, do you think staff have good levels of job satisfaction? |
| 9. Do you think that the terms and conditions of employment in the health service are sufficient to attract and retain staff? |
| 10. In your opinion, what are the main reasons for staff leaving posts/leaving the HPSS? |
| 11. Do you employ assistant/trainee clinical psychologists? If yes, what opportunities are available for their development? |
| 12. What in general is the role of the trainee/clinical psychologist at present? |
| 13. How do you see the role of the assistant/trainee clinical psychologist developing in the next 5 years? |
| 14. Do you use bank or temporary staff to fill posts? If yes, what level/type of posts? |
| 15. What are the initiatives/challenges facing the profession in the next 5 years that may change/extend the role of the clinical psychologist? |

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14. In your view, do you think there should be greater development of the Consultant Grade post in Clinical Psychology. If so, what do you think would help or hinder this development

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Appendix B: Terms of reference

The Terms of Reference for the review were as follows:

To review the predictions and assumptions made in the previous review.

To provide an analysis of the current clinical psychology workforce in N Ireland, including:

- Size, composition, sectoral distribution, age and gender
- Working conditions and patterns (including in relation to gender), and whole time equivalent data
- Continuing professional development commitments
- Specialist service commitments
- Setting within which people are working (eg hospital, community, private)
- Vacancy rates at the time of the review.

To provide an analysis of current and future recruitment and retention issues, including:

- Opportunities at entry level
- Career development and specialisation
- Qualifications held
- Career breaks/leaving employment
- Returnees
- Working arrangements
- Increased competition from other sectors in recruiting and retaining staff.

To provide a prediction of future demand, including:

- Number of clinical psychology staff required to meet service demands

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- An assessment of the number of clinical psychology training places that should be commissioned to meet demand
- Sectoral distribution including specialisation
- Services demanding the skills of these staff and the context within which these services are delivered
- Skill-mix options.

To provide recommendations whereby services could be commissioned and delivered optimally:

- In the statutory sector
- Through multidisciplinary working.

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Appendix C – Advisory Group Members

| Name | Title | Organisation |
|------------------------------|---|--|
| Joyce Cairns | Deputy Director Of Human Resources | DHSSPS |
| Elizabeth Brownlees | Asst. Director of Human Resources | Homefirst Community HSS Trust |
| Gerry Cunningham | Head of Psychology Services | Foyle HSS Trust |
| Robin Davidson | Service Manager | Belfast City Hospital HSS Trust |
| Bridie McElhill | Clinical Psychology Services Manager – North & West Belfast HSS Trust | Representing Amicus/NSF |
| Chris McCusker | Asst. Director Doctorate in Clinical Psychology | Queens University of Belfast |
| Ian McMaster | | Chief Medical Officer Representative, DHSSPS |
| Nichola Rooney | Consultant Clinical Psychologist | Royal Belfast Hospital for Sick Children |
| Brian McCrum | Chair NIDCP | Homefirst Community HSS Trust |
| Melanie McClurg | Workforce Planning Unit | DHSSPS |
| Arlene Connolly/Bobby Murphy | PSAB | DHSSPS |
| Ian Blair | Head of school of Health Sciences | University of Ulster |
| Bridie Pilkington | | |