

Predictions on the Future of Clinical Psychology in Wales: A Modified Delphi Study

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for the degree of Doctor of Clinical Psychology**

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Declaration

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

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SUMMARY

The NHS has recently undergone major reorganisations in both England and Wales, although this process has been significantly different in the two countries. In addition, severe financial cutbacks have affected public services throughout the whole of the UK, and look likely to continue to do so for some years. It is important to try to anticipate how these, and other, major changes are likely to impact upon clinical psychology in order for the profession to prepare to meet the inevitable challenges these changes will bring, and so that clinical psychology can continue to make the best possible contribution to healthcare.

This study utilised a modified Delphi survey (Linstone & Turoff, 2002) in order to attempt to produce a credible view of the future of clinical psychology in Wales in 2022. The Delphi method was originally devised as a means of forecasting the future by gaining the collective views of identified experts in the area of study. In this study, eight senior clinical psychologists from Wales participated in a semi-structured interview that was designed to gain their views on the likely future of clinical psychology in Wales. The transcribed interviews were then analysed, using Grounded Theory (Corbin & Strauss, 2008).

The interviews yielded eighty predictions concerning the future of clinical psychology in Wales in 2022. These predictions were communicated back to the experts, who were then asked to rate their agreement or otherwise with each prediction. The results were collated, and the implications for clinical psychology in Wales in 2022 analysed. The Grounded Theory analysis of the interview transcripts also produced a simple model for understanding the reasons behind many of the experts' predictions, and for guiding the generation of further predictions. The model was evaluated against the criteria of "fit", "understanding", "generality" and "control" (Corbin & Strauss, 1990), and "respondent validation" (Mays & Pope, 2000), and is proposed as a credible model for understanding and guiding further predictions on the future of clinical psychology in Wales in 2022.

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CHAPTER 1: INTRODUCTION

1.1 LITERATURE SEARCH STRATEGY

The purpose of this research project was to create a credible view of the future of clinical psychology in Wales in 2022. The literature considered to be relevant to the study included all publications concerning the future of clinical psychology generally, but particularly in Wales or the UK. Articles concerning the future of closely related professions, such as psychotherapy, counselling, or other branches of applied psychology, were also regarded as relevant. Systematic searches of selected databases were carried out in order to identify this literature. Searches of selected databases were also carried out to identify the relevant literature on forecasting methods.

In order to identify publications relevant to the future of clinical psychology in Wales, the following search terms were used:-

- Future of clinical psychology in Wales
- Clinical psychology in Wales
- Psychology in Wales
- Future of clinical psychology
- Future of psychology
- New Ways of Working
- Psych* and future
- Psych* and Delphi.

The academic databases searched were PsycINFO and Medline. It was thought that there might be some relevant publications in the non-academic literature, and so Google was also used.

In addition to searching these databases, the websites of the following organisations were searched:-

- The British Psychological Society
- The Division of Clinical Psychology of the British Psychological Society
- The Department of Health
- The NHS Information Centre
- The National Health Service
- NHS Wales
- The Welsh Government.

A systematic search was also carried out for articles about forecasting methods, using the following search terms:-

- Forecasting methods
- Forecasting methodology
- Prediction methods
- Prediction methodology.

The databases searched included PsycINFO and Medline, but it was thought that relevant literature might be in other databases, which were unfamiliar to the researcher, and so Google Scholar was also used.

The various searches did not identify a single publication specifically focussing on clinical psychology in Wales, and there was only one study concerning aspects of the future of clinical psychology in the UK which used an accepted forecasting method. Three further studies had employed forecasting methods to predict the future of psychology in the UK, but these were not restricted to clinical psychology. These four studies all employed Delphi methodology for forecasting.

The searches identified a number of studies which used forecasting methods (a type of Delphi survey, in all cases) to predict the future of other professions, some of which are closely related to clinical psychology. The majority of these were located in the

US rather than the UK. Finally, the searches found some publications which certainly addressed the future of clinical psychology, including in the UK, although still not specifically in Wales, but these were all either the predictions or the aspirations of individual authors, using no accepted forecasting methods.

1.2 CLINICAL PSYCHOLOGY: HISTORY AND DEVELOPMENT

1.2.1 The Beginnings

The term “clinical psychology” was first used by Lightner Witmer in 1907 in a journal article in which he described his work at the laboratory of psychology at the University of Pennsylvania. The initial focus of clinical psychology was upon school children who “had made themselves conspicuous because of an inability to progress in school work as rapidly as other children, or because of moral defects which rendered them difficult to manage under ordinary discipline” (p. 1). More than a hundred years have passed since Witmer’s innovative work, and in that time clinical psychology has undergone substantial changes. The scope of the profession has broadened enormously, so that now it encompasses all age ranges, and whereas, in Witmer’s laboratory, clinical psychology was entirely concerned with assessment, clinical psychologists have increasingly engaged in treatment and other forms of direct and indirect psychological intervention.

1.2.2 The Scientist-Practitioner Model

The changing roles of clinical psychologists have led to various attempts to define their exact nature and distinctive skills. One of the most influential of these was the adoption of the ‘scientist-practitioner’ model, which emphasised the research base of the activities. The “Boulder Conference”, held in Boulder, Colorado in 1949, is generally credited with being particularly influential in this. The Boulder Conference was convened by the American Psychological Association, in partnership with the Veterans Administration and the US Public Health System, in order to agree mainly upon the training of clinical psychologists. The model which the Conference recommended, and which was then adopted, was the scientist-practitioner model,

which emphasises that clinical psychologists should be trained and proficient in undertaking research, and also in the clinical applications of established psychological knowledge (Raimy, 1950). This model has had its critics from its beginnings (e.g. see Plante, 2010), but it has never been discarded by the profession, and a relatively recent survey of clinical psychologists in the UK, both qualified and in training, by Kennedy and Llewelyn (2001) concluded that most of them endorsed the model. They did note, however, that this support appeared to reflect more an “attitude to practice rather than a commitment to participation in the academic community requiring submission of research papers to refereed journals” (p. 77).

1.2.3 Clinical Psychology in the UK

The first training courses for clinical psychology in the UK were established in 1957, at the Maudsley Hospital and Tavistock Clinic in London, and the Crichton Royal Hospital in Dumfries, Scotland. The first training course for clinical psychology in Wales was an in-service NHS course, established in Cardiff in 1975.

It was shortly after this, in 1977, that another significant event in the history of clinical psychology in the UK occurred. This was the publication of a report on the role of clinical psychologists in the health service, by Trethowan (1977). Clinical psychologists at that time were struggling for more autonomy, including, for example, the right to accept referrals directly from GPs without needing permission from their psychiatrist colleagues. The Trethowan report recognised clinical psychology as an autonomous profession in its own right, and the report’s acceptance by the NHS marked a highly significant victory for clinical psychology. It is probably true to say that it was not accepted immediately, nor with complete good grace, by every psychiatrist, and the animosity between the professions which that struggle had fuelled still lingers in places, thirty-five years later. As recently as two years ago, a Consultant Psychiatrist known to the researcher refused to allow “his” mental health team to make referrals to a clinical psychologist. Such examples are relatively rare nowadays, but were commonplace prior to 1977. The Trethowan report also made recommendations about the organisation of psychology services, effectively creating the District or Area Psychology Departments, which found great favour with the majority of clinical psychologists. Finally, the Trethowan report stated what it

regarded as the core skills and roles of clinical psychologists, which were clinical skills, research and teaching.

1.3 CLINICAL PSYCHOLOGY AND THE NHS

As various commentators have pointed out, the history of clinical psychology in the UK is linked strongly to its place within NHS services (e.g. Turpin & Llewelyn, 2009). The NHS has funded the majority of training places since the first courses were established, and continues to do so. All the clinical psychology training places in Wales are currently entirely NHS funded. The NHS also employs the large majority of clinical psychologists, and sets a general standard for pay and conditions. It has, therefore, been highly influential in determining not only the numbers of psychologists, but also such things as areas of work, career opportunities and pathways, and the role of clinical psychologists in healthcare.

1.3.1 The MPAG and MAS Reports

The NHS was also essentially responsible for another important event in the development of clinical psychology in the UK. In the late 1980's it was becoming clear that the number of trained clinical psychologists was far short of the number of available posts, and that the number of training places available was nowhere near sufficient to hold out the prospect of any change in that imbalance in the foreseeable future. Accordingly, the Department of Health commissioned the Manpower Planning Advisory Group (MPAG) to review clinical psychology in the UK (1990). The MPAG, in turn, commissioned a report from the Management Advisory Service (MAS).

The purpose of the Review of Clinical Psychology Services (MAS, 1989) was essentially to identify the core competencies of clinical psychologists, to recommend upon the preferred model of services (i.e. the role of clinical psychologists), and to determine the levels of staff and skill mix required to fulfil that role.

The MAS report recommended that clinical psychologists should become fully independent practitioners, given equal status with medical practitioners, and taking responsibility for the provision of psychological care, either directly by the clinical psychologists themselves, or by other professionals working under their direction. The report called this the “shared-care” model. The report also recommended a large increase in the numbers of clinical psychologist posts in the NHS, with a commensurate increase in training places.

Not surprisingly, perhaps, the MPAG did not accept the MAS’s proposals for a “shared-care” model. Even if the MPAG had accepted it, it is difficult to believe that the medical profession would have been willing to countenance another profession being afforded equal status to its own. Despite this, the MPAG did acknowledge the shortage of trained clinical psychologists, and made recommendations to increase training places. In the event, though, one of the consequences of the 1991 NHS reforms which resulted from the 1989 white paper, “Working for Patients”, was that workforce planning became a regional role, rather than a centralised Department of Health role, and so the recommendations were never implemented. In Wales, workforce planning, and the training of adequate numbers of clinical psychologists, became the responsibility of the Welsh Office.

One of the purposes of the MAS report was to identify and describe the core competencies of clinical psychologists. The scientist-practitioner model of training and practice, although it was the most popular and influential model, was not accepted universally. One of the consequences of this was that, in 1989, when the MAS report was published, the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) did not actually have a formal statement about the core competencies of the profession. The MAS report, however, although essentially advocating the scientist-practitioner model, described the core competencies in a way which was new to the profession. It is difficult to improve upon the original wording from the report itself, so it is reproduced unchanged here:-

“The utilisation of psychology is not confined to clinical psychologists – it is used extensively by a wide range of healthcare staff. The range of other disciplines’ application of psychological techniques is infinitely variable, from no use of

psychological method, to being as skilled as a clinical psychologist in particular tasks. The range of psychological skill possessed across the various disciplines can be located within a skills framework related to three levels of activities:

- Level 1 basic “psychology” - activities such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.

- Level 2 undertaking circumscribed psychological activities (such as behaviour modification). These activities may be described by protocol. At this level there should be awareness of the criteria for referral to a psychologist.

- Level 3 activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

Clinical psychology is the only profession which operates at all three levels. It is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychology from other disciplines” (p. 3)

This description of the unique skills of clinical psychologists found considerable favour within the profession, and in 1992 the DCP published the first edition of the “Core Purpose and Philosophy of the Profession”. This document drew heavily from the MAS report, and described the unique skills of clinical psychology as being what the MAS report called “Level 3” skills. Subsequent versions of the document (e.g.

2010) retain this notion of the unique skills of clinical psychologists, and also reiterate the scientist-practitioner model of working:

“Clinical Psychologists are more than psychological therapists; they are scientist-practitioners” (p. 2).

“The transferable skills of clinical psychologists include the systematic application of an extensive range of theoretical models and a broad evidence and knowledge base to novel situations” (p. 4).

“Because of their particular training in the relationship of theory to practice, clinical psychologists will be able to draw on a number of models (bio-psycho-social) to meet needs or support decision making ... what makes this activity unique to clinical psychologists is the knowledge base and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise psychological data and knowledge from a psychological perspective is one that is unique to psychologists” (pp. 5-6).

The MAS report had also added to the three core roles of clinical psychologists identified by Trethowan (1977) of clinical skills, research, and teaching, and included staff support, supervision, service planning, management and organisational activities, amongst others. The DCP (2010) has now identified the core competencies of clinical psychologists as comprising :-

- transferable skills (essentially equivalent to MAS level 3 skills)
- psychological assessment
- psychological intervention
- audit and evaluation
- research
- personal and professional skills
- communication and teaching skills

1.3.2 Agenda for Change

In addition to such things as the MAS report (1989), there are, of course, many other influences which have shaped clinical psychology in the UK over the years, but there are a further two which are worth mentioning specifically, in order to understand the situation in which clinical psychology in the UK currently finds itself, and which may well have considerable implications for the future. The first of these was a specific event, the introduction of new pay and conditions of service for almost all staff groups within the NHS, as set out in Agenda for Change (Department of Health, 2004), and implemented in October 2004. The second is not one specific event, but more of a trend towards the privatisation of health care services, which has its origins in “Working for Patients” (1989), and which, in England at least, appears to be gathering considerable pace in 2012.

The broad thrust of Agenda for Change was to evaluate the job of all NHS employees (with the exception of medical staff and dentists, who successfully resisted being included, and the most senior managers, whose pay was often locally negotiated) against a common set of criteria. There were sixteen criteria in all, ranging from such things as the knowledge and experience required to do the work, and the scope of managerial and financial responsibilities, to the physical demands of the job. Each criterion was given a range of weighted scores, and each post was assigned a score for each criterion. The total number of points which the post scored determined the pay band assigned to that post. It was persistently rumoured, although never confirmed, that the Agenda for Change scoring had to undergo a hasty revision when, shortly before its general release, it was finally applied in a trial to clinical psychologist posts. Clinical psychology was the only non-medical profession at the time which required a doctorate level of basic training, and as a consequence, all clinical psychologist posts were found to score much higher than had been anticipated (the knowledge factor was by far the most heavily weighted of the 16 factors). The criteria were, it was rumoured, quickly revised, but clinical psychologist posts nevertheless tended to score very highly, and so were put on pay bands which were notably higher than those of colleagues from other professions.

The application of Agenda for Change to clinical psychology posts was not as consistent across the UK as had been intended, although clinical psychology was certainly not alone in that. Some posts, and even some whole departments, reported receiving much lower pay bands than they had expected. Many, though, gained increases in pay, some of them quite substantial. In Wales, although there was also some variation, no department suffered badly and most clinical psychologists were assimilated onto higher pay rates than they had previously received. The researcher, who had been heavily involved in the process of implementing Agenda for Change in his own Trust, was informed by the Finance Director that the highest percentage salary increase for any staff group in his Trust was for clinical psychology.

The effect of this was to turn the spotlight on clinical psychologists in a way which had not previously been the case. Perhaps not surprisingly, managers wanted to know what they were receiving for their money, and, inevitably, if such services could be obtained more cheaply. It became a common experience for clinical psychology services within NHS Trusts to experience considerable pressure to reduce pay bands of staff. Managers became keen to consider whether some, or even all, of the tasks of clinical psychologists, particularly psychological therapies, could be undertaken by other staff on lower pay bands. Agenda for Change facilitated this too. For example, if a manager wanted a person to carry out psychological therapy, it was no longer necessary to employ someone from any particular profession, or, indeed, from any profession at all. Agenda for Change allowed and encouraged employers and managers to look simply for a person with proven knowledge and experience of psychological therapy, for example, a diploma in Cognitive Behavioural Therapy (CBT). The pay of such a person could then be assessed based on them having a diploma level of qualification, rather than, for example, a doctorate in clinical psychology, or even a nursing degree, along with a diploma in CBT. The Improving Access to Psychological Therapies (Department of Health, 2008) project has made considerable use of this, employing people with a relatively basic level of, usually, CBT training at pay scales well below those of clinical psychologists. That is not to suggest that to do so necessarily provides a substandard service. There is clearly a considerable demand for this level of therapy, and, arguably, if someone can perform therapy competently at a reduced cost then it is not really justifiable for a clinical psychologist to undertake that work. The overall effect, though, has been for the costs

of clinical psychology, and the tasks they undertake, to be subjected to increasing scrutiny.

1.3.3 Privatisation of Healthcare

The trend towards the increasing privatisation of health care services has its origins in “Working for Patients” (1989). This was the attempt by the Conservative government at the time to improve the efficiency and quality of the NHS by imposing market forces upon it. This was done by separating the NHS into “purchasers” and “providers”, and by allowing the purchasers (i.e. the Health Authorities, and fundholding GP practices) the freedom to determine from whom they bought the services they required. They were not tied to purchasing from the Units or Trusts which had previously been part of the same organisation. The idea was that competition would drive up quality of care, as well as leading to the closure of inefficient or simply unnecessary health facilities (such as some of the London hospitals; well loved by the public, but regarded as superfluous). One of the consequences of this purchaser-provider split was that purchasers could look to other, non-NHS, services to provide the healthcare they required. Whilst healthcare would continue to be free at the point of delivery, it would not necessarily be provided by NHS employed staff.

When the Labour government came to power in 1997, many of the previous administration`s reforms were dismantled. For example, the power and the resources which had been given to fundholding GP practices, allowing them to purchase some services directly, were withdrawn and the fundholding scheme discontinued. The broad separation, though, between commissioners of services and providers of services was maintained, although the element of competition between providers was removed, allowing NHS services to remain more stable. With the return of a Conservative government, though, in 2010, it became clear that privatisation of healthcare was firmly back on the agenda.

England in 2012 is heading towards a massive reorganisation of the NHS, as first set out in the government white paper “Equity and Excellence: Liberating the NHS” (2010). These proposals were taken forward and established in the Health and Social

Care Act 2012, in March 2012. It is beyond the scope of this thesis to discuss this Act and its implications in any detail. It is clear, however, that it is a return to the Thatcherist view that increased competition is the chosen way to drive up quality and increase efficiency in healthcare. On 5th March 2012, the Department of Health website published an article by the Health Minister, Simon Burns, explaining how “well-regulated competition will offer people real choices, will help drive up the quality of care”. Peedell (2011), though, regards the Act as containing policies which will inevitably lead to increased privatisation of healthcare, and this is clearly now happening. There are many examples of clinical services being put out to tender, with bidders including for-profit organisations. For example, Serco, which is a large international company providing services in areas such as education and transport as well as health, has gained the contract to provide community health services in Suffolk, which will involve approximately 1000 staff transferring out of the NHS to become Serco employees (information obtained from Serco website, press release, 2012).

Some elements of the Act are also now having profound effects upon many clinical psychology services in England. The researcher has spoken personally to a clinical psychologist whose whole Speciality was made redundant, and other examples have been cited in personal communications on the DCP Managers Special Interest Group email network. Wales, however, is not subject to the Health and Social Care Act 2012, and so is not experiencing the same move towards privatisation of health care services as is happening in England.

1.3.4 The NHS in Wales

The NHS in Wales has always been slightly different from the NHS in England. Even before devolution, the NHS in Wales did not have Regional Health Authorities, as England did. The role of the English Regional Health Authorities was fulfilled by the Welsh Office, and the senior officers within the NHS in Wales were therefore civil servants, rather than career health service managers.

The situation in Wales changed further with the devolution of some of the powers from Westminster to the newly formed Welsh Assembly Government (WAG) in

1999. WAG, mindful of Welsh pride that the architect of the NHS, Aneurin Bevan, was Welsh, was committed to maintaining the NHS, and at one stage even gave a commitment to eliminate any reliance on non-NHS health providers. Whilst this was not achieved, and was probably not achievable, WAG did stop competition between providers, and encouraged NHS Trusts (providers) and Local Health Boards (commissioners) to work in cooperation, whilst remaining separate organisations.

Since the devolution of powers to WAG, which changed its name to the Welsh Government in May 2011, the differences between the NHS in England and the NHS in Wales have become considerably more marked and significant. Wales, for instance, never had Foundation Trusts, nor Primary Care Trusts, and, as mentioned, it is not subject to the Health and Social Care Act 2012. In England, much of the NHS revenue is to be given to GPs to commission services, but there are no plans to follow suit in Wales.

NHS Wales was the subject of a massive reorganisation in 2009, which involved the re-amalgamation of the commissioning organisations with the provider Trusts, resulting in the formation of Local Health Boards. With no split between providers and commissioners, there is no competition between providers, and so no scope for private companies to take over existing healthcare services, as has happened in Suffolk, and other places in England.

A final major difference between England and Wales which is likely to have a strong impact upon clinical psychology is the power of the Welsh Government to add to the Mental Health Act (1983). In 2010, the Welsh Government passed the Mental Health (Wales) Measure 2010. A “Measure” is effectively a local Act. The Measure requires mental health services in Wales to provide, amongst other things, services in primary care, assessments on demand for former users of secondary mental health services, and independent advocates for compulsorily detained patients. Exactly how the Measure will be implemented remains to be seen, but there are potentially important roles for clinical psychologists in the new services. For example, mental health services in primary care are highly likely to have psychological therapies as a major component.

It is clear that currently England and Wales are moving further apart in the way in which they approach the provision of healthcare. Huge similarities remain, of course, but there are already differences, and these are increasing. The effects of the different NHS systems in the two countries upon clinical psychology are also becoming clear. There have been no redundancies of clinical psychologists from NHS posts in Wales, and no services involving clinical psychologists have been put out to tender. Some vacant posts have certainly been lost, due to budget restrictions, but that has been a fact of life in the NHS for many years. Clinical psychology will be existing in a markedly different environment in each of the two countries, and so there is a strong likelihood that the profession will progress differently in each country over the next few years or more.

1.4 THE ROLE OF CLINICAL PSYCHOLOGISTS

1.4.1 Psychotherapist or Scientist-Practitioner?

The context in which clinical psychology operates, and will develop in the future, is different in Wales to that which exists in England. Nevertheless, many of the current concerns of the profession are common to both countries, and probably to Scotland and Northern Ireland too. The debates concerning various aspects of the activities and roles of clinical psychologists continue, as they seem to have been doing for many years. One major area of debate is essentially about whether the core role of clinical psychologists is to be a psychotherapist, or whether it should properly adopt the scientist-practitioner model. The January 2011 edition of Clinical Psychology Forum was a special issue, entitled “Clinical Psychology Getting Lost?” In it, Hassall and Clements (2011) argue that “clinical psychology is increasingly evolving as a psychotherapy profession” (p. 7). They question whether doing so will enable clinical psychology to survive and thrive in the future. Mowbray (2011), the author of the 1989 MAS report, in the same issue as Hassall and Clements, considers that “the clinical psychology profession took the money and ran after the MAS Review (1989) without implementing the justification behind supporting its continuation and expansion” (p. 35). He further considered that what was required was “an expansion from the narrow confines of clinical therapeutic activities, hence the need for greater numbers of psychologists, and a sharing of level 2 skills with other disciplines to

cover the demand, thereby releasing level 3 psychologists to focus on the complex issues of health” (p. 35).

Given the current environment in the NHS in England, and its move towards increasing competition and outsourcing services, it would seem crucial that the profession resolves this debate about exactly what its purpose and role should be. If clinical psychology as a profession is not clear about what it is there for, it is difficult to see how it can effectively market itself and expect to be purchased against any kind of determined competition.

That is not to imply that the problems which clinical psychology may encounter in the future have not been recognised by many people well before now. Indeed there have been many attempts to get the profession to agree a clear direction and to follow it decisively and collectively. Mowbray (2011) reflects upon the efforts he and others have made since clinical psychology “took the money and ran”. For example, he cites his proposal for a College of Healthcare Psychology (Mowbray, 1991) which would bring together the currently disparate applied psychology professions in healthcare such as clinical, counselling, health and forensic psychology. The purpose of such a college was to provide a wider base of psychological knowledge applied to healthcare, and to break down the barriers and rivalries between the various applied psychologists, which Mowbray (1991) believes have been hugely damaging to the image and reputation of the applied psychology professions.

In 2004, Taylor and Mowbray put forward a proposal for creating associate clinical psychologist posts. These were to be psychology graduates, trained to carry out level 2 therapy, thereby allowing fully qualified psychologists to work at level 3. This proposal was taken up in some places, but was then essentially overtaken by the Improving Access to Psychological Therapies initiative (IAPT). Neither the associate clinical psychologist idea, nor the IAPT initiative, have yet been taken up in Wales, although there is currently a working group looking at IAPT for Wales. Mowbray (2011) cites other initiatives he has suggested in the interim, but ends up lamenting that “few of these ideas have combusted beyond a spark of interest” (p. 37). He views the current climate as being right for the “assertive development of psychology as

force to be reckoned with” (p. 38), but is concerned that “anything less will confine the profession to a dark corner” (p. 38).

1.4.2 New Ways of Working for Applied Psychologists

The BPS has also taken seriously the problems clinical psychology may expect to encounter in the future, and the worrying lack of consensus around its role and purpose. New Ways of Working for Applied Psychologists (Lavender and Hope, 2007) was a joint initiative between the BPS and the National Institute for Mental Health in England, established in 2005, with the purpose of:-

1. Reviewing the roles of psychology graduates and primary care mental health workers.
2. Reviewing training needs for applied psychologists.
3. Mapping the workforce and identifying good practice.
4. Identifying the best organisational models for psychological services within the NHS. Reviewing the leadership development needs of applied psychologists.
5. Identifying how applied psychologists can improve access to psychological therapies.
6. Identifying the ways for applied psychologists to contribute within multidisciplinary teams.
7. Clarifying the role and training needs for applied psychologists in applying the new mental health legislation.

The New Ways of Working for Applied Psychologists (NWW) initiative consulted widely across the applied psychology professions and involved many other stakeholders in its consultations. Seven workgroups were set up to address each of the objectives listed above and each produced comprehensive reports which mapped out a coherent direction for applied psychologists in health, including clinical psychology. Five years and more later, however, there seems to have been a disappointing lack of change. The suggested role for psychology graduates seems to have been dropped altogether, or else superseded by the IAPT project in England, where, disappointingly, not all of the projects even include a clinical psychologist.

The suggested training models, which involved closer cooperation between the different applied psychology professions, are no longer even being considered, it seems. The aspiration for the leads of applied psychology services in Trusts to be board level appointments may have happened in a few places, but it is very rare at the most, and has certainly not occurred in Wales. In fact the board membership of the reconstituted Local Health Boards, which came into being in 2009 in Wales, is set out in the legislation which established them, and provides no place for the lead of any profession except medics and nurses. In short, NWW seems to have had little impact, and clinical psychologists, at least according to Mowbray (2011), continue to work in ways which in the long term may not be in the best interests of the survival of the profession.

1.4.3 Marketing Clinical Psychology

The DCP has recognised that the profession needs to establish clearly its identity, and also to make considerable efforts to ensure that its unique skills and potential contributions to health care are known and valued. That is, clinical psychology needs to market itself if it is to continue to thrive. The need for the profession to agree on its unique skills and then to market these effectively is reflected in the work done by the DCP to produce a marketing strategy for the profession (DCP, 2007a; 2008). The marketing strategy specifically recommended that the future of the profession should follow the direction laid out in the NWW documents and so represents an admirable attempt by the profession to determine its chosen future and then to work collectively to achieving it. As has been mentioned though, NWW has never really progressed, and the profession is still not agreed on its proper role and future. One of the areas addressed by the DCP marketing strategy concerned identifying the distinctive contribution clinical psychology can make to services. In modern parlance, what is clinical psychology's "added value"?

The core skills of clinical psychologists are put forward in a DCP briefing paper, (DCP, 2007b) and are given as:

1. Assessment
2. Formulation
3. Intervention
4. Evaluation and research
5. Communication

“Formulation”, as described in this paper, is essentially the application of level 3 skills as defined within the MAS report (1989). “Communication”, for some reason, is neither defined in the briefing paper nor discussed further, whilst teaching and training, which were identified as core skills of clinical psychologists in the Trethowan report (1977) seem to have been lost altogether (unless, of course, they are now “communication”). As a matter of interest, these core skills are very similar to, but not entirely the same as, the core skills listed in the 2010 edition of the DCP’s Core Purpose and Philosophy of the Profession.

The “added value” of clinical psychologists, as described in the marketing strategy, is regarded as something different from the core skills, and comprises the following seven themes: complexity, humanising, innovation, skilling others, versatility, psychologically informed services and motivation (DCP, 2007a). Each of these themes is discussed and explained in the strategy. They are noted as applying to adult mental health services, but the assumption seems to be that they actually apply more widely.

It appears to this researcher that the source of some of the potential problems clinical psychology may have to face in future, and perhaps is already having to face in England, can be identified in the previous three paragraphs. If the core skills of clinical psychologists are not in themselves distinctive enough to separate clinical psychology from other professions, then marketing the profession is clearly going to be difficult. In addition, if what is actually distinctive about clinical psychology can only be described in terms of a number of themes, the nature of which are certainly not all immediately obvious from their title, then it is hard to see how clinical psychology is going to be able to get the message across easily and, just as

importantly for effective marketing, quickly. The profession appears to need a better, clearer way of describing its activities and qualities to help it in the task of marketing itself over the coming years. The researcher has been asked many times over the course of his career “what does a clinical psychologist actually do exactly”? There is a great need for an easy answer to that question, and one which the whole profession will endorse.

1.5 THE FUTURE OF CLINICAL PSYCHOLOGY

1.5.1 Leadership

There are strong concerns for the future of clinical psychology, particularly in England, but events there are too close for clinical psychologists in Wales to feel at all safe or complacent. It is the view of the researcher, who was himself Head of Psychology for a Welsh Health Authority (later a Trust, and later still a Local Health Board) for more than twenty years, that one of the primary roles of the leader of a service is to look ahead, to attempt to judge what the future might hold for his or her organisation, and then to prepare that organisation for the expected future. With these challenges in the offing, there is going to be a pressing need for clear direction and strong leadership for clinical psychology in both England and Wales.

The NHS Leadership Framework (2011), developed by the NHS Institute for Innovation and Improvement, identifies seven domains related to effective leadership.

These are:

1. Creating a vision
2. Setting direction
3. Improving services
4. Demonstrating personal qualities
5. Managing services
6. Working with others
7. Delivering the strategy.

Within the “setting direction” domain are several elements including “identifying the context for change”. The framework says that competent leaders:

1. Demonstrate awareness of the political, social, technical, economic, organisational, and professional environment.
2. Understand and interpret relevant legislation and accountability frameworks.
3. Anticipate and prepare for the future by scanning for ideas, best practice and emerging trends that will have an impact on health outcomes.
4. Develop and communicate aspirations. (section 5.1).

In other words, the best leaders are good at anticipating the future, and then at making effective preparations to meet the future challenges. The DCP has also recently developed a leadership framework (Skinner *et al.*, 2010), which draws upon the NHS leadership framework, and adapts and expands it specifically for clinical psychologists. It should be said that both these frameworks recognise that leadership is not necessarily the sole province of senior professionals and managers, but can be demonstrated and practiced by people at all levels of the organisation.

1.5.2 A View of the Future

A view of the future is an important foundation for creating a vision of how clinical psychology could develop and for being able to steer the profession effectively to where it can make the best possible use of its unique skills and contribution to health care. For clinical psychologists in Wales, one question to ask is whether there is anything in the literature which may provide a credible view of the future? There are certainly the views of Mowbray (1991; 2011), Hassall and Clements (2011), and NWW, as discussed earlier, all of which give suggestions for how they consider clinical psychology ought to proceed.

There are also attempts by a few clinical psychologists to state how they consider the profession is most likely to develop in the future. For example, Turpin and Llewelyn (2009) write about the challenges facing clinical psychology and how some of the

current pressures are shaping the profession. They recognise that the future of clinical psychology is bound very closely to the future of the NHS:

“ ... it is probably realistic to say that where clinical psychology in the UK positions itself in the future will be determined in large part by organisational and political decisions regarding the future of the NHS and the rest of the public sector” (p. 336).

Since they wrote this, the NHS in Wales has undergone a massive reorganisation, whilst the NHS in England is currently in the throes of an even greater, but substantially different, reorganisation. Turpin and Llewelyn (2009) recognise the problem discussed earlier of clinical psychology struggling to define itself and its unique skills clearly, and in terms which other professions will understand. They note the importance for clinical psychology of being able to provide evidence of unique competencies, rather than simply claiming competence, in an environment where effectiveness and value for money are increasingly important. In such times they recognise the need for anticipating the future:

“Reading the future is hazardous but it is nonetheless needed for effective strategic planning” (p. 343).

They recognise also that competition from other professions is likely to impact upon clinical psychology, and suggest that the profession therefore needs to emphasise its “capacity to work with a range of clients, using a range of psychological approaches, and at different organisational levels, and with well-developed research and audit skills” (p. 345), as well as promoting the contributions that clinical psychologists can make beyond direct therapy, such as comprehensive assessments, supervision, and formulation. They also draw attention to how the current changes may impact upon such things as career pathways. The problem is that, whilst their views and perceptions are clearly well informed, as would be expected from such senior members of the profession, there are two major drawbacks for any readers who want to gain a credible view of the future of clinical psychology. First of all, they are their own personal views. That is, they are not the result of any accepted forecasting procedure. The credibility of their views is therefore derived entirely from their own personal credibility. Secondly, they actually predict very little about how they expect

it will unfold, as opposed to what clinical psychology needs to do to make it unfold in the way the profession wants. For instance, if the profession fails to identify its unique selling points, what do they consider are likely to be the actual consequences? These and other questions are not addressed.

There are actually very few examples of research using accepted forecasting methodologies to predict the future of clinical psychology. There are forecasts which concern workforce numbers, for example, such as the number of trained clinical psychologists in post at a particular point in time, or the numbers which are likely to be needed. The problem with these is firstly that they give no clue about any changes to the role, organisation, activities, etc., of clinical psychologists. The second drawback is that, in Wales at least, they are notoriously unreliable. The author has been personally involved in exercises attempting to validate the figures which the Welsh Government has for clinical psychologist numbers, and they seem to bear little or no resemblance to reality. He discovered, for example, that his own organisation had been submitting staff numbers to the Welsh Government which assumed that all primary care counsellors were clinical psychologists. Other than these purely numerical forecasts, though, there are very few examples in the published literature of studies using accepted forecasting methodology to predict the future of clinical psychology.

1.5.3 Delphi Studies on the Future of Clinical Psychology

A study by Kennedy and Llewelyn (2001) used Delphi methodology (Dalkey & Helmer, 1963, taken from Linstone & Turoff, 2002) to examine whether clinical psychologists continue to regard the scientist-practitioner model as the most appropriate one for the profession, and to gain the profession's view on the future training of clinical psychologists. The Delphi method was originally devised as a means of forecasting the future by gaining the collective views of identified experts in the area of study. It is discussed in detail in the following chapter. Kennedy and Llewelyn's research confirmed that the profession's continued preference was for the scientist-practitioner model, but, as mentioned earlier, they suggest that this is reflected more in attitude than in participation in research. Their study also suggested that clinical psychology would be mostly a state provided service and therefore would

continue to be “heavily influenced by NHS priorities” (p. 77). Other predictions from their research included:

1. Larger numbers of clinical psychologists would be trained.
2. Cost effectiveness and government directives would be major influences.
3. Working in teams would be another main theme.
4. Health psychology and forensic psychology would grow, but clinical psychology involvement in adult mental health services would decrease.
5. Consumer influence would increase.
6. Consultancy role would increase.

These predictions, viewed from 2012, can be seen to have been largely accurate, and would no doubt have been valuable aids to the leaders of the profession when they were first published. The drawback for current leaders of clinical psychology services, of course, is that they are now over ten years old and the context of healthcare has changed dramatically in the last few years, and looks set to continue to change for some time yet.

Delphi methodology has also been applied to predicting the future of the discipline and application of psychology as a whole, i.e. not restricted to clinical, nor even to applied, psychologists (Haggard and Weinreich-Haste, 1986; Haste, Hogan and Zachariou, 2001). Both these studies set a target date, which was approximately twenty five years into the future. The 1986 study is now simply too long ago to have anything more than curiosity value. The more recent study can at least claim to still be current, given that its target date is 2025, but the predictions were made more than ten years ago, when concerns were, as already stated, very different. The predictions this study produced were related to four main themes, which were optimism, fragmentation, reputation, and biological basis for psychology. Some of the predictions do relate to clinical psychology, though, and give a view of the future which may still provide current clinical psychologists with ideas about the profession in 2025. For example:

“Psychologists will have the same status as doctors in primary care, as psychological therapies become available to all through healthcare provision” (p. 33).

“A new profession of medical psychology will arise from a hybrid of psychiatry and clinical psychology” (p. 33).

Smith (1975) used a Delphi method to look at the future of psychology over the following fifty years. The study was not confined to clinical psychology. Smith predicted that the number of psychologists would increase considerably and there would be move towards a register of psychologists by the end of the last millennium. He also predicted a breakthrough in neurophysiology which would make it possible to produce drugs targeted at certain types of behaviour and that would be complemented by progress in psychological methods of behavioural control.

Other professions have used Delphi methodology to predict their own futures, and some of these may appear to relate closely to clinical psychology. For example Norcross, Hedges and Prochaska (2002) conducted a Delphi study on the future of psychotherapy in 2010 in the United States. Neimeyer and Norcross (1997) looked at the future of psychotherapy and counselling psychology in the United States, whilst Cassidy (2007) conducted a Delphi survey on the future of psychiatric music therapy in 2016, also in the United States. The problem with these, and others in a similar vein, is that their relevance to clinical psychology in the UK is highly questionable, given that they are different professions in a completely different healthcare context. It is difficult to regard them as providing credible guides about the future of clinical psychology in Wales. Even if there were a Delphi study focussing on clinical psychology in the UK, its direct relevance to Wales would be limited, given the differences already discussed in direction between the NHS in Wales and England.

1.6 THE PURPOSE OF THE STUDY

A credible view of the future of clinical psychology in Wales would be extremely valuable, if one could be gained. To quote one of the participants in this study, who is currently Head of Psychology in one of the Welsh NHS Local Health Boards, “if you know how the future is likely to unfold, you can prepare accordingly and maximise your chances of whatever it brings ... it’s about anticipation and then how to manage, to react ... to try to safeguard the profession” (Expert 4). If clinical psychology in

Wales is to have the best chance of not only surviving but of thriving in the future, it will be extremely helpful to have a credible picture of what the future is most likely to be. This study is an attempt to provide just such a picture. In order to have the most chance of being useful and applicable, it was decided to carry out a Delphi survey to gain a view of clinical psychology in Wales ten years in the future, i.e. in 2022. It was thought that predictions over longer periods would have less chance of being accurate, and therefore less chance of being useful, but that shorter periods of time may not give the profession sufficient time to appraise the results and take any action deemed necessary. Ten years seemed to offer the best balance between utility and accuracy, and hence was the timescale chosen for a Delphi study on the future of clinical psychology in Wales.

CHAPTER 2: METHOD

2.1 OVERVIEW

The purpose of this study is to attempt to gain the most credible view of the future of clinical psychology in Wales in 2022. This chapter describes the design and implementation of a suitable methodology for achieving this goal. A Delphi survey (described in detail later in the chapter) was selected as the most suitable procedure, but there are many possible variations upon the classical Delphi design. This study adapted the basic methodology in order to achieve the most suitable design for the purpose; the nature of the adaptations and the rationale behind them are described. One major change from the classical Delphi survey was to interview all the participants face-to-face, rather than to sample their views via written questionnaires. The analysis of these interviews required the use of a qualitative method, and Grounded Theory (Corbin & Strauss, 2008) was selected as providing the most suitable approach.

2.2 RESEARCH DESIGN

The initial problem was to select or design a method which would yield what could be confidently regarded as credible predictions about the future of clinical psychology in Wales. There are various methods for making predictions about the future, including both quantitative (statistical) and qualitative (judgemental) methods. Statistical methods are generally appropriate where past numerical data are available which can be extrapolated in some way to provide valid forecasts of the future. A simple and familiar example of this would be predictions about the final outcome of elections by sampling the views of a small number of the electorate beforehand, and then extrapolating the results to the full electorate. Such methods would not be relevant in this case, though, because few relevant numerical data exist. Predictions could be made about the number of trainees, perhaps, or the number of vacant posts, but no numerical data exist to help predict other aspects of the profession of clinical psychology, such as their role, or new areas for development. In a study of this nature, qualitative methods of prediction are necessary.

Various qualitative prediction methods exist. Market research is an area familiar to most people which employs many of these methods, but some rest upon the assumption that an expert in a particular field is likely to be able to give better forecasts and predictions about their area of expertise than less informed people would be able to do. Expert forecasting methods obtain forecasts from experts in a structured way, and most of them are based upon the idea that “*n* heads are better than one” (Dalkey, 1972). For example, the Nominal Group Technique (Delbecq & Van de Ven, 1971) can be utilised to produce forecasts. The drawbacks of this technique include the logistical difficulties sometimes encountered in getting enough experts into one place at one time to carry out the group exercise required, and also, perhaps more crucially, the potential for group pressures to distort the judgements of the participants. In circumstances where group pressures may be a concern, Delphi surveys may be more suitable. Delphi is appropriate to use in areas in which there is controversy or a lack of clarity (Iqbal and Pipon-Young, 2009), but it is mostly regarded as a prediction method (Linstone and Turoff 1975).

2.2.1 The Delphi Method

According to Linstone and Turoff (1975),

“Delphi may be characterized as a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem”. (p. 3)

The basic format of the Delphi method is that identified experts in the area of study are asked their opinions about the topic being considered. This is usually done in the form of a written questionnaire. The responses to the questionnaire are then collated in some way by the researchers, and the results are fed back to the expert participants as a series of statements generated from the responses to the initial questionnaire. The experts are then usually asked to rate their agreement or otherwise with these statements, perhaps by using a Likert scale or something similar. This results in the production of numerical data showing, for example, the strength of agreement with each statement, or the percentage of the experts who agreed with it. This iterative process allows for participants to change their views after having been exposed to the

views of other panellists, and it can be repeated a number of times, if required. The ultimate aim is to get consensus of opinion or, at least, to reach a point where the experts' opinions are relatively static. The survey is carried out in such a way that the experts do not know which opinions originate from which expert, and, ideally, do not know how many of the other experts supported a particular opinion. This procedure is designed to avoid any one person exerting undue influence upon the outcome by virtue of their perceived status, knowledge and/or expertise, and also to prevent participants from simply changing their views to fall in line with the predominant view. The most prevalent view may not necessarily be the "right" view. The aim is to try to produce a richness of views for all the experts to consider, without pressure to adopt any one particular view. This procedure clearly has advantages over group or committee procedures such as the Nominal Group Technique, in which individuals who are particularly vociferous and/or confident in how they express their views, may exert undue influence upon the outcome.

The Delphi method is generally accepted as having been developed by the RAND Corporation in the 1950's, where the first application of "Project Delphi" was an attempt to obtain a reliable consensus of opinion from a group of experts on the "selection, from the point of view of a Soviet strategic planner, of an optimal US industrial target system and to the estimation of the number of A-bombs required to reduce the ammunitions output by a prescribed amount" (quoted in Linstone and Turoff, 2002, p. 10, taken from Dalkey and Helmer, 1963). Stone Fish and Busby (2005), however, draw attention to Quade's (1967) report that the Delphi method's first application was rather more prosaic. Quade says, in a book which was published by the RAND organisation and which therefore lends considerable credibility to his claim, that its first use was to predict the winners of horse races!

Having described the basic format of the Delphi method, it has to be acknowledged that there is actually considerable disagreement about what exactly are the essential elements or principles. There are certainly a number of variants of the basic method.

Beretta (1996) lists the common characteristics of Delphi techniques as being:-

- A panel of experts are used as the respondents.
- Exercises are conducted in writing, using sequential questionnaires.
- There is an attempt to produce a consensus of opinion.
- Anonymity of the panel and statements are guaranteed.
- There is use of iteration and controlled feedback.
- Exercises are conducted in a series of rounds. A summary of previous rounds is communicated to and evaluated by the panel.

Rowe and Wright (1999) give four key features of the Delphi method:-

- Anonymity of Delphi participants, to reduce social pressure to conform to group views.
- Iteration to allow participants to change or refine their views in the light of the group`s progress from round to round.
- Controlled feedback to inform participants of the ideas and views of other participants.
- Statistical aggregation of group response, allowing quantitative reporting and interpretation of data.

Other authors give other lists of essential or key features of the Delphi method (e.g. Strauss and Zeigler, 1975), all with many common features, but still with some variations on what constitute “essential” or “key” features. Perhaps this is why so many variations of the original (“Classical”) Delphi method have evolved.

In 1970 Turoff described a “Policy Delphi”, the essential purpose of which is to generate views on policy, and which therefore often produces verbal information rather than numerical data. Since then the number of variations on the Delphi theme has multiplied rapidly. Hasson and Keeney (2011) list ten different variations: - Classical, Modified, Decision, Policy, Real time/consensus conference, e-Delphi, Technological, Online, Argument and Disaggregative Policy!

The title of this thesis describes the method used in it as a “Modified Delphi”. It now transpires, though that a “Modified Delphi” already exists (McKenna, 1994) and so this thesis must be content to be merely a modified Delphi, rather than a Modified Delphi.

It is clear that there is no single Delphi method, but that numerous variations have been developed from the original theme. This thesis has produced yet another variation, but, as Stone Fish and Busby state (2005), taking the idea from Linstone and Turoff (1975):-

“How a researcher designs and implements the Delphi technique is not as important as the philosophical assumption underlying its usage. The Delphi method rests on the idea that it is possible and often quite valuable to reach consensus through a collective human intelligence process”. (p. 239)

The conclusion reached is that there is no single, “right” Delphi method, but rather, as Skulmoski, Hartman and Krahn (2007) say:-

“ the method is modified to suite the circumstances and research question”.
(p. 5)

2.2.2 Project Design

This design of this study was based on the essential idea of gaining the collective views of a number of identified experts in the area in a way which would allow the exchange of views, but eliminate social pressure to conform to the majority view, or to the view of potentially dominant individuals. In addition it was decided that, whilst a clear aim of the study was to gain the experts` specific predictions about the future of clinical psychology, it was also of considerable interest to the researcher to understand how the experts had arrived at those predictions and what they regarded as the most important factors over the following 10 years in determining the future of the profession. This was therefore also taken into consideration when designing the method for the study.

In the first instance, it was decided to collect the initial views of the expert participants by face-to-face interview, rather than by sending them a questionnaire. The reason for that was that the researcher wanted to try to obtain the richest possible information from the experts. As already mentioned, as well as eliciting a series of predictions about the future of Clinical Psychology in Wales, he was also seeking to understand the reasons behind any predictions the experts made. It was thought that this could be done better in a semi-structured interview, which would allow some degree of interaction between the expert and the interviewer, would allow the interviewer to pursue topics in more detail if they seemed to warrant it, and to ask questions about any new ideas which appeared during the interview. Written responses to a questionnaire would be likely to yield far less information, and are not always easily interpreted, whereas in an interview setting, any further clarification required could be elicited immediately.

The relatively small number of potential experts in the area (the criteria for “expert” in this study are given later) also made face-to-face interviews manageable. Delphi studies carried out by post or email can have potentially hundreds of participants, many of whom may not even be in the same continent as the researcher, but this study identified only approximately fifteen potential participants. In addition, they were all in Wales and so did not present insurmountable logistical problems for interviewing face-to-face.

2.2.3 Grounded Theory

As mentioned earlier, it was anticipated that the depth of information captured during the initial interviews would be much greater than simply a number of predictions. The expectation was that the interviews would also elicit common themes or ideas about the influences upon Clinical Psychology over the following 10 years, and that identifying these was an important aim of the study. It was also considered that it would be valuable to feed this information back to the participants to guide their further thinking. It was decided that the content of the initial interviews therefore needed a qualitative method of analysis, suited to analysing data of this sort.

Grounded Theory (Corbin and Strauss, 2008) offered one suitable method for analysing the data. Other possibilities considered included Thematic Analysis (e.g. Boyatzis, 1998) and Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2009). Whilst any of these methods might have been broadly suitable for the task, it was considered that Grounded Theory offered the best method for analysing the data. The researcher was looking for reasons behind the predictions made by the experts. That is, the hope was to find explanations for the predictions and, if at all possible, to gain an overall view of the influences and forces which might shape Clinical Psychology in Wales over the following 10 years. Grounded Theory, as the name implies, is mostly thought of as being a method for deriving theory from qualitative data, but it can be used as a method “to make sense out of masses of qualitative data” (Corbin and Strauss, 2008, p. x). The researcher was certainly expecting to generate “masses of qualitative data” from the interviews, but was not really expecting that a unifying theory would emerge. As mentioned, he was really only hoping to be able to identify what the experts regarded as the main influences upon clinical psychology in Wales over the following 10 years, and Grounded Theory is applicable even when there is no expectation nor attempt to produce a final theory (Henwood and Pidgeon, 1995). On the other hand, the researcher’s view was that once all the data were gathered, it would certainly be worthwhile attempting to construct a theory from them, if at all possible. Grounded Theory therefore seemed to be well suited to the task, and so was chosen as the preferred method for analysing the data from the initial interviews.

Grounded Theory has been used to analyse the data from Delphi studies on at least one previous occasion (Walker, Barker and Pearson, 2000, who describe their method as an “augmented Delphi”), but it appears not to have been used very often. Conceivably it is used more than is reported, though, given that many articles do not specifically state how they analyse the data from the first round of questionnaires.

It was anticipated that the data from the first round of interviews would be fed back to the participants in the form of a number of opinions or predictions, accompanied by any themes concerning influences upon clinical psychology which emerged from the Grounded Theory analysis. The participants would then be asked to comment upon these in the second interviews. Initially it was thought that these second interviews

might not need to be carried out face-to-face, but could instead be done by telephone or video link. It was later decided that the second interviews should also be carried out face-to-face, because the first round of interviews was found to be so successful in generating discussion, ideas and predictions. The intention for the second round of interviews was not simply to ask participants to state their level of agreement or otherwise with the predictions, or to put them in rank order, as is usually the case in Delphi studies. The intention was rather that participants would be asked to comment upon the analysis and predictions from the first interviews, and so the data collected from the second round of interviews would again be extensive and qualitative, rather than the quantitative data which Delphi studies usually generate. It was therefore anticipated that the analysis of the second interviews would again utilise Grounded Theory. In the event, the actual format of the second interviews was quite different from what had been anticipated. The reasons for this are discussed later in this chapter. The outcome, though, was that only the first set of interviews was analysed using Grounded Theory.

It is for the reasons just mentioned, particularly the use of face-to-face interviews rather than questionnaires, the use of Grounded Theory for analysing the interviews, and the preference for producing completely qualitative data rather than deriving some quantitative data from the predictions, that this study is regarded as a “modified Delphi study”.

2.2.4 Criteria Used to Identify “Experts”

One of the first tasks in designing the study was to establish who would be suitable participants for a Delphi study on the future of Clinical Psychology in Wales. Stone Fish and Busby (2005) make the point that the selection of suitable participants is a critical element of a Delphi study. Dalkey (1969) goes even further and regards the participants` knowledge of the subject matter as the most important element in reaching a credible outcome. Linstone (2002), however, warns against “illusory expertise” (p. 566), making the point that an expert is not necessarily the best forecaster.

In this study, the experts were chosen because they held positions in clinical psychology in Wales which the researcher considered required them to have a strategic view of the future of healthcare and clinical psychology in Wales. That is, part of their role was to look ahead and to anticipate the future of healthcare and clinical psychology. Their knowledge and expertise should therefore be particularly well suited to a Delphi study. Heads of clinical psychology departments from both public and private sector health organisations in Wales would be expected to have the most informed views about the future of clinical psychology, and so current heads of departments, or people who had been in such posts within the previous 2 years, were regarded as having the necessary expertise. In addition, the Chair of the Welsh Branch of the DCP, and the Chair of the Applied Psychologists in Health National Special Advisory Group (APHNSAG), a national committee of senior psychologists which has an advisory role to the Welsh Government, would also need to have a strategic view of healthcare and Clinical Psychology in Wales. The inclusion criteria for potential participants were therefore set as:-

1. Qualified Clinical Psychologist.
2. Currently, or within the last two years, holding the post of Head of Psychology Department/Profession within a public or private healthcare organisation in Wales,

or

Chair or immediate past Chair of the Welsh Branch of the DCP,

or

Chair or immediate past Chair of APHNSAG.

There were no exclusion criteria.

2.2.5 Identification and Recruitment of Experts

Potential participants were identified from the Directory of Practitioner Psychologists working in health and social care settings in South, West and Mid Wales, which is maintained by the South Wales Doctoral Programme in Clinical Psychology, and from the personal knowledge of the researcher. Fourteen potential participants were identified in this way. It was recognised that this method might have missed a very small number of potential participants, but it was thought that fourteen was a sufficient number, given that the planned sample size was for eight participants (see next section). A Delphi study does not necessarily require random selection of participants. They should be chosen for their expertise, rather than through a random process (Stone Fish and Busby, 2005), and so the possibility that one or two potential candidates were missed was not regarded as a significant flaw in the procedure. It was thought to be desirable, though, that the candidates should represent a mixture of backgrounds and experiences, and so it decided that, of the eight participants, there should be at least one from each of:-

- The NHS
- A private healthcare organisation
- A professional organisation i.e. DCP or APHNSAG
- North Wales
- Mid Wales
- South Wales

As already stated a Delphi study does not necessarily require random selection of participants, but in this particular study it was considered important to randomise the selection of the eight participants from amongst the fourteen potential participants. This was because the researcher was in the unusual position of himself meeting the criteria for “expert”, and he knew personally almost all the potential participants. Randomising the selection of the participants was regarded as necessary to ensure that the he did not, consciously or otherwise, select people whom he knew to have similar views to his own. The eight potential participants who were to be initially invited to take part in the study were therefore selected by the method now described.

The fourteen candidates were each assigned a number from one to fourteen; this was done simply in the order in which they had been identified. A random sequence of numbers from one to fourteen was then generated from a programme on www.random.org. The first eight numbers in the sequence identified the eight people who would first be invited to take part, as long as there was at least one person from each of the categories identified earlier. In the event, there was, but had that condition not been met, then the first extra person from a category in the list of eight people selected would have been discarded, and replaced by the next person on the list from the missing category. The first eight people selected appeared to include at least one person from each category, but further checking revealed that one of the people in the Directory of Practitioner Psychologists who had the title “Head of Psychological Services”, was not, in fact, head of the whole department, but was instead head of one section (equivalent to a Head of Speciality in most NHS psychology services). As such, this person did not actually meet the criteria for expert, and so was discarded and replaced by the next appropriate person on the list. These eight people now selected were found to meet all the criteria for experts, and for the required mix of backgrounds, and so would be invited to participate in the study. If any of them declined to do so, then the procedure would be to invite the next person on the list to participate in their stead, as long as there was still at least one person from each category. If there was not, then the procedure described above for meeting that condition would be adopted.

2.2.6 Sample Size

Sample sizes for Delphi studies vary considerably, not least because the number of recognised experts in a particular field may be very large or extremely small. The sample size may also be limited by the time and resources available to the researcher. The Delphi process actually easily allows for very large sample sizes to be used, given that the survey is often done by questionnaires sent out by post or email. In such surveys, collecting the information may not be a significant limiting factor, although, of course, collating the information from large numbers of questionnaires could still be very time consuming. In this particular study, the decision to conduct face-to-face interviews with all the participants was a major limiting factor upon sample size.

There are various recommendations upon sample size in the literature. Turoff (2002), for example, recommends sample sizes between ten and fifty. Sample sizes in the survey of Delphi studies by Skulmoski, Hartman, Krahn (2007) ranged from four to one hundred and seventy-one. Murphy *et al* (1998) comment that:-

“There is very little actual empirical evidence on the effect of the number of participants on the reliability or validity of consensus processes”.

(p. 37)

Powell (2003) concludes that the participants do not have to be a representative sample for statistical purposes, and that the qualities of the expert panel are more important than the numbers.

The selected method in this study of interviewing every participant face-to-face would clearly produce a considerable amount of data, and so, given the various considerations, it was decided to limit the sample size to eight participants. This would allow for the possibility of a small amount of drop-out from the participants, would result in a large amount of rich data for analysis, and is a manageable sample size for analysis using Grounded Theory.

2.2.7 Number of Rounds

A classical Delphi study typically uses three rounds of questionnaires (Powell, 2003; Stone Fish and Busby, 2005), but there is considerable variation, and studies employing two, or even one round, are not uncommon (Skulmoski, Hartman, Krahn, 2007). These latter authors conclude that there is not necessarily a right way to conduct a Delphi, but that the method can be “modified to suit the circumstances and research question”(p. 5). Iqbal and Pison-Young (2009) recommend that a two round Delphi is most suitable if the main aim is to “take the temperature of opinion on a topic” (p. 599) rather than to reach a consensus. If the objective is to reach consensus then presumably any number of rounds may be required, although there would always be constraints of time, resources, and not least, the motivation of the participants. In any case, not all Delphis would have the aim or expectation of arriving at consensus. As Thompson (2009) points out, the reality is that Delphi studies are “most likely to

produce a time limited snapshot of expert opinion with areas of agreement, overlap and divergence” (p. 422). The current study was not expected to produce consensus on all predictions, but rather, in line with Thompson’s views, to identify areas of agreement and disagreement.

Skulmoski *et al* (2007) note Delbecq, Van de Ven and Gustafson’s (1975) suggestion that two or three iterations are sufficient for most research. They conclude that “if the goal is to understand nuances (a goal in qualitative research) and the sample is homogeneous, then fewer than three rounds may be sufficient to ... uncover sufficient information” (p. 11).

Restrictions of time and resources in the current study, and the desire not to exhaust the energy and patience of the participants for the task, meant that the intention was to keep the number of rounds to a minimum. The initial round of Delphi is often open-ended, in order to give the experts the opportunity to consider the area of study without their thinking being restricted. This round then generates the areas to be scrutinised more thoroughly in subsequent rounds. It is possible to reduce the number of rounds by producing a more restricted questionnaire for the first round, or even by generating some of the statements for participants to consider. These variations do run the risk of losing potentially important contributions from the participants by restricting their thinking at the outset, but a well-designed semi-structured interview/questionnaire would help both to open up the thinking of the participants, and also to draw their attention to important areas which they might not otherwise have considered. A pilot study would be one way to produce such an interview schedule, or the opinions of some experts could be sampled beforehand to help construct it. Thus it should be possible to reduce the number of rounds of the Delphi without reducing the quality of the final output.

It was considered that the group of participants in the study would be relatively homogeneous (all senior Clinical Psychologists in Wales), and so the variation in opinions might be expected to be quite low. That is, it seemed reasonable to expect that there would be a lot of common ground, even if there were considerably diverging views on some of the predictions and the issues identified. In addition, it was thought that the combination of a well-designed semi-structured questionnaire,

administered at an interactive face-to-face first interview, would not only generate a considerable amount of information, but would also elicit almost all of the issues to be considered by the experts. It was therefore anticipated that the feedback given to the participants after the first round would not be very likely to lead to the generation of many more ideas of any great significance. It was also thought likely that if they were going to make changes to any of their initial predictions, it would be at this point. It seemed unlikely that any feedback given after a second round would be significantly different from that given after the first, and so the researcher anticipated that a third round would actually be likely to yield very little different from the second round. It was therefore decided that, for the purposes of the current study, a semi-structured questionnaire would be designed and used to guide the first round of interviews, and that two rounds would then be sufficient to produce valid and stable predictions.

It should be noted at this point that a feature of the feedback to be given to the participants after the first round was that it would not include any information about which participants, or how many participants, had given which opinions or predictions. Bolger and Wright (2011) note that participants in Delphi studies show a tendency to move their opinions towards the consensus view, if they are given that information, and so recommend that “it is good Delphi practice to, wherever possible, remove any indications of consensus and confidence. This means avoiding feeding back individuated choices, judgements, reasons, etcetera, in favour of summaries over several panel members ... and not feeding back confidence in any form whatsoever” (p. 10). The current study followed these recommendations. It was decided to feed back all the predictions and ideas from the first round of interviews to all the participants, but without any indication of who had generated which ideas, or how many experts had supported them.

2.2.8 Design and Validation of Initial Semi-structured Interview

The purpose of the semi-structured interview designed for the first interviews was to encourage the participants to think widely about the influences upon clinical psychology in Wales over the next ten years, to ask them for their views (predictions) about the future of clinical psychology, and to guide their thinking to major areas (such as Training, Career Pathways, etc.), if they did not otherwise address these. The

intention was to prompt thoughts on various areas of clinical psychology without restricting ideas, or steering the opinions of the participants.

A first draft of the semi-structured interview was produced by the researcher who drew upon his own knowledge, as someone who met the study's criteria for "expert", to identify many of the potentially important areas for the participants to consider. This semi-structured questionnaire was then refined in consultation with the researcher's supervisor, also a senior clinical psychologist, after which it was discussed with one of the researcher's senior clinical psychologist colleagues for their comments and validation. The final version (Appendix A) was agreed by all as being suitable for the purpose. In any case it was recognised that the semi-structured interview might itself evolve over the course of the interviews. The purpose of it was to prompt the experts in their thinking about the future of clinical psychology; it was not therefore necessary for each person to receive a completely standardised questionnaire.

2.3 PROCEDURE

2.3.1 Gaining Approval for the Study

All the required information about the study was submitted to the South East Wales Research Ethics Committee for approval. The decision of the Committee was that the study did not require review by an NHS Research Ethics Committee because it would only be recruiting NHS staff who would be recruited by virtue of their professional role. The study was also submitted to the Aneurin Bevan Health Board Research and Development Committee, which approved it.

2.3.2 Invitation to Participate

The eight potential participants were initially contacted by an email from the researcher, inviting them to take part in the study (Appendix B). Attached to the email was an information sheet, informing them broadly of the nature and purpose of the study, and what would be required of them (Appendix C). The email asked them to inform the researcher if they were willing to participate. In the event, all eight

accepted the invitation to participate, after which the researcher contacted them directly to arrange a suitable time and venue for the first interview.

2.3.3 First Interviews

The researcher agreed to meet each participant individually at a convenient place, in order to make the process as easy as possible for them. At the beginning of the interview, the researcher gave a further brief explanation of the nature and purpose of the study, explained what would be required of the participant, and invited any questions. Once all was clarified to the participant's satisfaction they were asked to sign a consent form (Appendix D) for taking part in the study. Finally, the researcher reiterated that he was interested to know what the participant thought was the most likely future for clinical psychology in Wales in ten years time, as opposed to what they hoped it would be. At this point, the digital voice recorder was switched on, and the interview commenced. The researcher had given an undertaking that this interview would not last more than one hour, and, in most cases, that was achieved. This was no mean feat when asking clinical psychologists to voice their opinions about the state and future of their profession.

During the interview, the researcher tried hard to avoid giving encouragement or otherwise, or direction for any particular views or opinions expressed by the participants. He did not give any information about what other participants had said, as these would clearly be potential sources of considerable bias. There was, of course, some interaction between the researcher and the participant, and so it is acknowledged that the researcher may have unintentionally influenced the participants' opinions at times. The researcher diverted from the exact format of the semi-structured interview on occasions in order to gain clarification, to explore areas not identified within the semi-structured interview, or to help the conversation to flow.

2.3.4 Transcription and Analysis of Interview Recordings

Each first interview was transcribed verbatim, with the exception of clearly unnecessary words (such as "um" "er", or repeated words). Scrutiny of the interviews

yielded eighty specific predictions made by the experts about the future of clinical psychology in Wales in 10 years time.

The transcriptions were then analysed, using Grounded Theory. The original expectation had been that the interviews would produce a number of predictions, and that the Grounded Theory analysis would then help to show the reasoning behind those predictions. The intention had been that all the predictions and the reasoning would then be fed back to the participants and that the second round of interviews would explore their views and predictions, and particularly whether these had changed or not. It was hoped in that way to arrive at a relatively stable collective view, albeit probably with areas of both agreement and disagreement, about the future of clinical psychology in Wales. In the event, analysis of the interviews did indeed help to show the reasoning behind the experts' predictions. Slightly unexpectedly, though, it also yielded a coherent model for organising and understanding predictions on the future of clinical psychology in Wales. Such a model was clearly potentially extremely interesting. It was therefore decided to feed this model back to the participants and to focus the second interviews mainly upon their views about the model. Accordingly, in the written feedback sent to all the participants, the model was presented and described (Appendix E), and they were asked to consider particular questions about it, including their general views about it, and whether it could be improved.

There were also questions designed to evaluate the model, based upon the four criteria for evaluation of Grounded Theory analyses provided by Strauss and Corbin (1990), which are:-

- **Fit.** That is, the model should reflect reality.
- **Understanding.** The model should be readily understandable, and should make sense to the participants.
- **Generality.** The model should ideally be applicable to a variety of situations.
- **Control.** The model should provide ideas for action.

It was also considered important to confirm that the participants considered that the model incorporated the opinions they had given during their interviews (Respondent Validation, Mays & Pope, 2000), and so they were asked this specifically. All these questions were then included in a second semi-structured interview schedule (Appendix F), which was administered at the second face-to-face interviews.

The eighty specific predictions about clinical psychology were also included in the written feedback sent to all the participants, in the form of a questionnaire asking them simply whether they broadly agreed with the each prediction or not, or whether they had no opinion about it (Appendix E). They were asked to note if they wished to discuss any of these predictions in more detail during the second interview, but otherwise the intention was simply to gather brief information about the degree of support for each prediction. The predictions were organised in the questionnaire into sections which corresponded to some of the main themes which had emerged from the initial analysis.

2.3.5 Second Interviews

It was clear at this stage that the main content of the second interviews was going to be about evaluating and validating the model, and that there would therefore be no reason to analyse these interviews using Grounded Theory. A semi-structured interview schedule was constructed to evaluate the model, as described in the previous section. The researcher contacted each of the experts and arranged to meet them for the second face-to-face interviews. All eight of the experts agreed to continue to participate in the study, and several expressed considerable interest in the model. The interviews were then carried out, recorded and transcribed. The responses of the experts were then collated by the researcher, but without using any structured method of analysis.

2.4 METHODOLOGICAL RIGOUR AND QUALITY

Corbin and Strauss (1990) suggest four criteria against which the product of a Grounded Theory study can be evaluated. These criteria, which were mentioned earlier in this chapter, are “fit”, “understanding”, “generality”, and “control”. It was

thought that these criteria were extremely well suited to evaluation of this model. Whether the model is “right” in its predictions cannot, of course, be known for some years, and so its current value is based almost entirely upon whether it has credibility within the profession of clinical psychology. If the model is regarded as credible, then its forecasts will also have credibility with the people who might make use of it. It was therefore considered that gaining the expert participants’ opinions upon the model generally, and against these criteria in particular, constituted a sound way to evaluate it. It was also important to ensure that the researcher had derived the model from the views of the participants rather than allowing it to be overly influenced by his own ideas, i.e. respondent validation (Mays & Pope, 2000). This is always important in Grounded Theory studies, but perhaps particularly in this case where it would be expected that the researcher had well formed views of his own. The second semi-structured interview (Appendix F) was therefore designed with these criteria in mind.

Establishing methodological rigour in qualitative research is always problematic, but perhaps particularly so in Delphi studies, and there is little agreement upon how to do it (Hasson & Keeney, 2011). As Hasson & Keeney point out, the usual criteria of validity, reliability and trustworthiness are not easy to establish. One major problem is that there is no single Delphi method, but instead there are numerous variations (Modified Delphi, Policy Delphi, etc.), and within each of these variations the way they are applied can vary substantially in terms of numbers of experts, numbers of rounds, ways to feedback the information, etc. This means that there is no procedure which can be adopted which can be regarded as conferring acceptable scientific rigour upon the study. Hasson & Keeney make an eminently sensible observation and recommendation:-

“Delphi results do not offer indisputable fact ... instead they offer a snapshot of expert opinion, for that group, at a particular time, which can be used to inform thinking, practice or theory”. (p. 7)

They conclude by recommending that measures of rigour for both qualitative and quantitative research be applied to each Delphi study. The initial intention in this particular Delphi study was that there would be no numerical data, and although this

was changed later in the course of the study, the numerical data gained were very limited and not amenable to statistical analysis. From the point of view of ensuring rigour, the whole study is regarded as essentially a qualitative study.

Elliot *et al* (1999) suggest a number of guidelines to “encourage better quality control in qualitative research” (p. 215). They propose seven guidelines which are common to both qualitative and quantitative research, and a further seven which are pertinent solely to qualitative research. These were taken as being appropriate for this study, and the way in which they were addressed was as follows.

2.4.1 Guidelines Common to both Qualitative and Quantitative Research

1. Explicit scientific context and purpose.

The literature relevant to the area was reviewed, and the research question stated explicitly.

2. Appropriate methods.

The rationale for the selection of the Delphi method and Grounded Theory has been provided.

3. Respect for participants.

Participants were invited to take part in the study, and efforts were made to accommodate their availability. Language in all written and spoken communication was appropriate, and respectful. The anonymity of the participants was maintained such that no views or opinions can be attributed to any particular person. All views expressed were given equal weight, and no negative evaluations were made about any of the opinions expressed by the participants.

4. Specification of methods.

A comprehensive Method chapter forms part of this report.

5. Appropriate discussion.

The researcher has attempted to ensure that any conclusions or implications drawn from the analysis of the results are based upon sound reasoning.

6. Clarity of presentation.

The researcher has attempted to write clearly and concisely. Whether he has succeeded is for others to judge.

7. Contribution to knowledge.

It was anticipated that if the study achieved its stated purpose of making credible predictions about the future of clinical psychology in Wales in 10 years time, this would provide an extremely valuable guide for the profession.

2.4.2 Guidelines Pertinent to Qualitative Research

1. Owning one`s perspective.

A researcher needs to recognise that their own theoretical orientation, values, experiences, background, etc., influence their interpretation of the data, and they also need to make these explicit, so that readers may take them into consideration in their own understanding of the research results.

In this case, the researcher is a 61-year old male who has lived and worked in South Wales for approximately 27 years. He is a qualified clinical and forensic psychologist, and this research forms part of the requirements for a doctorate in clinical psychology. The researcher is now semi-retired, working as a Consultant

Clinical & Forensic Psychologist in a purely clinical role. Up until 2 years ago, though, he had spent the previous 22 years as head of psychology for a large NHS Trust. It is his strongly held view that one of the most important functions as a head of department is for the post holder to seek continually to look ahead, to try to anticipate what the future holds for healthcare in general and for clinical psychology in particular, in order to prepare the profession for whatever the future might bring. As such, even though the researcher no longer holds a post which carries that responsibility for the profession, he remains very interested in a strategic view of clinical psychology. It was this continuing interest which led him to this research topic. The researcher has been very aware throughout the study that his views were likely to influence his interactions with the participants, and that there was the potential for him to influence the expressed opinions of the participants. He is also aware that his views would be very likely to influence his interpretation of the data.

The researcher kept a journal throughout this study in which he recorded his thoughts about the progress of the study, in order to try to ensure that he remained aware of how his own thoughts, values and behaviour might influence both the process and the interpretation of the data.

2. Situating the sample.

This refers to the necessity to describe the research participants and their circumstances so that a reader can judge the relevance of the findings. The inclusion and exclusion criteria for the participants, and the rationale for adopting these, along with the sampling method, are clearly stated earlier in this chapter.

3. Grounding in examples.

This refers to the need for researchers to provide examples of the data to illustrate their analyses. Data are provided in this report in the form of quotes from the participants to illustrate the concepts derived from the data by the Grounded Theory analysis. The specific predictions for the future are listed and attributed

to the participant who made that prediction. If necessary these can be found in the transcriptions of the interviews.

4. Providing credibility checks.

Elliot *et al* (1999) suggest that it is good practice for researchers to check the credibility of the concepts or categories they have derived from the data. In this case the model produced was presented back to all the participants for their comments, and it was discussed with them in some detail during the second interviews. The iterative process of Delphi studies lends itself well to checking credibility with the participants.

5. Coherence.

The analysis should be presented in a way which integrates the findings in an understandable form. In this case, the participants were asked in the second interview to give their opinion upon whether the model was clear and understandable.

6. Accomplishing general vs. specific research tasks.

Elliot *et al* (1999) recommend that where a general understanding of a phenomenon is intended, this should be derived from an appropriate range of instances, and that where the goal is to understand a specific instance, it should be described sufficiently for others to be able to understand it too. Limitations regarding the extension of any findings to other instances should be addressed. The purpose in this case was to gain an understanding of the various influences upon clinical psychology in Wales over the following 10 years.

7. Resonating with readers.

This means that material should be presented in such a way that readers judge it to have accurately represented the subject matter (Elliot *et al*, 1999). In this study the participants were asked their opinion upon whether the model took their

views into account, whether they agreed with the model, and whether they had suggestions for improving it.

This chapter has described the method used in the study, the rationale for using a modified Delphi design, and the measures undertaken to evaluate and validate the results. Those results, and their analysis, are presented in the following chapter.

CHAPTER 3: RESULTS AND ANALYSIS

3.1 OVERVIEW

The transcripts of the first round of interviews were analysed using Grounded Theory, as described in the Method section, and the results are presented in this chapter. Forty-seven separate concepts were identified, and these are all described in Section 3.2, along with supporting data in the form of selected quotes from the interviews with the participating experts. The experts are referred to by a number only, in order to maintain their anonymity.

Further analysis of the concepts resulted in a number of them being grouped together, first into subcategories, and then into a smaller number of major categories. These are shown in Figure 3.1, and are also described in Section 3.2. The analysis allowed a model for explaining and guiding predictions for the future of clinical psychology in Wales in 2022 to be derived from the data. This model is presented in Figure 3.2, and is described in detail in Section 3.3.

The second round of interviews included questions designed to validate the model, as described in the Method chapter. The collated results of the interviews are presented in Section 3.4, supported by selected quotes from the experts.

The first round of interviews also produced 80 specific predictions concerning the future of clinical psychology in Wales in 2022. These predictions were fed back to the experts in the questionnaire administered prior to the second interview (Appendix F). The collated responses to the questionnaire are shown in Table 3.1.

3.2 ANALYSIS OF THE FIRST ROUND OF INTERVIEWS

The eight first-round interviews of the experts were analysed using Grounded Theory, and forty-seven concepts were identified. Further analysis then identified several sub-categories, and major categories. All the concepts are described below, organised into

the major categories and sub-categories. For the sake of clarity, the major categories, with their respective sub-categories, if any, are shown in diagram form in Figure 3.1.

3.2.1 Major Category 1: Major Service Drivers

The view which emerged from the interviews with the experts was that there were three principal forces which were likely to drive and shape the future of clinical psychology in Wales over the following ten years. These are financial constraints, government policies and an increasing demand for psychological therapies.

3.2.1.1 Subcategory: Finance

All of the experts cited financial restrictions as continuing to exert strong pressures on healthcare generally, including upon clinical psychology, over the following 10 years.

Concept: Financial Restrictions

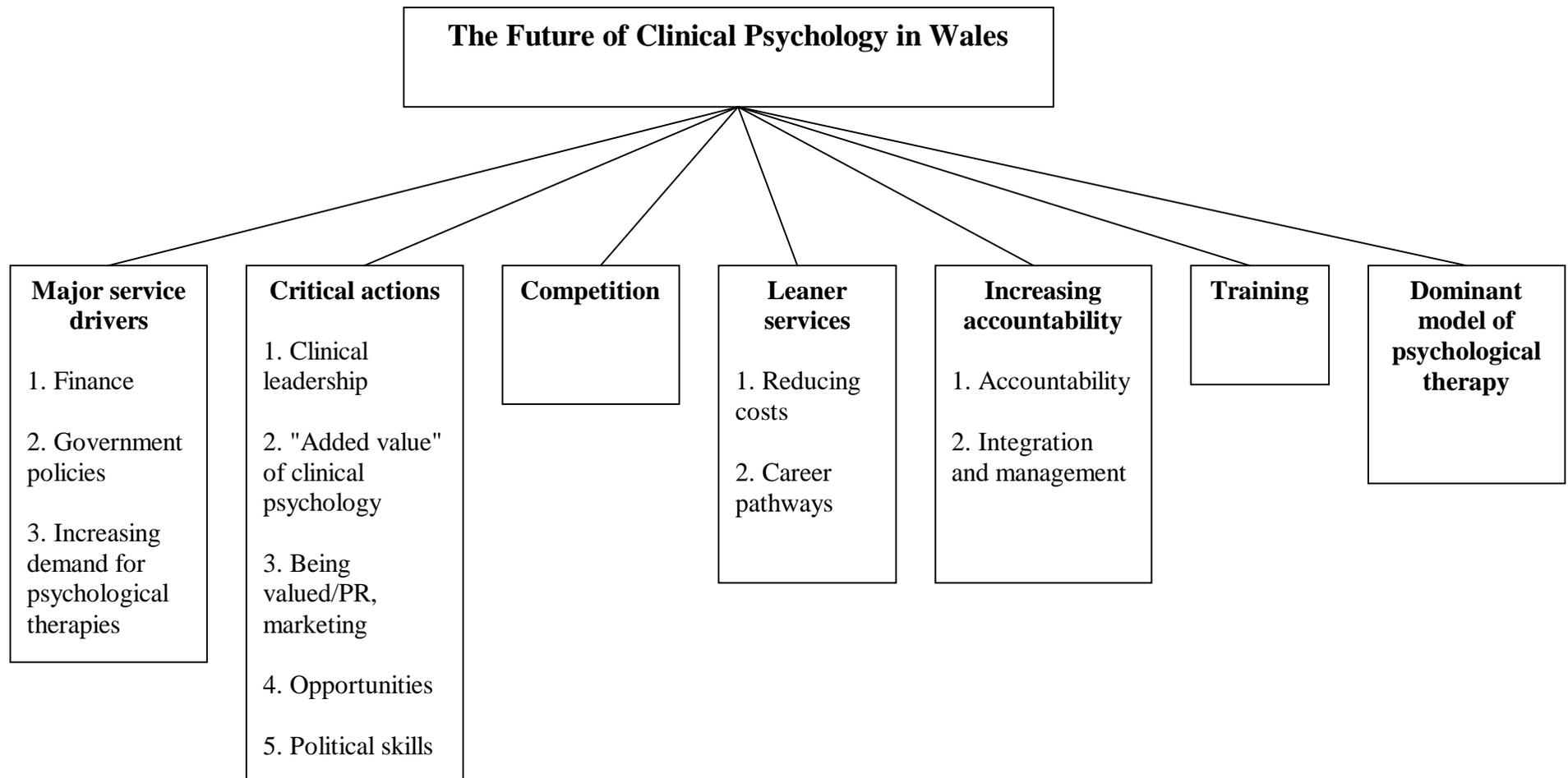
Financial restrictions, and the various possible effects of them, were mentioned by all the experts.

Exp 1 (Expert 1). “The thing which comes to mind first, regrettably, is finances. I think the current financial climate will put more pressure on us than ever before to demonstrate that we offer value for money”

3.2.1.2 Subcategory: Government policies

Government policies, both from Westminster and the Welsh Government, were predicted to have a major impact upon clinical psychology. In particular, the drive from the current Westminster government to privatise health service provision, and the Welsh Government's agenda to modernise the health service in Wales.

Figure 3.1. Major categories, with sub-categories, derived from the analysis of first round interviews on the future of clinical psychology in Wales



Concept: Government policies

Several of the experts spoke about government policies being important influences upon health care.

Exp 6. “I think the political context is really important in Wales, in terms of what’s driving the Welsh Government and what’s driving services, and I think that the most important driver for clinical psychology will be the political agenda”.

Concept: Privatisation agenda

Some of the experts regarded recent developments in the NHS in England as signalling a deliberate move by the Westminster government towards privatisation of healthcare, and thought that this would inevitably happen in Wales over the next few years.

Exp 8. “Obviously there are concerns that the current government is trying to sneak in privatisation of the NHS through the back door”.

Concept: Modernisation agenda for NHS in Wales

There was a general recognition that the Welsh Government is putting pressure on the Local Health Boards to modernise services, and to become more efficient in their delivery of services, and that this would affect clinical psychology over the next several years.

Exp 6. “I guess the political driver ... is around modernising the NHS in Wales. I suppose the zeitgeist at the moment is around making services leaner”.

Concept: Reorganisation of NHS Wales

Given the recent history of the NHS for frequent reorganisations, it was perhaps surprising that few of the experts speculated upon the possibility of major organisational change over the following ten years. One of them, though, was quite

specific about at least one of the potential changes which would impact upon clinical psychology.

Exp 3. “The current, what is it, five health boards, they won’t be here in ten years time. We’ll probably have had two or three reorganisations by then and it again is going to be a major influence on what pans out”.

3.2.1.3 Subcategory: Increasing demand for psychological therapies

The experts considered that there would be a continued and growing demand for psychological therapies, by both the increasingly aware service commissioners and the public.

Concept: Demand for psychological therapies

All the experts considered that demand for psychological therapies would increase over the following ten years. Various influences were put forward to account for this, including users becoming more aware of its value, and an increase in the psychological distress in the general population.

Exp 4. “I think in the next ten years, if the economic recession bites as deeply as people are telling us it’s going to, I think ... we may see far greater numbers of people presenting in need of services”.

3.2.2 Major Category 2: Competition

Many of the experts considered that over the following 10 years there would be increasing competition for a lot of the work and roles that clinical psychologists currently perform.

Concept: Competition

The experts considered that competition for the work and roles of clinical psychologists would come from other applied psychologists, such as counselling and

forensic psychologists, as well as from other professions trained in specific psychological therapies, and that services may be contracted out to providers outside the existing NHS.

Exp 8. “I guess, thinking of the current government, obviously you would predict that there is going to be a move towards far more competition amongst providers; services being contracted out, so rather than services automatically being provided in-house by the NHS you could predict that a lot of services, of which psychology might be one, might be bought in from other providers”.

Exp 1. “That brings me on to another influence, which is the growth in alternatives to clinical psychology, so the presence of CBT therapists, the presence over the border of IAPT trained people, the possibility of using counsellors, you know, all of those sorts of things”

3.2.3 Major Category 3: Critical Actions

If the profession is to be able to successfully resist the competition from other providers for psychological services, the experts proposed that a number of actions must be carried out

3.2.3.1 Subcategory: Clinical leadership

The experts considered that clinical psychologists should take on clinical leadership roles in order to promote good psychological care in healthcare services. This would require training and development of leadership skills, and taking on posts which involve clinical leadership.

Concept: Clinical leadership

The majority of the experts regarded it as highly desirable that the profession should take the lead in the development and provision of psychological care in health services, both to improve the quality of services and also to enhance the influence of clinical psychology.

Exp 6. “I think that’s why we need the leadership at a clinical level as well. It’s about developing clinical psychologists, they can actually take the lead in enhancing psychological practice at all levels”.

Concept: Increased consultation role

It was generally thought that for clinical psychologists to take on stronger leadership roles they will need to increase the time they put in to consultation and supervision.

Exp 8. “I guess if my predictions turned out to be true then you’d probably see what would continue to be the same would be the supervision and consultation roles of psychologists, but perhaps the emphasis would have changed so there would be more of that and less of the hands on clinical work”.

Concept: New roles

A few of the experts identified new roles for clinical psychologists which would give them increased leadership responsibilities or potential. The main examples cited were the roles of Approved and Responsible Clinicians, which are now available to clinical psychologists under the 2007 amendments to the Mental Health Act (1983).

Exp 8. “I guess the first opportunity that springs to mind, or potential opportunity, is that psychologists could, if they wanted, become Approved and Responsible Clinicians”.

Concept: Training for future demands

Some of the experts spoke about the necessity for developing leadership skills in clinical psychologists, if they are to be able to take on leadership roles successfully, and that this should not just be aimed at the most senior members of the profession, but should include people at all levels of the profession, including trainees.

Exp 7. “I think about how training is kind of trying to adapt to that market place of the future, and what’s coming up on the horizon. There’s been an increase in preparing

trainees and qualified people in terms of, you know, consultancy, leadership skills ... there's been more emphasis on preparing people at that early stage for just coming out and supervising straight away".

Concept: Professional confidence

There was a view amongst some of the experts that clinical psychology, as a professional group, has become more confident over the last several years, as evidenced by such things as the number of clinical psychologists in Wales during that time who have taken on Clinical Director roles.

Exp 1. "I think we are growing in confidence as a profession, which is partly about, you know, numerical. We have got bigger, quite substantially bigger, over the last twenty years, haven't we, and I wonder whether in ten years time you might see more psychologists in those kinds of leadership roles".

3.2.3.2 Subcategory: Professional definition/ "added value" of clinical psychology.

It was considered that one of the critical actions which would influence the future development of the profession is for clinical psychologists to agree what it is which they can do which other professions either cannot do at all, or cannot do nearly as well as clinical psychologists. That is, clinical psychology needs to agree and define its "added value". This then needs to be stated in a way which can be readily understood by managers, commissioners and users. The strong view which emerged from the interviews was that clinical psychology's "added value" was having a high level of expertise which could, and should, be applied to complex problems.

Concept: Added value of Clinical Psychologists

It was generally recognised that clinical psychology has had a problem with describing clearly and concisely what it is, exactly, that the profession can do which sets it apart from all other professions.

Exp 8. “Well I guess clinical psychology is going to have to find its unique selling point, as Alan Sugar would say”.

Exp 4. “I think there’s been a proliferation of other groups of professionals who, to varying degrees, claim the territory that’s historically been ours and I don’t see that’s going to stop. I think that’s going to continue and grow, so that’s another influence and that comes back to how do we, you know, how do we market ourselves? What’s our unique selling point, are we really different, if so how? What is it that we believe we do, not just well but better than the other people who purport to do some of those things? And then again, how do we demonstrate that really, because it won’t be enough to just say we do it”.

Concept: Complexity

There was a strong view amongst the experts that one of the qualities which separates clinical psychology from other professions is their ability to deal with complex problems, and that this was an important component of “added value”.

Exp 8. “Psychological therapists, for want of a better word, can do the routine stuff, but if it becomes particularly complex then actually you need someone like a psychologist with a greater level of skill and understanding, and that might be the activities which we continue to be asked to do”.

Concept: Calibre of clinical psychologists

One of the experts thought that clinical psychologists are mostly particularly clever, competent and effective people, and that these qualities are noticed and valued by their work colleagues.

Exp 3. “I have to say quite a lot of psychologists even at junior levels are seen as being bright sparks, and as people who, you know, have got added value in that they’re dead sharp, and they can often do things, and they’ve got a can-do mentality, and will find ways round difficulties and find alternative ways of doing things”.

3.2.3.3 Subcategory: Being valued/PR/marketing

There was a recognition that, having defined “added value”, the next, very crucial, step for the profession is to ensure that what clinical psychology can provide is known, valued and wanted by commissioners, managers and users. It was seen as an essential part of this that clinical psychology must take opportunities to demonstrate clearly what it can accomplish.

Concept: Commissioners` knowledge of clinical psychology

Some of the experts thought that clinical psychology does not have a high profile amongst the senior people who control resources, and that they are often unaware of what clinical psychology can offer to the services they are planning or commissioning.

Exp 7. “At the moment it feels like the awareness of clinical psychology out there in NHS structures at senior levels in workforce sort of planning areas, seems to be quite limited.”

Concept: Users` influence

The influence of service users on planners and commissioners of health services was mentioned by some of the experts as something which is increasing, and which may lead to increased demand for clinical psychology services in the future.

Exp 7. “The other thing DCP Wales is kind of looking at is making the public more aware of us, because my experience of when the public know about what we do is that actually they really like us compared to other kind of experiences or services they might get in the NHS”.

Exp 1. “I think it`s clear that the service user voice, or user organisations, or sufferer organisations or whatever you want to call them, seem to have a big influence on policy development. They have the ear of the Welsh Government in a very influential way as I see it”.

Concept: Influencing the policy makers

Some of the experts thought that clinical psychology has become more effective in recent years in promoting the profession with government and policy makers, and that this will be very beneficial in the future.

Researcher: “So do you think that’s something that both in England and Wales, but I suppose particularly in Wales, that we’re getting a bit better at, is the links with the policy makers”?

Exp7: “Yes, some of those processes are happening and I think in the long term the potential is there, useful and beneficial”.

Concept: Demonstrating what we do

There was a feeling amongst some of the experts that clinical psychology needs to be able to define clearly what it is which sets it apart from other professions, and then, crucially, it needs to demonstrate these capabilities to influential planners and commissioners of services. The feeling was that clinical psychology currently does not do this very effectively.

Exp 2. “We need to be very clear about what it is that we’re supposed to be delivering, and then delivering it effectively and showing that we do. And I don’t think we’re great at any of those things”.

3.2.3.4 Subcategory: Opportunities

A number of opportunities were predicted over the next 10 years for clinical psychology to develop and to show what it is capable of accomplishing in healthcare. These include developing services in physical health, leading psychological therapy services, and moving into primary care.

Concept: Clinical health psychology

Several of the experts were optimistic that physical health was an area in which clinical psychology will have opportunities to develop over the following ten years, despite the financial restrictions which are likely to continue within the NHS.

Exp 7. “I think what’s happening in health psychology, health, physical health is an opportunity for clinical psychologists that’s happening now, and I assume that’s going to continue”.

Exp 4. “I think there are opportunities for service development certainly in physical health. I think that’s a vastly untapped area, and I think a lot of medics in physical health, who are working in physical health settings, are remarkably open to psychological interventions”.

Concept: Psychological therapy services

Several of the experts thought that multidisciplinary psychological therapy services would be likely to develop over the following ten years, perhaps replacing traditional psychology departments, and that these would present clinical psychologists with opportunities to take a lead in their development and management.

Exp 1. “I think services will become more psychological. I think there’ll be a move from sort of a psychology service to psychological therapy services”.

Concept: Money saving capabilities/opportunities

Some of the experts thought that there are development opportunities for clinical psychology in areas where they can demonstrate financial gains for the organisation. These include some areas of physical health, but also other areas where there are clients with complex needs who are high risk of harm to self or others, such as forensic services and personality disorder services.

Exp 1. “We’ll be doing more of the things that save organisations money ... diabetes, cardiology, all of those physical health things, but also, you know, employee well-being services I think have a pretty good evidence base. There’s probably quite a lot under that umbrella of saving organisations money and delivering a better service into the bargain”.

Concept: Primary care/community psychology

Primary care and the community were regarded by some experts as providing potential for service developments over the following ten years, particularly in light of the Mental Health (Wales) Measure 2010 which requires Local Health Boards to provide primary care mental health services.

Exp 4. “In ten years time we may find more clinical psychologists working in a primary care setting ... and I wonder also whether community psychology may be an area of growth”.

Concept: Innovation and creativity

Some of these concepts can easily be seen to fit into more than one category, and “Innovation and Creativity” could clearly fit into the “Added Value” category. The ability of clinical psychologists to use their skills and knowledge of psychology to create novel solutions to difficult problems has long been regarded by clinical psychologists as one of their defining capabilities (DCP, 2010; MAS, 1989). Some of the experts considered that this ability is recognised by other professional colleagues, and that this will continue to create opportunities for clinical psychologists to demonstrate their value in the future.

Exp 2. “The thing that gives me hope that we can do something different is that people keep coming back for our service and wanting that personal ability to be creative with psychological theory and practice”.

Concept: Developing psychological skills in other staff

It is very clear that members of other professions are being trained in, and then delivering, psychological therapies. Many of the experts saw that as an opportunity for clinical psychologists to take on leadership roles by supporting the training and supervision of those other professionals.

Exp 2. “I think there is an opportunity in other professions delivering psychological therapy, and psychologists being able to understand the therapy that’s being delivered and support it”.

3.2.3.5 Subcategory: Political skills

There was a recognition that if clinical psychologists are to thrive in the future they will need to gain more power and influence than they currently have, which will require gaining both formal power through taking on leadership/management roles, and also informal power through being politically astute.

Concept: Political skills and awareness

Some of the experts thought that clinical psychologists need to become more politically astute in order to influence managers, planners and commissioners.

Exp 6. “Leadership is going to be really important for psychology, and I think that the training courses have a part to play in that as well, by getting some other competencies in place for psychologists. I think getting those systemic skills in place, negotiating skills as well, thinking about becoming much more politically astute, and aware of how much the political agenda shapes the delivery of services”.

Concept: Power/influence of medical staff and nurses

There was a concern amongst some of the experts that other professions, particularly medical staff and nurses, have much more power within healthcare organisations than clinical psychologists, and that clinical psychologists had actually lost power over the

previous several years. The danger of having relatively less power is that the profession becomes more vulnerable if the financial restrictions lead to cuts in posts.

Exp 2. “It’s just informal influence and power that people have which is an establishment power, and I think that nurses carry a lot and psychologists ... are aspiring to carry more but they are not in a position where they have an equal level of power. And if we come under the crunch financially, I think it is likely to impact, that the more powerless professions will lose out in that process”.

Exp 3. “Years ago psychologists really got into strong leadership positions ... that’s been reversed. We’ve got I think it’s eight separate programmes like learning disability, acute mental health, community mental health, forensic etc, each of those has a head of programme, all of them now are psychiatrists except one who is a consultant nurse. No psychologists got those positions”.

3.2.4 Major Category 4: Leaner Services

The continuing severe financial restrictions are predicted to create considerable pressure for clinical psychology services, in common with the rest of healthcare, to be leaner and cheaper. This will create pressure to reduce pay bandings, which in turn will affect career pathways and advancement, and career choices.

3.2.4.1 Subcategory: Reducing costs

There are currently strong demands to reduce costs, and these are expected to continue to have an impact upon clinical psychology for many years

Concept: Downward pressure on bandings

Most of the experts noted that there is considerable pressure to reduce costs by reducing the pay bands of clinical psychology posts, and they expected this to continue.

Exp 8. “In practice, budget holders obviously realise they can’t afford to have the whole hierarchy of psychology and are quite keen to just have people in lower paid jobs”.

Exp 1. “ ... there is, of course, massive downward pressure on bandings”.

Concept: Differentiation of bandings

Some of the experts felt that pressure to reduce costs would lead to there being clearer differentiation between the duties of lower banded posts and higher banded posts. Most expected that the direct clinical work would be predominantly carried out by lower banded staff, or even by other professions, and that the higher banded clinical psychologists would be supervising that work.

Exp 8. “...it might be the case in Wales that there would be a look to either more junior psychologists or people with a different level of qualification providing much more of the kind of the bread and butter work. There’d probably be an attempt to get far fewer higher up psychologists actually doing hands on work, so you might have more of the more highly qualified consultant level psychologists supervising the work of a lot more junior people, in terms of being able to get the costs down, such that the people who were doing the actual hands on therapy cost less than psychologists do today”.

Concept: Career advancement

Most of the experts thought that it will become much more difficult over the following ten years to advance up the career ladder, and that upgrading staff in post would become extremely rare.

Exp 8. “I suppose there’s been quite a difficulty for people progressing anyway, because of lack of money, lack of jobs, lack of opportunities, and I know certainly from talking to friends in England that when an experienced, say 8c, person has left, they are only able to recruit to Band 7 ... the emphasis these days is on banding the

job not the person, so if you go into a Band 7 job you can't expect that it will be re-graded for you".

Exp 2. "What I can see developing at the moment is a kind of a bit of a gulf between very senior psychology posts and very, you know just entry to the profession posts, and that it's going to be very difficult to sustain a career structure moving from one up to the other".

3.2.4.2 Subcategory: Career pathways

Reductions in posts, particularly at senior levels, were predicted to force clinical psychologists to look at new routes for career advancement. More people will look outside the NHS than traditionally has been the case. Routes to advancement might include taking on service management responsibilities (as opposed to professional management), and developing areas of high clinical expertise.

Concept: Career pathways

There was a generally agreed view that the anticipated reductions in posts, and in senior grade posts in particular, would mean that clinical psychologists will no longer be able to expect to advance easily up the career ladder. They will have to look for more specific pathways for career advancement, which might include taking on management responsibilities, or developing areas of high clinical expertise.

Exp 7. "... if you look at some of the other professions out there, as they've got more senior they've become more managerial and more in strategic positions as managers within healthcare organisations. And, you know, I kind of wonder if the more senior posts in clinical psychology a few years down the line, perhaps ten years down the line, might also get more redefined as managers".

Concept: Agenda for Change impact continuing

A few of the experts thought that some of the changes arising as a consequence of Agenda for Change will continue to impact upon clinical psychology for a long time.

The adoption of a common pay scale has meant that clinical psychologists` pay can now be easily compared with that of other professions with similar responsibilities, and this might lead to clinical psychologists being expected to take on more responsibilities to justify their pay bandings, or to further pressure to reduce the bandings of posts.

Exp 7. “I think there’s been some changes already which are going to have a more permanent impact on the profession, so things like Agenda for Change coming into place, and if you look at how that’s impacted on jobs now and the transparency of the pay scales etc. ... And I think that change coming out of Agenda for Change is a more permanent change, and I can see that continuing long term”.

Concept: Loyalty to NHS reducing

Some of the experts thought that clinical psychologists have traditionally been strong supporters of the NHS, and have therefore been reticent to move in to the private sector. They thought that this loyalty to the NHS is reducing now, as a consequence of significantly reduced job opportunities.

Exp 5. “I think psychologists are far more positive and amenable about going in to the independent sector now. You know, a few years ago, ten years ago, it seemed to be the worst thing that we could do and almost like we were betraying the NHS, but now it seems to be a far greater acceptance of that”.

Concept: Specialisation/expertise

It was suggested that one way for clinical psychologists to provide “added value” would be for them to become expert in a specialist area. It was thought by several of the experts that this would then provide a route to more senior posts.

Exp 3. “The things that they’ll be doing differently are perhaps that they’ll become even more specialised in a particular area, even more expert, even within a Speciality”.

Concept: Changing role of Community Mental Health Teams (CMHTs)

Posts within CMHTs are currently a common place for clinical psychologists to begin their careers, but the development of specialist services, such as assertive outreach teams and home treatment teams, has changed the nature of the work of the CMHTs. One of the experts was unsure as to what the future role of clinical psychologists within these teams might be, and even whether they would continue to be employed within them.

Exp 4. “I’m not sure whether CMHT’s will exist in quite the same way that they do now, within an adult mental health setting ... I’m wondering if the rump for CMHT work almost gets smaller and smaller. So in terms of the role of a traditional CMHT type psychologist, which I know is thinking about it at a very clinical level, I’m not sure where that will be”.

Concept: Mobility and transferable skills

The anticipated reduction in the number of senior posts led some of the experts to suggest that it will become more commonplace for clinical psychologists to attempt to transfer to different specialties in order to advance their careers, and that to do this they will need to emphasise the transferability of the skills and experience they have acquired during training and afterwards.

Exp 4. “There may be more lateral movement, but I think it may be in and out of public, private sector and it may be across speciality. There’s always been that notion that when we’re trained we have transferable skills and we ought to be able to apply them with different kinds of clinical populations or groups of people”.

3.2.5 Major Category 5: Increasing Accountability

The experts expected that growing demand for psychological therapies in a period of severe financial restraints will lead managers and commissioners to exercise increasing control over the activities of clinical psychologists. They will want to specify what work clinical psychologists undertake, and to monitor it closely. There

may be pressure to undertake more direct psychological therapy, particularly for lower grades. Continuing professional development (CPD) and post-qualification training will be in line with organisational goals rather than with individuals' aspirations.

3.2.5.1 Subcategory: Accountability

It was expected that individuals and services will increasingly be asked to account for what they do. Their activities will be agreed with managers and then monitored to ensure they are providing what the organisation requires.

Concept: Accountability

As finances get more restricted over the following years, many of the experts expected that the work of clinical psychologists will become more closely controlled and monitored by managers and commissioners.

Exp 3. "The overall economic financial climate, that of the last year, has had a massive influence on not only psychology but obviously all disciplines, but has certainly hit us to a degree where there's now far greater control of our budgets, and indeed what we do, by people other than heads of psychology ... It's increasing our accountability".

Concept: Individual's development/ CPD in line with organisation's goals

Several of the experts thought that healthcare organisations will direct or control the professional development and CPD of staff, including clinical psychologists, more tightly than they have in the past, and that they will require them to be directed towards the goals of the organisation.

Exp 7. "So in ten years time what sort of post-qualification training will people be doing? I think what's happening is it's obviously getting much more focussed around our roles and job".

Concept: Demand for direct therapy

Some of the experts thought that closer scrutiny by managers of the work that clinical psychologists do might lead them to require clinical psychologists to devote more of their time to direct clinical work, in order to meet the expected increase in demand for psychological therapy.

Exp 1 “I think there is pressure around to do more, to do more face to face work”.

Concept: Demonstrating value for money

Many of the experts recognised that clinical psychologists are often regarded as expensive, compared to other professions. With the growth in the number of people from some of these other professions getting trained in various psychological therapies, the experts thought that there would be an increasing necessity for clinical psychologists to demonstrate that they provide value for money.

Exp 1. “I think this issue about demonstrating value for money will be huge”.

3.2.5.2 Subcategory: Integration/management

The requirement to monitor and direct clinical psychology activities more closely is expected to lead to the operational management of clinical psychologists passing to service managers, although a professional hierarchy will remain.

Concept: Professional hierarchy

Most of the experts thought that, whatever the arrangements for operational management of clinical psychologists were, there would continue to be a professional hierarchy in healthcare organisations over the following ten years, with a single head of profession.

Exp 3. “We’ve got to have, and I think we still will have, a specialty psychology manager doing the professional appraisal and so forth”.

Exp 4. “I would expect that there would still be professional accountability that comes down some kind of line, or chain, or hierarchy from a psychologist”.

Concept: Models of management

The majority of the experts thought that clinical psychologists will increasingly be managed by service managers over the following ten years, leading to the decline of the traditional clinical psychology department model of organisation.

Exp 7. “What I don’t want to see happen, but I think is probably going to happen in ten years time, is actually we’ll become more and more ... managed by other people within organisations”.

Concept: Integration

There were mixed feelings about the integration of clinical psychology into multidisciplinary services. Some of the experts expressed the view that clinical psychology needs to become more integrated into those services, which would usually involve becoming operationally managed within the service.

Exp 6. “I think psychology does need to be much more integrated in health services”.

For an opposing view, see the quote from *Exp 7* for the previous concept (models of management).

3.2.6 Major Category 6: Training

There was a lot of speculation amongst the experts about what might happen to the training of clinical psychologists over the following ten years, and particularly how financial restrictions might impact upon it.

Concept: Cheaper alternative routes to Health Professions Council (HPC) registration

One of the experts thought that with training and qualifications now accredited by the HPC, there might be attempts to find cheaper routes to qualification than the current three year doctorate courses. The HPC changed its name to the Health and Care Professions Council (HCPC) in August 2012, after the end of the data collection.

Exp8. “ ... given that we`re now regulated by the HPC, I wonder whether you might get new ways of training to meet HPC criteria, kind of bypassing the BPS ... I`m sure there will be attempts made to try and get people trained via a cheaper route”.

Concept: Training

There were a lot of different views expressed about the future of clinical psychology training courses over the following ten years. Whilst some of the experts were more optimistic than others, almost all of them recognised that the cost of training clinical psychologists means that things like the number, size, and duration of the courses in Wales are likely to come under close scrutiny.

Exp 5. “The future of training in clinical psychology is a threat, again I think that`s part of the funding structure. I understand that funding has become more difficult to come by for training new clinical psychologists and we seem to be training less of them in Wales than we were before”.

Concept: Emphasis on competencies

A few of the experts suggested that clinical training courses will increasingly produce qualified clinical psychologists who are already accredited in one or more specific therapies, because employers will want proven competencies rather than any particular professional qualification.

Exp 7. “I think one of the things clinical psychology is heading towards, ... is clinical psychologists almost like covering themselves, doing therapies, skills, training, to get

accreditation to be able to say, well, I am a clinical psychologist, but actually I am also an accredited CBT therapist”.

3.2.7 Major Category 7: Dominant Model of Psychological Therapy

Most of the experts considered that the major model of psychological therapy in 10 years time would still be a variant of Cognitive Behaviour Therapy.

Concept: CBT/dominant models of therapy

The majority of the experts thought that “third wave” CBT therapies, or their successors, would remain dominant over the following ten years.

Exp 8. “I might be a bit blinkered because I think these third wave ones, where you try to attempt to change people`s relationships with their thoughts, I think they`re so brilliant that I can`t think anything else that might come along and supersede them”.

3.3 A MODEL FOR GUIDING PREDICTIONS ON THE FUTURE OF CLINICAL PSYCHOLOGY IN WALES IN 2022.

3.3.1 Emergence of the Model

The model described in this section was derived from analysis of the first round of interviews with the experts. The researcher followed the guidance from Strauss & Corbin (2008) to identify concepts first, and then organised them into the categories described in the previous section of this chapter. The expected outcome of the analysis at this stage was for little more than a list of predictions for the future, and the identification of a number of general trends or themes in the data which might help in understanding the reasoning behind the predictions. The researcher was not expecting a model for predicting the future of clinical psychology to emerge. Having identified the concepts and categories described previously, though, the researcher then tried fit these together into a coherent whole. Many different structures were tried before one was found which seemed to organise the data clearly and helpfully.

What then emerged was a model for guiding predictions on the future of clinical psychology in Wales in 2022 (that is, ten years from the time that the interviews had been carried out with the experts).

The researcher was very mindful of the fact that his task during the analysis was to attempt to understand and structure the views and ideas that the experts had given during their interviews, whilst at the same time remaining aware of the fact that his own expert knowledge of the area could both help and hinder that task. That is, his expert knowledge could be helpful to the analysis if it allowed him to make sense of the data more readily than a naïve researcher might have been able to manage, but it could also be unhelpful if he then imposed too much of his own thinking upon the emerging model. It is not really possible for the researcher to give an unbiased view as to whether or not he succeeded in maintaining a balanced perspective during the analysis, although he certainly attempted to do so. This is one reason why it was felt to be particularly important that the evaluation and validation of the model should include Respondent Validation (Mays and Pope, 2000).

The researcher tried many different ways to structure the concepts and categories before arriving at the model which is presented later in this chapter, but it is not easy to describe the exact process by which the model emerged from the data. The researcher began by identifying concepts, and he then tried to organise these into categories in a variety of ways. He made many attempts to link categories together in a coherent manner, but initially was not able to do so. He then thought to try to use a timeline to link the categories. This proved to be a useful way to organise the data, and it allowed a first model to emerge. This required some further refinement, but eventually the researcher was satisfied with the model. The researcher kept a journal throughout the study, and it may help to illustrate the process and course of his analysis to present some extracts from this journal:

- 17.02.2012. “All first interviews completed. Notes made on each interview”.
- “Need to identify concepts, categories, propositions”.
- “N.B. GT is interpretive; my task is to interpret the data, not just describe and report them”.
- “Way forward is to attempt to list concepts as a first stage”.

- 18.02.2012. “Begun listing concepts”.
 “Some thoughts for categories, but I am still trying to avoid putting structures on the data too early. Just collect all the concepts, check out they`re all there, then play with the data to derive categories, etc.”
- 21.02.2012. “Various “models” attempted. Some higher order categories:-
 Drivers - government policies
 - finance
 - increasing demand
 Value Added - critical, a crossroads
 If we do it properly, i.e. define it (added value) and/or get people to value us for something, will be ok at taking on competition.
 If we don`t do it properly, so are not valued, then competition will overtake us, take key roles, etc.
 Also, having decided/established our added value, so it is wanted, we have to deliver it”.
- 23.02.2012. “Some thoughts on organising the concepts:-
 Internal factors vs. external factors?
 Drivers, modifiers.
 Innovative factors vs. keeping what we have.
 User demand, professional status”.
- 11.03.2012. “Thoughts about categories. 11 or 12 initially from 47 concepts. One or two seem anomalous:-
 Dominant model - this is not so much about clinical psychology as about therapy, so will be dominant for all psychological therapists”.
- 12.03.2012. “Struggling to get a satisfactory model. I know the working of it, i.e. I could describe what happens/will happen, but it`s difficult to put it down as a clear model. Tried a lot of diagrams – most ended up in the bin. ?Draw it as a timeline? – i.e. from now, how it will unfold, until 10 years from now?”

Timeline - some things will happen over the next 10 years - will be better outcome if they occur in a particular order. That is, some drivers operating now, and will continue. Some actions/consequences of the drivers are inevitable almost, e.g. services will get leaner. Some actions will only happen if we make them happen, but they do need to happen if the profession is going to be able to deal with the challenge we all expect will occur from other professions”.

17.03.2012. “Having produced a first go at a model, and sent it off, ... I realise I have missed out a category! I have been putting “increased accountability” into “leaner services”, but they are different. One is getting cheaper, more efficient, the other is having to agree/account for what we do ... There is, I think, an overarching category here, but I can't quite grasp it”.

26.03.2012. “Model has been stable in my mind for a while. It is much better for splitting “leaner services” into “leaner services” and “increased accountability” ”.

Some months later the researcher reflected upon the process of arriving at the model, and recognised that his expert knowledge of the area had probably been influential in allowing him to recognise when the model was satisfactory:

18.07.2012. “Gradually, all the things which had been floating around in my head, and which I had been thinking about for days and days, trying to fit together, finally fell into a shape which I felt comfortable with. Once I had produced it in draft, quite quickly I realised that it was fine, it fitted all the things I had been thinking about ... now I look at it, it's very simple and clear, so what was the problem!! But it took ages to arrive at that”.

3.3.2 A Summary of the Model

This model is intended to represent the main ideas of all the participating experts about the future of clinical psychology in Wales in 2022, structured and organised into a coherent whole. It illustrates their views that continuing financial constraints, government policies, and increasing demand for psychological therapies, will be the major factors shaping Clinical Psychology over the following 10 years. As a consequence of these factors, the profession will be under pressure to become leaner and cheaper, and commissioners and managers will also want to ensure that clinical psychologists are working to the priorities of their employing organisation. In addition, there will be strong competition from other professions to provide many of the activities which clinical psychologists currently carry out, particularly the provision of psychological therapies. There are a number of critical actions, which the model describes, which the profession needs to undertake in order to meet these challenges successfully. The model is able to incorporate and account for many of the specific predictions made by the experts about the future of clinical psychology in Wales. The full list of predictions is provided in Table 3.1. A diagrammatic representation of the model is given in Figure 3.2.

3.3.3 The Basic Elements of the Model

3.3.3.1 Major service drivers

There are three major forces driving the future of Clinical Psychology. They are:-

- Severe financial constraints, which will affect clinical psychology, along with many other health services, and which the experts expected would continue for most or all of the following 10 years.
- Government policies, both from Westminster and the Welsh Government, which will impact upon clinical psychology. In particular, the drive from the Westminster government to privatise health service provision, and the Welsh Government's agenda to modernise the health service in Wales.

- Continued and growing demand for psychological therapies, by increasingly aware service commissioners and the public.

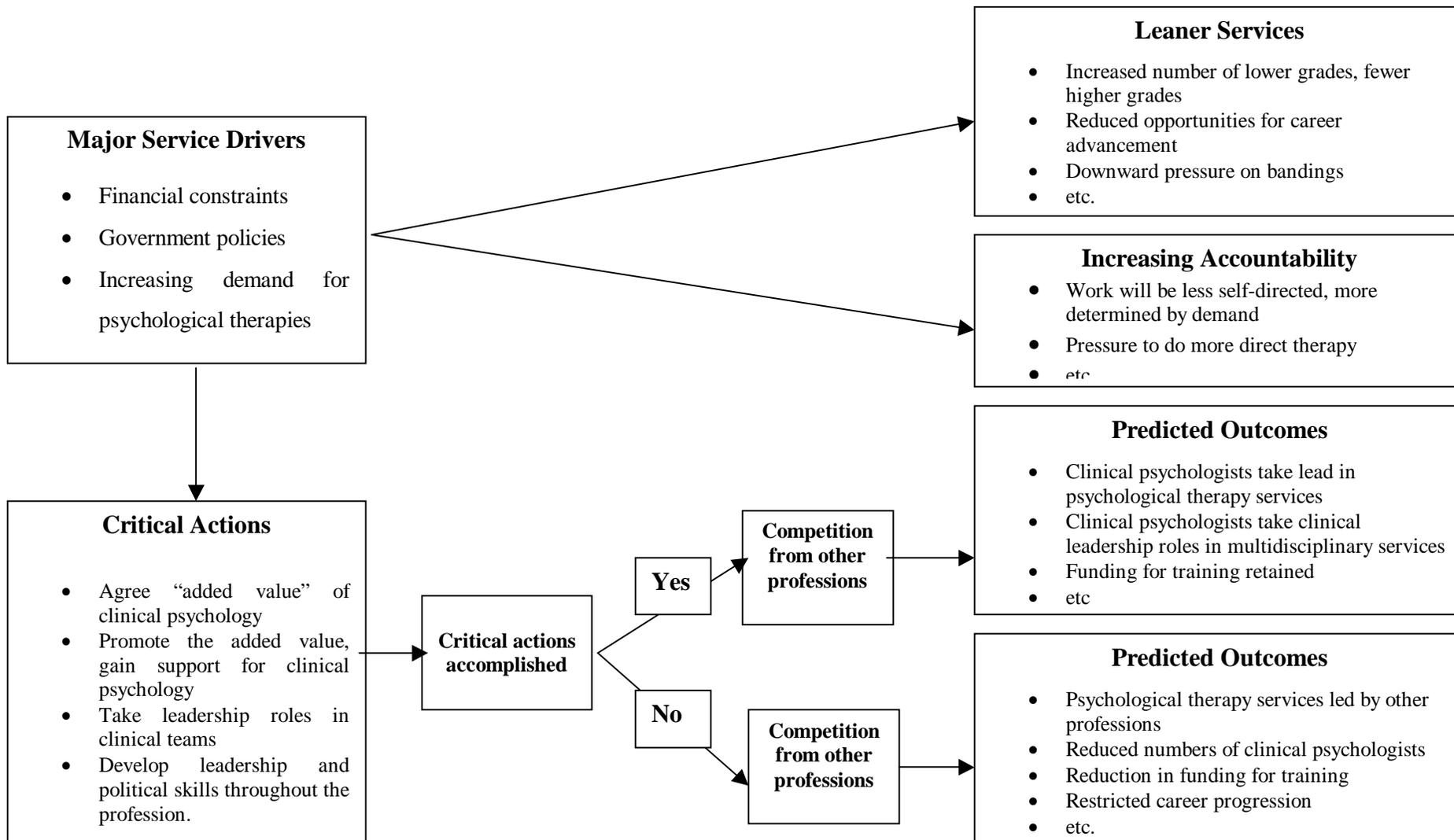
3.3.3.2 Leaner services

The major service drivers will create a strong demand for clinical psychology to be leaner and cheaper. Clinical Psychology will see downward pressure on job bandings, resulting in a profession with a greater concentration of posts at the lower bandings and fewer opportunities for career advancement. The career route to higher banded posts, and to consultant grade posts in particular, will require increasing levels of specialist knowledge and expertise and/or taking on management or leadership roles. Clinical psychologists increasingly will look outside the NHS for career progression, as options within the NHS diminish. These processes are occurring to some extent already, and the prediction is that they will increase over the next few years.

3.3.3.3 Increasing accountability

The growing demand for psychological therapies in a climate where there are severe financial constraints will lead commissioners and managers to exercise increasing control over the activities of clinical psychologists. The work of clinical psychologists will be determined by demand, agreed with managers, and monitored more closely than is currently the case. There will be pressure for clinical psychologists to do more direct therapy, which may affect the lower banded posts particularly. Higher banded posts, and consultant grades in particular, will try to make better use of their expertise by increasing the amount of time given to providing clinical supervision, consultation, and advice to other practitioners of psychological therapies. Post qualification training will be much more in line with organisational goals than with personal aspirations.

Figure 3.2: A Model for Guiding Predictions on the Future of Clinical Psychology in Wales in 2022.



3.3.3.4 Competition

It is anticipated that between 2012 and 2022 there will be increasing competition for a lot of the work which clinical psychologists currently do, and the roles which they occupy. The competition will come from other applied psychologists in healthcare, such as counselling psychologists, forensic psychologists and health psychologists. It will also come from other professions such as counsellors and psychotherapists, as well as individuals from other professions who have received training, sometimes to a high level, in various psychological therapies. This competition already exists, but the experts predicted that it would increase significantly over the following several years. These competitors will look particularly attractive to commissioners and service managers if they appear to be able to do the same job as a clinical psychologist, but do not require such high salaries. In the context of the severe financial constraints, which were predicted to continue for most of the following 10 years, these other professions present a considerable threat to the pre-eminent position in the provision of psychological therapy and care which clinical psychology has occupied for many years.

3.3.3.5 Critical actions

There are a number of critical actions which clinical psychology must take in order to prepare for and resist the challenges to its current position as the primary profession providing and directing psychological therapies and care in health services. The model predicts that if these actions are accomplished successfully and in good time, then clinical psychology will retain its pre-eminent position amongst the professions providing psychological therapies and care. If, on the other hand, these critical actions are not accomplished, or are not accomplished in good time, then the model predicts that there are likely to be considerable negative consequences for clinical psychology, including possible reductions in posts, in numbers being trained, in career opportunities, in influence on healthcare, etc.

One of the first critical actions to be undertaken is for the profession to agree exactly what it is that clinical psychologists can do which other professions either cannot do at all, or cannot do nearly as well, and then to state that clearly in a way which can be

readily understood by commissioners, service managers, and service users. That is, clinical psychology needs to agree and define its “added value”. The question of what constitutes clinical psychology’s added value was not discussed specifically with the experts, but some consistent themes were discernible in the interviews:-

- **A high level of expertise and specialist knowledge.**

Exp 5. “We have such a wide range of skills, and we can apply those skills to a whole range of different patient types and difficulties and presenting problems, and we’re able to formulate those problems in a way which other disciplines can’t”.

Exp 2. “ Psychologists take a much higher level of training ... and draw from practice and theoretical models to support a client in a way that is most helpful to them”.

- **The ability and willingness to work with the most complex problems and clients.**

Exp 5. “ ... the most violent, the most suicidal, the most difficult person with the most difficult problems is the person everyone runs to the psychologist saying, what on earth do we do with this person”?

Exp 8. “Actually you do still need quite a lot of clinical psychologists with the training and the expertise to deal with the more complicated people”.

- **The ability to provide clinical leadership for psychological care, including clinical supervision, consultation, and advice to other professions.**

Exp 1. “I think that we can and should play a role in leading those services, in quality assuring that what they’re delivering is what they

should be delivering, that training and supervision is up to standard. I think that's a really important thing for clinical psychology to be involved in".

Exp 7. "There's been an increase in preparing trainees and qualified people ... in terms of leadership, consultancy, supervision. Because ... that's what we think we're moving towards, and it's our added value".

- **The ability to contribute psychological knowledge to the strategic planning of healthcare services.**

Exp 3. "I think the opportunity, as well, is the recognition for greater clinical leadership, and by that I mean inputting into the things like strategic and service planning".

Exp 6. "... we can best use our psychological skills to help shape and deliver psychological health services".

- **The ability to create innovative services which improve healthcare significantly and/or save money, especially in high risk, highly specialist areas.**

Exp 1. "One of the reasons a lot of people went out (of NHS services, into private facilities) was related to risk and to a level of specialism of intervention, and I think psychology is really well placed to offer something in both those areas. ... So I think there's probably quite a lot under that umbrella of saving organisations money and delivering a better service into the bargain".

Exp 2. "I think we do deliver something unique and different which has a high capacity to save money".

The model suggests that once the added value of clinical psychology is agreed by the profession, it is necessary to promote this so that it is known and wanted by people at all levels of healthcare; planners and commissioners, service managers, clinical teams, and service users. This will require some degree of promotion and marketing, of demonstrating what clinical psychologists can do, and sound political skills.

3.3.3.6 Predicted outcomes

The model indicates that if the critical actions are accomplished successfully, or at least considerably improved from their current state, then the predicted outcomes for Clinical Psychology in Wales in 2022 are generally positive, and are likely to include the following. These predicted outcomes are all taken from the specific predictions made by the experts, which are shown in Table 3.1. It is not intended to be a complete list.

- Training will continue to be funded at present levels. (Predictions H.4, H.11).
- Clinical psychologists will take on clinical leadership roles in multidisciplinary services. (Prediction E.4).
- Senior clinical psychologists will be involved in strategic planning of healthcare, and will advise on or direct psychological aspects of care at all levels. (Prediction E.5).
- Clinical psychologists will lead psychological therapy services, which will include other professions. (Prediction E.9).
- There will be opportunities for innovative service developments, led by clinical psychologists, particularly in physical health and in high risk specialist areas. (Predictions I.2, I.3).

-
- Clinical psychologists will increasingly take on clinical supervision, consultation and advisory roles in service provision in order to make best use of their expertise. (Prediction C.5).
 - There will be increasing numbers of clinical psychologists in management positions. (Prediction G.11).
 - Clinical psychologists will be dealing with the most complex problems, and so will be required to acquire specialist skills and knowledge. (Predictions E.7, E.11).

If, on the other hand, the critical actions are not accomplished sufficiently, or not in good time, then the model indicates that the predicted outcomes for Clinical Psychology in Wales in 2022 are likely to be much less favourable, and will include the following. Again, this is not intended as an exhaustive list:

- Reduced funding for training, leading to fewer training places in Wales, a possible reduction in the number of training courses, and a possible reduction in the length of training to a 2 year, non-doctoral training. (Predictions H.2, H.3, H.10, H.11).
- Clinical psychologists will be less highly trained, less skilled, and so will lose the “added value” which distinguishes them from other professions. (Predictions D.5, H.2)
- Clinical Psychologists will decline in numbers, with many available posts being taken by other professions. (Predictions D.2, D.4).
- Psychological therapy services in some cases will be led by other professions. (Prediction D.6).
- Clinical psychologists will find it increasingly difficult to attain positions of power and influence within health services. (Prediction F.4).

- Opportunities for career advancement within clinical psychology will be more restricted. (Predictions G.3, G.10).

This model is, of course, something of an oversimplification. In reality there is not likely to be a simple dichotomy dependent upon whether the critical actions are accomplished in time to deal with the threat of competition. The critical actions may be wholly or partly accomplished over the course of the 10 years from when the experts made their predictions, and the competition from other professions already exists. Nevertheless, although the reality is likely to be a more complicated picture than the two extremes shown in the model, the general prediction is quite clear; clinical psychology will face increasing threats from competition in the future, and how well it survives will depend, at least to some extent, upon how well and how quickly it addresses a few critical actions.

Finally, in producing the final version of the model, the researcher did not include all of the seven major categories which he had identified initially, and which are shown in Figure 3.1. Some elements of the “Training” category appear in the Predicted Outcomes; the model regards them as being amongst the consequences of the achievement or otherwise of the Critical Actions, rather than being a major influence upon the state of clinical psychology in 2022. The “Dominant Model Of Psychological Therapy” is also not regarded as exerting a major influence upon the state of the profession in 2022.

3.4 ANALYSIS OF THE SECOND ROUND OF INTERVIEWS: EVALUATION AND VALIDATION OF THE MODEL

The second round of interviews with the participating experts utilised a semi-structured interview (Appendix F). The rationale for the questions used is given in the Method chapter. The majority of the questions asked of the experts were specifically designed to evaluate and validate the model by testing Fit, Understanding, Generality and Control (Strauss and Corbin, 1998), and also Respondent Validation (Mays & Pope, 2000). In addition, they were asked to give their general views on the model, and any suggestions for improving it.

3.4.1 Experts` General Views on the Model

General opinions were very favourable by all eight experts:

Exp2. “ ... clearly predicts action to be taken ... enormously helpful to the profession ... It`s a very approachable model, quite powerful ... but it`s usable”.

Exp 1. “ ... it felt absolutely spot-on I would say, you know, almost to the point of thinking it fits so well, it seems so obvious”.

3.4.2 Questions Relating to “Fit”

3.4.2.1 Agree/disagree with the model?

All eight experts said that they agreed with the model, although *Exp 6* then qualified this by saying that s/he agreed with it except for the use of the term “lean”, which, *Exp 6* said, has a particular meaning in systems and organisations.

Exp 5. “ ... it was congruent with what I thought and what I felt, but it had extra bits in there as well which I hadn`t thought of”.

Exp 1. “ ... it feels like a very good fit with the way that I see the situation”.

3.4.2.2 Does the model reflect the reality in Wales?

Seven experts agreed with this without reservation:

Exp 7. “The things in there are the things people have been talking about and worrying about”.

Exp 8 was concerned whether the predicted outcomes would really flow from the Critical Actions, thinking that the “added value” of clinical psychologists needed not only to be defined, but also that commissioners needed to value and want it. In fact, this is identified in the model as one of the Critical Actions.

3.4.2.3 Does the model include all the most important elements?

Six of the experts agreed that the model included all the most important elements:

Exp 8. “Yes I do ... I think it does capture the main points, you know, certainly what’s driving services at the moment and the fact that psychologists need to do something to ensure that outcomes are good”.

Exp 3 thought that the model should include the idea of the profession acting together to accomplish the Critical Actions.

3.4.2.4 Does the model account for all the most important predictions?

Seven of the experts thought that the model accounted for all the most important predictions:

Exp 8. “[I would say so, yes”.

Exp 3 thought that “the (dominant) therapeutic model will be really important”.

3.4.2.5 The model suggests that the next 10 years will be critical for the future of clinical psychology. Do you agree?

All the experts agreed that the following 10 years were going to be critical for the future of clinical psychology:

Exp 2. “I agree. What I really like ... is that what it says is that we have to act now”.

Several experts made the point that some of the predicted outcomes are happening already:

Exp 4. “ ... disagree that it hasn’t happened yet”.

Exp 5. “ ... less than 10 years probably”.

3.4.3 Questions Relating to “Understanding”

3.4.3.1 Is the model clear and understandable?

All experts agreed that the model was clear and understandable:

Exp 8. “It`s very clear”.

3.4.3.2 Does the model make sense as a model for predicting the future of clinical psychology?

All experts agreed that the model made sense to them:

Exp5. “I had quite a positive emotional response to it when I saw it, because it kind of fitted my own internal world”.

Exp 1. “Yes I do, ridiculous only giving one word answers, but like I say, yes, it absolutely fits”.

3.4.3.3 Does the model link the elements together in a sound manner?

All experts agreed that the model put the elements together in a sound manner:

Exp7. “ ... puts it in an order which made it coherent”.

Exp3. “ ... easy to follow”.

3.4.4 Questions Relating to “Generality”

3.4.4.1 Does the model apply locally, to your own organisation?

All experts agreed that the model, which was intended principally to apply to the whole of Wales, was applicable to their own organisation:

Exp 8. “Definitely, yes ... it does certainly apply to how things are at (Local Health Board). It’s a useful way of looking at how to take things forward for the future”.

Exp 7. “...makes me think about ways I may frame my role”.

3.4.4.2 Do you think the model is applicable to other areas of the UK?

The experts were more varied in their responses to this question. Two said that they thought the model is applicable to other areas of the UK:

Exp 8. “Absolutely, I think it’s clinical psychology in the UK really ... everybody is facing similar challenges”.

One expert did not know if the model was applicable elsewhere in the UK, and the remaining five said “maybe”.

Two of the experts made the point that this model may already be out of date for England, whilst two others thought that it might well apply to other professions as well as clinical psychology:

Exp 4. “ ... England needed this 5 years ago”.

Exp 1. “ ... might fit other professions”.

3.4.5 Questions Relating to “Control”.

3.4.5.1 Do you think the model will help you to predict the future for clinical psychology?

All the experts thought that the model would help them to predict the future for clinical psychology:

Exp 6. “ ... the issues you`ve summarised in your boxes, we`re working through them now and it`s got me thinking about some areas already when I read it, so yes it will”.

Exp 2. “ ... it will be extremely helpful”.

3.4.5.2 Does the model give ideas for action to be taken?

All the experts strongly endorsed the model for giving ideas for action:

Exp 3. “Yes ... you`ve listed them in the Critical Actions section fairly comprehensively really. In fact there`s a few good ideas there that I`ve decided that I`m going to actually implement”.

Exp 8. “ ... it does really bring to the forefront of people`s mind that we have got to do something to prove ourselves. This really clarifies the importance of showing what we do”.

3.4.6 Questions Relating to “Respondent Validation”.

3.4.6.1 Do you think that, in producing the model, the views you gave at the first interview have been taken into account?

Seven of the experts thought that their views had been taken into account in producing the model:

Exp8 “ ... there`s a lot in there which covers the things I was thinking”.

Exp7. “It fitted in with my ideas ... with what I said”.

One of the experts agreed that most of what s/he had said had been incorporated into the model, but said that one important aspect had been omitted. This related to a view this expert had expressed that clinical psychology services develop and contract in cycles. This expert considered that the cause of this is that when clinical psychologists are in post, managers look at how expensive they are compared to other professions, and so often look for ways of replacing them with cheaper alternatives. When no psychologist is in post, though, staff then realise why they need one, and so try to re-establish posts:

Exp2. “Yes ... although not all ... I`ve got this thing about ebb and flow. This isn`t in the model”.

3.4.7 Suggestions for Improving the Model

Two of the experts said that they did not have any ideas about how the model could be improved:

Exp 4. “ ... nothing to add to it”.

Each of the other experts made suggestions for improvements as follows:

Exp 2 considered that the model would be improved if it made it explicit that it was anchored at a particular point in time, and that the factors which are now incorporated into the model may well change over time.

Exp 7 suggested that the model needed to give more consideration to how to achieve the critical actions. This person also thought that an important critical action had been omitted, specifically, the need to mobilise the whole profession into addressing the other critical actions.

Exp 8 suggested that once the added value of clinical psychology has been clearly identified, it then needs to be promoted and marketed (although this point is actually already included as one of the critical actions). *Exp 7* also made this point, and noted in addition that competitors may consider that they too possess the skills which clinical psychologists consider to be unique to themselves.

Exp 6 thought that the use of the term “leaner services” was misleading because it implied that the services would be based upon the lean thinking methods of production systems pioneered by Toyota and written about by Womack and Jones (2003).

Exp 3 considered that the model should take into consideration the forces specifically acting against the interests of clinical psychology. These include the actions of the medical and nursing professions in seeking to protect their own power bases, and also the envy and resentment which this expert considered is still directed towards clinical psychology from other professions because clinical psychology benefited greatly from pay increases under Agenda for Change. *Exp 7* agreed that the model should include “resistance” as a factor in determining the future of the profession.

The last suggestion for improving the model came from *Exp 4*, who thought that the model would be improved by identifying the specific government policies which were regarded as major service drivers.

3.5 PREDICTIONS ON THE FUTURE OF CLINICAL PSYCHOLOGY IN WALES IN 10 YEARS TIME

A total of 80 specific predictions about clinical psychology in Wales in 10 years time were made by the expert participants. These predictions were all fed back to all the experts in the form of a questionnaire (Appendix E), as described in the Method chapter. The experts were asked to note their agreement or otherwise with each prediction, and the collated results are given in Table 3.1. The questions are organised into sections which are very similar to, but not completely consistent with, the major categories from the Grounded Theory analysis of the first interviews. In the questionnaire, the expert who made each prediction, or one of the experts if more than one made the same prediction, is noted at the end of the prediction.

Table 3.1. Summary of experts' opinions on predictions

<u>Predictions</u>	Broadly Agree	Broadly Disagree	Don't know
A. Demand for Psychological Therapies			
A.1. There will be increasing demand for psychological therapies. <i>Exp 1</i>	8		
B. Leaner Services			
B.1. An increasing number of short-term contracts instead of permanent posts. <i>Exp 8</i>	4		4
B.2. Clearer differentiation of work by band/grade. <i>Exp 1</i>	6		2
B.3. Lower bands will do more direct clinical work, higher bands will do more consultancy. <i>Exp 1</i>	6	1	1
B.4. Increased number of lower banded posts, fewer higher bands (8c and above). <i>Exp 1</i>	8		
C. Increasing Accountability			
C.1. Work will be less self-directed, more determined by demand and agreed with managers. <i>Exp 8</i>	8		
C.2. CPD will be in line with organisational goals. <i>Exp 8</i>	8		
C.3. Clinical Psychologists will increasingly be asked to account for the work they do. <i>Exp 2</i>	8		
C.4. There will be pressure for more direct clinical work. <i>Exp 1</i>	6		2
C.5. There will be pressure to use Clinical Psychologists' skills to most effect, i.e. less direct work, more consultancy, supervision, training, etc. <i>Exp 6</i>	5	1	2
C.6. There will be a focus on outcomes rather than outputs. <i>Exp 6</i>	8		
D. Competition			
D.1. Other Applied Psychologists will have taken on many of Clinical Psychologists' current roles and posts. <i>Exp 7</i>	4	1	3

D.2. Other professions will have taken on many of Clinical Psychologists' current roles. <i>Exp 7</i>	6	1	1
D.3. Other professions, including other Applied Psychologists, will carry out some of our current activities more cheaply. <i>Exp 5</i>	7		1
D.4. Clinical Psychologists will decline in numbers. <i>Exp 2</i>	6	1	1
D.5. Clinical Psychologists will be less well trained and less skilled, especially in formulation, and so will lose some ability to compete. <i>Exp 5</i>		7	1
D.6. Other professions will be leading Psychological Therapy Services. <i>Exp 1</i>	4		4
D.7. Clinical Psychologists will remain the dominant psychology profession in healthcare services and will bring in other Applied Psychologists under their direction. <i>Exp 1</i>	3	2	3
D.8. Counselling Psychology will increase in size, influence, and uptake of posts. <i>Exp 8</i>	2	1	5
E. Role of Clinical Psychologists			
E.1. Clinical Psychologists will be dealing with complex problems. <i>Exp 2</i>	8		
E.2. Clinical Psychologists will take on new roles, such as AC/RC. <i>Exp 5</i>	4		4
E.3. Clinical Psychologists will have some prescribing rights. <i>Exp 3</i>	2	2	4
E.4. Senior grade Clinical Psychologists will be taking on clinical leadership roles in multidisciplinary services. <i>Exp7</i>	8		
E.5. Clinical psychologists at all levels will be guiding and directing psychological care. <i>Exp1</i>	6		2
E.6. Clinical Psychologists will have a role as high-level researchers. <i>Exp 2</i>	2	4	2
E.7. Clinical Psychologists will be dealing with severe and enduring problems which no one else can deal with. <i>Exp 5</i>	7	1	
E.8. Clinical Psychologists will move into multidisciplinary community services as CMHTs decline. <i>Exp 4</i>	5		3
E.9. Clinical Psychologists will be leading Psychological Therapy Services. <i>Exp 1</i>	5		3
E.10. A major part of the role will be to develop psychological skills in other staff. <i>Exp 6</i>	7		1

E.11. Clinical Psychologists will be dealing with the most difficult patients/problems, for which the current training is inadequate. There will be a lot of CPD aimed at developing high level expertise. <i>Exp 5</i>	6	1	1
F. PR/politics			
F.1. Clinical Psychologists will link more, and more effectively, with policy makers and commissioners. <i>Exp 7</i>	5		3
F.2. Increased knowledge about Clinical Psychologists by the public will lead to increased demand. <i>Exp 4</i>	6		2
F.3. Leadership and political awareness will be key skills, taught and developed from training onwards. <i>Exp 6</i>	6	2	
F.4. Power and influence is flowing back to medics and nurses; Clinical Psychology will become more marginalized. <i>Exp 3</i>	3	2	3
G. Career Pathways			
G.1. There will be an increasing number of jobs in the private sector. <i>Exp 8</i>	6	2	
G.2. Loyalty of Clinical Psychologists to the NHS will erode further. <i>Exp 3</i>	4	2	2
G.3. Many Clinical Psychologists will get stuck at lower level bands/grades due to reduced opportunities for career advancement. <i>Exp 2</i>	8		
G.4. Career advancement will be through taking on wider roles, such as clinical leadership, management, commissioning, etc. <i>Exp 6</i>	7		1
G.5. 8b will be the highest band for a purely clinical role. <i>Exp 7</i>	5	2	1
G.6. It will be very unusual to be upgraded in post. <i>Exp 8</i>	6		2
G.7. Upgrading in post will become commonplace again, in order to retain staff. <i>Exp 7</i>	1	5	2
G.8. The 7/8a Preceptorship model will be adopted fully. <i>Exp 7</i>		1	7
G.9. The effective number of grades will reduce, perhaps to “Entry” (7/8a); “Intermediate” (8b); “Consultant” (8c); “Senior Consultant” (8d/9). <i>Exp 4</i>	4	1	3
G.10. There will be no more senior posts (above 8c) created. <i>Exp 3</i>	2	3	3
G.11. There will be more Clinical Psychologists in service management posts. <i>Exp 2</i>	7		1
G.12. Transferable skills will be more recognised, allowing easier transfer across Specialties and organisations. <i>Exp 4</i>	5		3

G.13. Becoming more specialised, more expert, will be a common route to career progression. <i>Exp 2</i>	4	2	2
H. Training and Qualifications			
H.1. There will be various routes to HPC registration. <i>Exp 8</i>	4	2	2
H.2. Training will be reduced to 2 years. <i>Exp 2</i>	1	5	2
H.3. Training will be reduced to a Masters level qualification. <i>Exp 2</i>	1	5	2
H.4. Training will remain the same as it is now. <i>Exp 7</i>	3	3	2
H.5. Core placements in training will change. <i>Exp 1</i>	6		2
H.6. Training will be in multiple models. <i>Exp 7</i>	4		4
H.7. Training will be competency focused. <i>Exp 2</i>	8		
H.8. Training will include accreditation in one or more specific therapies. <i>Exp 7</i>	5	2	1
H.9. Training will be university-based. <i>Exp 2</i>	6		2
H.10. There will be one training course in Wales. <i>Exp 3</i>	2	3	3
H.11. There will still be two training courses in Wales. <i>Exp 5</i>	3	2	3
H.12. Training will be modular and shared with other professions. <i>Exp 2</i>	3	3	2
H.13. The emphasis on research in training will be dropped. <i>Exp 5</i>	1	6	1
H.14. Trainee numbers will reduce due to reductions in funding. <i>Exp 5</i>	6	1	1

I. New Developments			
I.1. Clinical Health Psychology is the most fertile area for future growth. <i>Exp 1</i>	5	2	1
I.2. There will be new developments in Clinical Health Psychology. <i>Exp 4</i>	6		2
I.3. Clinical Psychology will develop by saving money in high risk, highly specialist areas, e.g. forensic, PD. <i>Exp 2</i>	6		2
I.4. Clinical Psychologists will develop in Primary Care. <i>Exp 4</i>	4	2	2
I.5. Clinical Psychologists will not develop in Primary Care. <i>Exp 2</i>	3	3	2
I.6. There will be increasing demand for Clinical Psychologists to develop new clinical treatment programmes. <i>Exp 2</i>	5	1	2
J. Management and Organisation			
J.1 Traditional Psychology Departments in the NHS will decline or disappear altogether. <i>Exp 7</i>	5	2	1
J.2. Clinical Psychologists will be managed by service managers. <i>Exp 7</i>	7		1
J.3. A professional hierarchy will remain to ensure proper governance. <i>Exp 7</i>	6		2
J.4. Clinical Psychologists will continue to be predominantly managed by Clinical Psychologists. <i>Exp 1</i>		5	3
J.5. Heads of Profession posts will remain. <i>Exp 2</i>	4	1	3
J.6. Heads of Profession posts will increase due to reorganisation of LHBs (more of them). <i>Exp 3</i>	2	4	2
J.7. Clinical Psychology departments will evolve into multidisciplinary Psychological Therapy services. <i>Exp1</i>	4	1	3
J.8. Clinical Psychologists will be more integrated into multidisciplinary services, and less into traditional Psychology Departments. <i>Exp 6</i>	6		2
K. Models of therapy			
K.1. “3 rd Wave” cognitive therapies will remain dominant. <i>Exp 8</i>	7	1	
K.2. There will be a reaction against the dominance of CBT. <i>Exp 2</i>	2	2	4

L. Uneven provision of Services			
L.1. Provision of Clinical Psychology services will remain uneven across LHBs. <i>Exp 2</i>	6		2
L.2. The shift away from the predominantly therapist role by Clinical Psychologists will be patchy. <i>Exp 6</i>	4	1	3
M. Other Considerations			
M.1. There will be more demand for Welsh speaking. <i>Exp 4</i>	3	4	1
M.2. Standards of entry into the profession are falling, so in future qualified Clinical Psychologists will need more supervision and guidance. <i>Exp 4</i>		8	

CHAPTER 4: DISCUSSION

4.1 OVERVIEW

A two-round Delphi study was carried out to investigate experts' ideas about the future of clinical psychology in Wales in 2022. This yielded eighty specific predictions from the expert participants. In addition, Grounded Theory analysis of the first round of interviews in the Delphi process produced a model for guiding predictions on the future of clinical psychology in Wales over the following ten years. This model helps to account for some of the predictions that the participants gave, and it can also be used to produce further predictions.

Strong themes emerging from the interviews were that financial pressures, government policies, and increasing demand for psychological therapies would drive the profession to become more accountable for the work it does, and to become "leaner", i.e. more efficient, and with reduced costs. The experts predicted that there will be increasing competition from a number of different professions to provide some or all of the activities which clinical psychologists undertake. The profession can prepare for this competition by being clear about what it can uniquely provide, and by ensuring that managers and commissioners recognise and value it, and that they want clinical psychologists to provide it.

4.2 PREDICTIONS FROM THE DELPHI STUDY

4.2.1 Increasing Demand for Psychological Therapies

The expert participants made eighty separate predictions during the first round of interviews, and they were subsequently asked to rate each of them in a questionnaire, the results of which are shown in Table 3.1. Some broad themes can be discerned from scrutiny of these results. All the experts agreed that over the following ten years there would be increasing demand for psychological therapies (prediction A.1). One of the reasons for this is that it is strongly predicted that increased knowledge about

clinical psychology by the public will lead to increased demand (6 out of 8 experts agreed with this prediction, 2 did not know; prediction F.2). A further possible factor may be that clinical psychology will link more effectively with commissioners and policy makers, but the experts were less in agreement about this (5 agreed, 3 did not know: prediction F.1).

4.2.2 Leaner Services

There is also a strong view that clinical psychology services will become leaner, through possible reductions in posts (6 agreed, 1 disagreed, 1 did not know; prediction D.4) and the proportion of higher banded posts decreasing (all 8 agreed; prediction B.4). This might also be accompanied by pressure to differentiate the work done by clinical psychologists at different bands more clearly, with lower banded posts expected to do more direct clinical work and higher banded posts focusing more upon consultancy, supervision, etc. (6 agreed, 1 disagreed, 1 did not know; prediction B.3). There might possibly also be an increasing number of short term posts instead of permanent contracts, but overall the experts were not clearly in support of this prediction (4 agreed, 4 did not know; prediction B.1).

4.2.3 Increasing Accountability

The experts made several predictions which relate to the profession becoming more accountable for the work it produces. It is expected that clinical psychologists will increasingly be required to agree their work with managers and/or commissioners, and that these managers/commissioners will want to know that the agreed work is being carried out satisfactorily (8 agreed; prediction C.1). There was a feeling that there would be pressures and expectations both to increase the amount of face-to-face work (6 agreed, 2 did not know; prediction C.4), and also to make the best use of psychologist skills by increasing training, supervision, consultancy, etc. (5 agreed, 1 disagreed, 2 did not know; prediction C.5). At first sight, it might appear that these two demands are incompatible, that is, to demand both more face-to-face work and more training, supervision, etc. That assumes, though, that NHS managers and commissioners are always reasonable and rational. Six of the experts thought that

lower banded clinical psychologists will be doing more direct clinical work, and that the higher banded clinical psychologists will be involved more in consultancy, supervision, etc., which may be an acceptable way to meet both demands (6 agreed, 1 disagreed, 1 did not know; prediction B.3). All eight experts thought that there would be a focus on outcomes by 2022, rather on outputs, as is currently mostly the case (prediction C.6).

4.2.4 Competition

In the first round of interviews, all the participants thought that competition from other professions and providers would increase and be a major factor in determining the state of clinical psychology over the following ten years, but, perhaps surprisingly, this is not clearly represented in the ratings of the specific predictions relating to competition. Possibly there should have been a prediction which simply said “competition from other professions will increase over the next ten years”. As it was, there was some support for the prediction that other professions will have moved into at least some of the posts and roles of clinical psychologists (4 agreed, 1 disagreed, 3 did not know; prediction D.1. 6 agreed, 1 disagreed, 1 did not know; prediction D.2), and that clinical psychologists will have declined in numbers as a consequence (6 agreed, 1 disagreed, 1 did not know; prediction D.4). There was not a clear picture emerging from the experts about whether they expected other professions to have taken over lead roles for psychological services, but four thought that they would have done, and the other four did not know (prediction D.6). Interestingly, few of the experts thought that counselling psychology would gain much in terms of influence (2 agreed, 1 disagreed, 5 did not know; prediction D.8), so presumably they do not regard counselling psychology as the main source of competition for these posts. One can only speculate, but perhaps the expectation is that nurses and/or medics will lead psychological services in the future, as indeed has happened in places in England.

4.2.5 The Role of Clinical Psychologists

When making predictions about the role of clinical psychologists by 2022, there was a very strong expectation amongst the experts that they would be dealing with complex

problems (all 8 agreed; prediction E.1), and that these would be of such a severe nature that other professions would not be competent to deal with them (7 agreed, 1 disagreed; prediction E.7). “Complexity”, it may be recalled, is one of the seven themes which make up the “added value” of clinical psychology in the DCP marketing strategy (2007a; 2008). Many of the experts thought that the current basic level of training is not adequate to prepare clinical psychologists to carry out work of this difficulty, though, and that people will need to develop higher levels of expertise post-qualification (6 agreed, 1 disagreed, 1 did not know; prediction E.11). There was also a general expectation that clinical psychologists at all levels will be directing psychological care (6 agreed, 2 did not know; prediction E.5) and that the more senior grades will be taking on formal clinical leadership roles in multidisciplinary teams (all 8 agreed; prediction E.4) and psychological therapy services (5 agreed, 3 did not know; prediction E.5).

There was no clear support for the idea that by 2022 clinical psychologists would have consistently shifted their role away from the current, predominantly therapist, role (4 agreed, 1 disagreed, 3 did not know; prediction L.2). In retrospect, it is considered that the wording of this item is unhelpful in allowing any real conclusions to be drawn from it (“the shift away from the predominantly therapist role by clinical psychologists will be patchy”), but the suggestion seems to be that many clinical psychologists might continue to operate primarily as psychological therapists. It appears that the debate about whether clinical psychologists are mainly scientist-practitioners, making use of their level 3 skills (MAS, 1989), or whether they are primarily psychological therapists, may still not be resolved by 2022. Mowbray (2011) clearly believes that, if this turns out to be the case, it could be extremely damaging for the prospects of the profession, and would, as quoted in Chapter 1, “confine the profession to a dark corner” (p. 38).

4.2.6 Marketing and Influence

With regards to the power and influence of clinical psychology, there was some support for the idea that the profession will be better at influencing commissioners and policy makers (5 agreed, 3 did not know; prediction F.1), and a little more support

for the notion that the public will increasingly demand clinical psychology services as they get more knowledgeable about them (6 agreed, 2 did not know; prediction F.2). Political awareness and leadership are expected to be key skills which the profession will teach and develop from training onwards (6 agreed, 2 disagreed; prediction E.3), but whether clinical psychologists will be able to establish themselves as influential political players was not something the experts agreed upon (5 agreed, 3 did not know; prediction F.1. 3 agreed, 2 disagreed, 3 did not know; prediction F.4.). Given these views, though, it is very timely that the DCP has recently published its leadership framework, as described in the first chapter (Skinner *et al.*, 2010).

4.2.7 Career Pathways

The experts were in complete agreement with the idea that there are going to be fewer opportunities for career advancement in the future, with the result that many clinical psychologists will get stuck at lower grades (prediction G.3). What exactly constitutes a “lower grade” was not clearly defined but, from some of the interviews, it is taken to mean band 8b and below, or the equivalent outside the NHS. A number of other predictions which were strongly supported by the experts can readily be seen to be related to this. The essential idea is that this lack of opportunity for career advancement, especially from being upgraded in post (which has been a common practice now for a number of years) will force people to look for different routes to advance their careers (6 agreed, 2 did not know; prediction G.6).

There was a suggestion that clinical psychologists, who have traditionally been loyal to the NHS, will increasingly look for posts outside the NHS (4 agreed, 2 disagreed, 2 did not know; prediction G.2). At the same time, a clear majority of the experts thought that there would be increasing number of jobs in the private sector (6 agreed, 2 disagreed; prediction G.1). Interestingly, one of the experts from the private sector thought there would not be an increase in jobs in that sector, but that there would be an increase in the number of clinical psychologists applying for them.

There was some support for the prediction that there would be a ceiling to the level a clinical psychologist could reach in a purely clinical role, which would probably be

band 8b, or the equivalent (5 agreed, 2 disagreed, 1 did not know; prediction G.5). There was very strong support for the idea that one of the routes to career advancement would be through taking on wider roles, including clinical leadership and service management posts (7 agreed, 1 did not know; prediction G.4), and that clinical psychologists would be more prevalent in these roles by 2022 (7 agreed, 1 did not know; prediction G.11).

4.2.8 Training

There was a considerable diversity of views amongst the experts regarding the training of clinical psychologists in Wales in 2022. All agreed, however, that training would be competency focused (prediction H.7) and several thought that it would include accreditation in one or more specific therapies (5 agreed, 2 disagreed, 1 did not know; prediction H.8). There are clearly some concerns about training, though. There was strong support for the prediction that training numbers by 2022 would have reduced from their current levels (6 agreed, 1 disagreed, 1 did not know; prediction H.14) and whilst only one person thought that training would be a two year Master's programme by then (prediction H.3), four thought that there would be various routes to HPC registration (prediction H.1), now HCPC registration, and only three agreed that there would still be two training courses in Wales by then (H.11). There was strong agreement for the idea that core placements for training will have changed by 2022 (6 agreed, 2 did not know; prediction H.5). There was no clear view on whether training would be shared, at least to some extent, with other applied psychology professions, which was one of the proposals from NWW (Lavender and Hope, 2007) (3 agreed, 3 disagreed, 2 did not know: prediction H.12).

4.2.9 Areas with Potential for Growth and Development

Despite the general gloom from the experts about the likely economic state of the NHS in Wales, there was nevertheless some optimism that there are areas in which clinical psychology would be likely to develop over the following ten years. Physical health was regarded as one area where clinical psychology is likely to grow (6 agreed, 2 did not know; prediction I.2). Other areas of potential growth were predicted to be

those areas where money can be saved, especially in high risk and highly specialist areas such as forensic services, personality disorder, eating disorders, etc. (6 agreed, 2 did not know, prediction I.3). The experts were almost equally split about whether primary care will provide an avenue for developing clinical psychology services (4 agreed, 2 disagreed, 2 did not know; prediction I.4. 3 agreed, 3 disagreed, 2 did not know; prediction I.5). The Mental Health (Wales) Measure 2010 appears to offer some opportunities in primary care, but the experts were not all confident that these would be taken, nor perhaps even forthcoming. There was also some support for the prediction that clinical psychologists would be in demand to develop new treatment programmes (5 agreed, 1 disagreed, 2 did not know; prediction I.6). “Innovation” is another one of the seven themes of the “added value” of clinical psychologists, described in the DCP marketing strategy (DCP, 2007a; 2008).

4.2.10 Management and Organisation

With regards to the future management and organisation of clinical psychology services, although none of the specific predictions were accepted by all eight of the experts, it is easy to discern a strong theme in the predictions which is that “traditional” clinical psychology departments (by which is meant separate departments, managed by clinical psychologists) will not be sustained (5 agreed, 2 disagreed, 1 did not know; prediction J.1). Instead, clinical psychologists will become more integrated into multidisciplinary teams (6 agreed, 2 did not know; prediction J.8) including, possibly, multidisciplinary psychological therapy services (4 agreed, 1 disagreed, 3 did not know; prediction J.7), and that, within these, they will be managed operationally by service managers (7 agreed, 1 did not know; prediction J.2). Although it had initially been predicted by at least one of the experts, by the time they filled in the questionnaire, none of the experts thought that clinical psychologists would be predominantly managed by other clinical psychologists by 2022 (5 disagreed, 3 did not know; prediction J.4). Most of the experts expected, though, that a professional hierarchy would still be maintained (6 agreed, 2 did not know; prediction J.3), although they were less optimistic that Head of Profession posts would be retained (4 agreed, 1 disagreed, three did not know; prediction J.5).

4.2.11 Other Predictions

At the first interview, one of the predictions had been that the standard of candidates entering the profession is falling, and that this would mean that more recently qualified psychologists would require more supervision and guidance from senior colleagues. By the time the questionnaire was answered though, there was complete consensus from the experts that standards were not falling (8 disagreed; prediction M.2).

The majority of the experts predicted that cognitive therapy, in some form or other, would remain the dominant model in therapy over the following ten years (7 agreed, 1 disagreed; prediction K.1).

Finally, there was mainly an acceptance of the idea that the provision of clinical psychology services will remain uneven across Local Health Boards (6 agreed, 2 did not know; prediction L.1).

4.3 THE MODEL FOR GUIDING PREDICTIONS ON THE FUTURE OF CLINICAL PSYCHOLOGY IN WALES IN 2022.

The purpose of carrying out the first interviews face-to-face, and then analysing them using Grounded Theory, was to try to gain better understanding of the experts' views about the influences upon clinical psychology over the following ten years, and about their reasons for making the predictions they did. In these aims, the study surpassed the initial hopes by yielding a model for understanding and guiding predictions on the future of clinical psychology by 2022. The model has been described already in the Results and Analysis chapter and so will not be repeated here. Looking at the model, though, it can be seen to account very well for a number of the predictions the experts made. The model shows that there are a small number of major service drivers (finance, government policies, increasing demand for psychological therapies) which the experts predicted would influence clinical psychology over the following ten years. The model shows that these forces will lead to certain outcomes, which come under the general headings of "Increasing Accountability" and "Leaner Services".

There is a clear message to the profession here, which is that these are almost inevitably going to occur, and so whilst each service should clearly do all it can to minimise the effects upon it, it is highly unlikely that such effects will be able to be avoided entirely. It is interesting to note from looking at the experts' predictions in these two areas (e.g. B.4, increased number of lower banded posts, fewer higher banded posts: C.1, work will be less self directed, more determined by demand and agreed with managers) that there is quite a high level of agreement between the experts. That is, they all appear to recognise that these broad effects are likely to occur, and there is also a reasonably high level of agreement between them about what the specific effects will be (see Table 3.1, summary of experts' opinions on predictions, sections B and C).

There was strong agreement between the experts that clinical psychology would face competition for the services it provides over the following ten years. As some of the experts commented, it is happening already, and in England in particular it is substantially more advanced than in Wales.

In order to prepare to meet this competition, the model describes a number of "Critical Actions" which the profession needs to accomplish, and there are different predictions for the future which are likely to result, depending upon whether the profession has accomplished these Critical Actions or not. The model proposes that much of the uncertainty about the future for clinical psychology reflects concerns about how well the profession will be able to market and promote itself, and how well it will prepare for, and respond to, competition from other professions. The DCP has, of course, anticipated this some years ago, with the development and publication of its marketing strategy for the profession (DCP, 2007a; 2008).

The model proposes that if the Critical Actions are accomplished well, and in good time, then the outcomes for the profession are generally positive. On the other hand, if the Critical Actions are not accomplished, or not in good time, then the outcomes for clinical psychology are more negative. See Section 3.3.3.6, Predicted Outcomes, for examples of both eventualities.

The model is not only able to account for many of the predictions which the experts generated, but it also guides anyone using it to make further predictions. For example, if there is continuing pressure for Leaner Services, as the model shows, then one possible outcome may be that clinical psychologists will come under pressure to give shorter appointments, so that they can see more clients in a given period of time. This is a reasonable prediction from the model, although it is not one which any of the experts gave.

4.4 EVALUATION OF THE RESULTS

4.4.1 Reliability and Validity

As discussed earlier, qualitative research methods present particular difficulties when attempting to establish reliability and validity, and this study employed two qualitative methods, Delphi and Grounded Theory. With regards to the Delphi method aspect of this research, the researcher has taken Elliot *et al.*'s (1999) guidelines into account, as described earlier, and so would argue that he has made reasonable attempts to ensure reliability and validity of the results. Given that Delphi designs vary so much, though, it is necessary to examine this particular design to see if it presents idiosyncratic problems concerning reliability and validity.

In the opinion of the researcher there is at least one major concern which this variation of the Delphi method presents. The problem arises because of the decision to carry out all the interviews face to face. In such a situation there is the potential for any interviewer to influence the interviewees, knowingly or otherwise. This would not need anything as obvious as direct statements or leading questions, but could easily be done unwittingly by such things as facial expressions, tone of voice, nodding or shaking of the head, different wording of questions, encouraging or discouraging further discussion, etc. This is a potential problem even if the interviewer was relatively naïve concerning the subject matter, but this study is rather unusual in that the researcher/interviewer was also an expert in the area being considered. Even if there were no signs or indications from the researcher that he approved or otherwise of the participants' statements, he was known to all the participants and some of his

views are likely to have been known also. In carrying out a Grounded Theory study, expert knowledge of the area is not necessarily a problem and can be helpful in that the researcher may see links or themes which a naïve person might miss. “Professional experience can enhance sensitivity ... experience can also enable researchers to understand the significance of some things more quickly” (Corbin and Strauss, 2008, p 33). In a Delphi study, though, an expert carrying out the interviews could be seen as one expert exerting an influence over the opinions of the other experts, which is one of the very things that Delphi studies are designed to eliminate. The researcher was well aware of this possible influence and he did attempt to reduce it as much as possible, but it remains a possible source of influence upon the participants.

It is the view of the researcher that any influence he had upon the results of the research would have mainly occurred during the first interview. The questionnaire asking the participants for their agreement or otherwise with the eighty predictions was completed by them without the researcher being present. The second interview focussed upon the evaluation of the model rather than upon the experts` views on the predictions. It is the contention of the researcher, then, that although it is entirely possible that he influenced the participants` views during the first interviews, they would have had the chance to reconsider these in private when going through the questionnaire, and could have changed their original views or predictions with little outside influence. So whilst the initial generation of the predictions is possibly methodologically flawed, the subsequent judgements on the eighty predictions may be less so.

In the end, the researcher needs to follow the advice cited earlier by Hasson and Keeney (2011) and present the results as a snapshot of the views of a group of identified experts at a particular point in time, (i.e. December 2011 – May 2012), under the circumstances described. The reader then has the information to allow them to make their own judgement about how much credibility they will give to the predictions, and how much it should inform their thinking and practice.

The real accuracy of the predictions may not be clear for several years, and as regards the reliability of the predictions, the researcher will concede that another interviewer, or another method of gathering the information (e.g. by email, or questionnaire), might well have elicited different information. The first interview was, after all, deliberately semi-structured, allowing for variation between participants and allowing the researcher to follow other avenues of enquiry if he saw fit. The reliability, therefore, is clearly questionable and not really testable, so any reader must take these issues into account when deciding how much credibility to afford the conclusions.

4.4.2 Evaluation of the Model

Evaluating the model generated by Grounded Theory presents some different problems in establishing its validity and reliability. Interviewing the participants face to face is an acceptable and uncontentious procedure in Grounded Theory studies, even when the interviewer has expert knowledge of the subject area, as mentioned earlier (Corbin and Strauss, 2008). In order to be assured of the methodological rigour of the Grounded Theory element of this study, the researcher not only followed the guidelines from Elliot *et al* (1999), but also evaluated the study against “fit”, “understanding”, “generality” and “control” (Corbin and Strauss, 1990), and finally against “respondent validation” (Mays and Pope, 2000). While these checks do not, of course, guarantee reliability and validity, they do enhance the credibility of the results.

As can be seen from the responses of the participants in the second interviews, the general opinions of the model were extremely favourable. It could be argued that the researcher might have unwittingly or otherwise influenced these responses. He was, after all, presenting his analysis back to the participants, who may then have been influenced to voice strong support for it by, for example, the perceived status and seniority of the researcher. In fact, the researcher must acknowledge that in one of the earliest of the second interviews, he did at one stage find himself beginning to defend the model against some relatively mild criticism. He made efforts to stop doing so and reflected upon it later in his journal. Thereafter he made particular efforts to

present and discuss the model without displaying any bias. The following is an extract from the researcher's journal:

01.05.2012. "Did a second interview today - aware that I was getting into defending the model. Realised this and tried to stop doing so. Need to be clear that this isn't MY model - it's my interpretation of what they were saying. Don't defend it, just listen to the comments, evaluate them, use them if they warrant it, etc. I am quite pleased with the model, and pleased it is being well received - another email today saying it's "fantastic" - but I need to distance myself from that for now. Also - try to avoid, at the beginning of the interview, saying that I'm pleased with it - that creates demand for people to agree, makes them less likely to be critical".

The researcher was not aware that he acted in ways that might have influenced participants in any of the subsequent interviews. Nevertheless, he was aware that his own emotions (defensiveness, annoyance, approval, etc.) at the time might still have been perceived by the participants and this is known to affect the judgement of participants in such circumstances. As Corbin and Strauss (2008) describe:

"there is no doubt that such emotions are conveyed to participants and in turn that participants react to researchers' responses by continually adjusting their stances as the interview or observation continues ... One might even say, due to this reciprocal influence, that researcher and participant co-construct the research (at least data collection) together (Finlay, 2002)" (p. 31).

The overall view of the participants was that the model was very good and helpful. They also gave mostly very positive answers to all the questions relating to "fit". The researcher would then argue that the model is a sound model for its purpose. There was complete agreement from the participants that the model was clear and understandable ("understanding"). There was less agreement about the "generality" of the model. The participants all regarded it as applicable to their own organisations, and also to Wales overall, but they were less sure about its applicability to other parts of the UK. There was a perception that the situation in England, particularly, was very different from that in Wales and that, in some respects, England had already

moved to a place beyond the application of the model. That is, the view from some was that clinical psychology in England was already suffering due to competition for services. “Generality” within Wales, though, was strongly supported. There was also complete consensus amongst the participants that the model was helpful for predicting the future of clinical psychology and for giving ideas for action to be taken to support the profession (“control”). Finally, the participants were in agreement that the model had taken good account of their views (“respondent validation”), with the exception of one of the participants who considered that it had not incorporated one element of their views which was particularly important (see Section 3.4.6.1).

The overall picture which emerges from the evaluation is that the model has high credibility with the expert participants. While it has to be acknowledged that the researcher is likely to have influenced the evaluation of the model by the participants to some extent, their responses were so overwhelmingly positive that it is hard to cast serious doubt upon their reliability. Finally, the participants made some suggestions for improving the model which are described in Section 3.4.7. It has already been acknowledged that the model is something of an oversimplification, although some of the experts remarked that its simplicity was one of its strengths:

Exp 2. “It’s a simple model ... but that’s very helpful ... It benefits from its simplicity”.

It was suggested that the model has to be seen as anchored at a particular point in time, which echoes the view of Hasson and Keeney (2011) concerning Delphi studies that the results should be presented as a snapshot of the views of a group of identified experts at a particular point in time. It was suggested that some of the labels for categories within the model could be improved. For example, that the label “Leaner Services” could be misleading and would be better changed to something else, such as “Reducing Costs”. It was also pointed out that “Leaner Services” and “Increasing Accountability” are also predictions, so are not clearly differentiated from the two “Predicted Outcomes” categories. Overall, though, none of the experts suggested that any major revisions to the model were necessary, and so at this stage all the criticisms and suggestions for improvement are merely noted.

4.5 METHODOLOGY: STRENGTHS AND WEAKNESSES

This research project combined a Delphi method with a Grounded Theory method. It is possible to view this study as not one, but two separate studies, each one of which was methodologically relatively uncontentious. The one study was essentially a Grounded Theory study; eight participants were interviewed using a semi-structured interview about the future of clinical psychology in Wales, and the interview transcripts were analysed using Grounded Theory. A model was derived from the analysis which was fed back to the participants for evaluation and validation. This is a methodologically straightforward Grounded Theory study. The second study was a Delphi survey of the views of identified experts concerning the future of clinical psychology in Wales. The predictions each made during an initial interview were fed back to all of the participants, without attributing any of the predictions to any one particular person. The participating experts did not, in fact, know who else was participating. The participants then rated their agreement or otherwise with the predictions and these results were collated. Again, this was a brief, but relatively straightforward, Delphi study without any major methodological problems, other than the use of an expert as the interviewer. It is necessary, though, to consider whether the combination of a Delphi study with Grounded Theory in this study is methodologically sound.

There are many variations of the basic Delphi method, as discussed in the Method chapter, but there is only one published example of Grounded Theory being used to analyse data gained from the first round of a Delphi study (Walker, Barker & Pearson, 2000). The possible problem of the researcher/interviewer also being an expert has been discussed already in this chapter. A possible strength of this, though, was that the researcher was able to keep the Delphi procedure relatively short by being able to design a semi-structured interview which prompted the participants to address many of the most important areas. The other possible strength was that the researcher's knowledge of the area enabled him to extract the model from the data and to recognise its potential value and validity. The drawback was the possible influence he had on

the experts which may have confounded one of the primary aims of the Delphi method.

One way in which the basic Delphi procedure complemented a Grounded Theory study particularly well was that the iterative process of the Delphi method easily allowed the researcher to go back to the experts with the Grounded Theory analysis, and to gain their opinions about it in some detail. Again there were possible confounding factors because of the researcher being an expert, but that does not detract from the fact that a procedure which included taking the Grounded Theory analysis back to all the participants allowed excellent opportunity for evaluation of the model by those participants. In this particular case, of course, there was really no other option available than for the researcher to carry out the interviews, but future studies may be better able to avoid this potentially confounding factor by, for example, using a non-expert as the interviewer. So the Delphi procedure seems to have enhanced the evaluation of the Grounded Theory analysis of the first interviews. On the other side, Grounded Theory provided an excellent method for a structured analysis of the mass of data produced by the first Delphi interviews. The overall conclusion is that the synthesis of these two methods enhanced both of them.

The researcher recognised that his perceived status or knowledge may have influenced the participants, as has already been discussed. It might have been possible to assess this, but the study did not do so, which is perhaps a weakness of the study. It would have been possible, for example, to have asked the participants about it. It would have even have been possible to have done this in a way which kept their comments anonymous, e.g. by sending comments to a third person, or using forms with no identifier.

The researcher embarked upon the study with the stated intention of using the second interviews to gain the views of the participants on the predictions arising from the first interviews, and analysing their responses using Grounded Theory. In the event, he chose not to do this. The model which emerged from the first interviews was regarded as being potentially very interesting and the researcher did not want to lose the opportunity to evaluate it thoroughly. This flexibility was perhaps a strength of

the study, although arguably a weakness was that the original aim to gain the experts' collective views on the future of clinical psychology was lost to some extent. Feeding back and modifying the experts' predictions for the future took second place, even though this was the whole point of using a Delphi design.

Evaluation of the model was done entirely by gaining the views of the participants, and whilst their positive views of it were virtually unanimous, it would have added further credibility to the model if it had also been shown to a group of experts who had not participated in this first round of interviews, and evaluated against the same criteria of "fit", "understanding", "generality" and "control".

A final criticism of the methodology of this study was not so much in the design, as in the application. Some of the predictions listed in the questionnaire (Appendix E) are poorly worded. For example, some contained two predictions in one item, which some of the participants found difficult to answer. For example, in prediction B.4, "increased number of lower banded posts, fewer higher banded posts (8c and above)", it was pointed out to the researcher in the second interviews that these could be independent factors. One final thought for improving the method is that, in retrospect, the researcher considers that it would have been better to have given the participants a copy of the first semi-structured interview some time before interviewing them, in order to give them time to consider the questions. This procedure was in fact adopted for the second round of interviews.

In conclusion, this study shares some of the methodological problems of establishing reliability and validity with virtually all qualitative research. In addition, it has some problems which are unique, or at least relatively rare. The researcher has attempted to address these methodological problems and to establish the credibility of the results. Even if the model and predictions are valid and accurate, they are of little value unless they are afforded credibility within the profession. This is for others to judge.

4.6 IMPLICATIONS OF THE PREDICTIONS AND THE MODEL FOR THE FUTURE OF CLINICAL PSYCHOLOGY IN WALES IN 2022.

4.6.1 Major Themes

Some consistent themes emerge from the experts' predictions for the future of clinical psychology in Wales and they are clearly identified in the model. The major themes are that increasing financial restrictions, some government policies, and increasing demands for psychological therapies will inevitably drive clinical psychology into becoming more accountable for the work that it does. That is, the work that clinical psychologists do will be agreed with managers and commissioners beforehand, and those people will also want to know that the agreed work has been carried out properly. In addition, there will be the demand to become leaner, partly by working more efficiently and partly by reducing costs. There will also be increasing competition from other professions to provide the work which clinical psychologists undertake, and to provide it more efficiently and/or more cheaply. The model clearly illustrates the necessity for clinical psychology to take effective action, and quickly, in order to meet successfully the challenge of competition. The actions which the profession needs to take are labelled the "Critical Actions" in the model, and they include identifying the unique contribution clinical psychology can make to healthcare (our "added value") and then promoting and marketing it successfully.

There is really nothing very new in either the model or the predictions. The main themes have all been discussed for some time. The idea of the "added value" of clinical psychology, and the need to market the profession, have been recognised for a while in such things as the DCP marketing strategy (2007a; 2008). The contribution this study makes is to put these themes together into a simple and coherent model. The next few years are regarded by the experts as being critical for the future of the profession, and the model identifies the necessary actions to be taken. The experts' predictions also point out what they expect to be the opportunities for the profession over the following ten years.

As *Exp 2* pointed out, one of the strengths of the model is that it is formed from the collective views of some of the most senior clinical psychologists in Wales, and is endorsed by them, and so is likely to have good credibility in the eyes of the profession as a whole in Wales. This is important if, as *Exp 7* proposed, one of the Critical Actions which is not in the original model is to mobilise the whole profession to address the other Critical Actions. Certainly it would be sensible, if the predictions in the model are accepted as valid, that the whole profession in Wales should be aware of it, that individual services and departments should develop and implement strategies for local action, and that an all-Wales group, presumably APHNSAG, should do the same with an all-Wales focus. The model is intended to guide predictions on the future of clinical psychology across Wales as a whole, but the reality is that local services are likely to face different circumstances. There will be differences in the competition encountered, and differences in the way in which clinical psychology is perceived and valued by commissioners, managers and users. The outcomes in different areas or organisations are therefore likely to be different, but the model should be broadly applicable in each area or organisation.

4.6.2 The Critical Actions

A number of clear implications for clinical psychology as a profession, and also for individual clinical psychologists, flow from the experts' predictions and from the model. The most important actions to accomplish are those which the model identifies as the "Critical Actions".

These have been stated in the previous chapter (Section 3.2.3) but it is worthwhile listing them again here. They are:-

- The profession needs to agree its "added value", i.e. what clinical psychologists can do which other professions either cannot do or cannot do as well as clinical psychologists.
- Once the added value of clinical psychology has been agreed by the profession, this must then be effectively marketed so that it is known and

wanted, especially by the people who direct, control, or influence resource allocation.

- A major part of effective marketing will be for clinical psychologists to demonstrate their ability to lead clinical teams in the provision of psychological treatment and care.
- Some clinical psychologists must develop expert skills in specialist areas which are wanted and valued by their host organisation.
- Leadership and political skills need to be taught and developed in clinical psychologists, starting from training.

The experts' views of what constitutes the "added value" of clinical psychology have been described in the previous chapter (Section 3.3.3.5). Briefly, they are:-

1. A high level of expertise and specialist knowledge.
2. The ability and willingness to work with the most complex problems and clients.
3. The ability to provide clinical leadership for psychological care.
4. The ability to contribute psychological knowledge to the strategic planning of healthcare.
5. The ability to create innovative services which improve healthcare significantly and/or save money especially, in higher risk, highly specialist areas.

These components of added value are in strong accord with the notions of added value proposed in the DCP marketing strategy (DCP, 2007a; 2008), and so it seems that there is reasonably good agreement within the profession about what are its unique skills. The problem of how to describe these quickly and succinctly remains, though. The profession needs to find a way to express these clearly and briefly, and in a way which can be easily understood by non-clinical psychologists and in particular by managers, commissioners and users.

It is interesting to note that what is regarded by both the DCP and the expert participants in this study as the “added value” of clinical psychology is far wider than the comparatively restricted psychological therapist role, and is much more consistent with the scientist-practitioner role.

4.6.3 Clinical Psychology and the other Applied Psychology Professions

This study has focused intentionally solely upon clinical psychology, rather than upon applied psychologists in healthcare or upon psychological therapy services. The participants have identified that other professions, including other applied psychologists in healthcare (particularly counselling, health and forensic psychology) constitute a threat to the future of clinical psychology. The model suggests that if clinical psychology is to meet the challenge from these other professions successfully, then clinical psychology needs to be able to establish clearly what differentiates it from those other professions. This, however, begs two extremely important questions. The first of these is, is it actually possible for clinical psychology to state its unique skills in a way which clearly differentiates it from those other professions? It is not sufficient for clinical psychology alone to agree this. Other professions, particularly the other applied psychology in health professions, need to agree with what clinical psychologists regard as their unique skills, and this may not be as straightforward as it might appear. *Exp 6* described the difficulty of trying to explain in simple terms to a GP the difference between a clinical psychologist and a counselling psychologist:

“A GP approached me and said, so what is the difference between a clinical psychologist and a counselling psychologist ... if I refer somebody who`s depressed, what are they going to get? And, you know, I found that quite a challenging question”

The researcher himself was present at a conference in Birmingham some years ago at which the then chair of the DCP and the then chair of Division of Counselling Psychology each gave a presentation on the unique skills of their own profession. They were not able to agree on any single point of differentiation. This means that

although clinical psychology may be able to agree within the profession on what is its added value, upon presenting that to users, commissioners and planners, it may find other professions claiming that they also have those skills. This is not to suggest that there is no difference between the professions, it is just raising the question of how easy it will prove to state it in a way which others agree with, and understand. Clinical psychologists need not only to be able to define their “added value”, but commissioners, managers and users must understand and accept it, want it, and be prepared to commission it. It would clearly be a huge problem for marketing the profession if clinical psychology was not able to accomplish these tasks successfully.

The second important question the profession needs to ask itself is, is it actually desirable, or even justifiable, for clinical psychology to set out to continue to thrive at the possible expense of other applied psychology professions? As *Exp 3* said, “we have to be clear that we`re not just doing it because we want to survive”. This researcher suggests that perhaps the profession should not start with the question of how to ensure it survives and thrives in Wales in 10 years time. A more ethically acceptable starting point would perhaps be to ask how can we ensure the best possible psychological care in health services in Wales in 10 years time? The answer to such a question might well recognise the need to make the best possible use of the unique knowledge bases and skills of several different applied psychology professions. In fact, several of the experts recognised and valued the contribution that other applied psychologists can make to health care:

Exp 1. “We`ve employed counselling psychologists and I feel very comfortable with that. If you take neuropsych out of it, what do I do that`s professionally different ... I struggle a bit with that”.

Exp 8. “I think there`s much more recognition now that clinical and forensic psychologists have different skills and training and experience, but are of equal ability and equally capable to do certain jobs”.

It was the general view of the experts that other psychology professions do present a threat to clinical psychology, but it was not the general view that clinical psychology

should necessarily attempt to resist those threats. At least some of the experts appeared to be saying that clinical psychology needs to embrace those other professions (as indeed clearly already happens in several departments) rather than seek to continue to thrive at their expense. This, of course, is consistent with the broad message from NWW (Lavender and Hope, 2007).

In retrospect, it would have been very valuable to have specifically asked the experts their views on the future relationship between clinical psychology and the other applied psychology professions during the second interviews. On the one hand, the profession may decide to try to continue to thrive at the expense of other applied psychology professions in health; on the other hand, it may decide to include those other professions and promote all of them together. Over recent years there have been clear signs that the various applied psychology professions in Wales are moving closer together. Counselling, forensic and educational psychologists are now employed in some healthcare organisations in posts which previously would have been exclusively reserved for clinical psychologists, and the former Welsh Clinical Psychology Advisory Committee has metamorphosed into APHNSAG (an advisory group to the Welsh Government). On the other hand, clinical psychology remains the only profession to receive NHS funding for training, and it shows no sign of wishing to share this around. Indeed, as finances get tighter it would not be surprising to see a tendency for clinical psychology to try to look after itself as its first priority. There is then a strategic, and possibly even an ethical, decision which clinical psychology needs to take about whether to attempt to define and promote applied psychologists in health collectively, or whether to try to survive at the possible expense of the other psychology professions. This project, unfortunately, did not take the opportunity to gain specific opinion and guidance from the participants. Nevertheless, the recommendation from this study is that the profession does need to address this question.

Whilst it may be difficult, and not even desirable, to differentiate clearly between clinical psychology and some of the other applied psychology professions, there was no suggestion from any of the experts that the same was true with regard to other professions carrying out psychological work. They regarded the “added value” of

clinical psychologists as clearly separating them from the capabilities of those other professions, such as nursing and counselling. The implication for the profession for the future is that clinical psychologists should make efforts to get into positions of leadership of psychological services, particularly of psychological therapy services, where their expertise would naturally suit them to these positions. It was recognised that there are examples in England where psychological therapies are not only led by non-psychologists, but do not always even have a psychologist as a member of the team, so clinical psychologists may need to make specific efforts to prepare themselves and put themselves forward for such posts. There was also a recognition that other professions can, and do, provide psychological therapy, and that it is not advantageous for the profession to continue to provide a service which could be provided more cheaply by someone else. If there are any Clinical psychologists currently employed who are carrying out therapy which other professions could provide reasonably effectively, they need to consider changing their role, perhaps to work with clients whom other professions would not be competent to treat. This will be necessary if they are going to be able to meet the challenge of competition in the future, or else they may need to be prepared to work for lower (i.e. more competitive) salaries.

4.6.4 Career Pathways

The results of this study suggest that there may be major changes to the career pathways which clinical psychologists can expect in the future. Up until relatively recently it had been commonplace for a number of years for clinical psychologists in Wales to be upgraded in post. There was, of course, a limit to how far up the career ladder individuals could expect to progress without having to move to a completely new job, but the researcher is personally aware of several people who have reached consultant level posts (pay band 8c in the NHS, or equivalent) without moving, and many more who have progressed to band 8b. The implication for the future, though, is that clinical psychologists will need to be prepared to move to other posts, to other departments, or even to other specialities, in order to advance to higher level posts. One of the predictions by the experts which they all agreed upon was B.3, “increased number of lower banded posts, fewer higher banded posts (8c and above)”. With

fewer jobs, securing a post at a higher grade will be more difficult and, again as predicted, many clinical psychologists may find that they never achieve consultant level post (prediction G.3, “many clinical psychologists will get stuck at lower level bands/grades”).

The experts generally agreed that one of the routes to higher graded posts will be through taking on wider roles, particular leadership and management roles (prediction G.4). One of the practical problems for clinical psychologists currently in the NHS who have ambitions to take on these leadership roles, is that they usually get very little experience of formal leadership or management at lower grades. To put this into context, newly qualified clinical psychologists expect, and get, to be appointed in the NHS at band 7. They can then advance to band 8a or even 8b without having to take on any management or leadership responsibilities. Other professions, however, usually take on substantial managerial responsibility at band 7, or even on lower bands. A nurse, for example, can expect to be in charge of a ward at band 7. The consequences of this for clinical psychologists are two-fold. Firstly, management positions which may suit a clinical psychologist, e.g. clinical team manager, are often banded at, or below, their existing band. Perhaps not surprisingly, clinical psychologists seem to have been reluctant in the past to take on these posts, but they may need to consider such opportunities more carefully in the future if they want to gain management experience. Gaining management experience may become increasingly important in the future, because the second consequence is that, if clinical psychologists wish to apply for more senior leadership posts, which carry bandings at 8c or more, they may well find that they are in competition for these posts with candidates from other professions who have already gained a significant amount of management experience at lower bands. If clinical psychologists want to become leaders and/or managers, they may need to consider taking a detour early on in their careers in order to gain suitable experience to prepare them for the more senior posts.

Alternatively, or better still, in addition, clinical psychologists should be prepared to undertake management and leadership training, coaching, and mentoring, early in their careers. Clinical psychology services, departments, and the profession countrywide might consider establishing leadership and management programmes, or

setting up individualised development programmes. These should help individual clinical psychologists to further their own careers, but in doing so the result would be that clinical psychologists get established in influential positions in healthcare, which is beneficial for the whole profession. It is, in fact, identified in the model as one of the Critical Actions necessary for the sustained welfare of the profession. The DCP's leadership framework (Skinner *et al*, 2010) again looks to be a very timely development.

The experts were not clearly in favour of the idea that another route to career advancement will be to develop specialist expertise (4 agreed, 2 disagreed, 2 did not know; prediction G.13), so it remains only a suggestion for individuals to consider. There is, perhaps, the danger that overspecialising may become something of a career cul-de-sac, although the majority of the experts thought there would be more acknowledgement of the transferability of skills, which would allow transfers to other specialities, if necessary (G.12, 5 agreed, 3 did not know).

The overall picture which emerges is that, in the future, clinical psychologists will need to be more prepared to move around in order to advance up the career ladder and that they may benefit in the long term if they sacrifice early advancement to gain valuable leadership or management experience. Developing a specialist area of high expertise may help also. Something else which emerges from the picture painted by the experts is that remaining in a post for which the duties are purely clinical work is not likely to lead to advancement. Furthermore, if the clinical work undertaken is not clearly complex, and therefore beyond the capabilities of, for example, a nurse trained to Master's level in cognitive behaviour therapy, then that post may become rather vulnerable.

Whilst these predictions may sound sombre, most of the experts actually thought that clinical psychologists in Wales would broadly succeed in accomplishing the Critical Actions over the following ten years, which would then mean increasing numbers of clinical psychologists in influential positions. That, in turn, would be good for the survival and health of the profession.

4.6.5 Accomplishing the Critical Actions

The model identifies the Critical Actions which the profession needs to accomplish in order to survive and thrive over the following ten years, and there are some suggestions and implications from it as to how these could be accomplished, but the study did not specifically address this question. Obtaining further suggestions and guidance on how to accomplish the Critical Actions would clearly be extremely helpful, but such an exploration was beyond the scope of this study. A further study could look at exactly this area though, and some kind of Delphi design would be one way to go about it. There are, though, other ways in which such an important issue could be addressed, and it may be that some kind of group process which encourages brain storming would be a better way of generating effective ideas.

The final, crucial, implication for the profession from this study is that the next few years will indeed be critical in determining the future of clinical psychology in Wales in 2022. The Critical Actions provide clear suggestions about what the profession should address and accomplish, and there may well be more. The profession needs to be working on these now.

4.7 CONCLUSIONS

The stated purpose of this study was to provide the profession of clinical psychology with a credible view of its future in Wales in 2022. It has to be acknowledged and understood that the predictions, and the model derived from the thoughts and opinions of the experts, are no more than best guesses. They are simply snapshots of opinion taken at a particular point in time, under the circumstances which prevailed then, but may not tomorrow. But they are the combined views of eight of the most senior clinical psychologists in Wales, and there is no comparable piece of published current research on the future of clinical psychology in the UK, let alone in Wales specifically. They are, therefore, at least for the moment, our best guesses.

This study has produced eighty specific predictions on the future of clinical psychology in Wales in 2022, many of which have complete, or strong, support from

a group of eight experts. It was also hoped to be able to identify the main reasons behind the predictions the experts made, and in this the study has surpassed the initial expectations of the researcher by producing a coherent model for guiding predictions on the future of clinical psychology in Wales. The opinion of the researcher, therefore, is that the original purpose has been accomplished. In a qualitative study of this nature, however, credibility is essentially a judgement for each individual reader to make. The test must be whether the profession accepts the results as credible and then actually uses the predictions and the model to help bring about the best possible future for the profession of clinical psychology, and, ultimately, to provide the best possible psychological care in health services for the people of Wales.

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APPENDIX A

A Delphi Study on the Future of Clinical Psychology in Wales-Version 1

Semi-Structured Interview: First Interview

Introduction to interview:-

As has been explained to you previously, this research project is attempting to predict the future of clinical psychology in Wales in 10 years time, by gaining the opinions of a group of experts, such as yourself.

I need to check with you that you are happy for me to record this interview and then to transcribe it verbatim. I will be analysing all the interviews, trying to identify themes and concepts, and areas of agreement or disagreement. I intend to include direct quotations from the interviews in the final report, but they will not be identified as coming from specific individuals.

Finally, I would just like to stress that I want you to tell me what you think is the most likely state of clinical psychology in Wales in 10 years time, rather than how you would like it to be.

Do you have any questions before we start the interview?

1. What do you consider will be the most important influences upon clinical psychology in Wales over the next 10 years?
2. Describe clinical psychology as you expect it to be in Wales in 10 years time.
3. What do you think clinical psychologists in Wales will be doing differently in 10 years time, and what do you think they will be doing the same as they do now?
4. How do you expect clinical psychology to be organised and managed in 10 years time in Wales?
5. Do you think there will be any changes to the main roles and activities of clinical psychologists in Wales in 10 years time?
6. Do you expect there to be any changes in the dominant therapeutic models used by clinical psychologists in Wales in 10 years time?
7. What do you expect to be the main career pathways for clinical psychologists in Wales in 10 years time?

Semi-Structured Interview: First Interview. Continued

8. What do you think will have happened to training for clinical psychology in Wales in 10 years time?
9. What do you consider will be the main opportunities and threats for clinical psychology in Wales over the next 10 years?
10. Do you have any other ideas or views about clinical psychology in Wales in 10 years time which we have not covered already?

Thank you for your cooperation.

Version 1.6

10.09.2011.

APPENDIX B:**A Delphi Study on the Future of Clinical Psychology in Wales-Version 1**

Invitation to participate: text of email to be sent to potential participants:-

Version: 1.3

03.09.2011.

Dear

I am writing to you to invite you to participate in a research study which I am undertaking in part fulfilment of a “top-up” doctorate in clinical psychology. The purpose of the study is to predict the future of clinical psychology in Wales in 10 years time.

The study will use a modified Delphi survey procedure, which is accepted as being an appropriate method for making predictions about the future trends and developments in an area such as clinical psychology. Delphi surveys involve identifying a number of experts in the area of interest, who are then asked to give their opinions about the future of that area. The opinions of the participants are collected individually and are then collated and fed back to them. The participants are then asked to give their opinions again, to see if and how they have changed in light of the opinions and ideas of the other expert participants. The opinions are collected and fed back in such a way that it is not possible for participants to attribute any particular views to specific individuals. This is done to ensure that no one person exerts an undue influence upon the ideas of other participants. This iterative process can be repeated, if necessary, until views become relatively stable. The general idea is to try to gain a collective view of the future from recognised experts in that area.

I am inviting you to participate in this study because of your expert knowledge of Clinical Psychology in Wales, and I would be very grateful if you would consent to take part. If you do participate, it will involve undergoing two semi-structured interviews, each conducted by myself. The first will take place face-to-face, and I will meet you at a place of your choosing. I am happy to travel to wherever is most convenient for you. It is anticipated that this interview will last no longer than one hour. The interview will be recorded for later transcription and analysis. Once I have completed and analysed all the initial interviews, I will feed the results back to you by email. Shortly after this I will carry out a second interview with you, either face-to-face, or by telephone or video link. I anticipate that this interview will last less than one hour. Once again the interview will be recorded for later transcription. The data will then be analysed and a report written up for submission to Cardiff University for the degree of Doctor of Clinical Psychology.

I would be very grateful if you would consent to participate in this study. It is, of course, entirely voluntary, but given the rapidly changing nature of healthcare in Wales, it should provide the profession with valuable guidance about how to ensure we continue to make the best possible contribution to healthcare. It should therefore

be of significant interest to you in your position as a senior member of the profession in Wales. Once the report is finalised I will, if you wish, send you an electronic copy.

I have attached to this email a document providing more detailed information about the nature of the study, and of the tasks which participants will be asked to undertake.

If you are interested in participating in this study, or perhaps would like to know more about it before committing yourself, please contact me and I will answer any further questions you may have. If you are then happy to proceed, I will make arrangements with you to meet and carry out the first interview.

I look forward to your hearing from you.

With thanks,

Alan

Alan Wright
Consultant Clinical Psychologist
Aneurin Bevan Health Board
Forensic Psychiatry Service
Brecon House
Mamhilad Park Estate
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NP4 0YP

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APPENDIX C:

PARTICIPANT INFORMATION SHEET

A Delphi Study on the Future of Clinical Psychology in Wales-Version 1

Introduction

You are invited to participate in a research study, the purpose of which is to predict the future of clinical psychology in Wales in 10 years time.

In order to help you to decide whether to participate or not, I have prepared this information sheet to ensure that you understand why this project is being carried out, and what participation would involve for you. I would be happy to go through this sheet with you, and to answer any questions you might have.

The information sheet explains the purpose of the study, and what will be involved for you if you agree to participate. It also provides basic information about the design and conduct of the study.

Background Information

In October 2009, NHS Wales was subject to a major reorganisation. Since then, severe financial cutbacks have affected public services throughout the UK. It is important to try to anticipate how these and other changes are likely to affect Clinical Psychology services, in order for the profession to be able to adapt to them successfully, and to continue to make the best possible contribution to healthcare in Wales.

Purpose and design of the study

The proposed study utilises a modified Delphi survey to gather predictions about the future of Clinical Psychology in Wales. Delphi surveys are accepted as being an appropriate method for making predictions about future trends and developments in an area such as clinical psychology. They involve identifying experts in the area of interest, who are then asked to give their opinions about aspects of the future, either in interviews or by written questionnaire.

All interviews are carried out individually in order to prevent any one person from dominating discussions, or from unduly influencing the views of other people by virtue of their perceived expertise or status. Information from the questionnaires or interviews is then analysed and fed back to all participants, but without attributing particular views to specific individuals. In traditional Delphi surveys this information is usually fed back as a series of statements about the future, which participants are then asked either to put in rank order, or to rate their level of agreement or disagreement with each on a rating scale.

In this study, heads of clinical psychology departments from Welsh public and private sector organisations, along with other selected senior members of the profession, will be invited to participate.

The study will use a modified version of the Delphi Survey. All participants will be interviewed by myself, and the interviews will be recorded, transcribed verbatim, and then analysed using Grounded Theory methodology. The analysis will attempt to identify common ideas and themes in the interviews, and also areas of consensus and of disagreement. This initial analysis will be fed back to the participants, who will then be re-interviewed, having had the opportunity to review their previous ideas in light of the views of the other participants. The second interviews will also be recorded and transcribed, and will again be analysed using Grounded Theory methods. The study will end at this point, and a report will be produced for submission to Cardiff University in part fulfilment of the degree of Doctor of Clinical Psychology.

Grounded Theory is an accepted qualitative method of analysis, well suited to analysing interviews, and it allows a more detailed analysis of the content of the interview than the standard Delphi method. Modifying the Delphi survey in this way will also allow broader discussion of the reasons why participants have arrived at their views and what they consider will be important influences upon the future of Clinical Psychology in Wales. Utilising Grounded Theory methods to analyse the interviews will provide a much richer analysis than would be possible simply by generating a series of statements and asking participants to rate their agreement or otherwise with them.

Participation in the study

I am inviting you to participate in this study because of your expert knowledge of Clinical Psychology in Wales. If you do participate, it will involve undergoing two semi-structured interviews, each administered by myself. The first will take place face-to-face, and I will meet you at a place of your choosing. I am happy to travel to wherever is most convenient for you. It is anticipated that this interview will last no longer than one hour.

Once I have completed and analysed all the initial interviews I will feed back the results to you by email. Shortly after this I will carry out a second interview with you, either face-to-face, by telephone, or by video link. The second interview should take place within approximately three months of the first interview. I anticipate that this second interview will last less than one hour. The data will then be analysed and a report written up for submission to Cardiff University for the degree of Doctor of

Clinical Psychology. Once the report is finalised I will, if you wish, send you an electronic copy. The study is attempting to predict the future of Clinical Psychology in Wales over the next ten years, and I am hoping that it will therefore be both interesting to participate in, and also valuable to you in your position as a senior member of the profession in Wales.

If you are interested in participating in this study, or perhaps would like to know more about it before committing yourself, please contact me and I will attempt to answer any questions that you may have, and to arrange with you to proceed if that is what you decide to do. Participation in the study is, of course, entirely voluntary. If you agree to take part, I will ask you to sign a consent form, and you will be given a copy of this for your own records.

You are free to withdraw from the study at any time, without giving a reason for doing so. If you do, data from any interviews you have given to that point will not be used in the study.

Confidentiality

An important element of the Delphi survey design is that none of the views or opinions put forward by the participants can be identified as coming from specific individuals. The reports generated by the analysis of the first and second interviews may contain verbatim quotes from participants, but pseudonyms will be used to prevent anyone from identifying their source. This confidentiality will be maintained even after the end of the study. It is, however, quite normal for participants to know who the other participants are, and so I would anticipate sharing this information with all participants. If you would prefer that your own participation is not known to others, though, please let me know and I will ensure that your anonymity is protected.

Recordings of the interviews will be transcribed verbatim and then analysed. Once the interviews have been transcribed, the recordings will be deleted. The transcriptions will be retained for 5 years after the end of the study. They will be kept under lock and key at the offices of the Cardiff University Clinical Psychology Training Scheme. The transcriptions will be available to myself and my Research Supervisor, Dr Neil Frude, only.

Once the study has been completed, and should the final report be accepted by Cardiff University, it is intended to present the results at conferences and professional meetings of clinical psychologists.

Further information and contact details

For any further information about this research project, or to discuss your possible participation in it, please contact:-

Alan Wright
Consultant Clinical Psychologist
Aneurin Bevan Health Board
Forensic Psychiatry Service
Brecon House
Mamhilad Park Estate
Pontypool
NP4 0YP

Email: alan.wright@wales.nhs.uk

Telephone: 01495 745633

Mobile: 07969 451613

Further considerations

If you have a concern about any aspect of this study at any time either before, during, or after the study is carried out, you can speak to myself in the first instance, and I will try to address your concern. If you remain unhappy and wish to make a formal complaint, you can do this by contacting the Aneurin Bevan Health Board. Complaints can be made, in writing, to the Chief Executive, or by email to the complaints department, or by phoning the Call Centre. Contact details are:-

In writing to: Andrew Goodall,
Chief Executive,
Aneurin Bevan Health Board
Mamhilad House
Mamhilad Park Estate
Pontypool
NP4 0YP

Email: complaints2@gwent.wales.nhs.uk

Telephone: 01495 745656

In the event that you consider that you have been harmed during the research, and that this is due to someone's negligence, then you may have grounds for legal action for compensation against the Aneurin Bevan Health Board, but you may have to pay your legal costs. The normal Aneurin Bevan Health Board complaints mechanism will still be available to you.

All research in the NHS is scrutinised by a Research Ethics Committee. This study has been reviewed and given favourable opinion by the South East Wales Research Ethics Committee.

No funding has been received from any individual, group, or organisation for conducting this study, and there are no payments for taking part in it.

Alan Wright

Information sheet version 1.5

10.09.2011.

APPENDIX D:
CONSENT FORM

Project title: **A Delphi Study on the Future of Clinical Psychology in Wales-Version 1**

Chief Investigator: Alan Wright

Study number: AW.01

1. I confirm that I have read and understood the Participant Information Sheet, version 1.5, dated 10.09.2011, concerning the above study. I have had the opportunity to consider the information and ask questions, and I have had these answered satisfactorily.

Yes/No

2. I understand that my participation is voluntary, and that I am free to withdraw at any time without giving any reason, and without my rights to confidentiality being affected.

Yes/No

3. I understand that interviews with me will be recorded and transcribed.

Yes/No

4. I agree for verbatim quotations from the transcripts of my interviews to be used in reporting of the study, but I understand that no quotations or opinions will be able to be identified as originating from me.

Yes/No

5. I agree for my participation in the study to be known to other participants.

Yes/No

6. I agree to take part in the above study.

Yes/No

Name of participant:.....Signature:.....Date:.....

Name of researcher:.....Signature:.....Date:.....

Consent Form version 1.4.
10.09.2011.
1 copy for participant, 1 copy for research file.

APPENDIX E:

A Delphi Study on the Future of Clinical Psychology in Wales

Feedback of analysis of first interviews and questionnaire: text of email sent to participants:-

April 2012.

Dear

I have now completed all the first interviews for my research project and analysed the data so far. As promised I am now feeding this analysis back to you, in the attached file, and I will be contacting you shortly to arrange the second interview.

I am slightly embarrassed that the feedback is longer than I had originally anticipated and led you to expect, but I have to say that I am extremely pleased with the outcome so far, and so I hope you will find it interesting.

Please would you just confirm that you have received this. Thanks.

With regards

Alan

A Delphi Study on the Future of Clinical Psychology in Wales

First of all, many thanks for taking part in the first round of interviews for this project. I have now analysed all eight of the interviews I carried out, and I am writing to you to feed back the results, as promised. I will also be contacting you shortly to arrange the second interview. I have to say that the results of the first interviews have been fascinating, and so I hope that you will find this feedback interesting and useful.

It had always been my hope and expectation that this feedback would be relatively brief. My initial intention was simply to feed back to you all the various predictions which were made during the first round of interviews, and then to ask you to comment upon them at the second interview. In the event, though, once I began to analyse the interviews, a number of clear, strong themes emerged, which suggested that it might be possible to produce a model which could be used to guide predictions on the future of Clinical Psychology in Wales over the next 10 years. I am therefore going to feed back to you both the predictions and the initial attempt at this model. So, although the feedback is much longer than I had originally anticipated, I hope you will find it all both interesting and potentially useful.

I would be grateful if you would give some consideration to the proposed model, as I will be asking your views about it when we meet for the second interview. I would like to hear your general comments and opinions about it, and particularly, of course, if you have any ideas about how it could be improved. I will also be asking some specific questions about it, and so I thought that it would be best to tell you them now so that, if you wish, you have some time to consider them before we meet. The specific questions I will be asking you will be:-

- Do you consider that this proposed model reflects the reality of the situation for Clinical Psychology in Wales? That is, do you think that the elements of the model are indeed the most important elements, and that the way in which the model links them together is sound?
- Does the model make sense as a model for predicting the future of Clinical Psychology in Wales? Do you think it will help you to predict the future of Clinical Psychology in Wales in 10 years time?
- Does the model account for all of the most important predictions concerning Clinical Psychology in Wales in 10 years time? If not, what are the important areas which it does not address?
- The model is intended to apply to nationally, across Wales, but do you think that it would be applicable locally, to your own organisation?
- Do you think that this model could be applied to other parts of the UK?
- Does this model give you any ideas for action to be taken over the next few years?
- Do you think that the model takes account of the main views you gave at the first interview?

A Model for Guiding Predictions on the Future of Clinical Psychology in Wales in 10 Years Time

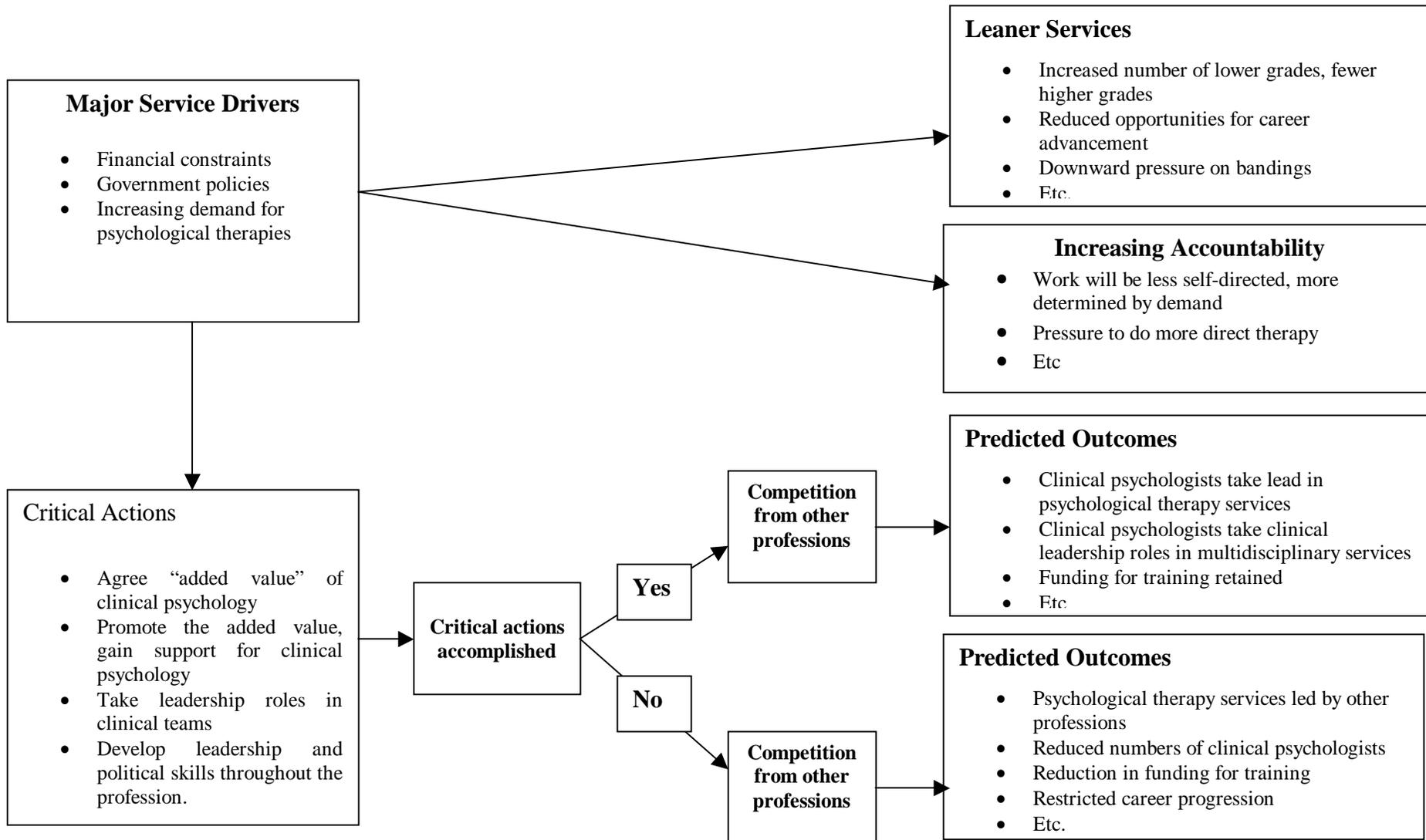
The model, which is presented in diagrammatic form below, is very simple but incorporates most of the strong themes which emerged from the analysis of the first round of interviews. These themes are not new, they have been discussed within the profession for some time and you will no doubt recognise all or most of them. The value of the model, if it has any, is that:-

1. It brings all the elements together into a coherent shape to guide predictions about the future of Clinical Psychology in Wales.
2. It is derived from in-depth interviews with 8 of the most senior clinical psychologists in Wales, and therefore will hopefully have the authority to guide the thinking and actions of the whole profession.
3. The ideas contained within the model have been recognised and discussed for some time, including the potential threats to Clinical Psychology. The model, though, is predicting that some critical processes will occur over the next 10 years which will be crucial in determining whether Clinical Psychology continues to thrive and develop in the years beyond that.

A summary of the model

In brief, the model suggests that continuing financial constraints, government policies, and increasing demand for psychological therapies, are the major factors which will shape Clinical Psychology over the next 10 years. As a consequence of these, the profession will be under pressure to become leaner and cheaper, and commissioners and managers will also want to ensure that they get exactly what they consider they need from clinical psychologists. In addition, there will be strong competition from other professions to provide many of the activities which clinical psychologists currently carry out, particularly the provision of psychological therapies. There are a number of critical actions, which the model identifies, which profession needs to undertake in order to meet these challenges successfully.

A Model for Guiding Predictions on the Future of Clinical Psychology in Wales in 10 Years Time



The basic elements of the model

1. Major Service Drivers

There are the three major forces driving the future of Clinical Psychology. They are:-

- The current severe financial constraints, which are affecting clinical psychology along with many other health services, are likely to continue for most or all of the next 10 years.
- Government policies, both from Westminster and the Welsh Assembly Government (WAG), will impact upon clinical psychology. In particular the drive from the current Westminster government to privatise health service provision, the WAG's agenda to modernise the health service in Wales, and both governments' requirements for services to be "leaner".
- Continued and growing demand for psychological therapies, by increasingly aware service commissioners and the public.

2. Leaner Services

The service drivers listed above will create a strong demand for clinical psychology to be leaner and cheaper. Clinical Psychology will see downward pressure on job bandings, resulting in a profession with a greater concentration of posts at the lower bandings and fewer opportunities for career advancement. The career route to higher banded posts, and to consultant grade posts in particular, will require increasing levels of specialist knowledge and expertise. Clinical psychologists will look outside the NHS for career progression, as private providers increase. These processes are occurring to some extent already, and the prediction is that they will increase over the next few years.

3. Increasing Accountability

The growing demand for psychological therapies in a climate where there are severe financial constraints will lead commissioners and managers to exercise increasing control over the activities of clinical psychologists. The work of clinical psychologists will be determined by demand, agreed with managers, and monitored more closely than is currently the case. There will be pressure for clinical psychologists to do more direct therapy, which may affect the lower banded posts particularly. Higher banded posts, and consultant grades in particular, will try to make better use of their expertise by increasing the amount of time given to providing clinical supervision, consultation, and advice to other practitioners of psychological therapies. Post qualification training will be much more in line with organisational goals rather than with personal aspirations.

4. Competition

Over the next 10 years there will be increasing competition for a lot of the work and roles which clinical psychologists currently do. The competition will come from other Applied Psychologists in healthcare, such as counselling psychologists, forensic psychologists and health psychologists. It will also come from other professions such as counsellors and psychotherapists, as well as individuals from other professions who have received training, sometimes to a high level, in various psychological therapies. This competition already exists, but it is predicted to increase significantly over the next several years. These competitors will look particularly attractive to commissioners and service managers if they appear to be able to do the same job as a clinical psychologist, but do not require such high salaries. There are already some examples, in England at least, of psychological therapy services not only being run by non-psychologists, but which do not even have a clinical psychologist as a member of staff. In the context of the severe financial constraints which are predicted to continue for most of the next 10 years, these other professions present a considerable threat to the position which clinical psychology has occupied for a long time.

5. Critical Actions

There are a number of critical actions which clinical psychology must take in order to prepare for and to resist the challenges to its current position as the primary profession providing and directing psychological therapies and care in health services. The model predicts that if these actions are accomplished successfully and in good time, then clinical psychology will retain its pre-eminent position amongst the professions providing psychological therapies and care. If, on the other hand, these critical actions are not accomplished and in good time, then the model predicts that there are likely to be considerable negative consequences for clinical psychology, including possible reductions in posts, in numbers being trained, in career opportunities, in influence on healthcare, etc.

One of the first critical actions to be undertaken is for the profession to agree exactly what it is that clinical psychologists can do which other professions either cannot do at all, or cannot do nearly as well, and then to state that clearly in a way which can be readily understood by commissioners, service managers, and service users. That is, clinical psychology needs to agree and define its “added value”. The strong view emerging from the analysis of the interviews was that the added value of clinical psychology is:-

- A high level of expertise and specialist knowledge.
- The ability and willingness to work with the most complex problems and clients.
- The ability to provide clinical leadership for psychological care, including clinical supervision, consultation, and advice to other professions.

- The ability to contribute psychological knowledge to the strategic planning of healthcare services
- The ability to create innovative services which improve healthcare significantly and/or save money, especially in high risk, highly specialist areas.

Once the added value of clinical psychology is agreed by the profession, it is necessary to promote this so that it is known and wanted by people at all levels of the profession; planners and commissioners, service managers, clinical teams, and service users. This will require some degree of promotion and marketing, of demonstrating what clinical psychologists can do, and sound political skills. One key ability to demonstrate is the ability to lead clinical teams in the provision of psychological treatment and care.

The profession also needs to ensure it is properly prepared to take on these roles. Clinical leadership and political skills need to be taught and developed in clinical psychologists at all levels, including during training. In addition, clinical psychologists must develop expert skills in specialist areas which are wanted and valued by their host organisations.

6. Predicted Outcomes

If the critical actions are accomplished successfully, or at least considerably improved from their current state, then the predicted outcomes for Clinical Psychology in Wales in 10 years time are generally positive, and include:-

- Training will continue to be funded at present levels.
- Clinical Psychologists will take on clinical leadership roles in multidisciplinary services.
- Senior clinical psychologists will be involved in strategic planning of healthcare, and will advise on or direct psychological aspects of care at all levels.
- Clinical Psychologists will lead psychological therapy services, which will include other professions
- There will be opportunities for innovative service developments, led by clinical psychologists, particularly in physical health and in high risk specialist areas.
- Clinical psychologists will increasingly take on clinical supervision, consultation and advisory roles in service provision in order to make best use of their expertise.
- There will be increasing numbers of clinical psychologists in management positions

-
- Clinical psychologists will be dealing with the most complex problems, and so will be required to acquire specialist skills and knowledge.

If, on the other hand, the critical actions are not accomplished sufficiently, or not in good time, then the predicted outcomes for Clinical Psychology in Wales in 10 years time are much less favourable, and include:-

- Reduced funding for training leading to fewer training places, possibly a reduction in the number of training courses, and possibly also a reduction in the length of training to a 2 year, non-doctoral training.
- Clinical psychologists will be less highly trained, less skilled, and so will lose their “added value” which distinguishes them from other professions.
- Clinical Psychologists will decline in numbers, with many available posts being taken by other professions.
- Psychological therapy services in some cases will be led by other professions.
- Clinical psychologists will find it increasingly difficult to attain positions of power and influence within health services.
- Opportunities for career advancement within clinical psychology will be very restricted.

This model is, of course, something of an oversimplification. In reality there is not likely to be a simple dichotomy dependent upon whether the critical actions are accomplished in time to deal with the threat of competition. The critical actions may be wholly or partly accomplished over the course of the next 10 years, and the competition from other professions already exists. Nevertheless, although the reality is likely to be a more complicated picture than the two extremes shown in the model, the general prediction is quite clear; clinical psychology will face threats from competition over the next 10 years, and how well it survives will depend, at least to some extent, upon how well and how quickly it addresses a few critical actions.

A further consideration is that whilst the model is intended to help in predicting the future of clinical psychology in Wales as a whole, the reality is that local services are likely to face different circumstances. There will be differences in the competition encountered, and differences in the way in which psychology is perceived and valued by managers, commissioners and users. The outcomes in different areas or organisations are therefore likely to be different, but the model should be broadly applicable in each area or organisation. Finally, there were a number of predictions made during the first interviews concerning clinical psychology which are not accounted for by this model. They are not necessarily inconsistent with the model, but they are independent of the major elements of the model. For example, the predictions concerning what will be the dominant models of psychological therapy are not dependent upon these factors. For the proposed model to be useful, it must be able to account for the most important predictions concerning clinical psychology, and so I would be grateful for your thoughts as to whether it does this or not.

Predictions on the Future of Clinical Psychology in Wales in 10 Years Time

Presented below are all the predictions made during the first interviews concerning the future of Clinical Psychology in Wales in 10 years time. I have sorted them into broad categories, to help in comparing them, and where possible I have used the same categories as the major elements of the proposed model. Some of the predictions are contradictory, which is to be expected. Some of the predictions were made by several people, whilst others were made by only one person, but I have not at this stage indicated how much support there was for each one.

Please look at all the predictions and indicate in the appropriate box next to each one whether you broadly agree or disagree with it, or whether you have no particular opinion about it. Please also note in the "Points for Discussion" column if there is anything about that point which you would like to discuss with me when we meet for the second interview. That might be anything from asking me for clarification, to wanting to make particular points about it, or to discuss it in more detail. It is my intention to discuss with you only those predictions which you note as meriting discussion; for all the others I simply want to know whether you agree with them or not.

I will also, of course, be interested to hear any new predictions which you might now make, having had a chance to think about things, and also having seen the views of the other people in the study.

I do apologise again for asking you to fill in this questionnaire. As I told you initially, my intention was that all you would be asked to do was to take part in two interviews, and in between to read some brief feedback on the results of the first set of interviews. In the event, this feedback is much longer than I had ever anticipated, and there is also this questionnaire to be filled in. I hope, though, that you will agree with me that the results obtained from the first interviews are well worth the extra effort. Thank you again for your time.

<u>Predictions</u>	Broadly Agree	Broadly Disagree	Don't know	<u>Points for Discussion</u>
A. Demand for Psychological Therapies				
A.1. There will be increasing demand for psychological therapies				
B. Leaner Services				
B.1. An increasing number of short-term contracts instead of permanent posts.				
B.2. Clearer differentiation of work by band/grade.				
B.3. Lower bands will do more direct clinical work, higher bands will do more consultancy.				
B.4. Increased number of lower banded posts, fewer higher bands (8c and above).				
C. Increasing Accountability				
C.1. Work will be less self-directed, more determined by demand and agreed with managers.				
C.2. CPD will be in line with organisational goals				
C.3. Clinical Psychologists will increasingly be asked to account for the work they do				
C.4. There will be pressure for more direct clinical work				
C.5. There will be pressure to use Clinical Psychologists' skills to most effect, i.e. less direct work, more consultancy, supervision, training, etc.				

<p>C.6. There will be a focus on outcomes rather than outputs</p>				
<p>D. Competition</p> <p>D.1. Other Applied Psychologists will have taken on many of Clinical Psychologists` current roles and posts</p> <p>D.2. Other professions will have taken on many of Clinical Psychologists` current roles</p> <p>D.3. Other professions, including other Applied Psychologists, will carry out some of our current activities more cheaply</p> <p>D.4. Clinical Psychologists will decline in numbers</p> <p>D.5. Clinical Psychologists will be less well trained and less skilled, especially in formulation, and so will lose some ability to compete</p> <p>D.6. Other professions will be leading Psychological Therapy Services</p> <p>D.7. Clinical Psychologists will remain the dominant psychology profession in healthcare services and will bring in other Applied Psychologists under their direction</p> <p>D.8. Counselling Psychology will increase in size, influence, and uptake of posts</p>				
<p>E. Role of Clinical Psychologists</p> <p>E.1. Clinical Psychologists will be dealing with complex problems</p> <p>E.2. Clinical Psychologists will take on new roles, such as AC/RC</p> <p>E.3. Clinical Psychologists will have some prescribing rights</p>				

<p>E.4. Senior grade Clinical Psychologists will be taking on clinical leadership roles in multidisciplinary services</p>				
<p>E.5. Clinical psychologists at all levels will be guiding and directing psychological care</p>				
<p>E.6. Clinical Psychologists will have a role as high-level researchers</p>				
<p>E.6. Clinical Psychologists will be dealing with severe and enduring problems which no one else can deal with</p>				
<p>E.7. Clinical Psychologists will move into multidisciplinary community services as CMHTs decline</p>				
<p>E.8. Clinical Psychologists will be leading Psychological Therapy Services</p>				
<p>E.9. A major part of the role will be to develop psychological skills in other staff</p>				
<p>E.10. Clinical Psychologists will be dealing with the most difficult patients/problems, for which the current training is inadequate. There will be a lot of CPD aimed at developing high level expertise</p>				
<p>F. PR/politics</p>				
<p>F.1. Clinical Psychologists will link more, and more effectively, with policy makers and commissioners</p>				
<p>F.2. Increased knowledge about Clinical Psychologists by the public will lead to increased demand</p>				
<p>F.3. Leadership and political awareness will be key skills, taught and developed from training onwards</p>				

<p>F.4. Power and influence is flowing back to medics and nurses; Clinical Psychology will become more marginalised</p>				
<p>G. Career Pathways</p>				
<p>G.1. There will be an increasing number of jobs in the private sector</p>				
<p>G.2. Loyalty of Clinical Psychologists to the NHS will erode further</p>				
<p>G.3. Many Clinical Psychologists will get stuck at lower level bands/grades due to reduced opportunities for career advancement</p>				
<p>G.4. Career advancement will be through taking on wider roles, such as clinical leadership, management, commissioning, etc.</p>				
<p>G.5. 8b will be the highest band for a purely clinical role</p>				
<p>G.6. It will be very unusual to be upgraded in post</p>				
<p>G.7. Upgrading in post will become commonplace again, in order to retain staff</p>				
<p>G.8. The 7/8a Preceptorship model will be adopted fully</p>				
<p>G.9. The effective number of grades will reduce, perhaps to “Entry” (7/8a); “Intermediate” (8b); “Consultant” (8c); “Senior Consultant” (8d/9)</p>				
<p>G.10. There will be no more senior posts (above 8c) created</p>				
<p>G.11. There will be more Clinical Psychologists in service management posts</p>				
<p>G.12. Transferable skills will be more recognised, allowing easier transfer across Specialties and organizations</p>				

<p>I. New Developments</p> <p>I.1. Clinical Health Psychology is the most fertile area for future growth</p> <p>I.2. There will be new developments in Clinical Health Psychology</p> <p>I.3. Clinical Psychology will develop by saving money in high risk, highly specialist areas, e.g. forensic, PD</p> <p>I.4. Clinical Psychologists will develop in Primary Care</p> <p>I.5. Clinical Psychologists will not develop in Primary Care</p> <p>I.6. There will be increasing demand for Clinical Psychologists to develop new clinical treatment programmes</p>				
<p>J. Management and Organisation</p> <p>J.1 Traditional Psychology Departments in the NHS will decline or disappear altogether</p> <p>J.2. Clinical Psychologists will be managed by service managers</p> <p>J.3. A professional hierarchy will remain to ensure proper governance</p> <p>J.4. Clinical Psychologists will continue to be predominantly managed by Clinical Psychologists</p> <p>J.5. Heads of Profession posts will remain</p> <p>J.6. Heads of Profession posts will increase due to reorganisation of LHBs (more of them)</p>				

J.7. Clinical Psychology departments will evolve into multidisciplinary Psychological Therapy services				
J.8. Clinical Psychologists will be more integrated into multidisciplinary services, and less into traditional Psychology Departments				
K. Models of therapy				
K.1. “3 rd Wave” cognitive therapies will remain dominant				
K.2. There will be a reaction against the dominance of CBT				
L. Uneven provision of Services				
L.1. Provision of Clinical Psychology services will remain uneven across LHBs				
L.2. The shift away from the predominantly therapist role by Clinical Psychologists will be patchy				
M. Other Considerations				
M.1. There will be more demand for Welsh speaking				
M.2. Standards of entry into the profession are falling, so in future qualified Clinical Psychologists will need more supervision and guidance				

APPENDIX F:**A Delphi Study on the Future of Clinical Psychology in Wales****Second Semi-Structured Interview**

Previously Prepared questions

- Please tell me your general opinions about the proposed model for predicting the future of Clinical Psychology in Wales, and particularly, of course, if you have any ideas about how it could be improved.
 - Clear?
 - Understandable?
 - Agree/disagree?
 - Any ideas about how to improve it?

- Do you consider that this proposed model reflects the reality of the situation for Clinical Psychology in Wales? That is, do you think that the elements of the model are indeed the most important elements, and that the way in which the model links them together is sound?

- Does the model make sense as a model for predicting the future of Clinical Psychology in Wales? Do you think it will help you to predict the future of Clinical Psychology in Wales in 10 years time?

- Does the model account for all of the most important predictions concerning Clinical Psychology in Wales in 10 years time? If not, what are the important areas which it does not address?

- The model is intended to apply to nationally, across Wales, but do you think that it would be applicable locally, to your own organisation?

- Do you think that this model could be applied to other parts of the UK?

- Does this model give you any ideas for action to be taken over the next few years?

- Do you think that the model takes account of the main views you gave at the first interview?

Supplementary questions

- Do you think that the profession will have accomplished the identified critical actions sufficiently, and it time, for Clinical Psychology to meet the challenge of competition successfully:-
 - In Wales
 - In your own organisation
 - In most organisations in Wales
 - In the UK?

- The model suggests that the next 10 years are going to be critical in determining the future of Clinical Psychology in Wales. Do you broadly agree/disagree?

- Any other thoughts, ideas, questions?

AW. 18.04.2012