PPN NORTH WEST Psychological Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELL-BEING

What Factors Impact on the Retention of Psychological Wellbeing Practitioners?

Report of a Survey into Second Destination & Retention of PWPs

March 2018

Liz Kell, Senior Lecturer in Counselling and Psychological Therapies, Course Lead Post Graduate Certificate in Primary Care Mental Health Practice, University of Central Lancashire.

Clare Baguley, Programme Manager, Psychological Professions Network, Health Education England North West

PPN NORTH WEST Psychological Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELL-BEING

Executive Summary

This report aims to describe the factors that impact on the retention rates of Psychological Wellbeing Practitioners (PWPs) and to identify the range of second destination roles that PWPs move onto post-qualification. It explores the self-reported reasons that PWPs are likely to leave their post and the range of issues which positively & negatively contribute to the retention rates of PWPs; finally it outlines a number of key recommendations that could positively impact on the retention of the PWP workforce through engagement with the PWP workforce and wider stakeholders.

Engagement with the PWP workforce was through an online survey conducted in August 2017, which was completed by 630 PWPs and ex-PWPs, and 173 stakeholders which included: 61 Service managers, 42 Supervisors, 17 Training Providers, 4 CCG Commissioners and 49 other IAPT team members including Clinical Leads, Counsellors, and CBT therapists.

The second destination of 70% of the PWP respondents was a High Intensity Therapist role, with a further 10% moving on to Clinical Psychology, with 41% of respondents citing Career Progression as their reason for leaving the role. Thematic analysis of the responses to improve the retention of the workforce were based around 3 main themes:

The PWP role particularly in relation to salary, accreditation/regulation, the diversity of the workforce, the PWP caseload, autonomy and flexibility within the role, fidelity to the model, CPD and training and job security

PWP Career Progression including options to progress within the role, access to CPD and direct or combined CBT training routes

IAPT Team/Services including wellbeing of the workforce, team systems including IT and supervision and admin processes, respect and value of the role and working relationships with other professionals

The report makes 9 key recommendations:

- Improved understanding of the impacts on the workforce of the impact of short-term temporary contracts on retention and sustainability of the PWP role.
- Improved understanding and monitoring of the impact and management of the needs of complex patients on patient flow and understood within the wider context of the impact on workforce retention and wellbeing.

- Consistent standards for PWP supervision in terms of type, frequency and management of complex patients' needs included into the specification for IAPT services.
- Access to leadership training and mentorship schemes for IAPT service managers.
- Widening of routes for recruitment of PWPs into training posts without the standard pre-requisite degree, with a view to paying attention to issues of Widening Participation.
- Equitable standards and systems for access to and funding of Continuing Professional Development (CPD) / upskilling across all NHS commissioned IAPT services.
- National and regional high-quality promotion of the PWP role and career opportunities.
- Systematic examination of the costs and benefits of Regulation of PWP as a profession, with reference to similar roles within the NHS where regulation has been achieved, for example in the Healthcare Scientist workforce.
- A national mechanism for monitoring and review of the application of PWP skills and competencies against Agenda for Change banding – linked to accreditation or regulatory framework

PPN NORTH WEST Psychological Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELL-BEING

PWP Second Destination and Retention Report

Introduction

The Psychological Professions Network was commissioned by Health Education England (HEE) in April 2017 to undertake an investigation of the second destination and retention of the Psychological Wellbeing Practitioner (PWP) workforce. This work was commissioned in recognition of the high turnover rate of 25% for PWPs identified in the Adult IAPT Workforce Census Report (2015-2016), with a range of 7-51% in different parts of the country. The brief was to better understand the retention rate of PWPs following qualification and the different destination of PWPs when they choose to leave their role, and to explore the reasons PWPs leave the posts and different factors which contribute to the retention rates of PWPs, and finally to identify key recommendations to improve the retention of the PWP workforce, which is an essential element of the IAPT service delivery model and integral to the success of the workforce plan laid out in the 5 Year Forward View for Mental Health, particularly in relation to the target to increase the access rates in IAPT services from 15%-25% by 2020/21.

This work follows an exploratory audit undertaken by HEE of the retention of the PWP workforce which recommended a more detailed exploration of the issue, particularly in relation to the large variation of retention in different parts of England.

Methodology

The project lead undertook a review of available data in relation to the retention rate of PWPs and their second destination following completion of training. There are inconsistencies in this data due to current reporting systems, but a broad overview of available information is presented.

A survey was devised for both the existing and previous PWP workforce and key stakeholders of the PWP workforce. The surveys were shared nationally through several different established networks and a snowball technique was undertaken to achieve a high response rate. The surveys were carried out in August 2017, 630 PWPs and ex-PWPs completed the survey and 173 stakeholders which included: 61 Service managers, 42 Supervisors, 17 Training Providers, 4 CCG Commissioners and 49 other IAPT team members including Clinical Leads, Counsellors, and CBT therapists.

Survey responses have been analysed by the project lead using a thematic analysis and grounded theory approach. It is acknowledged that some bias could be present due to the voluntary nature of the survey approach and the information based on individual experiences, but the high response rate will help to reduce the impact of any potential bias in this context. The use of the thematic analysis approach has helped to provide impartiality and rigour when presenting the views expressed.

Key Findings

Continued investment has been made into IAPT trainees year on year since 2011 however the rate at which LETBs are increasing their number of qualified PWPs varies (HEE/ESR 2018). Local workforce intelligence through the PWP Professional Network suggests that PWP retention rates following qualification is a key factor. This is further supported by data in relation to the workforce plan for 2016-2017 which highlights an 11% variance in numbers for the PWP workforce, and where numbers have increased, this may not be at the level required to maintain the workforce.

Survey Results

The results from the survey provide further detail to some of this information. From the PWP survey data only, for the people who have left the role the main destinations are:

High Intensity	68%
Clinical Psychology	10%
Management	8%
Other 'core profession' e.g. OT	2%
Outside Health and Social Care	2%
Other	10%

This data demonstrates the very high percentage of PWPs moving on to High Intensity training, and further highlights the very likely continuation of this pattern where more High Intensity training places become available as part of continued IAPT expansion, demonstrating a significant risk for the PWP workforce levels if retention rates and recruited numbers are not increased to counter-balance this workforce shift.

National data obtained demonstrates only a very small number of PWPs training at undergraduate level at just 3% in both years:

	2014-2015	2015-2016
Undergraduate	9	13
Postgraduate	280	385
Total	289	398

This was further supported by the results of the PWP survey which demonstrated 83% trained at a post graduate level with only 9% at undergraduate, further highlighting a very small uptake in the undergraduate route for this role despite its increasing availability for more than 5 years so far. This is a slightly higher rate than that recorded in the national data, but also potentially spans a larger period, and is still much lower than was envisaged when the undergraduate route was introduced. Within the survey there were a further 8% who referred to alternative training such as 'in-house only', however, there was limited detail to better understand the content and structure of this and further exploration as to the timescales and quality of this would need to be further explored.

48% of PWPs who completed the survey started in the role on Fixed Term contracts, with a large majority of these then moving to a permanent contract once qualified, although there was still a small percentage who remained on fixed term contracts, and this was more common where people were employed within the third sector where service funding issues were cited as impacting on job security. This factor is further explored within the Thematic Analysis below.

For the PWP survey respondents who were still working in the role, there was a good range of diversity in their time in the role suggesting a broad spread of experience which further validates the confidence in response rates:

Less than 12 months	24%
1-2 years	25%
2-4 years	22%
5+ years	17%

The survey also asked people about their intentions when starting as a trainee PWP to try to understand attitudes to the PWP role in relation to retention rates:

Just Training Year	2%
1-2 years	35%
Up to 4 years	18%
Over 5 years	2%
Indefinitely	6%
No fixed plan when started	37%

These results clearly highlight that, currently, the majority of PWPs see the role as a short term one even before starting, although the highest individual response rate stated that they had no fixed plan at the start which suggests there are potential opportunities to influence and change the current retention rates of PWPs.

Reasons for leaving the role were identified and weighted in terms of importance in both the PWP and the wider Stakeholder surveys with overall similar views, although the percentage of importance given to these was different across the two groups (NB the survey enabled people to provide more than one reason and rate these in order of importance):

	PWPs	**Stakeholders**
Career Progression	41%	29%
Lack of opportunities within role	24%	18%
Financial (higher salary)	22%	16%
Unhappy in job	19.5%	8%
Burnout	19%	21%
Job not as expected	16%	8%

Most useful previous experiences prior to working in the PWP role was also explored in terms of better understanding what skills may help people within the role, which are particularly useful

considerations in relation to the recruitment of the PWP workforce, as well as in relation to factors which may help people continue in the role. Again, these were explored with both the PWP and wider Stakeholder surveys with overall similar views, although again some differences in the importance given to these different factors across the two groups (NB the survey enabled people to provide more than one reason and rate these in order of importance):

	PWPs	**Stakeholders**
Experience of working with people with Common Mental Health Problems	21%	28%
Experience of working with people in a therapeutic role	19%	23%
Organisational/administrative skills	14%	19%
Experience of working in the NHS	9%	8%
Psychology Degree	13%	7%
Experience of working with people with SMI	11%	5%
Working in the Voluntary/3rd Sector	8%	4%

It is clear from these results that, for both groups, it is experience of working with people, and ideally experience within a therapeutic role which is seen as most valuable, and neither group rated a psychology degree as highly, suggesting there may be some opportunities to re-consider value given to these different factors when recruiting trainee PWPs.

Other useful skills and experiences were also highlighted:

PWP Survey	**Stakeholder Survey**
Personal experience of mental health problems	Communication skills
Telephone skills experience	'Working with people'
Life experience	Interpersonal skills
Teaching experience	Resilience
Admin experience within IAPT and other mental health services	Working in target/high volume environments

Suggestions to Improve the Retention of the PWP Workforce

Both surveys sought to identify specific suggestions and recommendations to improve the retention of the PWP workforce and through a process of thematic analysis several key themes were identified:

Theme 1: the PWP role

- Higher salary to reflect work undertaken
- Accreditation/regulation of the role
- To recruit a broader range of individuals into role and ensure quality experience of trainees
- Caseload and variety of patient work
- Autonomy and flexibility within the role
- Fidelity to the PWP model
- CPD and training
- Job security

Theme 2: PWP Career Progression

- Progression options within the PWP role
- Minimum requirements of length in post
- Access to CPD and training
- Direct or combined CBT training route

Theme 3: IAPT Team/Services

- Wellbeing of the workforce
- Increased support in relation to management, supervision and admin duties
- Improved physical conditions (including IT systems)
- More respect and value of the role
- Improved working relationships with other professionals and services
- Raise the profile of the role

Discussion of Findings

There was a large quantity of qualitative data gathered through the surveys undertaken and the thematic analysis helped identify key themes within this. These themes were identified through specific questions from both the PWP workforce and the wider stakeholders survey for recommendations to improve the retention of the PWP workforce. Several factors arose within these themes which are discussed below. Through the discussion of findings, some quotes from respondents are used to illustrate these factors in the respondent's own words.

Theme 1: The PWP Role

a) Salary to reflect the work undertaken by PWPs

The most consistent factor raised within the theme of the PWP role was in relation to the need for a higher salary to better reflect the volume and complexity of the work undertaken. This factor was raised by 44% of respondents within the PWP survey, with most respondents suggesting that the PWP role should be at AfC Band 6. This also made up 27% of respondents from the stakeholder survey. The comments included suggestions that this was more reflective of the level of training required to undertake the work *"to indicate the importance and intensity of the role",* and also in relation to the comparison with the High Intensity Therapist role, which was described by many respondents as different rather than more skilled and who felt that the difference in salary reflected the idea that the PWP role was "*seen as less".* There were also a significant number of comments in relation to the requirement for a salary which would enable PWPs to live and work effectively within this role in the current economic climate with one respondent stating, *"the current salary is not a cost of living salary – I currently live in poverty conditions and cannot afford to eat properly one week of the month"*.

Suggestions in relation to higher salary also highlighted significant disparity between PWPs in different organisations, particularly the limited access to increments and pay progression within third sector organisations, and included suggestions that the issues in relation to a higher salary were about

more opportunities to progress through increments and into AfC Band 6 level of pay to reflect experience and additional training, rather than just an expectation of a higher starting salary.

b) Caseload and variety of patient work and fidelity to the PWP model

63% of PWP comments and 45% of stakeholder comments related broadly to changes within the PWP role, particularly in relation to their caseload numbers, the variety of patient work undertaken and fidelity to the PWP model. There were a wide range of factors explored within this, including less emphasis on PWPs being solely responsible for assessment and triage within the whole service, which was felt to be an increasingly significant part of the PWP role and resulted in PWPs working with a much broader range of complex mental health problems than the original PWP model. This theme of working with people with a broader range of complexity was also highlighted as an issue more broadly, where both PWPs and stakeholders highlighted a change in the expectations of the range of patients PWP were expected to work with, and the lack of training, support and flexibility of approach to enable this work to be clinically safe and effective with one respondent stating that *"step 2 interventions should not be used because wait times are short than for step 3 interventions when it is evident at triage that patient fits criteria for step 3"*. This was also reflected in comments in relation to the need for clear guidelines and consistency in the PWP approach with another respondent suggesting the need for *"Clearer guidelines which are adhered to across the board for what types of difficulties PWPs should work with and what they should not work with. I have been asked to work with people with difficulties which I do not feel highly trained enough to deal with and consequently the client has not recovered, and I have felt deskilled".*

Within this factor there were also a large percentage of respondents making suggestions in relation to caseload size and the emphasis on targets within the PWP role. These made up 49% of PWP comments and 40% of wider stakeholder comments. There were two main threads within this, in terms of the complexity of patients on the PWP caseload and also in relation to the over-emphasis on targets over the quality and content of the interventions provided, with comments including *"the IAPT targets are unachievable and not sustainable with the level of complexity PWPs face on an everyday basis"* and that the targets needed to better reflect the type of patient's on the PWP caseload, for example the "*number of clinical contacts to depend on the severity of the depression and anxiety on PWPs caseload"* and ability to treat the patients as individuals who they can *"make a difference"* with rather than *"encouraged to view them as numbers".*

c) Autonomy and flexibility within the role

This factor was closely linked to the above factor in terms of management of caseload and approaches to patient work, including suggestions that PWPs should have *"more control over their rotas in terms of how to fit all the contacts in, in a way that suits them rather than blanket rota for all"*, and this also fitted in terms of approaches to work, with recognition that some PWPs felt skilled at group work and enjoyed this, while others were more comfortable with one-to-one work and there should be opportunities within services to work to the strengths of individual PWPs rather than expecting all PWPs to undertake the same duties.

This area also highlighted recommendations in relation to more flexible ways of working in both working hours and opportunities for some working from home, as well as in terms of variety of working practice where one service was highlighted as having good retention rates because *"PWPs are allowed time for project work"*. There was also a clear desire for more autonomy in the delivery of self-help interventions and not feeling constrained to a "*script"* in patient work, and to be more *"creative and resourceful"* in the materials utilised with patients.

There were also suggestions in relation to having longer sessions with patients and a larger number of sessions, particularly in relation to the more complex presentations PWPs were now regularly working with to reflect the additional challenge and work required with this patient group compared to the standard 'mild to moderate depression and anxiety' work initially envisaged for PWPs. Further consideration of this in relation to the PWP model is required, with consideration of both the breadth of problems and level of complexity PWPs work with and the evidence base in relation to this.

d) CPD and Training

This was a significant factor in both the PWP survey and wider stakeholder survey in terms of improvements to PWP retention rates with 29% of PWP respondents and 25% of stakeholder respondents referring to this. This factor was in relation to both the importance of the skills development itself, including comments such as "*Support and encouragement should be given to maintain and improve skills and knowledge and learn new ones", "trained to use more interventions", "regular update of clinical skills for whole PWP population", "increase training opportunities to help them feel supported and competent",* and also in relation to having time to access this *"more time for training"*, and that there should be parity with High Intensity CPD and Training *"the training should be managed in the same way as step 3 top-up training", "funding training to accommodate the variety of presentations PWPs are asked to work with".*

e) Recruitment and quality experience of trainee PWPs

From the PWP survey 6% of comments were in relation to the recruitment of PWPs, and a further 13.7% comments from the stakeholder survey. There were several different factors raised within this, including in relation to recruiting a broader range of people into the role. A separate piece of work has also been commissioned by Health Education England regarding Widening Participation of the PWP role and many of the comments raised in this survey are reflected within this report, these include further details in terms of a psychology degree not being an essential criterion, the value of life experience, and the importance of a non-graduate level of entry. This also further supports the results discussed earlier in relation to the most useful previous experiences for undertaking the PWP role. The report into the Widening Participation of the PWP workforce can be accessed here (LINK).

Factors in relation to the experience of trainee PWPs were also raised in relation to the importance of clarity of the job role from the start, and the protection of, and management of expectations of trainees. Different and longer training routes including the establishment of an Apprenticeship route, and the importance of recruiting a higher number of trainees PWPs were also highlighted within this

section. Comments included that the "*the course does not prepare you for the clinical role…because they aren't step 2 clients you're working with"* and the need for *"university staff having more say over what can be done in service"; "if training, only stay within training boundaries – not completing other workforce tasks".*

f) Accreditation/regulation of the role

4% of PWP respondents and 5.3% of stakeholder respondents referred to the challenge of the continued absence of accreditation or regulation of the PWP role and the perceived impact of this in relation to the low retention rates of the workforce. Comments included *"Allow PWPs to register professionally so that at least it feels like there is a safety net", "to be recognised as a trained professional", "make PWP a core profession so it is a widely known and respected profession"*. These statements closely link to other factors identified in Theme 3 in relation to respect and value of the role and will be further explored there.

g) Job security

There was a relatively small percentage of suggestions in relation to this – 1.5% of PWP respondents and 1.3% of stakeholder comments, however, the suggestions that were raised were viewed as important to those individuals in their specific situations, including in relation to employment terms and conditions, and the need for *"standardisation across organisations [in relation to] job role and security"*, including in relation to *"not recruiting people on fixed term contracts",* particularly in the third sector due to service funding issues.

Theme 2: PWP Career Progression

This was another significant theme throughout both surveys with 25% PWP comments and 33% stakeholder comments made in relation to this. There were several factors that ran throughout this theme:

a) Progression options within the PWP role

This was the most important factor identified in relation to PWP career progression raised by 35% of PWP respondents and 60% of wider stakeholder respondents. The ability to progress within the role – rather than always having to move on to a different role to progress – was clearly highlighted as a key factor which would help improve the retention of the PWP workforce. This is part linked with the earlier discussion in relation to a higher salary, in terms of the ability to specialise or undertake further training within the PWP role and receive financial recompense for this, and the need for there to be a broader range of options for what this progression can involve rather than just the currently commonly found Senior PWP role which is mainly in relation to supervision and management responsibilities – *"there should be a clinical progression route and a managerial route"*. Further comments included *"PWP specialist roles, where training and time is given to encourage PWPs to develop knowledge of working with specific presentations and in specific settings".*

b) Minimum requirements for length of time in post before career progression

While there was a lot of focus on the importance of progression within the role there was also focus on progression opportunities into HIT training and there were several different perspectives within this. Most comments suggesting that the minimum of 2 years in the PWP role before being able to

progress to HIT training should be more strictly adhered to, and a small number of comments suggesting this should move to 3 years, and should not be promoted as the expected route e.g. *"I…am not at all keen on the practice in some teams of encouraging anyone with 2 years PWP experience to apply for high intensity roles. The BABCP set the two-year guideline for sound reasons but a lot of PWPs and services treat this as a target to progress by that date. Due to this the PWP role is treated by some services as a HI factory farm and they'll interview very few external candidates for HI roles. The culture is that once you've done your time as a PWP for 2 years then it's time to move up".*

c) Direct or combined CBT training route

However, there were also comments, particularly within the PWP responses, suggesting that the requirement of PWP experience should be a shorter length of time before being able to move on to High Intensity training, and that there should be a more direct or combined CBT training route available for PWPs. This is not in itself a recommendation that would improve the retention of the PWP workforce per se, but clearly highlights that there are several PWPs who see progression to HIT as a natural next step within their career and therefore want some guarantee of their opportunities to do this. This suggests the need to consider whether this is the direction that is accepted as the way forward for the PWP role, as a direct route into High Intensity Training, or whether more focus needs to be given to developing the PWP role as a profession within its own right with clear developments and progression within the role.

There were also some suggestions of the potential to *"merge the roles of PWP and high intensity [therapist] to give people an incentive to make a career out of the role"* and *to "support PWPs in a more rigorous structured way with developing the specified competencies to become HI trainees".* This was also highlighted as being advantageous the patient group who are *"rarely step 2 suitable".* This also linked with earlier discussed suggestions in relation to higher salaries, where a combined role would equate to equal salaries across the two roles.

CPD and training factors which have already been discussed were also raised in relation to the theme of PWP career progression.

Theme 3: IAPT Team/Services

There were a wide range of factors identified within this theme and it is acknowledged that, particularly within this theme, there will be large variation in PWP experience. However, given the large response rate to the surveys, this information is important to be considered and was related to 24% of PWP comments and 17% of stakeholder comments.

"*A change in team perceptions of PWPs – a few years ago I heard that a counsellor thought that all we did was show people self-help books and ask them how they got on. We do an awful lot more than this. Another example is that in some services I have worked in it has felt like I was the lowest ranking*

member of staff as a PWP and like there was an expectation from some high intensity therapists that you were there to get them a coffee or to help them carry their bags. We do a very similar job. We have worked very hard for it just like them. We are not beneath them but sometimes it can feel that way."

Many of the factors within this theme were regarding relationships with other team members and other services and would require a whole service approach to different attitudes and leadership in relation to the PWP role: *"change the way the whole role is viewed by IAPT, it feels like PWP is not respected in its own right".* This is particularly in relation to the need to offer increased support in relation to management, supervision, and administrative duties, respect for and value of the PWP role within teams and with other professionals and services and, within this, improved working relationships with these professionals and services, in part through raising the profile of the role. Suggestions included *"better education of PWP roles for other health professionals – often not recognised as a profession", "less expectation from assessments or more time to complete admin", "involve the staff more in decision making", "supervisors and service leads to have gone through PWP training to gain knowledge of step 2 interventions", "others understanding how hard the role is", "better support e.g. resources, emotional support such as clinical supervision".*

Practical factors were also raised within this theme in relation to improved physical conditions for the PWP workforce including IT systems which support the work, and this linked closely to issues raised regarding the volume of PWP admin duties. Suggestions included *"to have adequate screening booths and rooms to see patients", "permanent desk as hot-desking is not always suitable for the role and intensity needed to achieve expectations when you do not have your paperwork available or printing access", "better working environment – proper equipment, space to work".*

The wellbeing of the workforce was also highlighted as an important factor within this section. A separate piece of work has been undertaken in relation to PWP wellbeing (link) within the North of England PWP group and these factors reflected outcomes from this report.

Recommendations and Next Steps

Recommendations in relation to improving the retention rates of the PWP workforce are drawn largely from the suggestions and recommendations made within the two surveys, and in consideration of the additional information gained from the other survey questions and data considered.

1. PWP Salary and Banding

A large percentage of responses, particularly in terms of suggestions to improve the retention of the workforce, were in relation to PWP salary and banding, however, salary and banding are two separate issues for any workforce, Salaries within the NHS and NHS commissioned services, and wider public services, are a national issue, particularly in relation to being an appropriate living wage, which is clearly a concern for areas of the workforce highlighted within this report, but it is outside the scope of this report to address this.

Regarding the banding of any professional role setting a clear standard in relation to the skills and training required to undertake the job, therefore must be considered within these terms for the PWP role as workforce development continues across the NHS and NHS commissioned services. What is clearly important from the responses received is that National Standards for PWP skills and competencies need to be clearly articulated against banding and adhered to across the country. In the absence of a regulatory body there needs to be a national process in place which monitors development of the PWP role and hold regular review of application of the standard across all services where PWPs are employed.

Recommendation 1: • A national mechanism for monitoring and review of the application of PWP skills and competencies against Agenda for Change banding – linked to accreditation or regulatory framework

2. PWP Job Security and Contracts

This was an area that linked to the concerns about banding and salaries but was also clearly a separate issue that is causing many difficulties for the PWP workforce. These issues need to be raised with commissioners in terms of their considerations of the impact on the workforce retention of the PWP workforce due to the significant use of fixed term contracts, as well as the wider issues of job security where services are frequently going through tender processes, and for those employed within smaller third sector organisations.

Recommendation 2: National guidance to commissioners on the impact of short-term temporary contracts on retention and sustainability of the PWP role.

3. Patient Complexity

Many PWPs and stakeholders highlighted issues in relation to patient complexity: IAPT services have been developed in relation to an extensive evidence base, and this should be utilised in relation to assessing patient complexity regarding whether a person requires a more complex intervention, and therefore to be stepped up to other services, or whether the step 2 low intensity interventions is right. Services must ensure that the appropriate problem statement and case formulation through timely and appropriate supervision are in place to ensure that the PWP is equipped to 'keep it simple' and work safely where the individual is presenting with more complexity than the original step 2 model outlined as appropriate for Step 2 interventions.

This links very clearly with the issues raised in terms of the amount of time spent with a patient, the number of sessions they received, and the level of flexibility and creativity in ways of working to ensure that, where PWPS are being asked to work with more complex problems, there is a clear evidence base to this being a different way of working in comparison to their 'standard' caseload. This also means there must be clarity and consistency in relation to step up processes: PWPs work to a bio-psycho-social model which does not necessarily fit with a diagnosis model used within other parts of the system, and pathways must be reviewed to ensure clear engagement on both sides to ensure patients are receiving the best support to meet their needs.

Recommendation 3: Improved understanding and monitoring of the impact and management of the needs of complex patients on patient flow and understood within the wider context of the impact on workforce retention and wellbeing

4. Supervision

The area of supervision is strongly related to the previous area of patient complexity, and one example of good practice is access to a third type of supervision in regards to the management of complex cases, which could be in the form of specialist supervision, but also in relation to the emotional impact of the patient work on the wellbeing of the PWP workforce which has not previously been given the same consideration as within other psychological professions. Based on the responses provided there is clearly large variety in the supervision received by PWPs, and services and commissioners need to ensure the PWP workforce are consistently receiving good quality, regular supervision which meets the needs of this specific role.

Recommendation 4: Standards for PWP supervision in terms of type, frequency and management of complex patients' needs to be monitored, ideally as part of the performance and contract management processes.

5. PWP recruitment

The PWP Undergraduate route has clearly had a very low uptake so far and it is important to first better understand the reasons for this, however, this links closely to the PWP Widening Participation Report undertaken by UCL in terms of the challenges of recruiting a more diverse group of trainee PWPs. This also links to the consideration of the options within services for recruitment into the role, for example, the introduction of an assistant practitioner role within IAPT services may lead to a new workforce group who then eventually progress to the role of PWP (rather than PWP always being the starting point).

Recommendation 5: Routes for recruitment of PWPs without the standard pre-requisite degree should be revisited and alternative routes for training explored, with a view to paying attention to issues of Widening Participation across the workforce.

6. Access to CPD and Further Training

The theme of access to CPD and training was highlighted by both PWP respondents and the wider stakeholders. The responses given clearly demonstrate that there are significant differences in PWPs experiences of this nationally, but it is a clear mandate within the NHS workforce that all qualified health professionals can maintain their skills through access to good quality CPD. Particularly due to the absence of a professional body for the PWP workforce to articulate appropriate timescales and forms of CPD, it is important that standards are clear in relation to this.

Recommendation 6: Clear standards and equitable systems funding for appropriate CPD/inhouse training needs to be part of all IAPT services operational plans and reviewed through contract and performance management monitoring arrangements.

7. Role Perception

It is understood that there is still a lack of wider understanding and knowledge of the PWP role. This has also been identified within the PWP Widening Participation Report and needs to be considered within the work undertaken to promote Mental Health Careers, as well as local services considering how they can work with local communities as well as other health colleagues within both mental and physical health services to improve the knowledge and understanding of the role.

Recommendation 7: A high profile campaign for promotion of the PWP role should be undertaken nationally

8. The PWP Role

As discussed in the themes above, there are some expectations about the linking of PWP and High Intensity Training, with suggestions of quicker and more straight forward routes from one to the other, and High Intensity Training is clearly the most popular next step for PWPs based on the survey responses. However, there are also many comments to suggest that there needs to be stricter adherence to the recommendations of not moving on to high intensity training too soon, and even some suggestions that this should be longer than the recommended 2 years currently in place (while recognising this is not always adhered to, particularly due to the potential for other clinical experience a PWP may have had prior to coming into the role).

There is now an opportunity for the formalisation and recognition of the PWP role as a career and profession in its own right and it is important that this is taken seriously and progressed to change the perception of the PWP role as one that is a 'stepping stone' to High Intensity, instead to a role that is diverse and rewarding, and therefore worth working in for a significant period of time; the success of this formalisation and recognition of the role will depend on national as well as local stakeholders and policy drivers, and it is only when this is achieved that a clearer understanding of the pathway to progress to High Intensity as *one* option for the workforce, rather than the only option, will be achieved.

The recent publication of the IAPT Manual may potentially provide answers to some of the issues raised in terms of more national standardisations for the role, particularly in terms of e.g. the volume of assessment and triage undertaken within the PWP role, but there needs to be clarity as to whether the manual has gone far enough to be explicit in this and if not then more work may be required to have these structures and guidelines more closely in place while retaining individual service flexibility to respond to local need.

It is clear that CPD and appraisal processes are important for the role, particularly in regard to skills development and practitioner autonomy and flexibility, and as such, standards in relation to PWP CPD and appraisals should be explicit for all services. The regulation and accreditation of the workforce is

a long-standing issue and the recent consultation in regard to the regulation of the health care workforce must consider new roles such as that of the PWP to ensure high standards of care and patient safety are prioritised within IAPT services.

Recommendation 8: A national working party should be established to examine the costs and benefits of Regulation of PWP as a profession, and look across the NHS to examples of similar roles where regulation has been achieved – for example in the Healthcare Scientist workforce

9. IAPT Teams

It is clear from the suggestions highlighted in this review that there are some quick wins achievable for IAPT teams in relation to the understanding, integration and respect of the PWP role within IAPT services, in terms of their relationships with other therapy team members, the engagement of managers in supporting the PWP workforce to feel valued within the service and to have their views heard and responded to, and support to develop their links and relationships with other services and therapists as appropriate to the service set up. This is also reflected within the IAPT Manual.

Many of the concerns raised in the report are not necessarily unique to the PWP workforce but rather link to what is already understood as best practice in relation to an engaged and respected workforce, but within busy and pressured environments such as IAPT services, the focus on targets and outputs has altered the balance and focus of the team purposes. It is within the gift of individual services to begin to undertake some of this work to improve the experience of the PWP workforce, as well as the wider workforces that they work alongside and within. NHS England have produced guidance for managers on Building Collaborative Teams which may be a useful resource to consider.

Recommendation 9: Access to leadership training and mentorship schemes for all IAPT managers

References:

Centre for Outcomes Research and Effectiveness University College (October 2017) Project Report to Health Education England: Widening Participation to Psychological Wellbeing Practitioner Training

The National Collaborating Centre for Mental Health (June 2018) The Improving Access to Psychological Therapies Manual

NHS Improving Quality (2014) Integrated Care and Support Pioneers Programme: Building Collaborative Teams A workshop guide for service managers and facilitators. Bringing teams together to deliver joined up care for people who use care and support services