

New Ways of Working for Psychological Therapists

WORKSTREAM TWO

Mapping the Psychological Therapies Workforce

Compiled and edited by:

Sally Aldridge
British Association of Counselling and Psychotherapy

and

Ruth Duffy
Improving Access to Psychological
Therapies Programme

Contents

Section 1 Introduction	3
Section 2 Current Workforce Data Collection Systems	4
Section 3 Workforce in IAPT Services	5
Section 4 Training	9
Section 5 Workforce and Training Requirements for the Future	13
Section 6 Guidance and Recommendations	15
Section 7 Conclusions	17
Section 8 Appendices	18
• Summary of workforce data systems	
• Membership of group	

Section 1 Introduction

Purpose

1. The purpose of this workstream was to explore current knowledge of the psychological therapy workforce both in terms of the numbers and types of staff and their existing trainings. The Terms of Reference were:

- To describe the size and nature of the Psychological Therapy workforce market and its associated trainings, public, private and third sector.
- To suggest mechanisms which will provide the ongoing provision of accurate workforce data.

2. The first stage was to survey the current workforce data and the methodologies used for workforce data collection. This was followed by the identification of current training programmes which could support the IAPT programme. This information was then utilised to suggest recommendations for the way forward.

3. For the purposes of the report some boundaries were set.

1. Data collection was limited to England
2. Data on training courses was restricted to clinical and counselling psychology, counselling, psychoanalysis and psychotherapy courses
3. Data on primary care services was included where relevant, although the focus was on IAPT services

4. The Workstream comprised a small group representing the major psychological therapy professions and people with knowledge and experience of statistical surveys. There was a larger consultative email group. The group worked collaboratively to pool information, review the collected data and produce recommendations.

Challenges

5. The decision to focus the NWW project on IAPT services presented a challenge, as IAPT is entering its second year and therefore the workforce data is limited. The programme is restricted to common mental health problems and is an England only initiative. The result is that this report has a narrow IAPT focus in places and a wider focus in others, for example with regard to training and psychiatric morbidity.

6. Psychological therapies lack clear boundaries and definition in terms of the people delivering such therapies, the activities delivered under the title and the training and competences required. In addition the psychological therapies encompass a wide range of theoretical and philosophical approaches. Given these facts it is unsurprising that data on the psychological workforce is inconsistent, incomplete and in some cases idiosyncratic.

Section 2 Current Workforce Data Collection Systems

7. There is no single system in place which provides workforce data across all the sectors of service provision. Data is collected by numerous organisations for a variety of purposes and the historic development of how this has been collected has led to the current mismatch of information. One of the underlying reasons for this is the range of employment contexts i.e. the statutory, voluntary and independent sectors, all of which require different sets of information for different reasons. In addition job titles are inconsistent for staff doing similar jobs, psychological therapy skills are described and understood in different ways, all of which leads to further confusion. Where there have been attempts to collect data e.g. the annual mental health service mapping, parts of the service have not been included.

8. Despite these difficulties there are a number of ways in which data is collected and usefully used. Within the NHS there are two major sources

- Electronic staff record
- NHS Annual Mapping exercise

9. Professional and regulatory registers are a further source of information but they each have their own advantages and disadvantages and the information they hold may overlap with each other and what is collected elsewhere.

- Health Professions Council (HPC) :-register of practitioner psychologists, arts therapists, drama therapists, music therapists and occupational therapists
- British Association for Counselling and Psychotherapy (BACP)
- British Association for Behavioural and Cognitive Psychotherapies (BABCP)
- United Kingdom Council for Psychotherapy (UKCP)
- British Psychoanalytic Council (BPC)
- Association of Child Psychotherapists (ACP)
- Royal College of Psychiatrists (RCPsych)

10. Additionally there are surveys or audits which may provide useful information

- Royal College of Psychiatrists Centre for Quality Improvement – National audit of psychological therapies for anxiety and depression in primary and secondary care (at the time of writing this is at the pilot stage)
- BACP map of practitioner training courses
- The Artemis Trust survey of the provision of Psychological Therapy Services in Primary Care in the UK.

11. An overview of the current collection of data can be seen in tabular format in Appendix 1

12. In summary all these sources of information provide useful and often differing information. However there is no one place where all of the data is available in a consistent way. As a result of this, difficulties are experienced when trying to source workforce data about those delivering psychological therapy. One step forward is the current recommendation that staff who have been trained as High Intensity Therapists or Psychological Wellbeing Practitioners (PWPs) can be identified by specific codes in the electronic staff record. If this information is to be of more use in the future a working group to agree how data is collected across all organisations would need to be established.

Section 3 – The Workforce in Improving Access to Psychological Therapy (IAPT) Services

Year 1 IAPT Workforce

13. In year 1 the IAPT workforce consisted of two main groups of staff – those delivering low intensity interventions – known as Psychological Wellbeing Practitioners (PWP, formerly Low Intensity Workers) and those delivering high intensity interventions some of whom retained previous professional training titles e.g. clinical psychologist, known as High Intensity Therapists.

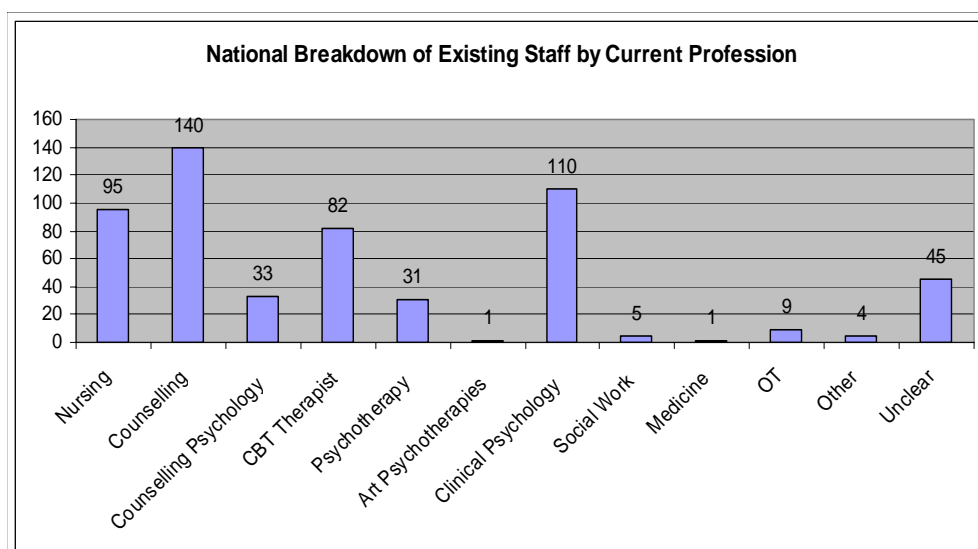
14. Each of these groups of staff were recruited into IAPT services. Some as practitioners who already have the skills, competency and expertise to deliver either low or high intensity interventions for mild to moderate anxiety and depression. There was an expectation that this would be one third of the total workforce and they may already have been employed in emerging IAPT services, and were known as the “existing workforce”. The others were recruited as trainees many of whom were recruited from the existing NHS workforce, or from other employers providing psychological therapy services.

15. Trainees attended a one year post graduate certificate training programme which had been specifically designed with a nationally agreed curriculum for each of the two groups of staff. For PWP this post graduate certificate course equipped trainees to carry out initial assessments, develop formulations and deliver a variety of low intensity interventions; much of this work is carried out on the telephone. High intensity trainees attended a post graduate diploma course which equipped trainees to deliver a range of CBT interventions for depression and anxiety conditions. An integral part of the training, for both groups, was linking the training to service provision and working under supervision in IAPT services.

Recruitment profiles

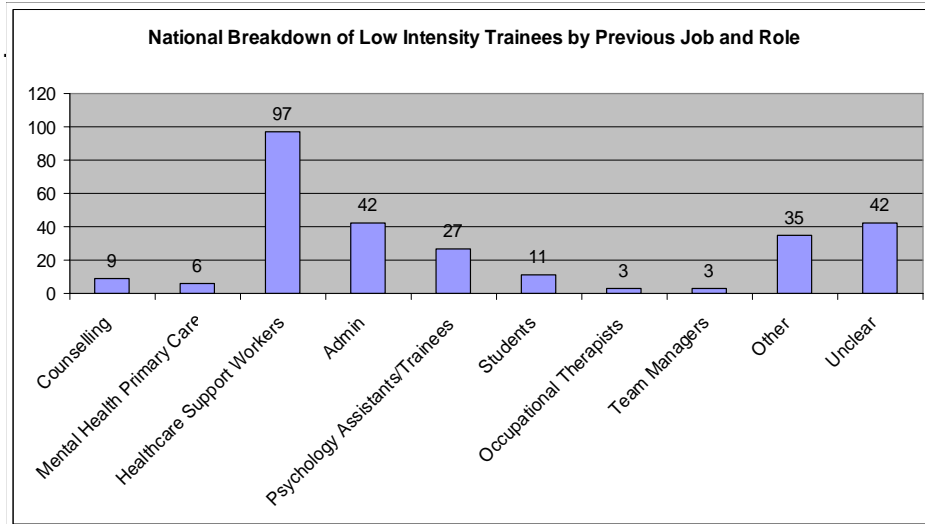
16. The development of the new psychological therapy IAPT service provided workforce challenges, in as much that some staff would need to be drawn from key positions in other services. Recruitment data from year 1 provides some insight into what actually happened and provides information for planning future years. Figure 1 below shows the existing workforce i.e. those who already had the skills, competency and expertise to deliver high intensity interventions and made up approximately a third of the staff. Four major groups made up this workforce counsellors (n = 140), clinical psychologists (n = 110), nurses (n = 95) and CBT therapists (n= 82).

Fig 1 Existing Staff by Profession



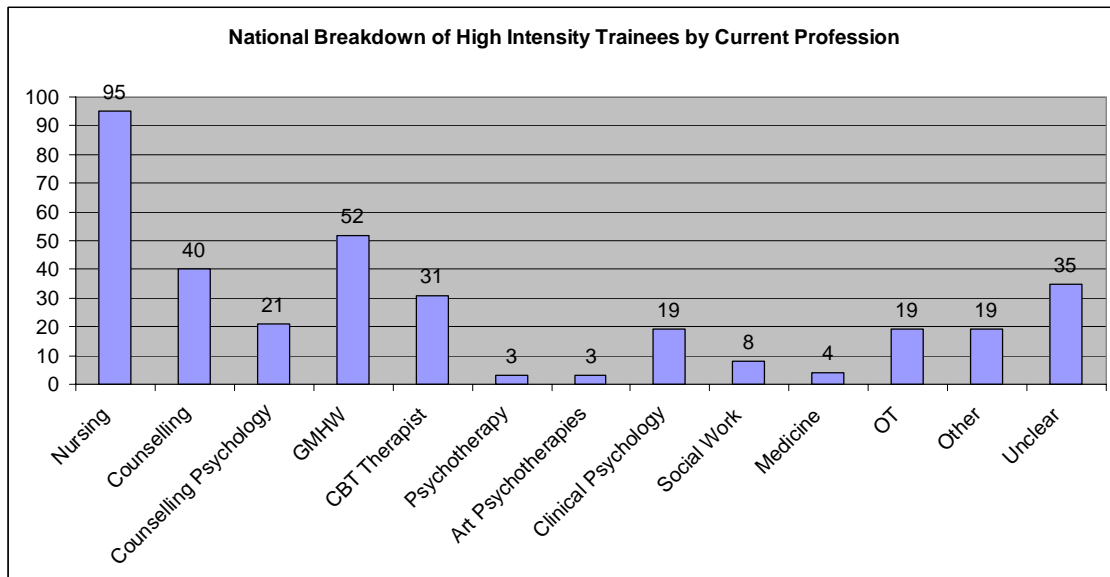
17. The recruitment of trainees into PWP posts attracted staff from a range of backgrounds as shown in the figure below. The largest numbers of trainees were recruited from Healthcare Support Work (n=97), followed by people from administrative jobs (n=42). It is interesting to note that there were 9 people from a counselling background who took up this route to enter the IAPT workforce.

Figure 2 Previous Job / Role of Psychological Wellbeing Practitioner Trainees



18. High Intensity trainees were drawn mainly from those with a nursing background (n=95) followed by graduate mental health workers (n=52) and those from a counselling background (n=40)

Figure 3 Previous Job / Role of High Intensity Trainees



19. This data gives an overarching national perspective however the data is not consistent across each of the Strategic Health Authorities (SHAs) as different approaches were taken. For example in both London and Yorkshire and Humber SHAs only 1 counsellor was taken on as a trainee. Clinical psychologists only became trainees in the East of England, London and the South West. The table

below shows the regional variation however the data is not complete and should therefore be viewed with some caution.

Table 1 Professional Background of High Intensity Trainees by Region

	Nursing	Counselling	Counselling Psychology	GMHW	CBT Therapist	Psychotherapy	Clinical Psychology
East Midlands	9	4	0	9	0	0	0
East of England	23	4	2	0	3	0	2
London	9	1	11	13	1	1	13
North West	20	5	2	8	10	2	0
South West	10	19	4	9	2	0	4
West Midlands	2	9	0	10	1	0	0
Yorks & Humber	9	1	0	1	14	0	0
South Central	No available data						
South East Coast	11	2	0	0	0	0	0
North East	2	4	2	2	0	0	0
Total	95	40	21	52	31	3	19

20. These regional differences will be interesting to follow as the programme develops in terms of assessing if there are differences in the quality of the newly trained staff depending on their previous backgrounds, the knock on effects of drawing staff from other services and the availability of staff for training in the future as the supply from some groups may diminish.

21. As IAPT is based in primary care it is interesting to compare it with other available data for psychological therapy services in primary / community care. Data from the Artemis Survey (where 27% of respondents were from the voluntary sector) reveals that 78% of respondents employed counsellors and /or psychotherapists and 66% employed psychologists (this includes clinical, counselling, assistant and GMHW). In addition 30% reported that staff included voluntary or unpaid counsellors which are not included in the new IAPT services. For 25% of these services there were training placements available.

Demographic data

22. The gender split in the new IAPT services is similar to that of what is found in NHS services and in the membership of counselling and psychotherapy associations, with a ratio of around four females to every male. In terms of the age profile in IAPT, there is a very even spread of people in their 20s, 30s and 40s. However, the people in their 20s are far more likely to be found in low intensity areas with those in their 30s and 40s much more common in high intensity areas. People who are 50 or older make up just 18% of the workforce.

23. The IAPT age profile varies from what is seen in the traditional counselling and psychotherapy professional bodies in that the IAPT workforce has a younger profile. It could be argued that this could mean that we are currently developing a workforce who have many years of work in front of them and we could have a sustainable service into the future. On the other hand we may not have the expertise which comes with years of experience.

24. As IAPT is an England only initiative, it is not therefore surprising to find that the majority of the workforce identified themselves as English or British, with 6% from other nationalities. The data revealed that 85% of the workforce stated they were white, with the next highest number for ethnicity being Asian or Asian British at 4%. All other ethnic groups account for 3% of the workforce. In developing an IAPT workforce it is important to ensure the demographic details reflect the local demographic profile and PCTs should be mindful of this in their recruitment processes.

Section 4 Training

25. The workstream accessed data on existing traditional psychological therapy training courses for 476 courses in England. This data for counselling and psychotherapy was first collected in a 2005 in a project on counselling and psychotherapy funded by the Department of Health and carried out by BACP and UKCP.. This survey which included 24 counselling and psychotherapy professional associations found that only

21% of respondents worked in health. Of those working in health 54% held a university qualification. It will be interesting to note if this changes with time as counsellors and psychotherapists enter the mainly health service based IAPT workforce.

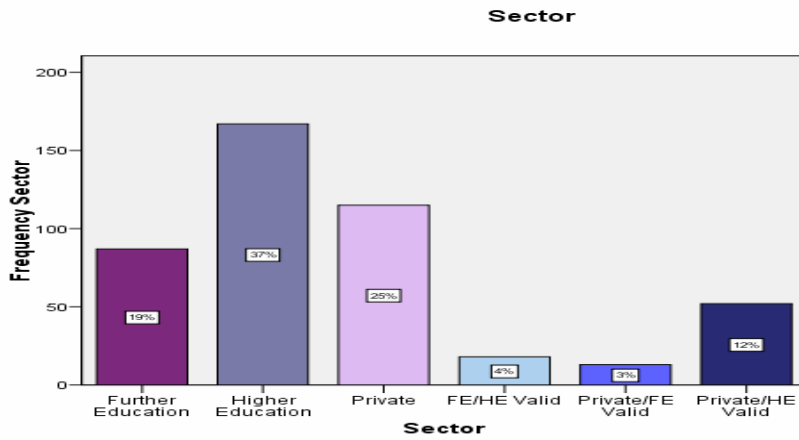
26. Since the initial survey BACP has carried out an annual update. For the purposes of this workstream, this was extended to include clinical and counselling psychology training courses and IAPT training courses. The training information has been collected using a variety of sources. Initially the process began by using information that was available to BACP, for example, Training in Counselling and Psychotherapy Directory (an annual BACP publication) and asking accredited trainers where they work. This was then followed up by extensive internet searching using professional body websites and search engines.

27. The 476 courses train people for work as clinical and counselling psychologists, counsellors and psychotherapists. Data on social work, occupational therapy, undergraduate psychology or nurse training courses was not collected as the aim of these training courses is not to produce competent psychological therapists. A calculation has been made of the potential number of new entrants to the field each year which is tentatively suggested to be around 16 people from each course, giving a total of around 7,000. It should be kept in mind that not all graduates will seek to find employment as psychological therapists.

28. The 476 training courses comprise 47% counselling, 23% psychotherapy and 9% clinical and counselling psychology, it is not immediately obvious how the remaining courses would wish to classify themselves or they may be a combination of more than one area. The Royal College of Psychiatrists' training which leads to a certificate on completion of training in psychotherapy is not included.

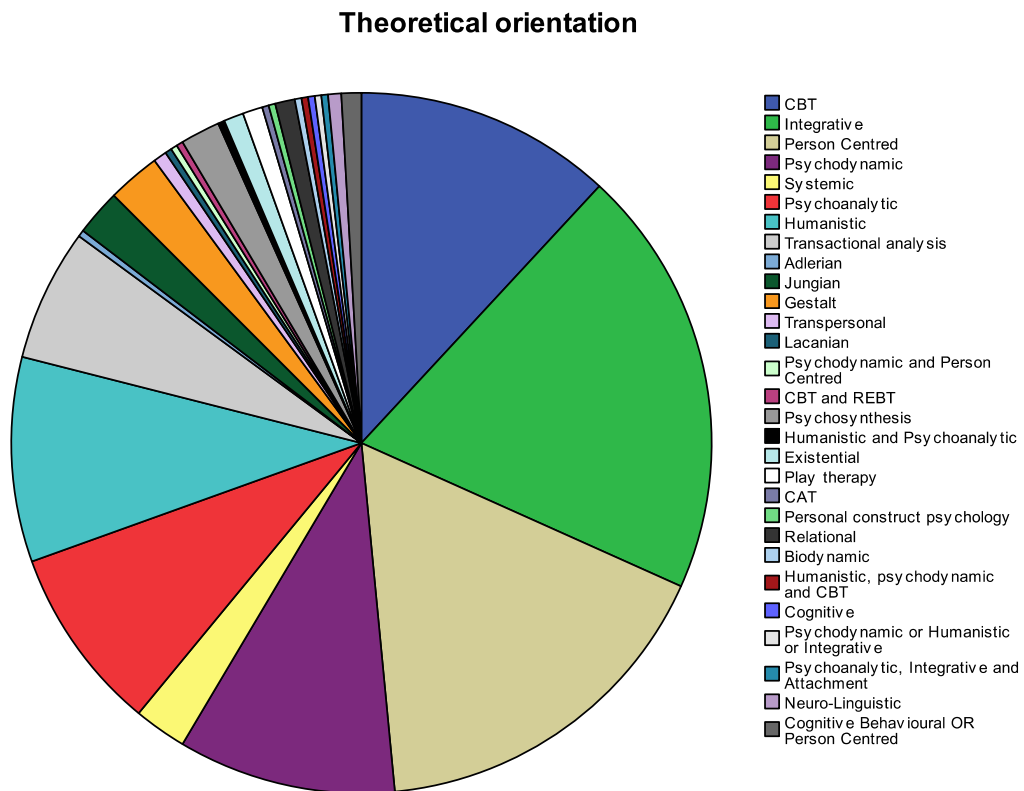
29. There is wide array of training courses available. Qualifications can range from Diploma through to Doctorates. Counselling and psychotherapy training is sometimes also delivered in the private sector where training organisations do not have any external validation for their courses. Figure 4 below illustrates the sector in which the psychological therapy training is being delivered

Figure 4 Sectors Delivering Training Courses



30. A wide range of theoretical perspectives are present in the trainings for psychological therapists. Estimates suggest that there are hundreds of different theoretical perspectives. The most commonly taught approaches are integrative, (the integrative approach may integrate several theories, or have an integrative theoretical model, or an integrative philosophy) person centred, cognitive behavioural and psychodynamic. This range of perspectives is seen in the figure below.

Figure 5 Range of theoretical perspectives taught on psychological therapy training courses



Distribution of Training

31. The geographical spread of current courses is not consistent across England. For the most part the major urban areas appear to be where the greatest supply of training is available. Not surprisingly this reflects the areas where there is highest incidence of psychiatric morbidity and therefore the likelihood of need for service provision. Unfortunately not all areas with high incidence of psychiatric morbidity are well served the most noticeable example being the North East. This availability of current training suggests that for many urban areas there should be staff available to provide a source for High Intensity trainees. The picture may be more problematic in rural areas where large geographical areas may have few courses, the South West of England being a good example. IAPT commissioners and service providers should bear this in mind when trying to source staff for the new services.

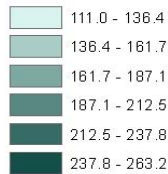
32. On the whole counselling, clinical psychology and the newly developing IAPT training courses are well distributed throughout all Strategic Health Authorities, but there are relatively few psychotherapy training courses outside of major urban areas and the majority of psychotherapy courses are in London. This information is shown in the map below.

All Training Course Locations against Any Neurotic Disorder per 1000K Pop by PCT

Training Course Location

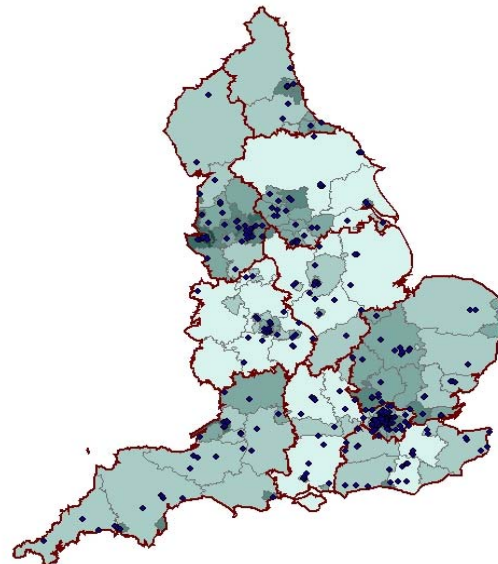
- All Training Course Locations

Any Neurotic Disorder per 100k Pop Rate1000k



SHA Boundaries

- SHA Boundaries



Based on Ordnance Survey Material (c) Crown Copyright. All rights reserved. DH 100020290 2007

33. If comprehensive access to courses is required in the future, innovative solutions rather than just providing more courses will be required. Some examples of what could happen include more use of e – learning, distance learning, different styles of delivery e.g. taught aspects over one week or week-end rather than a once per week delivery modular based training.

34. Some conclusions can be drawn from this data. On the whole there should be enough psychological therapists who would be eligible to become High Intensity trainees in the future. Many of these potential trainees will not have undertaken an initial training in CBT but many will have undertaken continuing professional development (CPD) in CBT and will have considerable experience of working with clients with anxiety and depression.

- There should also be a supply of counsellors and psychotherapists who would be suitably trained to take on the NICE recommended counselling and couples therapy interventions and brief psychoanalytic, with relevant induction opportunities.
- There will be availability across all geographical areas of Clinical Psychologists who could contribute to the IAPT services.
- A notable exception is the availability of those who have trained in Interpersonal Therapy and solutions to meet this current gap are currently being explored with SHAs to develop a critical mass of supervision and practitioners.

Section 5 Workforce and Training Requirements for the Future

35. As the implementation of IAPT continues there will be a need to consider several ongoing inter-relating factors.

Existing Staff

36. The existing staff for year 1 were drawn mainly from the nursing, counselling, CBT therapy and clinical psychology professions. The supply of skilled psychological therapists drawn from nursing, CBT therapists and clinical psychology is likely to reduce as there will be relatively small replacement of these individuals. If current clinical psychology courses ensure the full range of CBT competencies are included in the doctoral programme, this will help to meet some of this potential gap. There may be some counsellors, counselling psychologists and IAPT High Intensity Staff who were trained in previous years available to become the “existing staff” for new services but they may have training needs in the short term future whilst the IAPT programme establishes itself.

Psychological Wellbeing Practitioner Trainees

37. In year 1 the supply of this workforce has mainly come from existing healthcare support workers. This role offers career opportunities for people in the current support roles, but needs to be opened up more to people from local communities in order to develop representativeness. Furthermore, psychology graduates are more likely to want to move on from the role, probably into High Intensity or other psychological training – this is an expensive use of PWP training. It is important to recruit carefully and more to trainee posts, ensure non graduate entry routes are available at all higher education institutions and promote trainee PWP roles to provide career development. If this trend continues it may have an adverse effect on other parts of the health service.

High Intensity Trainees

38. The highest numbers of these trainees were from nursing (n = 95) and GMHW (n=52). The supply from both of these groups is likely to reduce over time, as there will be little replacement of suitably trained nurses and GMHWs are likely to deplete as nationally there are few training opportunities for this workforce. In year 2 of roll out clinical psychologists will increase in number, but in the longer term their training should become embedded within clinical psychology training. Counsellors are to be a possible supply source for this training opportunity.

Other Evidence Based Approaches

39. The widening of IAPT to deliver other evidence based approaches will require the provision of additional training. Some staff will need to deliver NICE recommended counselling and couples therapy. Staff recruited to deliver these approaches should have a post graduate qualification in counselling or psychotherapy and/or be accredited or registered with BACP, UKCP or CPC. The availability of current courses should meet demand. Interpersonal Therapy practitioners will also be required and a training programme has been proposed to address this.

Supervision

40. The national IAPT team is currently working on recommendations regarding supervision training for PWPs and High Intensity practitioners, to be published winter 2009/10.

Staff Turnover

41. As the programme continues there will be a natural turnover of staff. IAPT sites will have been able to gain access to initial training programmes however access to this type of training on an ongoing basis should be planned for both in terms of managing turnover and replacements, extending IAPT to all PCTs and enabling wider groups of staff, working with a broader range of clients to access training.

Section 6 Guidance and Recommendations

Commissioners of Services

42. Commissioners of future services need to take into account the staff that are required to deliver the range of NICE approved therapies. At the National Savoy Conference October 2008 it was agreed that this wider range of staff should be included in future services. To date the guidance has indicated that a team of approximately 40 staff would be required for a population of 250,000. In Year 1 of the IAPT programme. These staff are those who are either trained to deliver Cognitive Behavioural Therapy or have experience and training in delivering Low Intensity Interventions “existing staff” or are undertaking training as either High Intensity Therapists or PWPs (“IAPT trainees”). Commissioners of Services need to be aware of the potential difficulty in

- Sourcing those who can be deemed to have the skills to be deemed as the “existing staff”
- Sourcing potential trainees – especially in areas where there are few existing counselling and psychotherapy training courses where potential trainees for IAPT could have obtained psychological therapy skills
- The possible gaps in other services as staff leave them to become part of the new IAPT services
- Training staff to become IPT therapists.
- Increasing the numbers above 40 people for a population of 250,000 people to include the wider range of therapies.

43. Commissioners of services should consider their current commissioning arrangements and assess if contracts are already in place to deliver the range of services by appropriately trained individuals with supervision in place.

44. Service Commissioners will need to be aware that IAPT focuses on those with mild to moderate anxiety and depression. Their commissioning arrangements however should cover the whole range of required psychological interventions across all care groups.

Service Providers

45. Service providers will need to be aware of the same principles as those for commissioners; however additionally, they will need to ensure that staff have Continuing Professional Development (CPD) opportunities to keep them up to date with current levels of recommendations for practice. Where new IAPT services are being established service providers may need to provide additional training so that there are skilled therapists to make up the numbers of “existing staff”

Education Commissioners

46. Traditionally, counselling and psychotherapy training has not been commissioned by SHAs. This has been due to the fact that many of these staff have worked independently and organised their own training programmes. There is already in existence a large workforce which has trained by this means, but the training standards and levels are not consistent across the UK. There are also some evidence based psychological interventions for which there is little training in the UK, for example Interpersonal Therapy. With the introduction of specifically named counselling and psychotherapy interventions in the NICE guidelines there is a need to ensure that those delivering these services meet the required standards, have good supervision arrangements in place and are kept up to date with current practice. As a result of this commissioners of education and training should consider what is already available in their own region and where necessary build upon this.

47. Of the 476 courses that were identified as part of the mapping exercise, 181 led to postgraduate level qualifications. Almost half of the courses are within the South East corner of England within the London, South Central and South East Coast SHA's. There is limited provision in some areas particularly the North East SHA and the northern part of the North West SHA.

48. Each SHA should consider what is already in place and how accessible it is for those working across the region. Education and Training commissioners also need to consider their role in any CPD arrangements for these staff.

49. In addition it is their responsibility to commission some of the less available training programmes such as IPT. At present national work is in progress so that the required training for IPT meets the standards and there is a solution as to how to access this training.

50. Commissioners of clinical psychology training should consider the inclusion of the full range of IAPT CBT competencies in their current course provision

Service and Education Providers and Education Commissioners in the recruitment process

51. Service providers, when recruiting staff for IAPT sites must continue to ensure that the staff who make up the existing third meet the required level of competency for CBT. New trainees should be recruited in conjunction with Education providers. Steps should be taken to use this opportunity to widen the workforce and provide opportunities for staff to enter the psychological therapy workforce from backgrounds which would not have been previously possible. Guidance is available how those without traditional academic qualifications could become PWPs and how those without a traditional professional background could become a high intensity practitioner by using the Knowledge Skills and Attitudes framework (KSA).

Section 7 Conclusions

52. The availability of a competent psychological therapy workforce is likely to remain a challenge for those involved in this field of work. This workstream has however laid out the many challenges and suggested some possible solutions. One of the confounding factors is that there is a continual changing environment in terms of: the expectations of the skills and competency of the workforce, as new evidence based therapies are recognised; the numbers of staff who are available to be trained; the numbers of staff available who have been trained and the types of updates that they may require to keep them up to date. All of this points to the need to have good workforce data available so that both short and long term planning can take place at local, regional and national levels. This report outlines some of the data already available both in terms of staff and training, but should be accessed and used to develop workforce plans for psychological therapies.

53. The IAPT programme has already provided advice on how to overcome potential barriers e.g. on how to be more inclusive in who can train to become a psychological therapist, how to assess if staff have the correct level of competency and which psychological interventions should be included. Further work is required to ensure training is accessible in more flexible formats and that the workforce who are trained are able to deliver interventions to all parts of the population including those who may in the past been excluded e.g. those from vulnerable groups small ethnic minorities and those with specific disabilities.

Appendix 1 Summary of workforce Data collection systems

Source of information	What it provides	Limitations	Comments
Electronic Staff Record	<p>Workforce data in the NHS through the use of occupational codes for each professional staff group. It allows us to identify some psychological therapists:</p> <ul style="list-style-type: none"> • Medical psychotherapists • Clinical psychologists • Art therapists • Mental health nurses • Community psychiatric nurses 	<ul style="list-style-type: none"> - Only relates to the NHS - It does not provide information on the amount of time spent delivering psychological therapy - For mental health nurses and CPN's there is no indication of their level of training in the psychological therapies - This is a new process and experience thus far suggests the data can be incomplete and inaccurate 	<p>There is not currently a code which identifies those working in the IAPT programme. For the future it is planned that the numbers of high intensity and psychological wellbeing practitioners will be identified.</p>
NHS Mapping Exercise (formerly Durham database)	<p>Information on staff and where they work in the NHS</p>	<ul style="list-style-type: none"> - Not all localities participate in the process - Only relates to the NHS - Does not give information on the time spent delivering psychological therapy - Does not give information on specific training in psychological therapy 	<p>Changes would be required to collect useful data regarding psychological therapists</p>
Health Professions Council Register	<p>Is a register giving the name and status (whether there are</p>	<ul style="list-style-type: none"> - Does not give information on the time spent 	<p>It is anticipated that counsellors and</p>

	<p>any outstanding Fitness to Practice proceedings) of individuals in the fields of:</p> <ul style="list-style-type: none"> • Art therapists • Drama therapists • Music therapists • Practitioner psychologists • Occupational therapists 	<p>delivering psychological therapy</p> <ul style="list-style-type: none"> - Does not give information on where the registrant is working - Does not give information on specific training in psychological therapy 	<p>psychotherapists will become HPC registered professionals in 2011.</p>
Royal College of Psychiatrists	<p>Carries out a survey every two years. They provide a list of consultant psychiatrists and trainees in psychotherapy</p>		
British Association for and Counselling Psychotherapy	<p>A register of accredited counsellors / psychotherapists. There is also a specific membership category for those that have completed a relevant practitioner training course. Members are working in a wide variety of occupational settings A register of accredited training courses and counselling / psychotherapy services</p>	<ul style="list-style-type: none"> - Voluntary registration - Does not show how much time spent working as a counsellor / psychotherapist 	<p>The register will include staff working in a variety of settings, including the NHS.</p>
British Association for Behavioural and Cognitive Psychotherapies	<p>A register of accredited cognitive behavioural therapists There is also a list of training courses accredited by them</p>	<ul style="list-style-type: none"> - Voluntary registration - Does not show how much time spent delivering CBT 	<p>The register will include staff working in a variety of settings, including the NHS.</p>

	and a list of CBT trainings that they are aware of		
United Kingdom Council for Psychotherapy	A register of psychotherapists and then a separate register of psychotherapeutic counsellors. There are a series of member organisations many of whom deliver UKCP approved training courses	<ul style="list-style-type: none"> - Voluntary registration - Does not show how much time spent working as a counsellor / psychotherapist 	The register will include staff working in a variety of settings, including the NHS. The member organisations put forward individuals for registration with UKCP

Appendix2 - Group Membership

- Sally Aldridge (Co Chair)
- Ruth Duffy (Co Chair)
- David Daniel
- Giles Glover
- Val Huet
- Nick Turner
- Nicole Gideon
- Stephen Kellett
- Marcus Evans
- Judith Lask
- Catriona Walker
- Ian Simpson
- Rebecca Grace
- Maria Eyres
- James Atricham