Guidance on clinical psychology workforce planning

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Aims
The purpose of this guidance is to advise clinical psychologists and their local colleagues on methods of clinical psychology workforce planning, and to provide information to help to persuade others of the value of an appropriate clinical psychology workforce within local health services.

Introduction
Psychological care and psychological aspects of health and social care are at the heart of current national priorities for health services. This is evident, for instance, in the inclusion of mental health within the four priority areas set by the public health White Paper Saving Lives: Our healthier nation (Department of Health, 1999a). It is also evident in the fact that the other three priority areas of cancer, coronary heart disease and stroke, and accidents all require behavioural and lifestyle changes. In addition, there is a strong psychological emphasis running through the National Service Framework for Mental Health (Department of Health, 1999b) and the NHS Plan (Department of Health, 2000), with the latter retaining mental health and older people's services as priority areas for development.

The services that clinical psychologists can provide are therefore of huge national importance in the modern NHS, yet the clinical psychology workforce remains inadequate, as it has been for decades. Despite these national acknowledgements,
there are often local needs to justify proposed workforce developments, and this results in a steady flow of requests for advice to the Society office.

Different perspectives on workforce planning are possible. These include, firstly, a national training perspective, considering the current overall clinical psychology workforce and likely future needs in order to estimate the numbers of training places that should be commissioned. The current national arrangements, along with those for other NHS professions, are under review at the time of writing. A consultation document on the review of NHS workforce planning can be viewed at www.doh.gov.uk/wfprconsult. Readers of this paper beyond the consultation period will still find the information on national workforce planning at the Department of Health website, www.doh.gov.uk.

A second perspective is a population-based one, in which the size of the proposed clinical psychology workforce is derived from the size of the local population. The guidance that follows offers some suggested workforce figures, broken down by specialisms, linked to local population. However, the main approach offered here is guidance on methods of establishing needs for local clinical psychology services. This is the approach shown by a recent survey to have been most effective in securing developments in local clinical psychology workforces. This paper is written to provide guidance for people (primarily clinical psychologists) involved in local clinical psychology workforce planning.

**Background**

Early work aimed at clarifying clinical psychology roles and establishing appropriate staffing levels was published in the Trethowan Report (Department of Health, 1977), The Management Advisory Service Report (1989) and The Manpower Planning Advisory Group Report (1990). A separate reference list (Jellema, 1999) records many attempts to grapple with these problems over several decades. However, the issues remain complex and no simple answer has been achieved. The topic continues to exercise the NHSE Workforce Planning Unit, and clinical psychology workforce planning appears within the action plans set by the National Service Framework for Mental Health (1999).

**Which methods have worked in developing clinical psychology workforces?**

The Service Development Subcommittee distinguished two broad approaches to local workforce planning:

- **Population-based approach.** The first approach is to recommend a single set of figures that link the recommended clinical psychology workforce to population, or sets of figures linking workforce within each specialism to population. This has the advantage of simplicity, and is the approach used by the medical Royal Colleges. However, it is important to note that the Colleges have the power to deny accreditation for junior doctor training if consultant staffing is inadequate. Without this accreditation junior doctors in training grades, who comprise a substantial part of the hospital medical
workforce, cannot be employed. No such power resides within clinical psychology.

- Needs-based approach. The second approach is to advise on the features of the local environment and local health needs that should be taken into account in planning an appropriate clinical psychology workforce. This approach has higher face validity, as it is obvious that different numbers of psychologists in different specialities are and will be required in different places, and may therefore be more persuasive to managers and commissioners. The subcommittee sought opinions on the relative merits of these and other approaches as follows.

Survey of clinical psychologists
A brief questionnaire, enquiring about which methods had actually worked in securing appropriate developments in the local clinical psychology workforce, was circulated with the June 1999 Clinical Psychology Forum. The results were as in Table 1.

More than half our respondents said that a needs-based approach had worked, but more than a quarter favoured the use of both approaches. Other comments illustrated a useful range of methods: identifying needs locally and more widely, using evidence from local experience and more widely, building stakeholder relationships and seizing opportunities. However, one in seven of our respondents said that nothing had worked, perhaps illustrating the value of this whole exercise — help is required.

Views from the NHS Confederation
The reply to our enquiry from Andrew Foster, a Trust chair writing on behalf of the NHS Confederation, concurs with psychologists' overall support for a needs-based approach. This reply also draws attention to the value of linking with major national initiatives, specifically the National Service Framework.

A needs-based local approach
The survey and the views from the NHS Confederation summarised above suggest concentration on a needs-based local approach to clinical psychology

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>Population based</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Needs based</td>
<td>47</td>
<td>62</td>
</tr>
<tr>
<td>Both</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Neither</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Total replies</td>
<td>91</td>
<td></td>
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</tbody>
</table>
workforce planning. Whatever progress is made nationally on training needs assessment, identifying the competencies of psychologists or detailing numbers of psychologists in other health districts, the need for further local work is likely to remain. In a time of increasingly sophisticated health care commissioning and a growing emphasis on evidence-based practice, the case for workforce developments will also need to be made on the basis of local health care needs, and guidance on how clinical psychologists can help to meet them. The task is complex, and no easy solution is available. However, guidelines on methods and information sources are available.

The approach proposed here therefore is to:

- make explicit the distinct range of services clinical psychologists are capable of providing;
- identify features of local populations and organisational environments that determine the needs for clinical psychology services;
- clarify realistic and effective work patterns;
- offer guidance on practical steps to integrate knowledge of psychological services with the local environment so as to arrive at the clinical psychology workforce needed.

Clinical psychology skills and services

The range of work carried out by clinical psychologists is as follows:

- Direct clinical services. These are psychological assessments and interventions. They include psychometric, interview and direct observational approaches to assessment, and a range of psychological therapies, including cognitive behavioural and psychodynamic models which may be applied to work with individuals across the age range, couples, families or groups.

- Disseminating and promoting wider appropriate use of psychology in health care. This includes teaching, supervision and consultation, as well as the production and dissemination of guidance materials for staff or health service users, helping them to use psychological approaches.

- Research and development. Most clinical psychology research and development (R&D) in the NHS is service-related and applicable research — generally the development part of research and development. The most common kind is service evaluation — systematically examining to what extent and how particular health interventions affect the people to whom they are offered.

- Organizational and service development work. Clinical psychologists frequently contribute to the management, planning and development of their organisations. Managers and people with responsibility for developing and improving services share with clinical psychologists the core purpose of helping people to adapt and change.
The balance of work across these categories varies quite properly between localities and according to local needs. However, most clinical psychologists spend most of their time on the first work category - direct clinical work, and work of this kind is applicable across the spectrum of health problems.

Established specialisms in clinical psychology include adult mental health, child and adolescent mental health, couples and families, neurosciences, learning disability, older adults, physical disability, physical health problems, substance misuse and sexual health.

Local environments and needs

The fundamental basis for workforce planning is the health needs of the population served by the Trust, combined with awareness of the capacity of different staff groups (in this case clinical psychology) to contribute to meeting those needs.

- Overall NHS priorities. Local needs assessment and priority setting both take place within the context of increasingly clear national priorities. Key documents summarising these overall priorities are *The New NHS* (Department of Health, 1997) and *Saving Lives: Our healthier nation* (Department of Health, 1999a). National priorities are summarised in a recent NHS Confederation Briefing (NHS Confederation, 2000). Department of Health press releases, publications and circulars can all be viewed at the Department of Health website, www.doh.gov.uk. Within this context, the following are particularly important feature of the local population and environment.

- Client groups. Which client groups are served by the Trust? A Community Trust serving people with the full range of mental and physical health problems and disabilities in community settings will benefit from psychologists with appropriate expertise across a wide range of appropriate specialisms, including adult mental health, older adults, physical health, physical disability, child health, child mental health, substance misuse and perhaps others. A Trust providing acute hospital services would require a different range of specialisms and subspecialisms (disability rehabilitation, cardiac rehabilitation and pain management, for instance) but the same principles would apply.

- The population served. Population numbers cannot automatically generate numbers of psychologists needed, but there is of course a relationship between the size of the population served and the numbers of psychologists needed to meet their health needs. Having considered the client groups served and from that identified appropriate specialisms and subspecialisms, the size of the population needs to be taken into account in considering the numbers of psychologists needed within each specialism. Where should psychologists be deployed, and with whom should they work, in order to provide accessible services to meet the health needs of the population?

- The health needs of the local population. More detailed information, including deprivation indices, geographical factors and the health needs of particular
ethnic groups will supplement the information considered under the previous heading. Targeting inequality is a main theme in current NHS thinking. These factors should affect the specialisms and groupings within the local psychology department as well as the numbers within the groupings. For instance, in some localities it may be appropriate to establish a psychology sub-specialism working with a particular ethnic group, sex industry workers or other groups that may not exist in significant numbers in other localities at all.

- The Trust’s strategic emphasis. Some Trusts emphasise research and development, with a successful track record, strong partnerships and major R&D income, whereas others have a clear emphasis solely on meeting the health needs of their local population and others again emphasise innovative, perhaps preventive, care. Other emphases may be discerned. Differences of these kinds will influence the psychology specialisms and subspecialisms needed, and the numbers and particular skills of psychologists within them.

- The interests and needs of partner agencies. Partnership working is increasingly valued by the British Government throughout health care. Understanding the needs and interests of partner organisations can undoubtedly be extremely fruitful, and requires the development of personal contacts with key individuals in these organisations. Important partner organisations will be local primary care groups (and increasingly primary care Trusts), the health authority, the local social services department and local education authority. The need to involve service users in service planning and delivery is increasingly acknowledged. It is also useful to involve the local Community Health Council.

The importance of partnership working is shown by the fact that all major plans for developments in health services are drawn together in a Health Improvement and Modernisation Programme (HIMP) produced by each health authority in collaboration with its provider Trusts and the agencies outlined above. The NHS is a huge and hugely complex organisation, and readers needing more details on organisational structures are advised to seek further information, for instance in The Pocket Guide to the New NHS (NHS Confederation, 1999). Further information is available at the NHS Confederation website www.nhsconfed.net.

- Other providers of psychological services. Other providers of psychological services within health care include psychiatrists, psychotherapists, counsellors, nurse therapists and art therapists, as well as other applied psychologists, notably counselling psychologists and health psychologists.

**Realistic and effective work patterns**

It is not possible to prescribe a single work pattern for all clinical psychology posts. Rather, good management practice involves reviewing the job description and requirements for a particular post and agreeing an appropriate work pattern having taken account of a number of considerations, including:
the most appropriate service model for different services and specialisms;

the most appropriate psychological models for a particular service or client group;

the most appropriate modality for a particular service or client group;

special tasks and job requirements that may require specific time allowances;

the impact and demands of the work setting;

the impact of urgent demands that cannot be planned for within routine work patterns;

appropriate expectations of duties at differing grade levels;

the benefits of effective utilisation of experience;

the levels of complexity or challenge inherent in the workload demands and expectations;

the demands of appropriate teaching and training;

the requirement of appropriate and adequate supervision;

the need for appropriate research and evaluation;

adequate and appropriate opportunities for CPD;

the availability of peer support mechanisms;

appropriate levels of professional activities;

the stress of an individual’s work pattern and appropriate methods of avoiding negative consequences;

the impact of appropriate administrative tasks;

the availability of adequate secretarial and clerical support;

the availability of and ease of access to essential equipment and materials;

the training and supervision requirements of assistant psychologists;

Within management relationships, and especially through the staff appraisal process, the realism and effectiveness of intended work patterns should be monitored.

Putting principles into practice

Overview. The guidance below draws together the foregoing information to aid decisions on:

- the clinical psychology specialisms and subspecialisms required;
- the particular workstyles needed (emphasising clinical service provision, R&D and so on);
- the likely size of the specialisms and subspecialisms needed;
- The organisation and gradings that are appropriate;
- Appropriate management arrangements.

- The needs-based approach. The needs-based approach should operate at several levels. The approach promoted here for workforce planning is based on assessing health needs and identifying ways in which psychologists can contribute to meeting these needs. This broad approach is recommended as a basis for developing local communications and relationships, and for targeting scarce resources. It is psychologically consistent, offering motivation to local decision makers and planners (because their job is to meet health needs) and facilitation (showing them how psychologists can help).

- Assessing population needs. Key local information should be available within each Trust's Business Plan, in the local Health Authority's Director of Public Health's Annual Report, and increasingly in Health Action Zone plans. The NHS Plan (Department of Health, 2000) and National Service Frameworks (the first of which — for mental health — appeared in 1999) will increasingly set clear standards and performance requirements for the services to be provided for particular client groups. All of these should give clear and wide-ranging information on local health needs and broad plans within health and related agencies.

- Local Plans. The local HIMP will summarise the main developments in health and social services agreed by the health authority and its partner agencies, providing essential background for the next planning round. Clinical psychology developments will need to be proposed and accepted for inclusion in the HIMP if they are to be funded.

- Assessing needs for specialisation. The nature of the Trust, its needs and the needs of its population lead on to decisions about the psychology specialisms that would be appropriate. Appropriate expertise normally requires a psychologist at Grade B or consultant level heading each specialism, and there may be needs for similarly deep expertise in subspecialisms such as rehabilitation and psychotherapy within the mental health specialism, for example.

- Organisational models. It is increasingly common for the different providers of psychological services mentioned above to be managed within a single department, usually headed by a clinical psychologist by virtue of the breadth of clinical psychology training across client groups and service functions. The intended benefits of this kind of organisational arrangement include improved co-ordination between professions, clarity for referrers, and improved skill sharing and continuing professional development.

- Management arrangements. Organisational structures should be designed to promote the delivery of the desired services — form should follow function. This should influence first the reporting arrangements for the
most senior psychologist. If psychology as a discipline is expected to contribute significantly to the overall direction, development and success of the organisation, then the most senior psychologist should report to a person close to or at Board level. Management arrangements for psychologists within particular specialisms should reflect the needs for effectively integrated multidisciplinary services on the one hand, and the needs for professional direction, support and therefore quality on the other. One solution is line management accountability within a psychology department, with co-ordinating relationships between local psychologists and managers. Another solution is line management of psychologists by local managers or clinical directors, with professional accountability within psychology.

**Recommended staffing levels for particular specialisms**

The attached staffing levels in Appendix 1 are extracted from DCP Briefing Papers or are recommended by DCP Special Interest Groups.

**References**


*November 2001*
### Appendix 1. Table of staffing levels taken from briefing papers

<table>
<thead>
<tr>
<th>Title</th>
<th>Client group, population or facility</th>
<th>Requirement</th>
<th>Other advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for children, young people and their families (1993)</td>
<td>No staffing levels as wider than clinical psychology</td>
<td></td>
<td>See Appendix 2</td>
</tr>
<tr>
<td>Psychological wellbeing for users of domiciliary services (1984)</td>
<td>General Population of 250,000</td>
<td>Minimum of 4.0 FTE to work with adults Services headed by Grade B.</td>
<td>Clinical psychologists will also be required to work with children with a learning disability. Separate arrangements will need to be made</td>
</tr>
<tr>
<td>Services for people with learning disabilities and their carers (1990)</td>
<td>Children, adults, and older people</td>
<td>Specialist skills according to client group. Staffing levels will reflect local service configuration</td>
<td></td>
</tr>
<tr>
<td>Services for people with diabetes mellitus (1994)</td>
<td>Per 260,000 per population guidelines from MPAIR Group, 1980</td>
<td>0 grade clinical psychologists with specialist skills should be employed to lead and coordinate psychology services for older people. Some services for older</td>
<td></td>
</tr>
<tr>
<td>Services for older people, their families and other carers (1998)</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>Additional numbers</td>
<td></td>
</tr>
<tr>
<td>Using clinical psychology services (1995)</td>
<td>No staffing levels given</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for people affected by HIV/AIDS (1995)</td>
<td>Regional variations in prevalence and HIV/Service development make any recommendations. Clinical psychologists at Grade B for each consultant service is identified, higher staffing levels would seem appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services to obstetrics and gynaecology (1990)</td>
<td>Every women's health unit</td>
<td>1 UTE</td>
<td>Grade B with relevant specialist skills and experience to head service</td>
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<td></td>
<td>Specialist services e.g. prevention and treatment of postnatal depression</td>
<td>Additional people</td>
<td></td>
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<tr>
<td></td>
<td>1990</td>
<td></td>
<td>be employed to lead and coordinate psychology services for older people. Some services for older</td>
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<tr>
<td>Title</td>
<td>Client group, population or facility</td>
<td>Requirement</td>
<td>Other advice</td>
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<tr>
<td>Services for people with acquired neurological disorders and their</td>
<td>Young adults</td>
<td>1 wte per 250,000 residents</td>
<td></td>
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<tr>
<td>careers (1996)</td>
<td>For each multidisciplinary team</td>
<td>Include 1 wte who has specialised in</td>
<td>Proportion of time spent on different activities will vary depending on service development. Optimum use may mean limited amount of direct clinical work. 1 session per week for research and evaluation.</td>
</tr>
<tr>
<td></td>
<td>working with young adults</td>
<td>neurophysiology</td>
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<tr>
<td></td>
<td>Regional neuroscience centres</td>
<td>Dedicated department of clinical</td>
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<tr>
<td></td>
<td></td>
<td>neurophysiology</td>
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<td></td>
<td>Children</td>
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<td></td>
</tr>
<tr>
<td>Clinical psychology in adult services (1996)</td>
<td>General Population of 30,000</td>
<td>Minimum 1 wte (Tradesman) to provide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>basic services</td>
<td></td>
</tr>
<tr>
<td>Clinical psychology in dentistry (1998)</td>
<td>Treatment of dental phobia</td>
<td>700 hours for each 1000 population</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>Clinical psychology services in substance misuse services (1997)</td>
<td>General Population of 250,000</td>
<td>1 wte. Service will depend on local</td>
<td>1 session per week for research and evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>need and pattern of substance misuse</td>
<td></td>
</tr>
<tr>
<td>Clinical psychology services in primary care (1993)</td>
<td>Depends on local needs and service</td>
<td>1 wte adult mental health psychologist</td>
<td>Proportion of time spent in primary care varies according to level of development. Established services should have time allocated to service evaluation, research and consultancy</td>
</tr>
<tr>
<td></td>
<td>and service developments including</td>
<td>per 30,000 population (Tradesman)</td>
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<tr>
<td></td>
<td>the range of other specialist</td>
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<tr>
<td></td>
<td>psychological services</td>
<td></td>
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<tr>
<td>Services to Black and minority ethnic people (1993)</td>
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<td></td>
<td></td>
<td>Need to employ staff who reflect the racial and cultural composition of the local community. Where possible a post with special responsibility for services to ethnic minorities should be developed, and this post's role would be to develop skills and awareness within the department or team rather than take all referrals of Black and minority ethnic people. Other roles would include development of appropriate services and consultation. The responsibilities of this job would suggest that it should be a Grade B post.</td>
</tr>
<tr>
<td>Clinical psychology in dentistry (1998)</td>
<td>phobia</td>
<td>1000 population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cosmetia dental care</td>
<td>No figures for incidence — no figures for staffing</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2. Recommended staffing levels for clinical psychologists working with children and young people

This guidance was ratified by the Division’s Special Interest Group for Clinical Psychologists working with Children and Young People in July 2000 and supersedes that given in Briefing Paper 1.

Clinical psychologists contribute to promoting the mental health of children and young people across all four tiers of service provision outlined in the 1995 Health Advisory Service report Together We Stand.

- At Tier 1 they provide support and consultation to primary level non-specialist-mental-health providers.
- At Tier 2 they work with wide range of problems in the community working as part of uni-professional groups.
- At Tier 3 they work as part of multidisciplinary teams focusing on more severe and complex problems.
- At Tier 4 they working in specialised day units, inpatient units or as part of highly specialised outpatient teams.

Although it is recognised that exact staffing figures will need to be developed on the basis of local assessment of need, the following staffing levels are recommended as a minimum for a general population of 150,000 by the British Psychological Society.

Tier 2. Working as part of uniprofessional groups
Three wte clinical psychologists to provide input for children with behavioural and emotional difficulties in the community and to provide support to Tier 1 service providers.

Tier 3. Working as part of multidisciplinary teams for more severe problems
Three wte clinical psychologists to provide input for children with complex and enduring psychological difficulties seen within Tier 3 of child and adolescent mental health services
Two wte clinical psychologists to provide input for children with disabilities as part of a child development team (one post pre-school, one post school age).
One wte clinical psychologist to provide input for children with paediatric conditions as part of paediatric liaison team.

Tier 4. Working as part of highly specialised units or teams
Additional specialist posts would need to be provided to specialist adolescent services, youth offending teams and looked-after children.
Continuing professional training, recruitment and retention, supervision and management need to be considered in estimating resources. Departments with ten or more qualified staff will need to allocate up to 0.5 fte for these tasks.
One wte administrative support is needed for every four wte posts.