This report and the subsidiary
reports can be downloaded from
the NHS Education for Scotland
web site: http://www.nes.scot.nhs.uk/publications/clinicalpsychologywfp.pdf

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Clinical Psychology Workforce Planning Report

Designed and produced by Creative Link, North Berwick

Foreword

This report of a review of workforce planning for Clinical Psychology in Scotland carried out by a widely representative group was chaired by Mr John Cameron, Clinical Director of the Psychology Directorate of Greater Glasgow Primary Care NHS Trust. I am grateful to him and to his colleagues for the way in which they have carried out the review. NHS Education for Scotland (NES) has a direct interest in workforce planning in Clinical Psychology because of its responsibility for commissioning the training places in the discipline to meet the needs of the people of Scotland.

The process of the review has been effective in raising awareness of the urgent need to increase the number of psychologists working in NHSScotland. The report provides the evidence for a doubling in training numbers in Scotland. NES is committed to achieving this target.

It will be important to build on the evidence contained in this report by monitoring the utilisation of psychologists within rapidly developing and changing provision of psychological services. NES looks forward to contributing to work in partnership with the emerging national and regional workforce development centres.

Graham Buckley
Chief Executive

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- **This report is intended to provide an overview** of the key factors relevant to workforce planning for Clinical Psychologists, in the context of their role in multi-disciplinary teamwork in services across NHSScotland.
- **Executive summaries of subsidiary reports are appended** to inform workforce planning for psychological services for primary care, for people with learning disabilities and in cancer care.
- **Clinical Psychology is concerned with assessment and formulation of psychological problems and intervention to relieve those problems.** There is a strong evidence base for the contribution Clinical Psychology can make to the benefit of patients' physical and mental health and wellbeing over the life-span and across a wide range of NHS settings.
- **In spite of the broad applicability of psychology to healthcare,** the provision of qualified Clinical Psychologists per head of population in Scotland (one whole time equivalent (WTE) per 14,220) is significantly lower than for any other professional group in the NHS and insufficient to meet service requirements.
- **In Scotland there are two university-based doctoral training courses** for Clinical Psychologists with a combined output of 32 trained psychologists per year. Trainees are NHS employees who spend >50% of their time in supervised clinical practice.
- **In England, recognition of the need for a significant expansion** of the psychology workforce in the NHS has resulted in a steady increase in training capacity of at least 10% per year over the past six years. The Department of Health (DoH) is committed to further significant increases in training numbers by 2004.
- **Psychological interventions can be delivered by a variety of health professionals.** The role of the Clinical Psychologist therefore includes developing and evaluating interventions for delivery by others; consultancy and supervision to colleagues providing these interventions as well as delivering a direct service to patients with more complex psychological problems.

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- **The importance of psychological factors in healthcare is increasingly recognised** in contemporary health policy documents. This is welcomed but there are concerns both about enabling Clinical Psychologists to play a more active role in developing the shared agenda and about training sufficient numbers of psychologists to deliver it.
- **Clinical Psychologists represent 0.35% of the workforce in NHSScotland.** In 2000, NHS payroll data indicated that there were 360.2 WTE trained Clinical Psychologists. An earlier survey undertaken for the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) showed that in 1998 the majority were employed in services for mental health (43%); learning disabilities (21%) and children, young people and their families (15%). The remainder were distributed over services for forensic/sex offenders; neuro-psychology/neuro-rehabilitation; older adults; physical health medicine; alcohol and substance abuse.
- **Data collected for payroll purposes are inadequate for workforce planning.** The Workforce Planning (WFP) Group, with financial support from SCPMDE (now NHS Education for Scotland) is collaborating with the Information and Statistics Division (ISD) in two projects to map the current and future skill mix of staff employed in psychology services. A census of the workforce in September 2001 will provide a baseline against which to monitor change. A demand survey, linking future staffing requirements to planned service developments, is underway in Trusts across Scotland.
- **The subsidiary reports highlight the consequences of understaffing:** long waiting times (particularly in primary care); gross inequity of access to services (learning disabilities); absence of service provision in spite of evidence of patient need and potential benefit (cancer). Even if psychologists' skills are reserved for higher level tasks these services require a significant increase in the establishment which current training numbers are inadequate to meet.
- **Clinical Psychology faces the same challenges as other professions in meeting the service needs** of an ageing population and in serving remote and rural communities. There is a particular challenge for such a small profession of visibility to planners, both at national and local levels, to enable Clinical Psychologists to contribute their knowledge and skills effectively to strategic planning and service development.
- **The WFP Group considered the contribution to NHS psychology services made by psychologists with different levels and types of training.** Graduate psychologists enter the NHS as Assistant Psychologists. Their role, training and deployment is in urgent need of review. There is also a need to establish a career path, benchmarked against Clinical Psychology, to support the employment of psychologists with non-clinical postgraduate training (e.g. counselling, health, forensic, neuropsychologists).
- **Ideally, the number of trained Clinical Psychologists required would be derived from an assessment of patient needs** in the area to be served. In the absence of these data across Scotland, an estimate of the workforce required for any given specialty can be linked to population norms using published reference data from professional sources. On this basis a conservative estimate suggests that NHSScotland should have one Clinical Psychologist per 5,000 of population, i.e. a minimum establishment of 1,025 posts across all specialties, to provide equitable access to basic psychological services.
- **This first working estimate is intended to indicate at national level the order of magnitude of the change required.** Needs-based approaches to developing the workforce to meet local requirements should be encouraged.
- **Reliable and up to date workforce intelligence is essential to the planning process.** The report recommends that the census of the workforce providing psychology services in NHSScotland be developed and annually updated. The demand forecast survey should also be refined and conducted every two years.
- **National standards and resources are required to ensure that continuing professional development (CPD) is integral** to the duties of the workforce delivering psychology services.
- **Typically, retention of trained Clinical Psychologists within NHSScotland has been good.** However, >25% of these staff will be eligible for retirement in the next ten years. Action is needed to retain the skills and experience of staff aged > 55 years during the period of expansion i.e. over the next five to ten years.
- **One third of the present workforce works part-time.** Their needs, which have been ignored to date, should be assessed with a view to developing appropriate policies for flexible working and for continuing professional development.
- **The report makes the following recommendations** to enable the Clinical Psychology workforce better to meet the needs of NHSScotland:
  - psychologists should have input to strategic plans for psychological aspects of healthcare
  - the proposed Regional Workforce Centres should have responsibility for workforce planning for Clinical Psychology, with support and co-ordination from the National Workforce Unit
  - Local Health Plans should explicitly state how the psychological needs of their population are to be met and what resources are being provided for this
  - proposals to re-design mental health services need to be implemented to give patients across Scotland improved access to interventions delivered by appropriately trained staff
  - there is an urgent need for a substantial and sustained increase in training capacity in Scotland for Clinical Psychologists to meet workforce requirements
  - consideration should be given to national initiatives for retraining the existing workforce to meet changing service need
  - relationships between workforce intelligence, Local Health Plans and training need to be strengthened
  - workforce plans should be regularly re-appraised to ensure they are responsive to demographic changes
  - further attention should be given to the special problems of the remote and rural communities

Executive Summary

1

Introduction

In April 1999, Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) assumed responsibility for commissioning the training for Clinical Psychologists in Scotland. In September 1999, a review entitled 'Psychology Services in Scottish Healthcare' was jointly published by SCPMDE and Clinical and Applied Psychologists in Scottish Healthcare (CAPISH). This review addressed a wide range of service, training and workforce questions, which for the first time were approached with a clear uni-professional focus in a Scottish context.

The review clearly recognised:

- *the importance of good and informed psychological care across the Scottish Health Service*
- *the role of qualified psychologists in disseminating and supporting this model*
- *the chronic shortage of Clinical Psychologists in particular in NHSScotland*

The need for more informed, systematic workforce planning was therefore identified. Specifically, it recommended that the Clinical Psychology Committee of SCPMDE should include workforce planning in their remit. This is the first report of the Workforce Planning Group (WFP Group) appointed by the Clinical Psychology Committee of SCPMDE to address this need.

A request was also made for closer alliance with the Scottish Executive Health Department's Scottish Integrated Workforce Planning Group (SIWPG) in relation to this task. The aim of SIWPG was to provide guidelines and a model for workforce planning rather than to undertake workforce planning per se and a final report from that group has been published (SIWPG, 2002).

The SIWPG report recommended that workforce planning should:

- *be integrated with planning for services, for learning, finance and organisational development*
- *address the balance of supply and demand across the dimensions of time, organisation, geography and staff grouping*
- *be a continuous, iterative process*
- *have a multi-disciplinary, skill mix approach to service delivery, and involve key stakeholders*

These recommendations guided the review of factors influencing workforce planning for Clinical Psychology which is presented in this report.

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The contribution of Clinical Psychology to NHSScotland

Historical Background

The practice of Clinical Psychology as an applied health discipline dates back to the middle of the last century when it was realised that the use of psychometric tests could enhance the understanding of the presentation of patients with mental illness. During the 1950s and 60s, established psychological theories of learning were successfully applied to the treatment of neurotic disorders. These largely behavioural therapies were supplemented by other theoretical approaches, resulting in the range of modern cognitive therapeutic approaches available today. Alongside these therapeutic developments there was a steady stream of systematic research and evaluation of interventions which refined working models of formulation, assessment and intervention in dementia, schizophrenia, anxiety, depression and other common psychological problems.

From the 1970s these models were adapted and applied to the management and treatment of a wide range of physical illnesses, e.g. heart disease, cancer, diabetes beyond those caused by the somatising of distress e.g. pain. Research has confirmed the view held by many clinicians that influencing patients' beliefs, behaviour and emotions can alter the course of physical illness and recovery.

The survey by SCPMDE/CAPISH in 1999 showed that 7.95 WTE psychologists were working in oncology, cardiology, physical rehabilitation, stroke and HIV/AIDS in NHSScotland. As well as carrying out direct clinical work they were also researching the psychological variables which affect the development of illness and determine the degree of recovery. This knowledge base provides a useful perspective to medical, nursing and Allied Health Professions (AHP) staff in their work with patients.

In spite of the broad applicability of psychology to healthcare, the provision of Clinical Psychologists per head of population in Scotland is significantly lower than that of other professional groups in the NHS (See Table 1 overleaf).

Table 1: Headcount and Whole Time Equivalent (WTE) for all staff employed by NHS Scotland on September 30th, 2000 (by staff groups)

Staff Group	Headcount	WTE	Population Per WTE
All Staff	**136,167**	**113,143.6**	**45**
Nursing & Midwifery	61,464	51,228.2	100
Medical	12,777	11,557.4	443
Allied Health Profession	8,560	7,013.9	730
Dental	2,687	2,538.7	2,018
Senior Management	1,991	1,950.4	2,626
Scientific & Professional	1,310	1,191.4	4,300
Clinical Psychology:			
Qualified + Assistants + Trainees	597	526.3	9,733
Clinical Psychology:			
Qualified + Assistants	497	427.3	11,988
Clinical Psychology:			
Qualified	428	360.2	14,220

Source: *Medical and Dental Census; National Manpower Statistics from payroll; General Medical Practitioner Database; General Dental Practitioner Database - ISD Scotland*

Training

Clinical Psychology training in Scotland has a relatively short history compared to other professions. Postgraduate two-year training courses in the Universities of Glasgow and Edinburgh were established in the early 1960s with an intake of two or three diploma 'probationers' each.

Training now comprises a three-year doctorate, embracing psychometric and other psychological assessments, therapeutic and proactive interventions, research and statistical analysis, teaching and training across the spectrum of care. Each course now has an annual intake/output of 16 trainees per annum. There are currently 96 trainees undergoing the three-year training in the two universities in Scotland. Trainees are NHS employees. They spend approximately 60% of their time on clinical placements in the NHS working under the supervision of an experienced Clinical Psychologist. The courses are regularly monitored for accreditation by the British Psychological Society (BPS). Trainees who successfully complete accredited training are eligible for chartered Clinical Psychology status awarded by the BPS.

In 2001, there were 348 applications for 33 training places in Scotland. Currently, many undergraduate psychologists are advised against considering a career in Clinical Psychology because of the difficulty in obtaining a training place.

The number of training places in England has increased by 10% each year over the past five years and three new courses have opened. Last year, a recruitment campaign was launched to advise

psychology graduates of these improved training opportunities.

The implications for Scotland depend heavily on a number of factors including:

- recognition by the NHSScotland of a similar service need
- achieving flexible and innovative preparation for increases in training numbers by the NHS, the Universities and the national accrediting body, the BPS
- improved clarity from the profession and the services about the projected demand and supply of trained staff

The role of the psychologist

Clinical Psychology is concerned with the assessment and formulation of psychological problems and the development and evaluation of interventions to relieve those problems. There is a strong evidence base for the contribution Clinical Psychology can make to the benefit of patients' physical and mental health and well-being over the life-span and across a wide range of NHS settings.

In applying the discipline of psychology to healthcare, the specific role of qualified psychologists in facilitating good psychological practice has been reviewed. The Framework for Psychological Care in Health produced by the Area Clinical Psychology Advisory Committee (ACPAC) of Ayrshire & Arran Health Board and endorsed by the SCPMDE/CAPISH review, is based on earlier work by the Manpower Advisory Service (1989).

This identified three levels of psychological work in healthcare suggesting that:

- the provision of good psychological care is an issue for all healthcare professionals
- the qualified psychologist's role is: to work at the highest level, providing advice, supervision and training for others; to work directly with complex clinical cases; to carry out and support psychological research in the NHS
- there is an 'intermediate' level where non-psychologists or psychology graduates work to protocol in circumscribed areas of psychological work

This 'tiered' model of psychological service has proved to be applicable across a range of services, including Psychological Therapies, Child Health and Learning Disabilities. Too often though, the full potential of qualified psychologists is not adequately utilised in health service settings. In response to long waiting times, psychologists' skills may be focussed on direct patient care at the expense of other functions. This may keep waiting times in check but does not achieve the widest and most efficient benefits for patients and the health service as a whole.

The sub-group reports demonstrate that many psychologists are engaged in providing consultancy and supervisory expertise to colleagues in multi-disciplinary teams alongside a direct service to patients with complex psychological problems. The emergence of a skill mix of professionals available to provide psychological interventions is a very positive trend. This creates the basis for a tiered service, enabling psychologists to focus on complex issues while accredited psychological workers work to their appropriate and supported level of competence. The challenge is to ensure that the potential positive impact of a "new" high level role for fully qualified psychologists is realised in a less patchy way across Scotland.

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Recent influences

Clinical Psychology, like other NHS professions, is subject to considerable influence from developments in health policies and the Group considered it important to highlight these.

NHSScotland Policies

A range of recently published health policy documents and Health Department initiatives recognise, at strategic level, the need to heighten awareness of and to address, the psychological needs of patients across all specialties and all ages. The WFP Group selected examples to show the role that psychology plays in these specific areas and to emphasise that taken together these documents demonstrate that psychological aspects are central to the development and delivery of health services.

- Our National Health: A Plan For Action, A Plan for Change (Dec 2000)

This document provides a blue-print for a healthcare system which emphasises the importance of fostering well-being, as well as the treatment of ill-health. The emphasis on collaboration with and empowerment of patients as well as staff, recognises the importance of psychological factors in healthcare, and places the person at the centre of a dynamic system.

The further emphasis on psychosocial aspects of healthcare (such as poverty, housing and life-style) highlights the impact of the environment and culture on psychological as well as physical health, and the coping styles of individuals and communities.

All health professionals and their colleagues in other agencies play a part in the re-emphasis on the psychological well-being of patients. However, psychologists are particularly well-placed to provide the required knowledge and competence which underpins an understanding of human development across the life-span and across the priority disorders of heart disease, cancer and mental health.

- A Framework for Mental Health Services in Scotland: Services offering Psychological Interventions (2001)

This template for service re-design of the provision of adult psychological therapies reinforces the views expressed in A Review of Psychological Services in Scottish Healthcare (SCPMDE/CAPISH, 1998). This review suggested that the best use of psychologists is in the provision of teaching, advice, and supervision of the psychological work of others, as well as prevention and early intervention, research and audit, and direct work with patients who have complex psychological disorders.

The Framework recognises that others have expertise in psychological therapies. There are several examples across Scotland where other accredited practitioners are collaborating with psychologists in providing a responsive and flexible skill mix across the 'tiers' of healthcare from Primary Care to specialist services. In particular, the needs of those with anxiety and depression are catered for at the appropriate level of expertise, whilst enduring and complex cases are treated by fully accredited, trained therapists. Importantly, the accredited 'experts' ensure continuing supervision and a high level of expertise at each 'tier'.

Implementation of this Framework, however, is hampered by a dearth of 'experts', and waiting lists for psychological therapies continue to rise. Promising projects in service re-design initiated by the Mental Health & Wellbeing Support Group to tackle waiting times for psychological therapies in four NHS Board areas, provide examples of innovative practice.

- Local Healthcare Co-operative (LHCC) Development: Next Steps

This is an area where multi-professional partnership, service re-design and specific resources will be central to the successful reduction of waiting lists for psychological treatment. Close liaison with the Primary Care Team will be essential if the Framework for Mental Health is to be successfully implemented. The role of psychologists in a Primary Care setting is thoroughly explored in the report of the WFP subgroup on Psychology in Primary Care.

- Cancer In Scotland: Action for Change (2001)

This document gives a strategic commitment to explore the role of Clinical Psychologists in cancer care and recognises the psychological needs of patients. The report of the subgroup on Psychology in Cancer Care outlines the significant benefits to patients of evidence-based psychological interventions.

- Template for Child Health Services (2001)

The service structure in this document recognises the need for appropriate therapy services for children and young people in an integrated and combined Child Health Service. The theme of wellbeing and positive mental health is again stressed with attention to health promotion and illness prevention as well as assessment and treatment of more severe complex disorders. Clearly, psychologists have a major contribution to make across the spectrum of a similarly 'tiered' multi-disciplinary service.

- Same As You? A Review of Services for People with Learning Disabilities (2000)

A full revision of the care of people with learning disabilities is proposed by this document and there are major implications for the role of psychologists in this specialty. The key aim of social inclusion is largely achieved through 'continuous learning', through adapting behavioural patterns, receiving information and making choices. Assessment and psychological intervention in complex and challenging behaviours, including the autistic spectrum disorders, must also be a focus for informed psychological expertise.

- Scottish Intercollegiate Guidelines Network (SIGN) guidelines

Ten of the first 50 SIGN Guidelines highlight the psychological needs of patients, and in some cases e.g. breast cancer, specifically recommend the input of Clinical Psychology to the multi-disciplinary team.

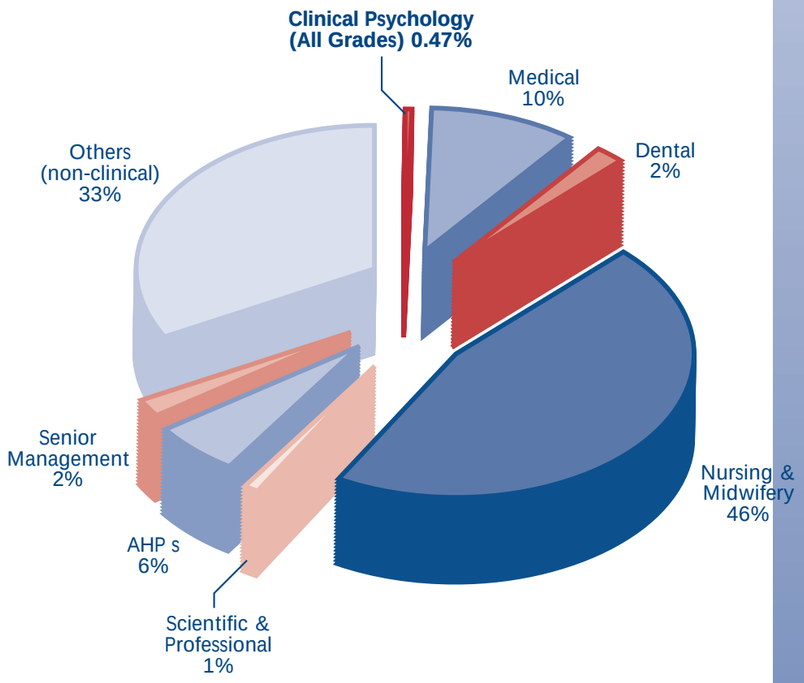
- Clinical Standard Board for Scotland (CSBS): Schizophrenia Standard

Standard 10 'Social and Psychological Approaches to Care' was included in the first phase of implementation of the Standards. This referred in part to the 1998 SIGN Guidelines on psychosocial interventions in schizophrenia. CSBS National Report (April 2002) indicates that in most Trusts in Scotland, compliance with this standard is poor particularly because of the absence of individuals with requisite clinical skills.

Figure 1 (below) demonstrates the percentage of Clinical Psychologists working for NHSScotland compared to other professional groups. This pie chart shows that even when Assistant Psychologists and trainees are included in the staffing numbers Clinical Psychologists comprise less than 0.5% of the total NHS workforce.

The SCPMDE/CAPISH survey undertaken for the Review (1999) provided information on the distribution of psychological services across specialties. Very few psychologists work in physical health specialties, such as oncology, cardiology, general medicine and stroke. Even the 'well-developed' specialties, such as Adult Mental Health, have high

Figure 1: Professional groups as percentage of NHSScotland staff



Source: Medical and Dental Census; National Manpower Statistics from payroll; General Medical Practitioner Database; General Dental Practitioner Database - ISD Scotland

numbers of vacant posts and remain under-resourced in psychology. At the time of the survey in Scotland (September, 1998), there were 300.2 WTE posts filled and 44.3 (13%) posts vacant. The 'traditional' specialities employed the majority of psychologists.

43.6% in Mental Health (including Primary Care)

20.7% in Learning Disabilities

14.8% in Care of Children, Young People and Families

5.3% in Forensic & Sex Offenders

(Source: SCPMDE/CAPISH Survey 1998)

The SCPMDE/CAPISH Review, 'Psychology Services in Scottish Healthcare' (1999), indicated a lack of consistent planning of psychological services within the NHS and highlighted the need for strategic planning to anticipate, develop and manage new fields of application for the profession.

Workforce planning

In preparation of this Report, the WFP Group took into account a wide range of influential factors and associated tasks, including:

- national and local service planning, focussing on specific service examples
- identification of service re-design and modernisation in the foreseeable future
- the desired positive impact on psychological care of deploying a mix of health professionals
- the current psychology workforce in NHSScotland (in post and vacancies)
- projected psychological need identified by key stakeholders
- training, funding, process, capacity and 're-design' potential
- potential recruitment and retention issues

As noted by SIWPG, this is a complex and necessarily iterative process. Guided by its principles, the Group decided to develop some service examples to examine the issues for psychology in NHSScotland. Three separate areas were explored:

- Primary Care
- Learning Disabilities
- Cancer;

requiring the establishment of sub-groups comprising group members and other colleagues.

Executive summaries from those reports are included as appendices. Common themes are considered in Section 5. Full versions of the sub-group reports are available from NES.

Management of workforce information

Information reflecting the skills and deployment of the psychology workforce in NHSScotland is not readily available. Data extracted from the Scottish Standard Payroll System (SSPS) are available for most Trusts in Scotland. The coding available within this system does not support the level of detail required for mapping the workforce engaged in providing Clinical Psychology services.

Consistent with the principles established through the SIWPG i.e. that planning should be locally derived and integrated across professional boundaries, there is a requirement to capture information on all clinical staff employed in psychology services. These may include Clinical Psychologists, Counselling Psychologists, Health Psychologists, other psychologists, and those who may not be trained as psychologists e.g. cognitive behavioural therapists. At present, the SSPS extract held nationally provides details only for Clinical Psychologists and Assistant Psychologists.

In addition, information on need for psychological services and the skill mix engaged in the delivery of psychological care is required to implement workforce planning effectively. These data requirements are not provided through the current SSPS either locally or nationally and the current SSPS system is impractical for collecting these data.

With the financial support of SCPMDE and the technical expertise of ISD, the WFP Group initiated two data gathering exercises to address these deficiencies. One is the collection of a census outlining details of the individuals currently in post. The second is a workforce demand survey that links planned service developments to the staff skills required to deliver them. It is recognised from the outset that there will be limitations to these projects, but the data, expected in late 2002, will be useful in themselves and in informing successive iterations of information gathering.

The WFP Group recommends that:

Workforce planning activities to be co-ordinated at local level for Clinical Psychology

Workforce planning needs to be informed by the regular collection of up-to-date, good quality data with an appropriate level of detail about the workforce

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Common themes from the sub-group reports

The sub-group reports commissioned by the WFP Group drew upon the experiences of Psychologists and others across the whole of Scotland. The common themes are considered below.

• Lack of adequate staff numbers

All sub-group reports testify to the dearth of Clinical Psychologists in each NHS specialty although this factor is expressed in different ways.

In the Primary Care Report, the small number of Clinical Psychology posts is reflected in high waiting lists. The report states that there are, *"literally thousands of patients waiting for excessively long periods of time for appointments. Consequently, there is little or no opportunity to offer a wider psychological service based on the skills of others. Management of waiting lists costs time and energy for clinical, administrative and clerical staff which could otherwise be better used."*

The concern in Learning Disabilities does not focus on waiting times. Most clients do not wait to be seen by a member of the multi-disciplinary team but the specialist psychological input may be absent, inadequate or provided by non-psychologists under supervision. In general, there is a small number of posts within Learning Disability services and wide variability in provision across Scotland as a whole. A questionnaire study undertaken by the Learning Disability Sub-group, for example, found that even in fully staffed areas, population ratios ranged from one Clinical Psychology post per 33,000 to one post per 140,000 (average 1 to 80,000) implying a gross inequity of access to services.

The under-provision of psychology in Cancer services is evident. Of 23,000 people diagnosed with cancer in Scotland annually, research data suggests that 20% will have psychological needs requiring skilled intervention. The 2.2 WTE Clinical Psychologists currently in NHS funded posts in cancer care in Scotland cannot be expected to meet the needs of oncology services which see over 4,000 new patients per year. The sub-group commented that this situation exists despite *"an impressive body of research evidence about the psychological needs of cancer patients and their carers and the efficacy of psychological interventions."*

• Changing models of service delivery

All sub-group reports highlight the need to develop different models of delivering psychological services to respond to change and the modernisation taking place within NHSScotland. The strategic focus has shifted from secondary to primary care with a growth in LHCC based services (Next Steps) whilst the 'Joint Futures' agenda heralds a further radical change in the delivery of health and social care services.

In response to these changes, all sub-group reports emphasise the requirement to redefine the balance of the type of interventions offered by psychologists relative to other clinicians. More importance should be given to training and supervising others in the delivery of psychological care in order to reserve the knowledge base and expertise of Clinical Psychologists for interventions with the most complex and demanding cases.

• Equity of access

Equity of access to services is clearly related to the availability of posts as well as recruitment. There is evidence of considerable variation across Scotland in the provision of posts on a population basis. When demographic and geographic factors are also taken into account it becomes more difficult to compare areas on the basis of service accessibility.

Different methods of achieving commonality were suggested by each group:

– the Primary Care sub-group returned to first principles and calculated a target figure for Scotland of 296 WTE for Primary Care and Mental Health out-patients based on demand and individual workload

– the Learning Disabilities sub-group gave no national figure but recommended that, since services seem to be already organised geographically within each Trust, a Consultant grade post should lead each main service element with at least one Grade A post as a support

– the sub-group reporting on Psychological Services to Cancer suggested a minimum need for 15 posts in Oncology across Scotland to work in the main Cancer Centres as part of the multi-disciplinary tiered services with an emphasis on tackling complex cases, supporting other staff and a particular focus on training

• Training

All sub-group reports focussed on the training role of psychologists in relation to other staff, seeing this as a major and expanding area of contribution to NHSScotland. More than half the Clinical Psychologists participating in a SCPMDE funded project to identify the educational needs of supervisors were already engaged in the teaching/supervision of other non-psychologists. The project is designed to inform the development of appropriate training for supervisors.

The training of psychologists themselves, however, is also seen as a priority area, both in terms of numbers and content.

The Primary Care report commented, *"There is little doubt that the current training throughput of 32 new psychologists per annum in Scotland is inadequate to meet the needs of Primary Care/Acute Mental Health alone. The British Psychological Society Division of Clinical Psychology has jointly with the DoH estimated a total requirement of 7,000 psychologists in order to implement the National Service Framework for Mental Health in England: this represents an increase of well over 50% over current numbers. If this were*

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'translated' to the numbers in Scotland (approximately one tenth of the population served in England), this would require an estimated 500 more psychologists for the full range of Mental Health work."

In addition, both the Learning Disabilities and Cancer groups felt that training courses offered by universities should review and increase the content of the curriculum in their areas in order to extend the awareness of those entering the profession of the potential psychology could make in these specialties.

All reports highlight the need for CPD activities to keep skills updated and to allow the service to remain innovative and responsive to changing circumstances.

Service challenges

- Psychologists' contribution to strategic developments

The opportunities for psychologists to contribute as a profession to the national picture in NHSScotland have historically been limited. The WFP Group identified particular challenges for psychology services in NHSScotland. The WFP Group are pleased to acknowledge the progress already achieved in the last three years through the setting up of the Chief Medical Officer's (CMO) Psychology Advisory Group and the Clinical Psychology Sub-Committee of SCPMDE, both of which have been pivotal to the development of national initiatives.

* Meeting increasing demand for services

Waiting times for psychological services are lengthy and growing across Scotland. This factor is due in part to an increasing awareness of psychological factors in healthcare and the presence of effective models of treatment. High volume referrals are not only seen in 'traditional' services, from General Practice for example, but are also a feature of many other psychology specialisms:

– Standard 10 of the CSBS for Schizophrenia, Psychosocial Interventions for Schizophrenia, will have considerable impact on the workload of Clinical Psychologists in Community Mental Health Trusts

– requests for psychological intervention for eating disorders and personality disorders are escalating without concomitant increases in specialist resources.

– Child, Adolescent and Learning Disability services face considerable pressure to develop specialist psychological care for Autistic Spectrum Disorders, highlighted particularly by the MMR controversy

At present, psychological assessment and treatment of patients is not determined by need but by the way Local Health Boards cope with demand. Very complex cases may not receive the psychological support they require due to long waiting times and/or inadequate service provision.

Re-designing services may enable the resources of trained Clinical Psychologists to be targeted at the most complex cases with other healthcare workers being trained to manage more routine problems. However, even this will create demands on trained psychologists since, if non-psychologists are to effectively provide psychological care, they will need to be well supported by qualified and experienced psychologists with adequate time to supervise their work.

- Research and Development

There is a strong evidence-base for psychological models of care and intervention. This is supported by a lively research culture among psychologists and the commitment to provide a user-focused psychological service. The contribution psychologists could make to good quality multi-disciplinary service-based research and audit is compromised by competing service demands on this small profession. As for all healthcare professions, research findings require to be embedded in policy formation at local and national level and implemented in practice.

- An Ageing population

The age structure of the population will continue to shift over the next 20 years. It is estimated that by 2021 just over a quarter of the population will be over 60 years of age.

This changing demography will require an increase in the number of psychologists working with elderly people. At present this is one of the less well staffed specialisms. Clearly, a consistent and structured approach to training and service development is needed to tackle this situation.

Remote and Rural areas

In 1998, the SCPMDE/CAPISH survey indicated that Borders and Highland had the poorest ratio of trained psychologists per head of population. At that time, the three "Island Boards" (Orkney, Shetland and Western Isles) had no psychology establishment at all. Since then, innovative work by psychologists has been undertaken to explore the use of telemedicine with links to services in neighbouring Health Boards such as Grampian and Highland. The need for workforce solutions tailored to the needs of those areas is essential to achieve greater equity of access to services across Scotland.

Designing services to meet expectations

The future role, deployment and training of Assistant Psychologists needs urgent review

Skill mix

In recent years the greater prominence of psychological theories and principles in healthcare has meant that concepts drawn from psychologists' research and practice have become integrated into the working practices of other professions. Psychologists have no wish to hinder the transmission of "psychological knowledge", but it should be acknowledged that they are the profession most appropriately skilled to oversee the dissemination of that knowledge base and its practical application and development.

It is therefore necessary to ensure that the NHSScotland psychology workforce is of a sufficient size and diversity to respond optimally to meet increased demand for a full range of services. In current circumstances this would involve the inclusion of Clinical Psychologists, graduate psychologists and psychologists with other postgraduate training (e.g. those with Counselling, Health, Forensic and Neuropsychological training).

- Graduate psychologists

Typically graduate psychologists aspiring to undertake clinical training have sought employment as Assistant Psychologists in the NHS. Until recently, tenure of these posts was limited to three years under Whitley Council terms and conditions. This restriction has now been removed. An Assistant Psychologist may now remain in post for longer, contributing substantially to the psychology services in that area. Roles and responsibilities of Assistant Psychologists vary considerably. Arrangements for their training and supervision are not regulated and there is no system for reviewing or accrediting posts or the competence of post holders.

The option of redefining the Assistant Psychologist's role as a training grade more closely linked to Clinical Psychology training, has been advanced and may represent a useful development. It is suggested that the new Special Health Board, NHS Education for Scotland should review the role of Assistant Psychologists within its training strategy for the profession in Scotland.

Whatever the outcome, it is important that training and support systems are developed to ensure that Assistant Psychologists continue to work under proper supervision and within the limits of their competence.

- Postgraduate trained psychologists

Clinical Psychologists comprise around 90% of the trained psychology workforce in NHSScotland. Of the remainder, the largest single group is Counselling Psychologists. Smaller numbers of Forensic Psychologists, Health Psychologists and non-clinically trained Neuropsychologists also have some patient contact.

Increasing demands within the NHS will open up opportunities for other branches of psychology. The mechanism for their employment is only partially established. Services employing Counselling Psychologists have had most experience in dealing with these issues. Parity with Clinical Psychologists is gradually becoming accepted. However, there is, as yet, no accepted career path for Counselling Psychologists and many remain in lower grades than Clinical Psychologists with equivalent experience.

Staffing the service

Awareness of need for psychological expertise in NHSScotland is explicitly and implicitly contained in a range of documents and reports from CSBS, as well as in SIGN Guidelines and in the Government White Paper, "Our National Health". None of these documents specifies how much input is required and from how many psychologists.

The BPS (Paxton & D'Netto, 2001) suggested two approaches to determine the workforce requirement:

1. Needs-based - determines numbers by regarding the features of the environment in which they will be employed and the tasks they undertake.
2. Population-based - links posts per specialism to population norms.

A BPS survey of local psychology managers showed a preference for a needs-based approach but many respondents indicated that in their experience both were relevant.

On a Scotland-wide basis it is currently impossible to estimate the numbers of posts required using the needs-based approach. There is insufficient detail available on the needs of each individual Health Board. Local judgement and negotiations must therefore be relied upon to achieve this task.

It is possible, however, to adopt a

A career structure for the employment of "non-Clinical" Psychologists in the Scottish Health Service should be established.

population-based approach to produce an indicative number against which current services can be benchmarked. Comparison of this figure with current data allows a judgement to be made about the relative level of training need which can inform the commissioning process for Clinical Psychology training courses.

National norms for Clinical Psychologists were first made available by the Trethowan Report (1977). There have subsequently been indications from various national reports about how many psychologists individual multi-disciplinary services require. The most comprehensive attempt has been made by the BPS which has produced a number of documents over the years containing quantitative guidance for specific clinical specialities.

Several criticisms can be levelled at this approach: guidance can quickly become out of date and fail to reflect the increased demands on present day services; it can promote a certain mind-set in terms of 'achieving the norm' whereby a maximum limit is set on aspirations; it can also preclude service innovation. However, the Group felt that using a population-based approach would generate an appreciation of the scale of the task and give a sense of direction to workforce planning.

The Group used BPS figures, as detailed in Paxton & D'Netto (2001). They were the most readily accessible, covering the range of clinical specialities required for a comprehensive psychology service. The figures adopted represent a highly conservative estimate. The authors of this report wish to stress that the numbers that the resulting workforce estimates are ***indicative*** and not ***definitive***. Using these BPS figures and making reasonable allowances for the present services where no norms exist (e.g. Forensic Clinical Psychology), it was possible to calculate the complement of trained Clinical Psychologists required by NHSScotland. For all specialisms the workforce required is of the order of **1,000 to 1,100 WTE**. This gave a ratio per head of national population ranging from one per 5,122 to one per 4,657.

For convenience, it is suggested that a ratio of **1 WTE Clinical Psychologist per 5000 of the population** be adopted.

This would give an **indicative national workforce requirement of 1,025 WTE psychology posts.**

(These calculations were based on Clinical Psychology numbers but could represent the total future trained psychology workforce in NHSScotland if other trained psychologists with clinical involvement are appropriately substituted.)

- *The Group recommends the use of a population-based approach to create interim indicators to monitor the growth in the NHSScotland psychology workforce.*
- *A national target should be set to be indicative of the "step change" required in the level of provision.*
- *The first target should aim for 1.00 WTE psychology post for every 5,000 people in the population.*
- *A minimum of 1,025 WTE psychology posts for NHSScotland will be needed to fulfil the population-based requirements.*
- *Local needs-based approaches to determine the psychology workforce must not be abandoned in favour of a single national formula and local flexibility should be encouraged.*

Workforce intelligence

The current problems in gaining reliable data on the psychology workforce have been highlighted. To maintain an iterative planning cycle two sources of information must be regularly updated.

- Information on workforce supply

The WFP Group initiated a census of all psychologists and non-psychologists providing a Clinical Psychology service within NHSScotland. A new database was established to collect information on individual contract details such as national insurance number, number of sessions and target population, personal details such as qualification year, and termination data such as date and reason for leaving. The first census was collected on 30th September 2001 and baseline data will be available late summer 2002. To support workforce planning and to establish ongoing trends, these data require to be maintained and collections adopted as part of a regular workforce dataset.

- Demand forecast

The WFP Group has also instigated a survey of all psychology services in NHSScotland that will link workforce deployment to the current and estimated future pattern of service provision. Issues relevant to Local Health Plans will be highlighted for the developing needs of the workforce as well as providing a national perspective on common areas of strength or weakness. To be of benefit, such an exercise needs to be repeated every two years and the data assimilated with the annual census of staff.

A demand forecast survey of all Clinical Psychology services should be conducted every two years.

Data collection of other psychology workforce (e.g. prison service) should be considered for inclusion in the future.

Continuing Professional Development

As with all clinical professions, there is a requirement for psychologists to keep their knowledge and skills up to date. The Division of Clinical Psychology of the BPS has recently published Guidelines for CPD (2001), which outline a system to follow, as well as highlighting core competencies for Clinical Psychologists with different levels of experience. Protected time and resources are needed to enable this or a similar

The collection of census details on the Clinical Psychology workforce in NHSScotland should be maintained and developed.

A demand forecast survey of all Clinical Psychology services should be conducted every two years.

Data collection of other psychology workforce (e.g. prison service) should be considered for inclusion in the future.

CPD must become an integral part of the psychology workforce.

National standards and resourcing for CPD are required if CPD is to become a reality.

system to be incorporated routinely into the work tasks of Clinical Psychologists.

While CPD is essentially an individual activity, there are common issues that are being addressed by local post-qualification courses e.g. specialist training to meet changing service needs. These experiences need to be better integrated and structured so that there is a national overview of CPD being offered which fits with workforce requirements. There must be the capacity to commission particular topics (e.g. a management training course on entry to B Grade for all Clinical Psychologists) so that there is a consistency of experience across Scotland.

Retention of trained staff

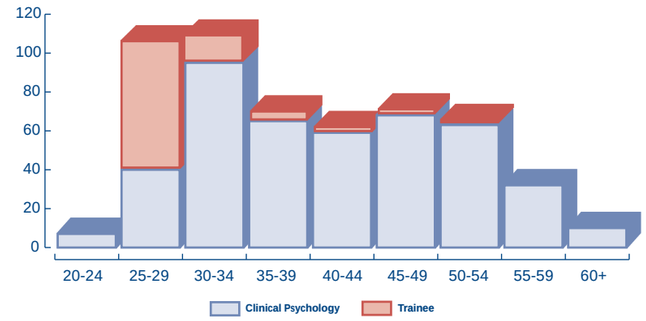
The retention of trained staff within NHSScotland has generally been good. Typically, over 90% of trainees take up a post in Scotland and those who do not are generally balanced by incomers. Movement of qualified psychologists does take place but this is generally within NHSScotland.

Currently the WFP Group does not consider it necessary to recommend a national strategy to improve retention of staff. Individual Trusts and Boards will need to look at this issue in respect of their own services and should be expected to develop their own strategies in line with their general recruitment policy.

However, there are concerns about the retention of managerial skill and clinical experience within the service due to the decrease in numbers with age. Currently, only 7% of psychologists employed by NHSScotland are aged 55 or over. This probably reflects the effect of retirement as the conditions of Mental Health Officer status are fulfilled. Over a quarter of all staff are aged 45 to 54 and it is likely that over the next ten years they will be lost to the service in a similar fashion. Figure 2 (opposite) illustrates the age distribution of Clinical Psychologists and trainees excluding Assistants in NHSScotland.

Although there are sufficient numbers of younger staff to fill the gaps, it will be necessary to ensure that they are properly prepared for the transition. It is therefore important to ensure that experienced staff contribute to the development of their successors and that the service establishes and promotes ways to achieve this.

Figure 2 - Age distribution of Clinical Psychologists in NHSScotland (ISD 2002)



The development of "step-down" mechanisms which allow relinquishment of certain managerial responsibilities prior to retirement or the facility to assume part-time clinical duties after retirement should be considered. Such strategies are likely to be extremely valuable over the next five to ten years while the capacity and numbers of the service expands.

Less than Full Time Working

The current gender balance of trained staff is predominately female (73%). This is even more pronounced among those in training (83% female; 17% male). Many staff reduce their work commitments for a period in their career due to family reasons. One third (29%) of the present workforce works part-time. The vast majority of those working less than full-time are female. Since many psychologists have split responsibilities within their posts there is, in general, little difficulty in accommodating part-time working within the service. If historic patterns continue, this would suggest an on-going, even an increased demand for less than full-time working. This has implications for training numbers. Training capacity needs to be increased to compensate for less than full-time working patterns.

It is important that the service is able to manage flexible working arrangements and to ensure that any extra supports for part-time workers are in place. Their particular training and CPD needs need to be addressed together with provision of support for the re-entry of those who take career breaks. Until now this issue has been largely overlooked. With the changing nature of demands it will require further investigation.

It is recommended that active steps are taken to retain skills and experience of staff aged 55 and above during the period of expansion in the next five to ten years.

The needs of part-time workers should be explored further and appropriate policies developed to support them in work.

The CMO Psychology Advisory Group (which should remain a representative body for the range of professional psychology organisations in Scotland) should develop a network of psychological experts, who will advise on the psychological aspects of strategic plans for patients.

The planning of the psychology workforce across Scotland should become the responsibility of Regional Workforce Centres once these have been established.

National workforce planning

In the context of a modern NHS, there is a need to facilitate the contribution of psychologists to policy development. The re-design of services which reduce the tension for Chartered Clinical Psychologists, between the high demand for direct work with patients and time required for training and supervising to empower others to develop their skills, requires impetus from a policy shift at National level. The need to re-design services around patient needs is recognised and endorsed.

Regional Workforce Planning

In order to ensure a consistent and sustained increase in the size of the workforce, Scotland needs to develop, promote and maintain a joined-up strategy for workforce planning that looks across Health Board boundaries. This strategy should focus on the level of demand for services and how this demand can be met while recognising and reflecting particular local needs. The Clinical Psychology WFP Group recommends that this function, which would also be appropriate for other service areas, should be a core responsibility of the new Regional Workforce Centres, supported and co-ordinated nationally by the proposed National Workforce Unit. These Centres were proposed by the Scottish Executive Health Department on 31st January 2002 in response to the Final Report of the Scottish Integrated Workforce Planning Group.

Local workforce planning

One of the main concerns of psychology managers is that they are often unable to influence strategic decisions affecting the creation of psychology posts. Almost 10% of the respondents to the BPS workforce planning survey replied that "nothing works" when asked how they were able to obtain more posts. A survey of Learning Disability Psychology Services conducted by the WFP Group produced equally pessimistic results, citing the experience of reasoned, needs-based proposals being rejected. There is the widespread feeling that psychology service developments arise on an 'ad hoc' basis.

The number of Clinical Psychologists working for NHSScotland results from an aggregate of local decisions made by Boards and Trusts based on their own local priorities. This report has identified the need for a managed increase in the Clinical Psychology workforce for Scotland, but recognises that Trusts must still be able to adapt staffing arrangements to suit changing patterns of local circumstances. We also recognise that the setting of rigidly defined staffing levels would be a constraint on innovative approaches to team design and skill-mix aimed at improving the patient's journey.

A changing role for psychology

Multi-disciplinary team working is increasingly the main vehicle for the delivery of care within the health service. While team-working is based around individual professions working within their particular competences, the strength of this approach lies in the co-operative merging of professional boundaries and partnership working. The pervasive nature of psychological issues in healthcare means that increasingly psychologists in multi-disciplinary teams are required to expand their role to incorporate more facilitative work by providing psychological advice and support to other professions.

While this is a welcome development that can have a very positive impact on the quality of care provided, it needs to be implemented consistently across Scotland. As a corollary to this way of working, tiered services need to be developed with clarity about the role of psychologists in facilitating the work of other accredited psychological workers.

Training

New Clinical Psychologists

The projection of 1,025 WTE Clinical Psychology posts is around 625 posts in excess of the present establishment (estimated to be just under 400 WTE). Figure 3 illustrates the time to reach this target depending on the training capacity. The calculations allow for retirals and assume all trainees remain in Scotland after qualifying. At present, retention of trainees is well over 90% and an inflow from elsewhere in the UK and abroad easily offsets those who are lost to the service.

Figure 3 illustrates that even with a doubling of the present training provision of 32 per year it would take ten years to reach the required level of staffing. These are crude estimates based on first approximations. There are additional relevant considerations. Clearly, if the numbers of Clinical

Local Health Plans should explicitly state how the psychological needs of populations are to be met and what resources are being provided.

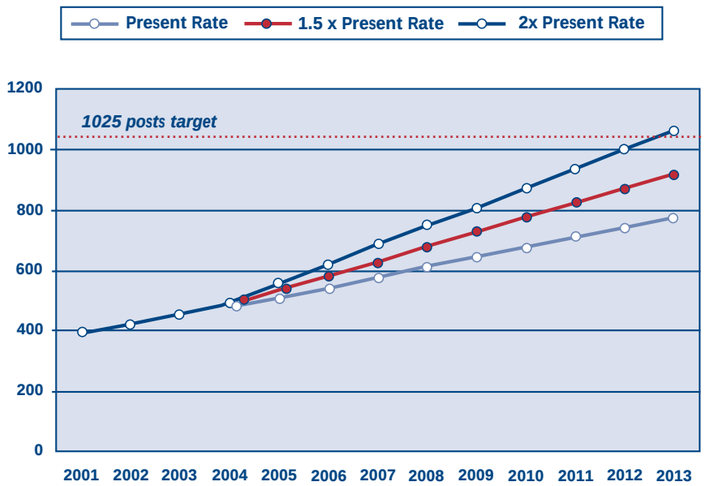
Service re-design and modernisation should be specifically addressed in the provision of psychological care, so that patients and the NHS benefit from the full range of skills available from psychologists.

A substantial increase in the numbers of Clinical Psychologists trained in Scotland is needed over a protracted period in order to meet workforce requirements.

Psychologists as suggested by the WFP Group are accepted, this will have major implications for the training of Clinical Psychologists in Scotland. Expansion of training capacity will increase demands on the clinical academic workforce. This report has not addressed the issues affecting planning for the clinical academic workforce. These warrant separate review.

The responsibility for commissioning Clinical Psychology training held by the SCPMDE passed to NES in April 2002 when SCPMDE was subsumed within that body. NES is continuing the work with stakeholders, begun by SCPMDE to develop and implement a strategy for expansion and modernisation of training in line with the aims expressed in 'Learning Together'.

Figure 3 – Different training rates and number of Clinical Psychologists in NHSScotland



Retraining the existing/potential workforce

Any development of the psychology workforce in Scotland will inevitably take place over a period of years. With the improved intelligence that will be available it should be possible to keep track of the rate at which clinical specialisms are staffed and where the level of demand has changed significantly. This may necessitate offering retraining to individuals to equip them with the specialist skills required to move into posts in areas of greater need. A national strategy will be required in order to make the best use of resources. Initiatives could include:

- "Conversion courses" for psychologists without clinical training
- Financial support for further specialised training
- Secondment to specialist units to facilitate transfer into a local vacancy
- Distance learning packages

Demographic changes

There are significant challenges in trying to address projected changes in the structure of the population during the life of any planning cycle. In the current state of development there are pressing priorities in core psychological services which could and should be dealt with first.

This prioritisation, however, cannot be allowed to continue indefinitely. Without reappraisal, the service needs of 2002 will determine the skills available to meet the needs of 2010 and beyond. It is therefore important that:

- the workforce plan has a limited time frame (e.g. three years) and is then reappraised
- the workforce should reflect the ethnic distribution of the population
- the range of specialisms needed is specified as clearly as possible based on current and accurate projections
- there is a strengthening of the relationships between workforce information, Local Health Plans and the commissioning of training places

Remote and Rural areas

A SCPMDE/CAPISH survey in 1998 indicated that two Health Boards have the poorest ratio of trained psychology staff per head of population, namely Borders and Highland. The three "Island Boards" (Orkney, Shetland and Western Isles) have no psychology establishment at all.

In terms of workforce planning, these areas will have to absorb the greatest percentage increase in posts. While the absolute numbers may not be large, the special problems of access, isolation and serving a dispersed population would suggest that a different approach will be necessary for service development. Possible options could include:

- increased investment in telemedicine
- "ring fenced" training opportunities for local residents with psychology degrees who are suitable for clinical training
- partnerships with larger services to provide specialist support and training for staff in rural boards
- consultancy from larger services to help establish a psychology service in Health Board areas without one

Retraining of the existing/potential workforce to respond to changing service needs must be given consideration and where appropriate national initiatives developed to share costs and experiences.

Workforce planning should be responsive to demographic changes and should reappraise requirements on a regular basis

Further attention should be given to the special problems of the rural communities to ensure improved local access to psychology services.

9

Summary of recommendations

Management of workforce information

- Workforce planning activities to be co-ordinated at local level for Clinical Psychology.
- Workforce planning needs to be informed by the regular collection of up-to-date, good quality data with an appropriate level of detail about the workforce.

Skill mix

- The future role, deployment and training of Assistant Psychologists needs urgent review.
- A career structure for the employment of “non-Clinical” Psychologists in the NHSScotland should be established.

Staffing the service

- The use of a population-based approach is recommended as an interim means of generating indicators to monitor the growth in the NHSScotland psychology workforce.
- A national target should be set to be indicative of the ‘step change’ required in the level of provision.
- On this basis the first target should be 1.00 WTE psychology post for every 5,000 people in the population.
- A minimum of 1,025 WTE psychology posts for NHSScotland will be needed to fulfil the population-based requirements.
- Local needs-based approaches to determine the psychology workforce must not be abandoned in favour of a single national formula and local flexibility should be encouraged.

Workforce intelligence

- The collection of census details on the Clinical Psychology workforce in NHSScotland should be developed and maintained.
- A demand forecast survey of all Clinical Psychology services should be conducted every two years.
- Data collection of other psychology workforce (e.g. prison service) should be considered for the future.

Continuing Professional Development

- CPD must become an integral responsibility of the psychology workforce.
- National standards and resourcing for CPD are required if CPD is to become a reality.

Retention of trained staff

- It is recommended that active steps are taken to retain skills and experience of staff aged 55 and above during the period of expansion in the next five to ten years.

Less Than Full Time Working

- The needs of part-time workers should be explored further and appropriate policies developed to support them in work.

Planning for service needs

- The CMO Psychology Advisory Group (which should remain a representative body for the range of professional psychology organisations in Scotland) should develop a network of psychological experts, who will advise on the psychological aspects of strategic plans for patients.
- The planning of the psychology workforce across Scotland should become the responsibility of Regional Workforce Centres once these have been established.
- Local Health Plans should state explicitly how the psychological needs of populations are to be met and what resources are being provided.
- Service re-design and modernisation should be addressed specifically in the provision of psychological care, so that patients and the NHS benefit from the full range of skills available from psychologists.

Training

- A substantial increase in the numbers of Clinical Psychologists trained in Scotland is needed over a protracted period in order to meet workforce requirements.
- Retraining of the existing/potential workforce to respond to changing service needs must be given consideration and where appropriate national initiatives developed to share costs and experiences.

Demographic changes

- Workforce planning should be responsive to demographic changes and should reappraise requirements on a regular basis.

Remote and Rural areas

- Further attention should be given to the special problems of the rural communities to ensure improved local access to psychology services.

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Appendix A:

Membership of the Clinical Psychology Workforce Planning Group

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Mr S Miller	Health Department, Scottish Executive Edinburgh
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Mr I Reid	Director of Human Resources, Gartnavel Royal Hospital, Glasgow
Mr P Ronald	Counselling Psychologist, Ayrshire and Arran Primary Healthcare NHS Trust
Dr A Smyth	National Director for Clinical Psychology Training, NHS Education for Scotland, Edinburgh
Dr S Whyte	Chair of Scottish Division, Royal College of Psychiatry, Gartnavel Royal Hospital, Glasgow
Mrs Z J Wight	Director of Psychological Services, Strathdoon House, Ayr

Appendix B:

Executive summary from the Workforce Planning Sub-group for Cancer

- More than 25,000 new cases of cancer are registered in Scotland each year. With incidence rates increasing and overall survival rates improving, the number of people in Scotland living with cancer and its sequelae will continue to grow.
- The Scottish Executive has identified cancer as one of its top three clinical priorities for improvement in NHSScotland. Cancer in Scotland: Action for Change recognised the need to develop services to support patients' psychological needs.
- Cancer causes distress and difficulty for patients and their carers. Approximately 20% of patients experience psychological problems sufficiently severe to warrant professional attention.
- Unrelieved psychological distress is associated with increased symptom burden, greater disability, poorer quality of life and poorer medical outcomes for patients, an increased burden of care for their carers and increased use of medical resources.
- Meta-analyses of data from randomised clinical trials confirm that psychological interventions offer significant positive benefits to cancer patients in the form of improved psychological wellbeing (reduced anxiety and depression), symptom relief, improved functional capacity and adherence to treatment.
- This has not been translated into evidence-based care for cancer patients in Scotland because of the lack of input from Clinical Psychologists to NHS cancer services.
- In May 2002 there were 2.2 WTE Clinical Psychologists employed by NHSScotland to provide services to people with cancer.
- The communication and counselling skills of all healthcare professionals are the key to providing good quality psychosocial healthcare for all patients. There is evidence that these skills can be improved by training, resulting in an improved capacity to recognise and relieve patients' distress.
- There is also evidence that protocol based interventions can be effectively delivered by non-psychologists with appropriate training and supervision from a Clinical Psychologist.
- The recommended model for provision of psychological service is therefore one in which Clinical Psychologists work within a multi-disciplinary structure to provide:
  - direct intervention for patients with the most complex problems
  - indirect input through teaching, training, supervision and consultancy for other professionals, to support them in providing basic psychosocial care and circumscribed psychological interventions
- Psychological interventions should be evidence-based and subject to audit and research to inform the continuing development and improvement of services offered. Clinical Psychologists are uniquely qualified to develop and evaluate the tailored, structured and comprehensive psychological interventions which are generally found most effective.
- It is estimated that a minimum of 15 WTE Clinical Psychology posts are needed to establish psychological services for cancer patients in NHSScotland.
- Investment will be required to support the training and CPD needed to attract Clinical Psychologists to work in this under-developed area.
- Developing a new service from such a low starting point will require collaboration across the UK, to make optimal use of available expertise to train and support Clinical Psychologists in learning how to apply their generic competence to this new specialty area.

Membership of the Clinical Psychology Workforce Planning Group for Cancer

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Professor David Peck (Chair)
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Dr Craig White
CRC Fellow in Psychosocial Oncology, Gartnavel Royal Hospital, Glasgow

Appendix C:

Executive Summary from the Workforce Planning Sub-group for Learning Disabilities

This report examines the workforce planning issues for Clinical Psychology within Learning Disabilities services.

The Group examining the issues carried out a survey of existing Learning Disabilities psychology services throughout Scotland. The survey sought information on the number of psychology staff employed and details of how services are provided. Having established the current status, the Group then considered what were the future service needs/developments, the requirements to meet these needs and the implications for education, training and recruitment. A number of recommendations were then made.

Recommendations/Areas for Consideration

- Most Health Boards organise their services into local area teams. Within each team there should be a minimum of two Learning Disability psychology posts, one B grade and one A grade. Where there are no local teams, e.g. Health Board wide service, then the BPS recommendation for a minimum requirement of one WTE Clinical Psychologist per 62,500 general adult population should be applied, with at least one post being for an experienced clinician, preferably at B grade. Children's services should be considered separately.
- There should be an increased number of places available on Clinical Psychology training courses.
- The amount and content of Learning Disabilities training on Clinical Psychology training courses should be reviewed.
- Consideration should be given to the development of a network of CPD training within a Learning Disabilities context and focused on newly qualified staff with a requirement to participate. This could also be expanded to cover staff at different stages in their careers
- A set of core competencies for psychologists working in Learning Disabilities should be developed. Consideration should be given to the changing role of psychology within Learning Disabilities, e.g. seeing more complex cases.
- To aid career progression and staff retention a new career structure for psychologists should be examined. This would include a review of the grades/spine points system.
- There should be a programme of management training for psychologists.
- The role of assistants and their ratio to trained staff should be considered.
- There will be no Learning Disability hospital provision after 2005 thus enhanced community services will be required. Planning should be taking place now to consider the shape of future service and workforce requirements.
- Consideration should be given to improved communications and national links between area services, e.g. networks for specialist services and whether there should be national lead persons for specialities.
- There should be an examination of how services are provided in rural areas. Should psychologists be jack of all trades or be specialists? This could consider the best way to spread skills, e.g. using intra Health Board specialists.
- There should be clear planning structures which enable psychologists to be involved at an early stage in service planning, e.g. input to HIPs and TIPs.
- The impact of the future organisation of health services requires to be considered, e.g. the provision of joint services with social work. How will Learning Disabilities Psychologists link with other professions, within teams (CLDTs), with Primary Care Workers and with other psychologists?
- A clear service plan for children's services and who provides them should be developed.
- A clear service plan for autism services and who provides them should be developed.

Membership of the Clinical Psychology Workforce Planning Group for Learning Disabilities

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Appendix D:

Executive Summary from the Workforce Planning Sub-group for Primary Care

- Recent Scottish Executive Health Department policy and guidance highlight the need for and direction of psychological intervention in Primary Care settings.
- The Primary Care Subgroup of the Clinical Psychology Workforce Planning Group (SCPMDE) carried out a small-scale survey of Psychology Departments in NHSScotland. The findings include the following:

– despite a significant evidence-base, Primary Care psychology services have developed on an 'ad hoc' basis, with little evidence of needs assessment, planning or promoting service development through Local Health Plans or Trust Implementation Plans

– long waiting times pertain for psychological treatment for adults across NHSScotland. Increasing demand consistently outstrips resources

– with very few exceptions, there is little evidence that psychologists are integrated members of Primary Care Teams, nor have bases in surgeries or health centres

– the bulk of work in Primary Care by psychologists is carried out with adults in direct one-to-one therapy

– there is limited access by Primary Care to elderly, child and health psychology services

– government policies have had little discernible impact on delivery of psychological services: the main focus being on tackling waiting times

- There are currently two broad psychological service delivery models which are reflected to varying degrees across LHCCs and Mental Health Services:

– psychologist providing clinics for direct patient contact for all of the dedicated time

– a 'tiered' model of psychological care, where the patient meets the right level of psychological competence according to need: the psychologist provides supervision, teaching and work with complex cases, as well as research, audit and prevention projects. This second model is emerging as an effective use of skilled resource (which can include other specialist therapists)

- Workforce planning in Primary Care must therefore take account of the impact of the wide range of professional and voluntary agencies concerned with psychological health in the community and Primary Care.
- In 1999, 172.74 WTE psychologists were identified as working within Primary Care and Adult Mental Health (i.e. 43.55% of all psychologists in Scotland). The majority of this resource is dedicated to attempting unsuccessfully to minimise waiting times. Time to develop the 'service re-design' recommended in HDL 75 (2001), and described as the second model above, is elusive unless specifically protected and funded.
- Regardless of the service model adopted, however, there is a dearth of trained psychologists in Primary Care. It is estimated that an increase of 58% within Primary Care and Adult Mental Health (excluding continuing care) would allow for a reduction in waiting times, as well as, at best, a revision of the most appropriate use of psychologists' time in these settings.

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Appendix E:

Glossary Of Abbreviations

ACPAC:	Area Clinical Psychology Advisory Committee
AHP:	Allied Health Professionals
BPS:	British Psychological Society
CAPISH:	Clinical and Applied Psychologists in Scottish Healthcare
CMO:	Chief Medical Officer
CPD:	Continuing Professional Development
CSBS:	Clinical Standards Board for Scotland
DoH:	Department of Health
ISD:	Information and Statistics Division
LHCC:	Local Healthcare Co-operative
MMR:	Measles, Mumps and Rubella combined vaccination
NES:	NHS Education for Scotland
NHS:	National Health Service
SCPMDE:	Scottish Council for Postgraduate Medical and Dental Education
SIGN:	Scottish Intercollegiate Guidelines Network
SIWPG:	Scottish Integrated Workforce Planning Group
SSPS:	Scottish Standard Payroll System
WFP:	Workforce Planning
WTE:	Whole Time Equivalent