Clinical Psychology Workforce Project
Division of Clinical Psychology UK

Dr Alison Longwill
Chartered Clinical Psychologist
Woodcote Consulting
Tel: 0207 148 7170
Mob: 07976 745396
mailto:alison@woodcote-consulting.com
November 2015
EXECUTIVE SUMMARY

Aims of the Project
The Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) commissioned an UK-wide Clinical Psychology Workforce Project with two main aims:

1) To gain a more accurate profile of the number and whole time equivalent (w.t.e.) profile of clinical psychologists in the UK, including gaps and inequities in service provision. For instance:

- Clinical psychology workforce by demography (age, gender, ethnicity), pay band, type of contract/hours or work, employer type, geographic location
- Clinical psychology specialisms (also by demography, pay band, type of contract/hours or work, employer type, geographic location
- Linking the above profiles to other indexes of need (e.g. index of multiple deprivation; population of area, NICE guidance etc.)

2) To identify and promote the important roles and increasing demand for clinical psychology skills in the delivery of health and care in both the public and private sector, linked to national policies and increased public demand for high quality psychological services

Key findings
The key findings of this project are outlined in data sources referenced in Sections 5; 6; 7; 8; and 9.

Demography

Around 80% of clinical psychologists are female (see 5.1) and this has implications for part-time working related to child-care and other caring responsibilities. There will be a need to ensure that training places match the requirements for part-time working and locum cover during periods of parental leave (see 10.8).

The modal age group for UK clinical psychologists is ages 35-39 and the mean age is c. 42 years overall (see 5.1; 6.1; 7.1; 8.1;).

A significant number of UK clinical psychologists intend to retire at age 55 (linked to mental health officer status) or at age 60 and this has implications for future service demands (see 10.1.1).

There are an increasing number of clinical psychologists in practice from black and minority ethnic groups (see 6.3; 7.3; 8.3) but this percentage still falls short of BME representation in the general population of the UK.

Geographic distribution: equity of provision

There are significantly fewer clinical psychologists per 100,000 head of population in Northern Ireland and Wales (see 5.3).

There are considerable inaccuracies in the central statistical information collected on numbers of qualified clinical psychologists with misattribution of other non-clinical psychology staff allocated to clinical psychology grades. This has resulted in an overall 10-15% over-estimate of the clinical psychology workforce (see 6.5.1; 9.2). This introduces a significant error factor in relation to current and future supply and demand modelling for clinical psychology.
There is also considerable variation in numbers and gradings of psychologists between various Regions and NHS Trusts within Regions (see 6.4; 6.5; 6.6; 7.5; 8.4; 9.2.1).

**Impact of austerity**

There is evidence that a number of clinical psychology senior posts have been down banded over the last 5 years; related to the climate of austerity in NHS and other public services and the requirement to meet cost-saving targets. This has been associated with loss and diffusion of leadership in some services (see 10.30.3).

**Areas and sectors of work**

Clinical psychologists work in a wide variety of specialities and areas of work (see 7.8; 9.2.2; 10.9). Around 80% of UK clinical psychologists work in the following specialisms (in descending order) – see 7.8; 9.2.2; 10.9)

- Adult Mental Health
- Child and Family
- Learning Disabilities
- Clinical Health Psychology
- Neuropsychology
- Older Adults
- Forensic
- Paediatric psychology
- Management
- Teaching and training others

The majority of UK clinical psychologists work in secondary and tertiary care services with only around 13% in primary care and 10% in higher education (see 10.9.1)

Developing areas of practice include services for older adults, sexually transmitted disease, addictions, long term physical health conditions, autism and Asperger’s Syndrome and brain injuries services.

Although the vast majority of UK clinical psychologists work in NHS services, there is an increasing trend for clinical psychologists to have some employment (or self-employment) outside their main NHS employment (see 10.4). Around 15% of clinical psychologists undertake additional employment of this type and this may represent a growing trend as people seek to diversify their prospects for income and career progression.

Most clinical psychologists (80%) have permanent employment contracts with the NHS but there has been some increase in fixed and short term employment contracts and locum work (see 7.9; 9.2.3; 10.7)

However, there are generally very high levels of retention of clinical psychology staff within NHS services (see 7.119.2; 12.3) and very low attrition from clinical psychology training courses.
This survey likely under-represents those psychologists engaged in independent practice as it is difficult to collect information about the range of organisations (often small or individual practices) involved in delivering care to this sector.

Professional membership

Around two thirds of online survey respondents were full members or in-training members of the DCP (see 10.29)

A significant minority of respondents reported that as they had to register with HCPC they did not see added value in becoming members of the BPS. This indicates that they did not recognise HCPC prime function as a regulatory body rather than a professional body supporting the development of psychology.

Key themes, concerns and service gaps

A narrative analysis of survey responses (n=1126) regarding clinical psychologists’ issues and perceived service gaps (see 10.30) revealed the following key concerns:

Lack of career progression
1. Preceptorships not used
2. Bands 7/8a career grade now, limited senior roles to apply to
3. Clinical psychologists moving areas, working part time, moving speciality to progress
4. Not supported with Continuing Professional Development to progress

“More for less” demanded
5. Down-banding of posts
6. Same pay, expected to do more
7. Newly qualified staff doing more in role than in past
8. Non-clinical psychologists doing parts of clinical psychologist role for less money

Need for broader working
9. Need to broaden role from just therapy e.g. consultancy, teaching, research
10. Not enough time to use other skills e.g. research, service development
11. Split in responses as some do not want to broaden their role out of tier 4 therapy
12. Need individuals to show more leadership

“Too much pressure”
13. Reduced funding, fewer clinical psychologists but waiting lists going up
14. Limiting targets reducing flexibility/creativity
15. High risk and complexity of case work

Non-NHS work in other public sector/independent and third sectors
16. Creative work possible, can be more rewarding
17. Feeling forced out of NHS due to lack of career progression, the pressure etc.
18. Need more support for non-NHS clinical psychologists from DCP/BPS
19. Trainees should be trained for working in non-NHS sectors too
20. Other organisations filling gaps in NHS services

Leadership needed
21. DCP needs to be stronger, advocate more and challenge more
22. Clinical psychologists need more training in leadership
23. Clinical psychologists need to undertake more management roles
24. Leadership roles key for clinical psychologists in services as managers and Board members
25. Want clarity on “what DCP is for” and why psychologists should join
26. Want DCP to be like Royal College of Psychiatrists

Career structure issues
27. Loss of Assistant Psychologist role
28. Loss of senior posts limiting supervision
29. Progression from undergraduate to consultant clinical psychologist unclear in NHS
30. Guidelines needed for what each grade of psychologist does/key competences
31. Neuropsychology training issues - access limited for many practising

Physical health development
32. Potential for increasing clinical psychologist roles in health services
33. Preventative and wellbeing promotion work

Resilience issues
34. Burn out, stress and demoralised by work pressures and bullying/blame culture
35. Clinical Psychologists well placed to lead to supporting others to be resilient
36. Need protected time for reflection and resilience building

Uncertainty about future
37. Ongoing threats of service reviews and down banding
38. More temporary or fixed term contracts
39. Future of profession in NHS unclear

Areas of development
Areas of service development and expansion include:
• General/physical health
• Older adult/dementia services
• Psychosis/inpatient services
• Personality disorder
• Private/independent practice
• Work for third sector/local authority/social care
• Child/CAMHS services
• Autism/Asperger’s Syndrome
• Neuropsychology/brain injury services
• Forensic services
• Occupational health
• Training others/supervision
• Complex case formulation
• Management and leadership of services
• Role in accreditation/regulatory bodies
• Commissioning and service development

Recommendations

The following recommendations arise from this project and need to be prioritised for further discussion and development:

Robust needs analysis

1. A systematic analysis of need for current and future clinical psychology services linked to national policies, best practice guidance (e.g. NIHCE guidance) and research evidence needs to be undertaken.

2. Evidence-based norms for high quality, effective clinical psychology services need to be developed and disseminated to service commissioners and providers and existing BPS guidance should be updated.

3. Recommended staffing levels should take account of geographic needs (e.g. rurality) and local indices of social deprivation.

Developing a robust workforce plan and model for clinical psychology

1. There is an urgent need to develop more robust supply and demand modelling for clinical psychology on a National basis.

2. Workforce development for clinical psychology should be underpinned by national policy implementation requirements and thorough analyses of needs, linked to sociodemographic indicators and the views of actual and potential service users and carers.

3. The workforce plans should include realistic assumptions about workload and specification of outcome measures.
4. Workforce plans need to factor in issues such as staff turnover, increasing trends for part-time and "portfolio" careers, early retirement and work outside traditional NHS services.

4. The workforce plan should address career progression pathways and key competences for each level of work.

5. Workforce plans (local, regional and national) should horizon scan for likely demographic changes and development of new specialty services with a five to ten-year development plan.

6. Clinical psychology workforce plans should be integrated within an overall strategy and development plan for psychological services.

**Addressing equity of provision**

1. Geographic and socio-demographic inequities in provision of clinical psychology services should be identified and addressed by those lead psychologists and those responsible for commissioning services to ensure fair and equitable access to services.

2. Retirement profiles and increased part-time working trends should be identified and addressed to ensure current and future continuity and stability of services.

**Expanding areas of need and demand**

1. Clinical psychology workforce plans need to include the increasing requirements from non-mental health NHS services (e.g. clinical health psychology (including public health, child and family services, neuropsychology, older adult services; employee wellbeing, expanding roles in IAPT and primary care) for clinical psychologists' expertise.

2. An increased role in primary prevention of psychological distress and more engagement in early intervention/primary care services are under-developed areas for clinical psychology.

3. The British Psychological Society should collate and provide increased evidence of the cost-effectiveness of their service delivery for the health and care economy.

4. The British Psychological Society should collate and provide increased evidence of the cost-effectiveness of their service delivery for the health and care economy.

**Scoping needs of non-NHS public and independent sector**

1. The needs of non-NHS employers including other public sector, private, independent and voluntary sector organisations need to be identified and to inform future training commission provision.

**Improving accuracy of baseline data**

1. Workforce planning for clinical psychology needs to be predicated on accurate baseline data. Inaccuracies and coding anomalies need to be addressed at national and local level and any misrepresentations in supply and demand modelling need to be rectified.

2. There needs to be a robust funded system for routinely and regularly collecting accurate information regarding clinical psychology workforce which is broken down by demographic characteristics of the workforce, locality, specialty and banding and which is routinely used for
workforce planning by commissioners and service providers. This is essential to identify trends in workforce supply and demand.

3. Proposals for developing a more robust workforce analysis and planning system for applied psychology (incorporating clinical psychology and other applied psychology divisions) should be supported by the British Psychological Society, Health and Care Professions Council and Health Education bodies in the UK.

**Engaging psychology leads in workforce planning**

1. Clinical psychology leads should be involved in workforce planning and check the accuracy of their local workforce information

2. Ensure that leadership and consultant clinical psychology posts are maintained at a sufficient level to maintain and develop services and ensure high quality and governance of psychological services.

3. Clinical psychology service leads should be fully involved in shaping current and future workforce plans for clinical psychology with senior managers, directors of their organisations and commissioners of service.

**Leadership**

1. Improve the quality and development and to manage clinical risk through expert supervision and guidance in psychological practice both within and outside the profession.

2. Development opportunities for extended clinical and leadership roles (including management and commissioning of services) should be identified and supported in accordance with recommendations of the Rose Review.

3. Psychology leads should contribute to leadership and development in provider, commissioning and accrediting or training bodies.

4. Strengthen local, Regional and National alliances to support clinical psychology service development. The BPS/DCP can play a pivotal role in promoting this professional structure and links to other key stakeholders, including service users and carers.

**Impact of austerity**

1. A more thorough analysis of the impact of down banding and loss of posts in service areas is needed, with a requirement to address areas where this has clearly resulted in decreased quality of service delivery, poorer outcomes and more limited access to psychological intervention. The impact on clinical psychology workforce morale and effectiveness should also be assessed and addressed.

2. Reduction in the competency and resilience of the clinical psychology workforce through loss of leadership and senior clinical consultant level posts will have an adverse effect on governance and outcomes in a climate of increasing demand and complexity of psychological needs of the population.

3. Evidence for the cost-effectiveness of psychologically informed systems of care and interventions should be developed and disseminated to provider—managers and commissioners of service.
Wider roles for clinical psychologists in systems and development of evidence-based practice and quality of healthcare

1. The wider contribution of clinical psychologists in consultancy, service development and management, research, development of outcome and clinical standards measures needs to be acknowledged and developed in health and care systems.

2. Supervision, reflective practice, and teaching/higher education are key areas to maintain quality and effectiveness of psychological service provision.

3. The depth and breadth of clinical psychology undergraduate and postgraduate academic training uniquely equips clinical psychologists to undertake a broad role in health and care design, development and delivery; including development of the evidence base for interventions and outcome measures. This includes the development of innovative, integrated services to improve health and wellbeing and prevention of distress.

4. Providers and commissioners should identify clinical risks associated with of poor quality of care and clinical outcomes if therapies and psychological interventions are misapplied and clinical psychologists can play a lead role in the governance, quality assurance and accreditation of such interventions.

5. A Chief Applied Psychologist post may be a useful addition to National planning for the psychological professions and help to ensure that psychological perspectives in the design and delivery of health and care systems are fully embedded in delivery.

Training and supply of clinical psychologists

1. A raft of national government policies highlights the contribution of psychological science in their development and implementation requirements, pointing to an increased demand for clinical psychology skills and expertise (see Section 3).

2. No further cuts to clinical psychology training should be envisaged until the policy implementation requirements for clinical psychologists have been fully scoped and analysed, as converging evidence would suggest the need for around a 10% increase rather than decrease in such posts is indicated. Psychology leads in a number of specialties report difficulties in filling some psychology vacancies including at the most junior (Band 7) and senior consultant posts (Band 8c and above), indicating a buoyant demand for clinical psychologists and need for more training opportunities. Currently, only 1 in 6 applicants for clinical psychology training achieve a training place (3968 applicants for 591 training places in 2015), suggesting that there is a robust supply of suitably qualified applicants for expanded training places.

There is a need to increase commissioning of training of clinical psychologists overall, with a particular focus on Regions with a low level of service and training provision. Statistics show that clinical psychologists tend to stay in the area where they have trained, further supporting the need for local training provision.

Resilience and capacity building.

Strategies for improving the resilience and wellbeing of the clinical psychology workforce need to be developed, including access to appropriate supervision, continuing professional development and personal support. This will help to address issues of burnout and low morale and improve the quality of service for service users and carers.
New models of applied psychology in health and care?

1. Development of new models of service delivery for clinical psychology should be evaluated including the potential for broader applied psychology services incorporating clinical, counselling, forensic, health and occupational psychologists offering flexible, tailored services to a variety of provider and commissioning organisations